IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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June 16, 2017

Sheryl Rickard, Administrator
Bonner General Hospital Home Health
520 N 3rd Ave
Sandpoint, ID 83864

RE: Bonner General Hospital Home Health, Provider #137032

Dear Ms. Rickard:

This is to advise you of the findings of the Medicare/Licensure survey at Bonner General Hospital Home Health, which was concluded on June 8, 2017.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health agency into compliance, and that the home health agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **June 29, 2017**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, comments or concerns, please contact Dennis Kelly, R.N. or Nicole Wisenor, Co-Supervisors, Non- Long Term Care at (208) 334-6626, option 4.

Sincerely,

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137032	A. BUILDING ______ B. WING ______	06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNER GENERAL HOSPITAL HOME HEALTH	520 N 3RD AVE SANDPOINT, ID 83864

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G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency conducted on 6/05/17 to 6/08/17. Surveyors conducting the survey were: Nancy Bax, RN, BSN, HFS, Team Leader Brian Osborn, RN, HFS Acronyms used in this report include: ASHD - Arteriosclerotic Heart Disease CKD - Chronic Kidney Disease COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus DME - Durable Medical Equipment EMR - Electronic Medical Record ID - Identification Number MSW - Medical Social Worker OASIS - Outcome and Assessment Information Set OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy RN - Registered Nurse ROC - Resumption of Care SN - Skilled Nurse SOC - Start of Care ST - Speech Therapy	G 000	RECEIVED JUN 29 2017 FACILITY STANDARDS	
G 102	484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.	G 102	Response to G 102: This has been corrected by Home Care Manager (see attachment A). Form was put into use on 06/09/17. Monitor and tracking will be completed by Home Care Health Unit Coordinators with results reported to Bonner General Health Regulatory and Clinical Practice Specialist Quarterly to ensure continued compliance with 484.10(a)(1)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheryl L Rickard — TITLE: CEO — (X6) DATE: 6/26/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 102	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patients were provided a written notice of patients' rights in advance of furnishing care to the patient for 11 of 11 patients (#1 - #6 and #8 - #12) whose records were reviewed. Failure to meet this requirement had the potential to result in patients not being aware of all their rights. Findings include: Each patient record reviewed included a form titled "ADMISSION CONSENT." The form included "PATIENT RIGHTS & RESPONSIBILITIES I acknowledge receipt of my rights and responsibilities as a patient (including OASIS rights) and I understand them. The State home health hotline number, its purpose and hours of operation have been provided and explained to me..." The top of the form had spaces for the patient's name, ID number, and date. The bottom of the form had a space for the signature of the patient or patient representative. However, the form did not include a space to document the date of the patient/representative signature. The consent forms in the 11 records reviewed did not include a date the consent form was signed. It could not be determined if the form was signed prior to the initiation of care. During an interview on 6/08/17 at 11:15 AM, the Manager reviewed the agency's admission consent form. She confirmed the form did not include a space to document the date of the patient/representative signature. The agency failed to ensure patients were provided written notice of rights prior to the	G 102		

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G 102	Continued From page 2 initiation of home health services.	G 102		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on medical record review and staff interview it was determined the agency failed to ensure coordination of care between disciplines occurred for 2 of 4 patients (#4 and #12) who received aide services and whose records were reviewed. This interfered with quality, safety, and continuity of patient care. Findings include: 1. Patient #4 was a 70 year old female admitted to the agency on 11/27/16, with a primary diagnosis of hemiplegia. Additional diagnoses included neuropathy, DM Type II, and chronic pain. She received PT, OT, and aide services. Her record, including the POCs, for the certification periods 3/27/17 to 5/25/17, and 5/26/17 to 7/24/17, was reviewed. Patient #4's record for the certification period 3/27/17 to 5/25/17, did not include SN visit notes. She received PT, OT, and aide services. Aide visit notes included documentation of "Observations reported to the Nurse" and "Comments." Examples include: - 4/06/17 - "Decreased energy level, Weakness or Unsteadiness...Client complained of insomnia. Stomach looks bloated."	G 143	Response to G 143: Education completed on 06/22/17 by Home Care Manager with Home Care Clinical Staff in attendance. (See attachment 1.) Follow up education completed on 06/26/17 (see attachment 2.) Process of Coordination of Care, reporting and documentation of observations revised, record to include name of clinician involved in collaboration. Education and monitoring will ensure staff compliance with 484.14(g). This will be monitored and tracked by Home Care Clinical Team through audits with results reported monthly to Bonner General Health Regulatory and Clinical Practice Specialist to ensure compliance with 484.14(g).	

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G 143	Continued From page 3	G 143		

- 4/21/17 - "Change in Pain, Swelling, Weakness or Unsteadiness, Decreased energy level...Client swelling in stomach - legs and feet."

- 4/24/17 - Weakness or Unsteadiness, Decreased energy level...Swollen stomach."

- 5/05/17 - "New Pain, Weakness or Unsteadiness, Decreased energy level...Client complained of severe pain in both feet."

- 5/19/17 - "Change in Pain, Swelling, Weakness or Unsteadiness, Decreased energy level...Patient is constipated. Stomach was distended and bloated. She stated she was very uncomfortable so suggested she call her doctor. Patient also stated her feet hurt."

