IDAHO DEPARTMENT OF HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

May 20, 2008

Karla Jensen
Helping Hands Home Health
1308 East Center
Pocatello, Idaho 83201

RE: Helping Hands Home Health of Southeast Idaho, provider #137102

Dear Ms. Jensen:

This is to advise you of the findings of the Recertification survey at Helping Hands Home Health which was concluded on May 14, 2008.

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. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 2, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

Patrick Hendrickson /sc Sylvia Creswell

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

Enclosures

HELPING HANDS HOME HEALTH

1430 E. 17th St. Idaho Falls, ID 83404
208-552-3222
"Because there's no place like home"

Dear Pat,

Attached are the tags that we needed to respond too. Thank you for being such a good person, you have really helped us with your willingness to give us information. That is very helpful. We don't feel so intimidated to ask questions.

Your Truly,

Karla Jensen

Karla Jensen
Administrator

RECEIVED

JUN 02 2008

FACILITY STANDARDS

6-9-08
copies to Nancy for H&F

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/16/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	137102		05/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS HOME HEALTH OF SOUTHEAST IDAHO	1308 EAST CENTER POCATELLO, ID 83201

(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 recertification survey of your agency. The surveyors conducting the recertification survey were: Patrick Hendrickson, RN, HFS, Team Leader Patricia O'Hara, RN, HFS Acronyms used in this report: HHA = Home Health Agency MSW = Medical Social Worker POC = Plan of Care RN = Registered Nurse SOC = Start of Care	G 000		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure that closed records of 1 of 2 patients (# 2), included a discharge summary. The findings include: * Patient #2 was an 80 year old female. Her S.O.C was 11/01/07 for Home Health Nursing	G 236	G 236 Responsible Party: Director of Nursing When the chart review is being done The reviewer will be directed to note That the discharge summary has been Filled out properly with the information Regarding the patients discharge. If The client has been discharged to a Facility the discharging RN will Note the facility they are going too On a discharge summary form. Effective date: June 1, 2008	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karla Jensen
TITLE: Administrator
(X6) DATE: 5-30-08

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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	137102		05/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS HOME HEALTH OF SOUTHEAST IDAHO	1308 EAST CENTER POCATELLO, ID 83201

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G 236	Continued From page 1 and Physical Therapy services. The patient was discharged on 11/26/07. The patient's clinical record was reviewed on 5/13/08. The record did not contain a discharge summary. On 5/13/08 at 3:00 PM, the HHA's Clinical Director reviewed the record and could not find a discharge summary. The Clinical Director could not explain why the record did not contain a discharge summary. The HHA failed to ensure that closed records included a discharge summary.	G 236	RECEIVED JUN 02 2008 FACILITY STANDARDS	
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the home health agency failed to ensure that initial assessment visits were held within 48 hours of a referral, or within 48 hours of the patients' return home for 2 of 11 patients whose records were reviewed (#'s 9 and 11). The findings include: * Patient #9 was an 73 year old female who was referred to home health because of abnormality of gait. The patient's clinical record included a "Referral for Home Health Services" form dated 5/2/08. The form stated the hospital had called the agency on 5/2/08 when the patient was being discharged and the physician had ordered a nursing evaluation for home health services. The patient's clinical record contained a "Start or Resumption of Care" dated 5/5/08, when the	G 332	G 332 Responsible Party: Director of Nursing/Administrator Nursing staff will be in-serviced to the Need and rules regarding late Paperwork. The rules will be In-serviced to the PT, OT, MSW as Well as the nursing staff. They will Have to verbally and in writing State that they understand and will Comply with the ruling. Effective date: June 1, 2008	

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	137102		05/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS HOME HEALTH OF SOUTHEAST IDAHO	1308 EAST CENTER POCATELLO, ID 83201

