

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

**CERTIFIED MAIL: 7007 3020 0001 4038 9970**

February 14, 2012

Teresa Dixon, Administrator  
Alliance Home Health Of Idaho  
440 East Clark Street, Suite A  
Pocatello, ID 83201

RE: Alliance Home Health Of Idaho, Provider #137115

Dear Ms. Dixon:

Based on the survey completed at Alliance Home Health Of Idaho, on January 31, 2012, by our staff, we have determined Alliance Home Health Of Idaho is out of compliance with the Medicare Home Health Agency (HHA) **Condition of Participation for Organization, Services, and Administration (42 CFR 484.14); Acceptance of Patients, Plan of Care, and Medical Supervision (42 CFR 484.18); and Evaluation of the Agency's Program (42 CFR 484.52)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Alliance Home Health Of Idaho, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction 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;

Teresa Dixon, Administrator

February 14, 2012

Page 2 of 2

- 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 each form.

**Such corrections must be achieved and compliance verified by this office, before March 16, 2012. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than March 8, 2012.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **February 26, 2012.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

GG/srm

Enclosures

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief

Kate Mitchell, CMS Region X Office



**ALLIANCE HOME HEALTH OF IDAHO, LLC  
440 E. CLARK STREET, SUITE A  
POCATELLO, IDAHO 83201**

Date: 02/21/2012

Sylvia Creswell  
Co-Supervisor  
Non-Long Term Care  
Idaho Department of Health & Welfare  
Bureau of Facility Standards  
3222 Elder Street  
P. O. Box 83720  
Boise, ID 83720-0009

RECEIVED  
FEB 23 2012  
FACILITY STANDARDS

Here is the completed Plan of Correction packet for correction of deficiencies as determined by the survey completed on January 31, 2012 at Alliance Home Health of Idaho in Pocatello. I am mailing it to you today, February 21, 2012.

If you have any questions please call me at 1-208-478-6677 or on my cell phone # : 1-208-251-1406. My e-mail address is [tdixon@alliancehhh.com](mailto:tdixon@alliancehhh.com).

Sincerely:

*Teresa Dixon RN*  
Teresa Dixon RN, Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the recertification survey of your Home Health Agency. The surveyors who conducted the recertification were:</p> <p>Gary Guiles, RN, HFS, Team Leader Aimee Hastriter, RN BS, HFS</p> <p>Acronyms used in this report include:</p> <p>CEO – Chief Executive Officer CMS – Centers for Medicare and Medicaid Services CNA – Certified Nursing Assistant DON – Director of Nursing LPN – Licensed Practical Nurse POC – Plan of Care OT – Occupational Therapy PT- Physical Therapist PTA – Physical Therapy Assistant QAPI – Quality Assurance and Performance Improvement RN – Registered Nurse SW – Social Worker</p>	G 000		
G 122	<p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION</p> <p>This CONDITION is not met as evidenced by: Based on staff interview and review of medical records and agency policies, meeting minutes, quality improvement information, and administrative documents, it was determined the Governing Body failed to ensure it assumed</p>	G 122	<p>POLICY (updated) "The Governing Body will assume full legal authority and responsibility for the operation of Alliance Home Health". PURPOSE: To ensure lines of authority are established and clearly delegated. To ensure that clients are provided with safe and appropriate quality services.</p>	02/01/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]*