- 5/22/17 - "New Pain, constipation, Swelling, Weakness or Unsteadiness, Decreased energy level...Client is bloated and constipated also states her feet hurt."

It could not be determined what nurse received the reports from the aide. Patient #4's record did not include documentation from a nurse or a therapist regarding the reports from the aide.

The Aide who wrote the notes and the Manager were interviewed together on 6/07/17 at 3:40 PM The Aide stated she did not know SN had ended services prior to the certification period beginning on 3/27/17. She stated she thought every patient had an RN Case Manager and she had never contacted a therapist to report a patient's change in condition. The Aide stated the aide note in the EMR had a field titled "Observations reported to the Nurse." She stated she entered information

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G 143	Continued From page 4	G 143		

into that field and the information went directly to the RN Case Manager.

During the interview, the Manager confirmed Patient #4 did not have an RN Case Manager for the certification period 3/27/17 to 5/25/17. She stated the Physical Therapist took over as case manager after SN services were discontinued. Additionally, she stated the comments entered into the "Observations reported to the Nurse" field were not automatically sent to the case manager. She stated the case managers reviewed the aide notes every 2 weeks when they completed the aide supervision visits. The Manager confirmed aide supervision visits for Patient #4 were not completed between 3/27/17 and 6/05/17.

During an interview on 6/08/17 at 3:05 PM, the Physical Therapist confirmed she took over as Patient #4's Case Manager when SN services were discontinued prior to the certification period beginning 3/27/17. She stated she did not realize she was responsible to supervise the aide after SN services were discontinued. She confirmed she did not complete an aide supervision note between 3/27/17 and 6/05/17. The Physical Therapist stated she did not read Patient #4's aide notes and was not aware of the changes in her condition.

The agency failed to ensure communication occurred between Patient #4's Physical Therapist and her aide.

2. Patient #12 was a 91 year old male admitted to the agency on 1/02/17, for care of his urinary catheter. Additional diagnoses included DM Type II, CKD, and localized edema. He received SN and aide services. His record, including the

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G 143	Continued From page 5 POCs, for the certification periods 3/03/17 to 5/01/17, and 5/02/17 to 6/30/17, was reviewed. Patient #12's record included an aide visit note dated 3/03/17, signed by the aide. The note documented cloudy urine. The field titled "Observations reported to the Nurse" stated "Nothing unusual to report." There was no documentation stating the observation was reported to the RN Case Manager. Patient #12's record included an aide visit note dated 3/29/17, signed by the aide. The note documented Patient #12's urine had a strong smell. The field titled "Observations reported to the Nurse" stated "Decreased energy level, Weakness or Unsteadiness." There was no documentation stating the observation was reported to the RN Case Manager. Patient #12's record included an aide visit note dated 4/04/17, signed by the aide. The note documented Patient #12's legs and feet were swollen. The field titled "Observations reported to the Nurse" stated "Weakness or Unsteadiness." There was no documentation stating Patient #12's swelling was reported to the RN Case Manager. The Aide who completed the visit notes was interviewed on 6/07/17 at 4:20 PM. She confirmed she did not report the changes in Patient #12's condition to the RN Case Manager. The agency failed to ensure communication occurred between Patient #12's RN Case Manager and her aide.	G 143		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC,	G 158	See next page please for Response to G 158	

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G 158	Continued From page 6 MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care followed a physician's order and written POC for 1 of 8 patients (Patient #9) who received SN services and whose records were reviewed. This resulted in the potential for omissions of care and unmet patient needs. Findings include: Patient #9 was an 80 year old female admitted to the agency on 5/05/17, with a primary diagnosis of heart failure. Additional diagnoses included pleural effusion and atrial fibrillation. She received SN and PT services. Her record, including the POC, for the certification period 5/05/17 to 7/03/17, was reviewed. Patient #9's record included an order dated 5/08/17, for a BMP (Basic Metabolic Panel) laboratory test to be completed on the first Monday of every month. The first Monday of June was 6/05/17. Patient #9's record included an SN visit note dated 5/31/17. The note stated a BMP laboratory test was completed during the visit. There was no documentation stating why the test was completed 5 days early. During an interview on 6/07/17 at 3:00 PM, the Manager reviewed Patient #9's record and confirmed the laboratory test was not completed on 6/05/17 as ordered. She was unable to explain why it was completed 5 days early.	G 158	Response to G 158: Education completed on 06/22/17 by Home Manager (See attachment 1.) See Physicians Order Home Care Policy (attachment B) and Plan Of Care Policy (attachment C.) Education and monitoring will ensure staff compliance with 484.18 with consistent awareness. Audits will be completed by Clinical and non-clinical Home Care Staff monthly and prior to claim release. Results of monitoring will be reported to Bonner General Health Regulatory and Clinical Practice Specialist for monitoring and tracking monthly.	

