COPY

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 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 18, 2011

Beverly Weber, Administrator
Creekside Home Health
4425 Burley Drive, Suite C
Chubbuck, ID 83202

RE: Creekside Home Health, Provider #137105

Dear Ms. Weber:

This is to advise you of the findings of the Medicare/Licensure survey at Creekside Home Health, which was concluded on January 6, 2011.

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.

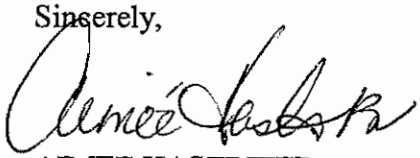
An acceptable plan of correction (PoC) contains the following elements:

- 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 **January 24, 2011**, and keep a copy for your records.

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

Sincerely,



AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

AH/srm
Enclosures

To: Aimee Hastriter

Fax: 208-364-1888

Pages (including cover): 11

Date: 1-21-2011

Creekside
Home Health & Hospice
4425 Burley Drive Suite C
Chubbuck ID 83202
(208) 637-1100 Office
(208) 637-1102 Fax

Regarding: Plan of Correction

Revised BW

Comments: Attached please find our plan of correction for your January 6, 2011 survey.

Thank You,

Beverly Weber RN

Regional Administrator

208-637-1100

CONFIDENTIALITY NOTICE: The documents accompanying this telecopy transmission contain information belonging to the sender that is legally privileged. This information is intended only for the use of the entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by the state law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error; please notify the sender immediately to arrange for return of these document.

January 21, 2011

Ms. Aimee Hastriter
Health Facility Surveyor, Non-Long Term Care
Idaho Department of Health & Welfare
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036

Dear Ms: Hastriter

Your survey team completed a Medicare/Licensure survey at the Creekside Home Health office in Idaho Falls on January 6, 2011. In response to your findings, we have developed a plan of correction. Enclosed is our plan. If you have any questions regarding the plan, you may contact me by phone (208-637-1100) or by email (beverly@creeksidehomehealth.com).

The Creekside Home Health team chooses to learn from the survey findings and to make improvements in the agency's processes and resulting patient care. Thank you for the role you play in ensuring compliance and quality of home health care.

Sincerely,

Beverly Weber

Beverly Weber, RN
Regional Administrator

4425 Burley Drive, Suite C, Chubbuck, Idaho 83202

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

PRINTED: 01/11/2011
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
	137105		01/06/2011

NAME OF PROVIDER OR SUPPLIER: CREEKSIDE HOME HEALTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 3686 WASHINGTON PARKWAY, IDAHO FALLS, ID 83404

(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 survey of your Home Health Agency.	G 000		
	The following surveyors conducted the survey: Aimee Hastriter, RN, HFS, Team leader Gary Guiles, RN, HFS Acronyms used in this report are as follows: RN - Registered Nurse		484.14(g) COORDINATION OF PATIENT SERVICES The recent transition from paper documentation to an electronic medical record (EMR) system will eventually result in an improvement in coordination of care among the agency staff. In this early phase, however, learning how to navigate within the system has been a challenge. The clinical directors provided in-services for the clinical staff on how and when to document care coordination within the EMR on 1/11/11 in Idaho Falls, 1/13/11 in Rexburg, and 1/20/11 in Chubbuck. Additional training will be provided on an individual basis to any clinicians unable to attend the scheduled classes and should be completed by 1/31/11.	1/31/11
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to ensure coordination of patient care was documented for 3 of 13 patients (#6, #8, and #18) who had received care from multiple disciplines and whose records were reviewed. This resulted in the inability of the agency to ensure coordination of patient care had occurred. Findings include: 1. Patient #6's medical record documented an 84 year old female who was admitted for home health care on 11/12/10 for congestive heart failure. She was currently a patient as of 1/06/11. The "Client Calendar Report" documented she	G 144		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Regional Administrator (X6) DATE: 1-21-11

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 144	Continued From page 1 received 7 nursing visits between 11/12/10 and 12/29/10, when nursing services were discontinued. During that same time period, 13 physical therapy visits were documented. No coordination of care between nursing and therapy was documented during that time period. The Regional Administrator was interviewed on 1/06/11 at 9:15 AM. She confirmed no coordination of care was documented in the medical record of Patient #6. The Physical Therapist for Patient #6 was interviewed on 1/06/11, during a home visit beginning at 12:30 PM. He stated he had spoken with the nurse about the care of Patient #6 but stated he was not sure if it was documented. The agency failed to ensure documentation of coordination of care between disciplines providing services to Patient #6. 2. Patient #8's medical record documented a 44 year old female who was admitted for home health care on 11/20/10 following an amputation of her left leg. She was currently a patient as of 1/06/11. She was re-hospitalized on 12/03/10 for further surgery on her leg and home health care was resumed on 12/11/10. Resumption of care orders on 12/11/10 called for the RN to continue visits for wound care and for the Medical Social Worker to evaluate Patient #8's social and emotional needs. As of 1/06/11, documentation of the social services evaluation was not present in the medical record. In addition, no mention of social services was present in coordination of care notes. The Regional Administrator was interviewed on	G 144	Continued from page 1 Additionally, the directors will conduct a monthly audit to ensure compliance with care coordination. This quality improvement project will continue until the agency is able to demonstrate 100% compliance for three consecutive months.	