Administrator

03-13-12

Any deficiency statement ending with an (\*) 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  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>		
(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 122	Continued from page 1 responsibility for the agency's operation. This resulted in the inability of the agency to ensure vital functions were carried out. Findings include:  1. Refer to G123 as it relates to the agency's failure to define organizational structure.  2. Refer to G128 as it relates to the agency's failure to provide oversight by the governing body.  3. Refer to G133 as it relates to the agency's failure to ensure oversight was provided by the Administrator.  4. Refer to G143 as it relates to the agency's failure to ensure coordination of care occurred.  5. Refer to G144 as it relates to the agency's failure to document coordination of care.  6. Refer to G156 as it relates to the agency's failure to ensure care was provided in accordance with patients' POCs and to ensure physicians were alerted to changes inpatient conditions.  7. Refer to G244 as it relates to the agency's failure to ensure an evaluation of the agency's program was completed.	G 122	The Governing Body shall define the corporate structure and clearly identify lines of authority. The Alliance Home Health organizational chart has been restructured to make it clearer to the staff.  This information has been distributed throughout Alliance Home Health to all of the staff and education provided. (see attached)	02/15/12  02/15/12
G 123	484.14 ORGANIZATION, SERVICES & ADMINISTRATION  Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable.	G 123	The Organization of Alliance Home Health of Idaho has been defined and set forth in writing. The Governing Body will accept full responsibility and Administrative control for the organization of /and services furnished by Alliance Home Health.	02/14/12



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  137115	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 123	<p>Continued From page 3</p> <p>was interviewed on 1/27/12 beginning at 10:05 AM. When asked who her supervisor was, she hesitated. She stated if she could call anyone her supervisor it would be the DON.</p> <p>The Branch Director for the Twin Falls office, an RN, was interviewed on 1/26/12 beginning at 1:40 PM. When asked who her supervisor was, she stated it was the Administrator.</p> <p>The Administrator was interviewed on 1/31/12 beginning at 12:45 PM. She stated the DON was responsible for nursing services at all locations. She acknowledged the organizations charts listing the CNA as the Branch Director created some confusion as to lines of authority.</p>	G 123	<p>Education was provided by the Administrator to the staff related to the Organizational Chart and lines of authority. Emphasis was placed on the Administrator's responsibility to supervise the Director of Nursing. The DON supervises all nursing services and staff. She will also work in conjunction with the Branch Director. The Branch Director is to manage the business and operations portion of the office. <i>Administrator will monitor compliance @ least quarterly by receiving reports from the Branch Director and DON. TD 3/13/12</i></p>	02/06/12 and again 02/20/12
G 128	<p>484.14(b) GOVERNING BODY</p> <p>A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of agency policies and governing body meeting minutes, it was determined the Governing Body failed to ensure it assumed responsibility for the agency's operation. This resulted in the inability of the agency to ensure vital functions were carried out. Findings include:</p> <p>1. The Governing Body failed to provide direction to staff.</p>	G 128	<p>The Governing Body and Administrator assume responsibility for providing education and direction to the staff related to agency operations. Monthly meetings (or more often if needed) will be conducted with the directors to provide education related to Alliance Home Health operations and its importance in offering the safest patient care services, to monitor outcomes, assess quality, and make improvements. The directors have been instructed to conduct meetings with the staff and educate them on the policies and procedures of Home Health so as to improve patient cares.</p>	02/01/12  02/20/12 and on-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 128	<p>Continued From Page 4</p> <p>Eleven Governing Body meeting minutes were documented for 2011, from 1/19/11 to 12/19/11. Meeting minutes discussed finances, insurance, submission of information to intermediaries and CMS, marketing, the composition of the Professional Advisory Group, and appointment of administrative personnel. The minutes did not discuss services provided to patients.</p> <p>The Governing Body meeting minutes did not reflect discussion of basic operations of the agency such as whether assessments were timely and appropriate, whether POCs were followed, or whether staff knew who to report to. Governing Body meeting minutes, dated 2/03/11, stated the DON was "...doing chart reviews to make sure that the orders are being followed according to the plan of care." No subsequent discussion of the chart reviews was documented. Governing Body meeting minutes, dated 3/16/11, stated the Administrator reminded Branch Directors there had to be an order for all home health cares. No subsequent discussion of orders was documented. Governing Body meeting minutes, dated 4/04/11, stated the Administrator wanted chart reviews done to make sure quality of care was not compromised. The results of chart reviews was not discussed in subsequent minutes.</p> <p>The Administrator was interviewed on 1/31/12 beginning at 12:45 PM. She stated she attended all Governing Body meetings. She stated care items were discussed at meetings but said those discussions had not been documented. She acknowledged no data was available to show follow through of the above items.</p>	G 128	<p>The Governing Body will meet at least quarterly and PRN. The GB will discuss appropriateness of patient cares, appropriateness of staff providing services. The Administrator will be responsible for bringing items of concern related to patient cares to the GB. Reports related to chart reviews results will be provided by the Administrator to the Governing Body and Professional Advisory Group at least quarterly.</p> <p>Minutes of preceding meetings will be reviewed at the Governing Body meetings at least quarterly to serve as a reminder of past discussions. Chart review results will be added to the Governing Body meetings and minutes at least quarterly and more often as needed. The Administrator will be responsible for obtaining information from the Director of Nursing and/or Branch Director of Pocatello about the preceding week's activities. The DON will be responsible for reporting to the Administrator any areas of concern in delivery of patient cares.</p> <p>Education by the DON was provided to all the home health staff regarding the necessity of chart reviews, following physician orders and documentation.</p>	02/14/12 & 02/17/12 & 02/21/12  02/10/12 & 02/21/12  02/15/12





STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 128	Continued From page 7 Director. The offices were referred to as branches.  The Administrator was interviewed on 1/31/12 beginning at 12:45 PM. She stated the branches had been providing services to patients since 2010. She stated there had been confusion among the Governing Body about whether or not the branches had been approved for operation. She stated the agency had submitted information to have the braches approved but this had not occurred as of the interview date.  The Governing Body did not obtain approval to operate branch offices.	G 128	available in these offices for clinical staff use. Supervision of the home health clinical staff will be the responsibility of the DON. The Home Health staff has been re-educated on the function of these remote offices and clinical staff has been identified that will provide home health services to patients in the counties defined by the CMS certified office (parent office). <i>office manger will check if records weekly to make sure they are current &amp; QA will monitor @ least monthly to follow up a compliance 3/13/12 TD</i>	02/06/12 & 02/20/12
G 133	484.14(c) ADMINISTRATOR  The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.  This STANDARD is not met as evidenced by: Based on staff interview and review of agency policies and meeting minutes, it was determined the agency failed to ensure the administrator organized and directed the agency's ongoing functions. This resulted in a lack of clear direction to staff. Findings include:  The Administrator did not provide transparent oversight of agency operations.  Eight Branch Director Meetings, which the Administrator directed, were documented	G 133	The Administrator and Governing Body reviewed the following: The Administrator organizes and coordinates functions of the agency by delegating duties and establishing a formal means of staff accountability and appoints a physician, registered nurse or health care professional to provide general supervision, coordination and direction for professional services of the agency. Develops a staff communication system that coordinates implementation of plans of treatment, utilizes services or resources to meet patient needs, and promotes an orderly flow of information within the organization. Identifies systems to recognize client needs, respond to client needs, and to measure the outcomes of interventions, utilizes this data to provide direction for Alliance Home Health improvements.	02/01/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 133	<p>Continued From page 8 between 1/19/11 and 12/19/11. The meetings did not separate minutes between Alliance Home Health and its 2 sister companies Hospice Alliance in Pocatello, Idaho and Alliance Hospice in Twin Falls, Idaho, so it was difficult to determine what items were related to the home health agency.</p> <p>The Branch Director Meeting minutes did not document direction or oversight for basic home health functions, including assessments, plans of care, and coordination of care.</p> <p>Quality assurance was mentioned in 4 meeting minutes, on 1/19/11, 3/01/11, 5/19/11, and 9/27/11. However, a review of the quality assurance program showed a complete quality program, including quality indicators and use of data, had not been developed. The parent office had gathered some data related to incident reports, infections, and chart reviews. However, no documentation was present that data had been gathered from the remote offices. The minutes did not document compiling of the data or action taken in response to data.</p> <p>Branch Director Meeting minutes mentioned branches sending medical records to the parent office in Pocatello on 4 different occasions including 3/01/11, 5/19/11, 9/27/11, and 10/18/11. However, at the time of survey, records were not available at the parent office from the Idaho Falls office and the Twin Falls office.</p> <p>The Administrator was interviewed on 1/31/12 beginning at 12:45 PM. She confirmed the above issues had not been resolved. She stated she had provided guidance to staff but they had not</p>	G 133	<p>The following presented at the Governing Body meeting: All Director meetings for Home Health will be held and documented separately from other minutes. Guidance and direction shall be clear and concise as it relates to expectations from the Administrator and DON in the provision of patient cares which includes basic home health functions, chart reviews, conducting assessments, completion of the patient plan of care, documentation guidelines, and coordination of care. Staff education was provided and will continue to be offered at least monthly throughout the year. This will be the on-going responsibility of the Administrator, the Director of Nursing and/or designee.</p> <p><i>Governing Body will monitor Administrator's compliance @ least quarterly through reports from QA. 3/13/12 TD at PAG</i></p>	02/01/12  02/20/12