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G 158	Continued From page 7 The agency failed to ensure Patient #9's laboratory test was completed as ordered.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure POCs included all pertinent interventions for 2 of 11 patients (#4 and #5) whose records were reviewed. This had the potential to result in unmet patient needs and adverse patient outcomes. Findings include: 1. Patient #4 was a 70 year old female admitted to the agency on 11/27/16, with a primary diagnosis of hemiplegia. Additional diagnoses included neuropathy, DM Type II, and chronic pain. She received PT, OT, MSW, and aide services. Her record, including the POCs, for the certification periods 3/27/17 to 5/25/17, and 5/26/17 to 7/24/17, was reviewed. Patient #4's record included a recertification assessment dated 3/24/17, signed by the Physical Therapist. The assessment stated	G 159	Response to G 159: Education completed 06/22/17 by Home Care Manager (see attachment 1.) See Plan of Care (attachment C.) Pressure Ulcer Prevention Protocol Policy (attachment D) was revised 06/09/17 and education completed on 06/22/17 by Home Care Manager. Education along with monitoring will sustain awareness and compliance of 484.18(a). Monthly audits will be completed by clinical and non-clinical staff with results reported to Bonner General Health Regulatory and Clinical Practice Specialist monthly for tracking.	

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G 159	Continued From page 8 Patient #4 complained of pain that ranged from 8 to 9, on a scale of 0 to 10, with 10 being the worst pain. It stated she had pain all of the time. Patient #4's POC for the certification period 5/26/17 to 7/24/17, did not include interventions to monitor or address her pain. During an interview on 6/08/17 at 3:05 PM, the Physical Therapist reviewed Patient #4's POC and confirmed it did not include interventions to monitor or address her pain. Patient #4's POC did not include interventions to address her pain. 2. Patient #5 was a 91 year old male admitted to the agency on 5/05/17, with a primary diagnosis of localized edema. Additional diagnoses included heart failure and COPD. He received SN, PT, and OT services. His record, including the POC, for the certification period 5/05/17 to 7/03/17, was reviewed. Patient #5's record included an SOC assessment dated 5/05/17, signed by the RN Case Manager. The assessment included a Braden Scale. The Braden Scale is a validated tool used by nurses to evaluate a patient's risk of developing a pressure ulcer. The total score can range from 6 to 23 with a lower score indicating a higher risk. Patients scoring 18 or less are considered to be at risk of developing a pressure ulcer. Patient #5's score was 16, indicating risk of pressure ulcer development. Patient #5's POC did not include interventions to prevent pressure ulcers. During an interview on 6/06/17 at 8:30 AM, the Manager reviewed Patient #5's record and confirmed his POC did not include interventions	G 159		

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G 159	Continued From page 9 to prevent pressure ulcers. Patient #5's POC did not include interventions related to his risk of pressure ulcer development.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure RN staff promptly alerted the physician to changes in patient conditions for 2 of 8 patients (#2 and #9) who received SN services and whose records were reviewed. This had the potential to interfere with physician updates to plans of care and to negatively impact safety and quality of patient care. Findings include: 1. Patient #9 was an 80 year old female admitted to the agency on 5/05/17, with a primary diagnosis of heart failure. Additional diagnoses included pleural effusion and atrial fibrillation. She received SN and PT services. Her record, including the POC, for the certification period 5/05/17 to 7/03/17, was reviewed. Patient #9's POC included a goal to maintain a stable weight. Her SOC assessment, completed on 5/05/17, signed by her RN Case Manager, stated her weight was 120 pounds. Her record included an SN visit note dated 5/11/17, signed by her RN Case Manager. The note stated her weight was 118 pounds. Patient #9's record	G 164	Response to G 164: Education completed with staff on 06/22/17 (see attachment 1) by Home Care Manager. Plan of Care Policy education (see attachment C) completed on 06/22/17 by Home Care Manager. Education focused on notifying physician with change of condition, process of documentation of notification in Electronic Medical Record defined by clinical team. Measures implemented on 06/22/17 with results to be monitored by Home Care Clinical staff through monthly audit process to maintain awareness and compliance with 484.18(b). Results of audits will be reported to Bonner General Health Regulatory and Clinical Practice Specialist for monitoring and tracking monthly.	

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G 164	Continued From page 10	G 164		

included an SN visit note dated 5/16/17, signed by her RN Case Manager. The note stated her weight was 114 pounds, indicating a weight loss of 6 pounds, which was 5% of her body weight, in 11 days. There was no documentation stating Patient #9's physician was notified of her weight loss.

During an interview on 6/08/17 at 10:35 AM, the RN Case Manager reviewed Patient #9's record. He stated he did not report Patient #9's weight loss to her physician.

The RN Case Manager failed to report a change in Patient #9's status to her physician.

2. Patient #2 was an 83 year old male admitted to the agency on 5/14/17, with a primary diagnosis of femoral nerve lesion. Additional diagnoses included pain in the right leg, DM Type II, and muscle weakness. He received SN, PT, OT, and aide services. His record, including the POC, for the certification period 5/14/17 to 7/12/17, was reviewed.

Patient #2's record included an SN visit note dated 5/30/17, signed by the RN Case Manager. The note stated "reports that he helped out during a transfer today with his left leg and pulled something in his knee and it is 'hurting like the devil now.'" The note documented his pain as 3 at rest and 7 when transferred to bed, on a scale of 0 to 10 with 10 being the worst pain. There was no documentation stating Patient #2's physician was notified of his injury and pain.