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G 332	Continued From page 2 nurse conducted the initial assessment. This was a span of 3 days from the physician's referral. The clinical record did not provide documented evidence that the physician was contacted to approve the delay in initial assessment and treatment. * Patient #11 was a 81 year female who was referred to home health because of difficulty walking. The patient's clinical record included a faxed physician's referral prescription ordering an evaluation for home health services dated 4/23/08. The faxed physician's order was transmitted to the home health agency on 4/24/08. The patient's clinical record contained a "Start or Resumption of Care" dated 4/28/08, when the nurse conducted the initial assessment. This was a span of 4 days from the physician's order to the date of the assessment. The clinical record did not provide documented evidence that the physician was contacted to approve the delay in initial assessment and treatment. An interview and record reviews with the Clinical Director on 5/13/08 at 4:00 PM, validated there was no documented evidence in the record that the doctors had been notified and approved the delays in treatments.	G 332		

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NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH OF SOUTHE	STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201		

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the recertification survey were: Patrick Hendrickson, RN, HFS, Team Leader Patricia O'Hara, RN, HFS Acronyms used in this report: HHA = Home Health Agency MSW = Medical Social Worker POC = Plan of Care RN = Registered Nurse SOC = Start of Care	N 000	RECEIVED JUN 02 2008 FACILITY STANDARDS	
N 185	03.07031.CLINICAL REC. N185 02. Contents. Clinical records must include: k. A discharge summary. This Rule is not met as evidenced by: Refer to Federal deficiency G236, as it relates to agency's failure to ensure that closed records included a discharge summary.	N 185	N185 Responsible Party: Director of Nursing When the chart review is being done The reviewer will be directed to note That the discharge summary has been Filled out properly with the information Regarding the patients discharge. If The client has been discharged to a Facility the discharging RN will Note the facility they are going too On a discharge summary form. Effective date: June 1, 2008	
N 186	03.07031.03.CLINICAL REC. N186 03. Clinical and Progress Notes, and Summaries of Care. Clinical and progress notes must be written or dictated on the day service is rendered and incorporated into the clinical record within seven (7) days. Summaries of care reports must be submitted to the attending physician at least every sixty (60) days.	N 186		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Karla Jensen TITLE Administrator (X6) DATE 5-30-08

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NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH OF SOUTHE	STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201		

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N 186	Continued From page 1 This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure that clinical progress notes were incorporated into the patient's clinical record within seven 7 days for 3 of 11 patient's (#'s 4, 9, 11,) whose records were reviewed. The findings include: The HHA's "Documentation" policy that was undated stated that employees were to submit the records to the office each Monday morning". * Patient #4 was a 77 year old female admitted to the HHA on 3/31/08 with diagnoses that included Hypertension and Diabetes. Her POC included Skilled Nursing visits 3-4 times a week for 2 weeks, then 1-2 times a week for 2 weeks. When the record was reviewed on 5/13/08 there was no documentation that Skilled Nursing visits had been made for the week of 4/6-4/12/08. On 5/13/08 at 3:00 PM, the Clinical Coordinator was interviewed. She confirmed that there were no skilled nursing visit notes for the week of 4/6-4/12/08. She did however find the notes on 5/14/08. * Patient #9 was admitted for home health services on 5/5/08. The patient's clinical record was reviewed on 5/14/08. The patient's Physical Therapy POC stated that Physical Therapy was to see the patient 2-3 times a week for 4 weeks. The record lacked physical therapy notes from visits made on the week of 5/5/08. * Patient #11 was admitted for home health services on 4/28/08. The patient's clinical record was reviewed on 5/14/08. The Patient's POC stated that Physical Therapy was to see the	N 186	N 186 Responsible Party: Director of Nursing/Administrator Nursing staff will be in-serviced to the Need and rules regarding late Paperwork. The rules will be In-serviced to the PT, OT, MSW as Well as the nursing staff. They will Have to verbally and in writing State that they understand and will Comply with the ruling. Effective date: June 1, 2008	

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N 186	Continued From page 2 patient 2-3 times a week for 6 weeks. The POC also stated that Occupational therapy was also to see the the patient 1-2 times a week for 8 weeks. The record lacked Physical Therapy and Occupational Therapy notes from visits that were made on the week of 5/4/08. An interview with the Clinical Director was conducted on 5/14/08 at 10:00 AM. She stated that she had been having continued problems with the contracted staff in submitting their notes in a timely manner.	N 186		