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

PRINTED: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 143	<p>Continued From page 10</p> <p>arrived for his visits and he had the bag and tubing coming up through the waist of his pants. She stated she encouraged him to use the bag properly as having the tubing and the bag above his bladder prevented proper urine flow and was an infection risk. She stated the RN Case Manager was aware that Patient#6 did not like to follow this direction.</p> <p>A home visit was conducted with the home health aide on 1/24/11 beginning at 12:45 PM. Upon arrival to Patient #6's home, he was found lying in his hospital bed with the tubing from his urinary catheter coming up through the waist of his sweat pants. The urinary bag was hung on the upper bed rail and was above the level of the bladder. The home health aide was observed to educate Patient #6 about the importance of keeping the urinary bag lower than the bladder and following the shower Patient #6 placed the tubing and bag down through his pants leg and was reminded to hang the bag on the lower portion of the bed when he lay back down.</p> <p>The RN Case Manager for Patient #6 was interviewed on 1/25/12 at 2:55 PM. She stated the home health aide had told her that Patient #6 did not like to his urinary bag positioned through his pan leg. She stated the bag was always properly positioned when she arrived for nursing visits and she was surprised to learn about the above observation. She stated she was not notified of specific occasions when Patient #6 was found at the time of a visit to have his urinary bag inappropriately positioned above his bladder.</p> <p>The home health aide and RN Case Manager failed to adequately communicate the difficulty</p>	G 143	<p>The Administrator and/or Director of nursing will provide on-going education to the clinical staff on effective communication between disciplines to help improve patient care services.</p> <p><b>POLICY:</b> All personnel furnishing services shall maintain a liaison and open communication to coordinate effectively and support the objectives outlined in the Plan of Care. This should be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction.</p> <p>CNA education was provided by the Director of Nursing on how to document, communicate and report any changes in the patient's physical, mental, and emotional condition to the RN Case Manager. This education has been offered to all clinical staff in verbal and written form.</p> <p>The Case Manager is to double check the CNA documentation at least weekly to make sure all extra documentation by the Aide is noted. The QA Manager and/or designee will be responsible for double checking compliance.</p>	02/15/12 & 02/21/12  02/15/12  02/17/15 & 02/21/12  02/21/15