During an interview on 6/08/17 at 9:30 AM, the RN Case Manager stated Patient #2's physician was not notified of the change in his condition.

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G 164	Continued From page 11 The RN Case Manager failed to report a change in Patient #2's status to her physician.	G 164		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure treatments were administered only as ordered by the physician for 2 of 5 patients (#3 and #10) who received wound care and whose records were reviewed. This resulted in unauthorized treatments, and had the potential to negatively impact the safety and quality of patient care. Findings include: 1. Patient #3 was an 85 year old male admitted to the agency on 3/24/17, with a primary diagnosis of pelvic fracture. Additional diagnoses included history of falling, DM Type II, and CKD. He received SN and PT services. His record, including the POCs, for the certification periods 3/24/17 to 5/22/17, and 5/23/17 to 7/21/17, was reviewed. Patient #3's record included an SN visit note dated 4/14/17, signed by an RN. The note stated new stage 2 pressure ulcers were identified on his right and left heel. The note stated the wounds were cleansed with wound cleanser, a protective film was applied around the wounds, and they were covered with foam dressings. Patient #3's record did not include a physician's	G 165	Response to G 165: Education completed on 06/22/17 by Home Care Manager (see attachment 1.) See Physicians Order Home Care Policy Attachment B) and Plan of Care Policy Please (see attachment C) Process of contacting MD office for Verbal Order prior to providing care in cases where MD has not responded to previous order request reviewed. Education and monitoring will ensure staff compliance with 484.18(c) with consistent awareness. Audits will be completed by clinical and non-clinical Home Care Staff monthly and prior to claim release. Results of audits will be reported to Bonner General Health Regulatory and Clinical Practice Specialist for monitoring and tracking monthly.	

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G 165	Continued From page 12	G 165		

order for the wound care provided on 4/14/17.

During an interview on 6/08/17 at 10:00 AM, the RN who completed the visit stated she sent a request for wound care orders to Patient #3's physician on 4/14/17, and it was signed by the physician on 4/17/17. She confirmed wound care was provided to Patient #3 on 4/14/17 without a physician's order.

Wound care was provided to Patient #3 without a physician's order.

2. Patient #10 was a 67 year old male admitted to the agency on 4/30/17, with a primary diagnosis of DM Type I. Additional diagnoses included pressure ulcers to the right and left heels and CKD. He received SN, PT, and OT services. His record, including the POC, for the certification period 4/30/17 to 6/28/17, was reviewed.

Patient #10's POC included diagnoses of pressure ulcers to both heels. However, his POC did not include orders for wound care to the pressure ulcers. Patient #10's record included an order for wound care, signed by his physician on 5/09/17.

Patient #10's record included an SOC assessment dated 4/30/17, signed by an RN. The note stated wound care was provided during the visit. SN visit notes dated 5/05/17 and 5/08/17, signed by the RN Case Manager, stated wound care was provided.

During an interview on 6/08/17 at 11:30 AM, the Manager reviewed Patient #10's record and confirmed wound care was provided during 3 SN visits, prior to receiving physician orders for

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G 165	Continued From page 13 wound care. Wound care was provided to Patient #10 without a physician's order.	G 165		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure the SN comprehensively re-evaluated the nursing needs for 2 of 8 patients (#2 and #11) who received SN services and whose records were reviewed. This had the potential to result in unmet patient needs and to negatively impact the quality of patient care. Findings include: 1. Patient #11 was a 72 year old male admitted to the agency on 4/28/16, with a primary diagnosis of lung cancer. Additional diagnoses included pressure ulcer to the left heel and COPD. He received SN, PT, OT, MSW, and aide services. He was discharged on 6/30/16. His record, including the POCs, for the certification periods 4/28/16 to 6/26/16, and 6/26/16 to 8/25/16, was reviewed. Patient #11's POC for the certification period 4/28/16 to 6/26/16, included an order for nutrition and hydration management. His record included an SOC comprehensive assessment dated 4/28/16, signed by the RN. The assessment documented "Loss of appetite." Additionally, it documented an unintentional weight loss of 10	G 172	Response to G 172: Assessment / Reassessment Policy revised on 06/09/17 by Home Care Manager. (see attachment E) Education on revised policies completed on 06/22/17 by Home Care Manager. Revision of policies and staff education will lead to improved staff assessment and patient care. Education and clinical staff monthly audit for compliance will lead to increased focus, compliance with 484.30(a). Audits will be completed by clinical staff monthly. Results of audits will be reported to and tracked by Bonner General Health Regulatory and Clinical Practice Specialist monthly.	