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NAME OF PROVIDER OR SUPPLIER CREEKSIDE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 3586 WASHINGTON PARKWAY IDAHO FALLS, ID 83404	

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G 144	Continued From page 2 1/06/11 at 9:45 AM. She stated Patient #8 had refused social service visits. She stated nursing staff were aware of this but it was not documented. She confirmed no documentation of coordination of care related to social services was present in the medical record between 12/11/10 and 1/06/11. The agency failed to ensure documentation of coordination of care between disciplines providing services to Patient #8. 3. Patient #18 was an 85 year old male admitted to the agency on 10/29/10 and discharged on 12/23/10. He was receiving care after hip surgery. He was also being treated for a pressure ulcer and congestive heart failure. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 10/29/10 through 12/27/10, contained physician orders for Patient #18 to receive skilled nursing care, occupational therapy, and physical therapy. The "Episode Visit Summary Report" indicated that between 10/29/10 and 12/23/10, Patient #18 received 3 nursing visits, 16 occupational therapy visits, and 22 physical therapy visits. The medical record contained the following evidence of communication between disciplines: a. The Physical Therapist documented, in the visit note from the initial evaluation on 10/29/10, he communicated with the Occupational Therapist. b. The visit note from the initial evaluation by the Occupational Therapist, dated 10/29/10, documented he spoke with the RN and the Physical Therapist to coordinate care for optimal	G 144		

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NAME OF PROVIDER OR SUPPLIER CREEKSIDE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 3686 WASHINGTON PARKWAY IDAHO FALLS, ID 83404	

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G 144	Continued From page 3 patient rehabilitation. c. A visit note dated 11/02/10, stated the Occupational Therapist spoke with the Physical Therapist to coordinate a schedule which would best fit the needs of Patient #18 and the caregiver. The medical record did not contain documentation of coordination of care between disciplines for the remainder of the certification period. On 1/06/11 at 3:35 PM, the Regional Administrator was asked to provide evidence of the coordination of care between disciplines providing services to Patient #18. She provided the above documentation related to the documentation of coordination of care. The agency failed to ensure documentation of coordination of care between disciplines providing services to Patient #18. 4. The policy "Coordination of Patient Care," dated 8/03/09, stated "case conferences" would be held on an ongoing basis and "Documentation of case conferences will be maintained in the patient's medical record." The policy did not state who would document this or where it would be documented. Other than that statement, the policy did not state how coordination of patient care would be documented. The Director of Nursing was interviewed on 1/10/11 at 1:40 PM. She stated the agency had converted to an electronic medical record in October of 2010. She stated the way coordination of patient care was documented	G 144		

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G 144	Continued From page 4 changed at that time. She stated the "Coordination of Patient Care" policy had not been changed since the new medical record system was implemented. She confirmed the policy did not direct staff how to document coordination of care. 5. Between 1/05/11 and 1/06/11, four skilled nurses were interviewed regarding documentation of the coordination of care. All confirmed there was coordination of care between therapy services and nursing services, whether it was in person, via a text message, or a phone call. All agreed this communication was not always documented in the medical record, and two nurses indicated staff were still learning how to properly document communication in the new electronic medical record. For example: a. On 1/05/11 at 10:25 AM, during an interview with a nurse, she stated there was coordination of care between the nursing staff and the therapist, however, since the transition from paper documentation to the electronic medical record there had not been a consistent process to document this communication. b. On 1/06/11 at 12:00 PM, during an interview with a nurse, she stated there is a lot of texting and phone calls between the disciplines providing care for patients. However, she said staff were still learning the process of documenting this communication in the new computerized system. c. On 1/06/11 at 1:00 PM, during an interview with a nurse, she stated there was communication between nursing staff and the therapists, but agreed this communication was not always documented.	G 144		

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	137105		01/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HOME HEALTH	3686 WASHINGTON PARKWAY IDAHO FALLS, ID 83404

