IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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June 30, 2017

Karla Jensen, Administrator
Helping Hands Home Health
2785 Bannock Highway
Pocatello, ID 83204

RE: Helping Hands Home Health, Provider #137102

Dear Ms. Jensen:

On June 23, 2017, a follow-up visit of your facility, Helping Hands Home Health, was conducted to verify corrections of deficiencies noted during the survey of April 6, 2017.

We were able to determine that the Medicare Home Health Agency (HHA) Conditions of Participation of **Patients Rights (42 CFR 484.10), Organization, Services & Administration (42 CFR 484.14) and Evaluation of the Agency's Program (42 CFR 484.52)** are now met.

Also 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 **July 13, 2017**, and keep a copy for your records.

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

Sincerely,

Dennis Kelly RN

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt

Enclosures
ec: Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137102	A. BUILDING _____ B. WING _____	R 06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS HOME HEALTH	2785 BANNOCK HIGHWAY POCATELLO, ID 83204

(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 000}	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification follow-up survey of your agency conducted on 6/23/17. Surveyors conducting the follow-up were: Nancy Bax, RN, BSN, HFS, Team Leader Laura Thompson, RN, BSN, HFS Acronyms used in this report include: POC - Plan of Care SOC - Start of Care	{G 000}		
{G 142}	484.14(f) PERSONNEL HOURLY/PER VISIT CONTRACT If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: (1) Patients are accepted for care only by the primary HHA. (2) The services to be furnished. (3) The necessity to conform to all applicable agency policies, including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA. (6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.	{G 142}	RECEIVED JUL 21 2017 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karla Jensen — TITLE: Administrator — (X6) DATE: 7/13/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137102	A. BUILDING _____ B. WING _____	R 06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS HOME HEALTH	2786 BANNOCK HIGHWAY POCATELLO, ID 83204

(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 142}	Continued From page 1 This STANDARD is not met as evidenced by: Based on review of agency contracts and staff interview, it was determined the agency failed to ensure the contracts utilized for therapy services clearly indicated the services to be furnished and/or the manner in which the services would be evaluated by the agency, for 3 of 3 current contracts. Failure to clearly outline expectations and evaluate services had the potential to impact the quality and coordination of patient care. Findings include: On 6/23/17 at 9:10 AM, the agency Administrator presented 3 contracts the agency utilized for therapy services. The contracts were incomplete, as follows: 1. The 3 contracts did not state how the services provided by the contractor would be evaluated by the home health agency, how the agency ensured the services provided met the terms of the contract, and how the agency ensured care provided was consistent with the POC. 2. The 3 contracts stated the discipline of the contracted individual. The 3 contracts did not specify the types of visits to be performed, such as SOC, patient evaluation, routine visits, and/or supervisory visits. During an interview on 6/23/17 at 10:40 AM, the Administrator confirmed the 3 contracts did not state how contracted services would be evaluated by the agency. She confirmed the 3 contracts did not specify the types of visits that would be furnished under the contract. The agency failed to ensure contracts for therapy	{G 142}	G 142 Person Responsible: Administrator Plan of Correction: Contract was modified to include the following: 1. Services provided by the contractor will be evaluated by the therapy manager, weekly, to ensure that the care being given is in accordance to the POC. Yearly the IC will be evaluated by the client to ensure the services provided meet the terms of the contract. (see item 11) 2. Contract will include the duties to be performed, job description, types of visits to be performed. All services to include necessary components. (see item 3 and 10) Each action includes the procedure for the plan of correction see Exhibit 1. These steps will improve the process and will clearly specify to the IC what is expected of them. To be completed by: July 14, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137102	A. BUILDING _____ B. WING _____	R 06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS HOME HEALTH	2785 BANNOCK HIGHWAY POCATELLO, ID 83204

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{G 142}	Continued From page 2 services included all necessary components.	{G 142}		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001245	A. BUILDING: _____ B. WING _____	R 06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS HOME HEALTH	2785 BANNOCK HIGHWAY POCATELLO, ID 83204

(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) COMPLETE DATE
{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 Laura Thompson, RN, BSN, HFS	{N 000}		
N 055	03.07021. ADMINISTRATOR N055 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: h. Insuring that if personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: ii. The services that are to be furnished; This Rule is not met as evidenced by: Refer to G142	N 055	RECEIVED JUL 21 2017 FACILITY STANDARDS **N055** Person Responsible: Administrator Plan of Correction: Contract was modified to include all of the services that are to be furnished. See Exhibit 1, section #3 and #10 These steps will improve the process and will Clearly specify to the IC what is expected of them. To be completed by: July 14, 2017	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karla Jensen — TITLE: Administrator — (X6) DATE: 7/13/2017