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G 172	Continued From page 14 pounds or more the the past 12 months. Patient #11's record included a case conference note dated 5/05/17, signed by an RN. The note stated "Patient is starting [chemotherapy], he is very weak, poor appetite...Trying to get someone in to help with nutrition..." Patient #11's SOC assessment completed on 4/28/17, stated his weight was 173 pounds. SN visit notes dated 5/02/17 and 5/05/17, documented loss of appetite, but did not document his current weight. The notes did not include documentation of his food and fluid intake, to determine his nutrition and hydration status. Patient #11's record stated he was admitted to the hospital on 5/10/17. During an interview on 6/08/17 at 10:50 AM, the RN who completed the SN visits on 5/02/17 and 5/05/17, reviewed Patient #11's record. He confirmed there was no documentation of his weight or his nutrition and hydration status on the 2 SN visits. The RN failed to evaluate Patient #11's nutrition and hydration status. 2. Patient #2 was an 83 year old male admitted to the agency on 5/14/17, with a primary diagnosis of femoral nerve lesion. Additional diagnoses included pain in the right leg, DM Type II, and muscle weakness. He received SN, PT, OT, and aide services. His record, including the POC, for the certification period 5/14/17 to 7/12/17, was reviewed. The agency's policy, "Ulcer Assessment & Documentation Guidelines for Home Health," effective 3/24/08, stated "E-Z Graph/full wound	G 172		

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G 172	Continued From page 15 assessment to be documented on existing wounds weekly until fully healed." Patient #2's record included an order for wound care to 3 stage 2 pressure ulcers on his buttocks and to a skin tear on his right lower leg. His record included SN visit notes with wound assessment and measurements documented on 3/22/17, and 2 weeks later on 4/05/17. No wound measurements were documented during the week of 5/28/17. During an interview on 6/08/17 at 9:30 AM, the RN Case Manager reviewed Patient #2's record and confirmed a wound assessment with measurements was not documented during the week of 5/28/17. The RN failed to assess Patient #2's wounds weekly as required by agency policy.	G 172		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure RNs appropriately prepared clinical notes for 2 of 8 of patients (#3 and #5) who received SN services and whose records were reviewed. This failure resulted in a lack of clarity as to the course of patient care. Findings include:	G 176	Response to G 176: Assessment and Reassessment Policy (see attachment F) was revised by Home Care Manager on 06/09/17 with education provided to Home Care Staff by Home Care Manager on 06/22/17. Process for inclusion of previous medical history defined and included in education 06/22/17. Process for documentation of all care provided each visit reviewed during staff meeting on 06/22/17 (see attachment 1). Revised policy and defined process improvements to ensure compliance with 484.30 (a). Compliance with revised policy / process will be monitored by clinical staff through monthly audits. Results will be reported to Bonner General Health Regulatory and Clinical	

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G 176	Continued From page 16 1. Patient #3 was an 85 year old male admitted to the agency on 3/24/17, with a primary diagnosis of pelvic fracture. Additional diagnoses included history of falling, DM Type II, and CKD. He received SN and PT services. His record, including the POCs, for the certification periods 3/24/17 to 5/22/17, and 5/23/17 to 7/21/17, was reviewed. Patient #3's record included an SOC comprehensive assessment, completed on 3/24/17, and signed by the RN Case Manager. It included an assessment of his current condition. However, it did not include documentation of Patient #3's prior medical history or the reason he was receiving home health services. It could not be determined why home health services were necessary. During an interview on 6/08/17 at 10:15 AM, the RN Case Manager reviewed the SOC assessment and stated he did not document Patient #3's prior medical history or current need for home health services. Patient #3's RN Case Manager failed to document all pertinent information. 2. Patient #5 was a 91 year old male admitted to the agency on 5/05/17, with a primary diagnosis of localized edema. Additional diagnoses included heart failure and COPD. He received SN, PT, and OT services. His record, including the POC, for the certification period 5/05/17 to 7/03/17, was reviewed. Patient #5's record included an order dated 5/05/17, for a serum potassium level. His record did not include documentation stating the blood	G 176	Continued response for G 176: Practice Specialist for tracking of compliance with this standard.	

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G 176	Continued From page 17 test was completed. During an interview on 6/06/17 at 8:30 AM, the RN Case Manager reviewed Patient #5's record. He stated the record included laboratory results showing the blood test was completed on 5/09/17. He confirmed he did not document the collection of blood for the laboratory test. Patient #5's RN Case Manager failed to document the collection of blood for the physician ordered laboratory test.	G 176		
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the home health aide provided services in accordance with physician orders and the aide POC for 2 of 4 patients (#4 and #12) who received home health aide services and whose records were reviewed. This had the potential to interfere with the safety and quality of patient care. Findings include: 1. Patient #4 was a 70 year old female admitted to the agency on 11/27/16, with a primary diagnosis of hemiplegia. Additional diagnoses included neuropathy, DM Type II, and chronic pain. She received PT, OT, MSW, and aide services. Her record, including the POCs, for the	G 225	Response to G 225: Home Care staff were educated on 06/22/17 by Home Care Manager (see attachment 1); 484.36(c)(2) was reviewed. Process of Assignment, Plan of Care, Physician Orders, on site Supervisory visits every 14 days, and documentation reviewed. Collaboration of care, process for communication, reporting and documentation defined. Home Health aide focused education completed on 06/26/17 with all Home Health aides (see attachment 2.) Education will improve compliance with 484.36(c)(2). Monthly Home Care staff audits will ensure sustained focus. Audit results will be reported monthly to Bonner General Health Regulatory and Clinical Practice Specialist for monitoring and tracking of compliance with 484.36(c)(2).	