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G 144	Continued From page 5 d. On 1/06/11 at 1:45 PM, during an interview with a nurse, she agreed more could be done to ensure the documentation of communication and coordination of care between disciplines. The agency failed to implement a system to document coordination of patient care.	G 144		
G 228	484.36(d)(1) SUPERVISION If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure home health aide supervisory visits were conducted for 1 of 2 patients (#18) who received aide services and whose records were reviewed. Failure to provide home health aide supervisory visits had the potential to impact safety and satisfaction with the delivery of patient care. Findings include: Patient #18 was an 85 year old male admitted to the agency on 10/29/10 for care after hip surgery. He was also being treated for a pressure ulcer and congestive heart failure. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 10/29/10	G 228	484.36(d)(1) SUPERVISION In the single case identified as having missing supervisory visits, the nurse discontinued services, but the remaining therapist did not assume the aide supervisory visits. The newly implemented electronic medical record (EMR) system has a built-in alert to remind the outgoing clinician to transfer the aide supervisory visits to the remaining skilled discipline (e.g., from nursing to physical therapy). Understanding the EMR aide supervisory alert and how to respond appropriately to it, however, is essential to maintaining compliance with the supervisory visits.	1/31/11

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	137105		01/06/2011

NAME OF PROVIDER OR SUPPLIER: CREEKSIDE HOME HEALTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 3686 WASHINGTON PARKWAY, IDAHO FALLS, ID 83404

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G 228	Continued From page 6 through 12/27/10, contained physician orders for Patient #18 to receive skilled nursing care in addition to care from occupational and physical therapies, and home health aide care. The aide was to see Patient #18 three times a week for 8 weeks. Patient #18's medical record contained documentation of an aide supervisory visit, completed by an RN, on 11/04/10. The last skilled nursing visit was documented on 11/08/10. Patient #18 continued to receive care for physical therapy, occupational therapy, and from the aide through 12/23/10. The medical record did not contain documentation of aide supervisory visits after 11/04/10. The Regional Administrator reviewed Patient #18's medical record and was interviewed on 1/06/11 at 4:15 PM. She stated the aide supervisory visits were originally entered into the computer system and attached to nursing visits as reminders. However, when nursing staff discharged Patient #18 from their services, the computer deleted any further visits from them, as well as the reminders for the aide supervisory visits. Therefore, therapy services were not alerted to complete aide supervisory visits for Patient #18. She confirmed there were no aide supervisory visits completed after 11/04/10. The agency failed to ensure professional staff would conduct supervisory visits for all patients receiving aide services.	G 228	Continued from page 6 Therefore, the clinical directors have arranged in-service training on the EMR supervisory alert and how to respond to it for the nursing, therapy, and scheduling staff. The in-service training will be completed by 1/31/11. Additionally, to ensure compliance with aide supervision frequency, the clinical directors will conduct a monthly audit for aide supervision. The agency will continue auditing for aide supervision compliance, making process changes and providing ongoing education as necessary, until compliance has reached 100% for at least three consecutive months.	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: CREEKSIDE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE: 3686 WASHINGTON PARKWAY IDAHO FALLS, ID 83404		

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey of your Home Health Agency. The following surveyors conducted the survey: Aimee Hastriter, RN, HFS, Team leader Gary Gulles, RN, HFS Acronyms used in this report are as follows: RN - Registered Nurse	N 000		
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 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 G144 as it relates to the failure of the agency to ensure coordination of patient care was documented.	N 062	TAG N 062: 03.07021. ADMINISTRATOR The recent transition from paper documentation to an electronic medical record (EMR) system will eventually result in an improvement in coordination of care among the agency staff. In this early phase, however, learning how to navigate within the system has been a challenge. The clinical directors provided in-services for the clinical staff on how and when to document care coordination within the EMR on 1/11/11 in Idaho Falls, 1/13/11 in Rexburg, and 1/20/11 in Chubbuck. Additional training will be provided on an individual basis to any clinicians unable to attend the scheduled classes and should be completed by 1/31/11.	1/31/11
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	N 119	Additionally, the directors will conduct a monthly audit to ensure compliance with care coordination. This quality improvement project will continue until the agency is able to demonstrate 100% compliance for three consecutive months.	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Regional Administrator — (X8) DATE: 1-21-11

STATE FORM 6899 G2W811 If continuation sheet 1 of 2

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N 119	Continued From page 1 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 G228 as it relates to the failure of the agency to ensure aide supervisory visits were completed.	N 119	TAG N 119: 03.07024.04. SK.NSG.SERV In the single case identified as having missing supervisory visits, the nurse discontinued services, but the remaining therapist did not assume the aide supervisory visits. The newly implemented electronic medical record (EMR) system has a built-in alert to remind the outgoing clinician to transfer the aide supervisory visits to the remaining skilled discipline (e.g., from nursing to physical therapy). Understanding the EMR aide supervisory alert and how to respond appropriately to it, however, is essential to maintaining compliance with the supervisory visits. Therefore, the clinical directors have arranged in-service training on the EMR supervisory alert and how to respond to it for the nursing, therapy, and scheduling staff. The in-service training will be completed by 1/31/11. Additionally, to ensure compliance with aide supervision frequency, the clinical directors will conduct a monthly audit for aide supervision. The agency will continue auditing for aide supervision compliance, making process changes and providing ongoing education as necessary, until compliance has reached 100% for at least three consecutive months.	1/31/11