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G 225	Continued From page 18 certification periods 3/27/17 to 5/25/17, and 5/26/17 to 7/24/17, was reviewed. Patient #4's record included documentation of aide visits on 5/26/17 and 5/30/17. Her POC for the certification period 5/26/17 to 7/24/17, did not include an order for aide visits. During an interview on 6/08/17 at 3:05 PM, the Physical Therapist confirmed there were no orders for aide visits for the certification period 5/26/17 to 7/24/17. Aide visits were provided to Patient #4 without a physician's order. 2. Patient #12 was a 91 year old male admitted to the agency on 1/02/17, for care of his urinary catheter. Additional diagnoses included DM Type II, CKD, and localized edema. He received SN and aide services. His record, including the POCs, for the certification periods 3/03/17 to 5/01/17, and 5/02/17 to 6/30/17, was reviewed. Patient #12's record included a home health aide care plan dated 1/02/17, signed by the RN Case Manager. The care plan did not include instructions for the aide to assist with catheter care or empty his urine collection bag. Aide visit notes dated 3/08/17, 3/17/17, 3/22/17, 3/24/17, 3/29/17, 4/07/17, 4/14/17, and 4/21/17, documented the aide provided assistance with catheter care, including emptying the collection bag. During an interview on 6/07/17 at 4:20 PM, the Aide confirmed she provided catheter care to Patient #12. Additionally, she confirmed catheter care was not included on Patient #12's aide care	G 225		

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G 225	Continued From page 19 plan. The agency failed to ensure care provided by Patient #12's aide followed the written aide care plan.	G 225		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure on-site home health aide supervisory visits were conducted by an RN or qualified therapist at least every 2 weeks for 2 of 4 patients (#4 and #12), who received home health aide services and whose records were reviewed. This had the potential to prevent the agency from identifying and correcting substandard care by home health aides. Findings include: 1. Patient #4 was a 70 year old female admitted to the agency on 11/27/16, with a primary diagnosis of hemiplegia. Additional diagnoses included neuropathy, DM Type II, and chronic pain. She received PT, OT, MSW, and aide services. Her record, including the POCs, for the certification periods 3/27/17 to 5/25/17, and 5/26/17 to 7/24/17, was reviewed. Patient #4's printed record was requested and provided on 6/05/17. It included documentation of aide visits 2 times a week from 3/28/17 to	G 229	Response to G 229: Home Care staff were educated on 06/22/17 by Home Care Manager (see attachment 1); was reviewed for compliance 484.36(d)(2). Process of assignment, Plan of Care, Physician Orders, on site Supervisory visits every 14 days, and documentation reviewed. Collaboration of care, process for communication, reporting and documentation defined. Home Health aide focused education completed on 06/26/17 (see attachment 2) with all Home Health aides. Education will improve compliance with 484.36(d)(2). Monthly Home Care staff audits will ensure sustained focus. Audit results will be reported monthly to Bonner General Health Regulatory and Clinical Practice Specialist for monitoring and tracking of compliance with 484.36(d)(2).	

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G 229	Continued From page 20 5/30/17. Her record included aide supervision notes dated 4/04/17 and 4/19/17. The 2 notes were signed by the Physical Therapist on 6/05/17. No additional aide supervision notes were present in Patient #4's printed record. During an interview on 6/08/17 at 3:05 PM, the Physical Therapist stated she was not aware she was responsible for supervising the aide after the RN discontinued SN visits. She stated she completed the supervision visit notes on 6/05/17 when she realized she had missed them. The Physical Therapist confirmed on-site aide supervision visits were not completed for Patient #4 from 3/28/17 to 5/30/17. The agency failed to ensure Patient #4's aide was supervised every 2 weeks. 2. Patient #12 was a 91 year old male admitted to the agency on 1/02/17, for care of his urinary catheter. Additional diagnoses included DM Type II, CKD, and localized edema. He received SN and aide services. His record, including the POCs, for the certification periods 3/03/17 to 5/01/17, and 5/02/17 to 6/30/17, was reviewed. Patient #12's record included an aide supervision note dated 3/13/17, signed by the RN. No further aide supervision visits were documented in the 7 week period between 3/13/17 and 5/01/17, the end of the certification period. During an interview on 6/08/17 at 10:10 AM, Patient #12's RN Case Manager confirmed aide supervision visits were not performed between 3/13/17 and 5/01/17. The agency failed to ensure Patient #12's aide	G 229		

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G 229	Continued From page 21 was supervised every 2 weeks.	G 229		
G 322	484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure encoded OASIS data was accurate at the time of the assessment for 2 of 11 patients (#3 and #10) whose records were reviewed. This resulted in the reporting of inaccurate OASIS data. Findings include: 1. Patient #3 was an 85 year old male admitted to the agency on 3/24/17, with a primary diagnosis of pelvic fracture. Additional diagnoses included history of falling, DM Type II, and CKD. He received SN and PT services. His record, including the POCs, for the certification periods 3/24/17 to 5/22/17, and 5/23/17 to 7/21/17, was reviewed. Patient #3's record included an SOC comprehensive assessment, completed on 3/24/17, and signed by the RN Case Manager. The assessment included a Braden Scale. The Braden Scale is a validated tool used by nurses to evaluate a patient's risk of developing a pressure ulcer. The total score can range from 6 to 23 with a lower score indicating a higher risk. Patients scoring 18 or less are considered to be at risk of developing a pressure ulcer. Patient #3's score was 17, indicating risk of pressure ulcer development.	G 322	Response to G322: Pressure Ulcer Prevention Protocol policy use revised on 06/09/17 by Home Care Manager (see attachment D.) Home Care staff were educated on revised policy on 06/22/17. (see attachment 1) Revised policy supports Braden Scale Risk protocol. Education of Oasis documentation process reviewed on 06/22/17. Revised policy and education will support compliance with 484.20(b) standard. Monthly audits will be completed by clinical staff to monitor compliance with results reported monthly to Bonner General Health Regulatory and Clinical Practice Specialist to monitor and track compliance with this standard.	

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G 322	Continued From page 22	G 322		

Patient #3's SOC assessment included an OASIS assessment. OASIS item M1302, asked if Patient #3 was at risk of developing pressure ulcers. It was answered "yes." OASIS item 2250(f) asked if the physician-ordered plan of care included interventions to prevent pressure ulcers. It was answered "not applicable" and stated a pressure ulcer risk assessment indicated Patient #3 was not at risk of developing pressure ulcers.

During an interview on 6/08/17 at 10:00 AM, the Manager reviewed Patient #3's SOC assessment and confirmed OASIS item M2250(f) was answered inaccurately.

Patient #3's SOC OASIS assessment was not accurate to reflect his risk of pressure ulcer development.

2. Patient #10 was a 67 year old male admitted to the agency on 4/30/17, with a primary diagnosis of DM Type I. Additional diagnoses included pressure ulcers to the right and left heels and CKD. He received SN, PT, and OT services. His record, including the POC, for the certification period 4/30/17 to 6/28/17, was reviewed.

Patient #10's record included an SOC comprehensive assessment, including OASIS items, completed on 4/30/17, signed by the RN. OASIS item M1000 asked "From which of the following Inpatient Facilities was the patient discharged within the past 14 days?" Patient #10's assessment stated he was discharged from the hospital and admitted to a skilled nursing facility on 4/15/17, 15 days prior to the admission to the home health agency. However, M1000 was answered "Patient was not discharged from

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 322	Continued From page 23 an inpatient facility." During an interview on 6/08/17 at 11:30 AM, the Manager reviewed Patient #10's record. She stated he was discharged from the skilled nursing facility within 14 days prior to his home health admission. The Manager confirmed M1000 was answered incorrectly. Patient #10's SOC OASIS assessment was not accurate to reflect his discharge from a skilled nursing facility.	G 322		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001060	A. BUILDING: ____ B. WING ____	06/08/2017

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey of your agency conducted on 6/05/17 to 6/08/17. Surveyors conducting the survey were: Nancy Bax, RN, BSN, HFS, Team Leader Brian Osborn, RN, HFS	N 000	RECEIVED JUN 29 2017 FACILITY STANDARDS	
N 016	03.07020. ADMIN. GOV. BODY N016 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: b. A patient has a right to be informed of his rights and has a right to be notified in writing of his rights and obligations before treatment is begun. HHAs must provide each patient and family with a written copy of the bill of rights. A signed, dated copy of the patient's bill of rights will be included in the patient's medical record. This Rule is not met as evidenced by: Refer to G102	N 016	This has been corrected by Home Care Manager (see attachment A) form was put into use on 06/09/17. Monitor and Tracking will be completed by Home Care Health Unit Coordinators with results reported to Bonner General Health Regulatory and Clinical Practice Specialist quarterly to ensure continued compliance.	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences	N 062	Education Completed on 06/22/17 with Home Care Clinical Staff (see attachment 1.) Follow up education completed on 06/26/2017 (see attachment 2.) Process of coordination of care, reporting and documentation of observations revised, record to include name of clinician involved in collaboration. Education and monitoring will	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheryl L Rickard   TITLE: CEO   (X6) DATE: 6/26/2017

Bureau of Facility Standards

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N 062	Continued From page 1 establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G143	N 062	ensure staff compliance with 484.14(g). This will be monitored and tracked by Home Care Clinical Team through audits with results reported monthly to Bonner General Health Regulatory and Clinical Practice Specialist to ensure compliance.	
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to G172	N 093	Assessment / Reassessment Policy revised on 06/09/17 by Home Care Manager. (see attachment E), Education on revised policies completed on 06/22/17 by Home Care Manager. Revision of policies and staff education will lead to improved staff assessment and patient care. Education and clinical staff monthly audit for compliance will lead to increased focus, compliance with 484.30(a). Audits will be completed by clinical staff monthly. Results of audits will be monitored to and tracked by Bonner General Health Regulatory and Clinical Practice Specialist monthly.	
N 097	03.07024. SK. NSG. SERV. N097 01.Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: e. Prepares clinical and progress notes, and summaries of care; This Rule is not met as evidenced by:	N 097	Assessment / Reassessment policy (see attachment F) was revised by Home Care Manager on 06/09/17 with education provided to Home Care Staff by Home Care Manager on 06/09/17 with education provided to Home Care Staff by Home Care Manager on 06/22/17. Process for inclusion of previous medical history defined and included in education 06/22/17. Process for documentation of all care provided each visit reviewed during staff meeting on 06/22/17 (see attachment 1) revised policy and defined process improvements to ensure compliance with 484.30(a). Compliance with revised policy / process will be monitored by clinical staff through monthly audits. Results will be reported to Bonner General Health Regulatory and Clinical Practice Specialist for monitoring and tracking of compliance with this standard.	

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N 097	Continued From page 2 Refer to G176	N 097		
N 119	03.07024.04.SK.NSG.SERV. N119 04. Supervisory Visits. A registered nurse or therapist makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days. This Rule is not met as evidenced by: Refer to G229	N 119	Home Care staff were educated on 06/22/2017 by Home Care Manager (see attachment 1); 484.36(d)(2) was reviewed for compliance. Process of assignment, Plan of Care, Physician Orders, on site Supervisory visits every 14 days, and documentation reviewed. Collaboration of care, process for communication, reporting and documentation defined. Home Health aide focused education completed on 06/26/2017 (see attachment 2)with all Home Health aides. Education will improve compliance with 484.36(d)(2). Monthly Home Care staff audits will ensure sustained focus. Audit results will be reported monthly to Bonner General Health Regulatory and Clinical Practice Specialist monitoring and tracking of compliance with 484.36(d)(2).	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G158	N 152	Education completed on 06/22/17 by Home Care Manager (see attachment 1.) See Physicians Order Home Care Policy (see attachment B) and Plan of Care Policy (see attachment C.) Education and monitoring will ensure staff compliance with 484.18 with consistent awareness. Audits will be completed by Clinical and non-clinical Home Care staff monthly and prior to claim release. Results of Monitoring will be reported to Bonner General Health Regulatory and Clinical Practice Specialist for monitoring and tracking monthly.	
N 161	03.07030.PLAN OF CARE N161 01. Written Plan of Care. A written plan of care shall be developed and implemented for each	N 161	Education completed on 06/22/17 by Home Care Manager (see attachment 1.) See Plan of Care (attachment C.) Pressure Ulcer Prevention Protocol Policy (see attachment D) was revised 06/09/17 and education completed on 06/22/17 by Home Care Manager. Education along with	

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N 161	Continued From page 3 patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: i. Medication and treatment orders; This Rule is not met as evidenced by: Refer to G159	N 161	monitoring will sustain awareness and compliance. Monthly audits will be completed by clinical and non-clinical staff with results reported to Bonner General Health Regulatory and Clinical Practice Specialist monthly for tracking.	
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G164	N 172	Education completed with staff on 06/22/17 (see attachment 1) by Home Care Manager. Plan of Care Policy education (see attachment C) completed on 06/22/17 by Home Care Manager. Education focused on notifying physician with change of condition, process of documentation of notification in Electronic Medical Record defined by clinical team. Measures implemented on 06/22/17 with results to be monitored by Home Care Clinical staff through monthly audit process to maintain awareness and compliance. Results of audits will be reported to Bonner General Health Regulatory and Clinical Practice Specialist for monitoring and tracking monthly.	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by:	N 173	Education completed on 06/22/17 by Home Care Manager (see attachment 1.) See Physicians Order Home Care Policy (see attachment B) and Plan of Care Policy (see attachment C.) Process of contacting MD office for Verbal Order prior to providing care in cases where MD has not responded to previous order request reviewed. Education and monitoring will ensure staff compliance with consistent awareness. Audits will be completed by clinical and non-clinical Home Care staff monthly and prior to release. Results of audits will be reported to Bonner General Health Regulatory and Clinical Practice Specialist for monitoring and tracking monthly.	

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N 173	Continued From page 4 Refer to G165	N 173		

RECEIVED
JUL 06 2017
FACILITY STANDARDS

July 5, 2017

Nancy Bax and Dennis Kelly
Health Facility Surveyors
Bureau of Facility Standards
PO Box 83720
Boise, Idaho 83720-0009

Dear Nancy Bax and Dennis Kelly:

This letter is in response to the request for clarification regarding the Written Plan of Correction (X4) ID Prefix Tag G102 for Bonner General Health Home Health. As of June 9, 2017 the agency corrected the deficiency by implementing a new form that includes a space to document the date of the patient/representative signature. As a quality assurance measure effective June 9, 2017, the agency will audit 100% of all Home Health admissions for the remaining year to ensure the consent form includes a date that indicates the form was signed prior to the initiation of care.

The remaining (X4) ID Prefix Tags G143-N173 have been addressed as stated in the Written Plan of Correction through staff education. Compliance for all areas will be monitored by monthly audits that will be completed on a minimum of 10% of the agency's patient census. Our goal is to be 90% compliant in all areas by December 31, 2017.

Sincerely,

Tami L. Feyen
Clinical Manager
Bonner General Home Health