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 143	<p>Continued From page 12</p> <p>#12's saturation levels were normally in the high 80's or low 90's. He explained that he always remained with Patient # 12 until her saturation levels were within the normal limits and she was comfortable. He stated during the visit on 1/02/12 he had a discussion with Patient #12 and her daughter, and Patient #12 was finally convinced to make an appointment to see her physician. He confirmed that his documentation lacked this information, as well as Patient #12's saturation level. He stated because Patient #12 had returned to stable condition and had a physician's appointment scheduled, he did not contact his supervising PT with this information.</p> <p>In addition, Patient #12's medical record contained a physician's order, dated 11/28/11, for an OT evaluation. There was no documentation of an evaluation or a reason the evaluation was not completed.</p> <p>The Case Manager for Patient #12, an RN, was interviewed on 1/26/12 at 10:35 AM. She stated she was not aware of the above incident and, in fact, did not hear from the PT until after Patient #12 was admitted to the hospital on 1/04/12 for respiratory difficulties. She stated communication with therapists was "hit or Miss." She stated that sometimes patients would actually be discharged from therapy and the office would not be notified. She agree this was an area that could use improvement.</p> <p>During the interview on 1/26/12 at 10:35 AM, the Case Manager explained she had inadvertently programmed an incorrect phone number for the Occupational Therapist into her work phone. Therefore, the Occupational Therapist did not</p>	G 143	<p>the therapist and Physical Therapy Assistant is following the patient's POC. PT specific chart review forms have been formatted for use.</p> <p>Education provided by the Administrator and DON on the following: <u>The RN Case Manager Job Description:</u> Provide nursing assessment, planning and care to maximize the comfort and health of patients and families in accordance with the Interdisciplinary Plan of Care. <b>COMMUNICATING PATIENT CARE:</b> <b>Duties:</b> Initiates communication with attending physicians, other staff members, therapists and other agencies as needed to coordinate optimal care and use of resources for the patient. Maintains regular communication with other Interdisciplinary team members to review patient cares. Maintains regular communication with the attending physician concerning patient/family cares. Attends the IDG meetings for Home Health or other pertinent patient care conferences as deemed necessary by the Director of Nursing. <b>MAINTAINS PATIENT RECORDS:</b> <b>Duties:</b> Maintains up-to-date patient records so that problems, plans, actions and goals are accurately and clearly stated, with changes reflected as they occur. <b>COORDINATING PHYSICAL CARE:</b> <b>Duties:</b> Accepts responsibility for coordinating the physical care of the patient by educating the patient, family and/or primary caregiver related to services as per the Plan of Care. Willing to also provide education to other members of the IDG related to patient cares, or by providing cares directly as deemed necessary and appropriate.</p>	02/07/12  02/21/12





STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 143	<p>Continued From page 15</p> <p>ordered 2 times a week for the first 2 weeks. Nursing visits were documented for 11/12/11, 11/14/11, 11/18/11, and 11/21/11. Patient #4's POC, dated 11/21/11, stated OT was to "evaluate and treat" her. The OT evaluation was not documented until 11/21/11, 9 days after her start of care. No documentation by the therapist or nurses explained why it took so long to conduct her evaluation.</p> <p>The DON was interviewed on 1/24/12 beginning at 2:50 PM. She reviewed the record and stated she did not know why OT services were not provided until 11/21/11.</p> <p>Coordination of care did not occur between nursing and OT.</p>	G 143	<p>The Home Health Interdisciplinary Team will meet every two weeks. The RN Case Managers will be responsible for communicating with the various disciplines involved in providing patient cares and will coordinate those cares. A report will be obtained from the therapist's about the condition and progress of services provided to their patients. This has been included in the IDT meetings. Nursing and Therapy staff received education by the DON to communicate frequently about patient cares, the progress towards goals and if there are any concerns or needs. The DON will be responsible for educating the nursing and therapy staff on the necessity of continued communication between disciplines.</p>	02/15/12
G 144	<p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure coordination of patient care was clearly documented in clinical records or minutes of case conferences for 2 of 11 sample patients (#6 and #9) who received care from more than one discipline. This had the potential to interfere with quality, coordination, and continuity of patient care. Findings include:</p>	G 144	<p>The RN Case Manage is responsible for coordination of cares among all disciplines providing services. Interdisciplinary Team meetings are being held every two weeks. All disciplines providing services will document patient care results on the IDT notes or give a report (verbal or written) to the RN Case Manager. Therapy services will attend IDT meetings as much as possible or will report cares to the RN to be added to the IDT notes. The Director of Nursing and/or designee will monitor the compliance of reporting and documentation among the disciplines to help with improvement of patient cares.</p>	02/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>	
(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 144	<p>Continued From page 16</p> <p>1. Patient #6 was a 90 year old male admitted to the agency on 12/06/11 for urinary catheter maintenance. His "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 12/06/11 through 2/03/12, contained orders for nursing services 1 time a week and home health aide services 3 times a week. the medical record did not contain documentation of coordination of care between the RN and the CNA.</p> <p>The home health aide who cared for Patient #6 was interviewed on 1/24/12 at 12/30 PM. She stated she usually spoke with a patient's Case Manager about one time a week and of course right away if there was a situation that needed to be communicated more urgently. She confirmed that she spoke with the Patient #6's Case Manager routinely but she did not usually document this communication.</p> <p>The RN Case Manager for Patient #6 was interviewed on 1/25/12 at 2:55 PM. She stated home health aide and nursing staff documented coordinated care in the supervisory section of the nursing progress note. She stated comments were documented on the visit note and the home health aide signed as an acknowledgement of receipt of the communications. She reviewed the supervisory visit documentation for Patient #6 and confirmed the home health aide did not sign the form and was not using it for documentation of communication.</p> <p>There was a lack of documentation of coordination of care between the home health aide and the Case Manager for Patient #6.</p>	G 144	<p>The RN Case Manager completes the Aide Plan of Care. A copy of the POC is given to the CNA prior to making the first aide visit. Any problems or concerns are to be reported to the RN Case Manger then documented on the Aide Visit Note. The RN Case Manager is to review Aide notes at least weekly. Education has been provided to the nursing staff (including the aides) to make sure documentation is complete, the RN Case Manager is notified if there are any problems and the supervisory visit notes are signed at least every two weeks by the CNA providing cares. The DON and QA Manger will monitor compliance with this. ~ <i>through quarterly chart reviews 3/13/12 TD</i></p>	02/21/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 144	<p>Continued From page 17</p> <p>2. Patient #9 was a 78 year old male admitted to the agency on 0/02/11 for care related to a hip fracture. His "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period from 9/02/11 through 10/12/11, indicated he received nursing for urinary catheter management and wound care, home health aide services, and was to be evaluated by speech therapy and physical therapy.</p> <p>Patient #9's medical record did not contain documentation of coordination of care between therapy services and nursing services. Documentation from nursing visit notes and the case conferences indicated that Patient #9 continued to receive therapy services but did not include communication about patient #9's progress regarding wound care or mobility and strength issues.</p> <p>The RN Case Manager for Patient #9 was interviewed on 1/26/12 at 3:30 PM. She stated she was aware of the physical therapy POC and confirmed there was communication between herself and the PT regarding Patient #9's progress. She stated the PT was anxious to know when Patient #9's wound healed so that ultrasound therapy could commence. She confirmed that this communication was not documented.</p>	G 144	Documentation related to coordination of cares must be completed between all disciplines. Progression of services and completion of goals must be documented as they occur. Open communication must be maintained between all staff. Education has been provided to the clinical staff and will be ongoing related to communication and documentation. The Administrator, Director of Nursing and/or designee will be responsible for this.	02/15/12
G 153	<p>484.16 GROUP OF PROFESSIONAL PERSONNEL</p> <p>The group of professional personnel establishes and annually reviews the agency's policies</p>			



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 153	<p>Continued From page 19</p> <p>meeting, "At this meeting was discussed the quality of services that have been provided through [agency] over the past year." However, there was no documentation of a discussion of the quality of services provided. The meeting minutes contained documentation of the discussion related to a new patient survey and who was responsible to develop the questions, deliver the surveys, and analyze the data.</p> <p>c. During the meeting on 10/12/10, the community liaison expressed concern that patients and families may not be aware they always had the option of deciding which home health agency to choose when they required care at home. It was documented that the agency would "work" to provide community education. There was not documentation as to how this education would be promoted or who would be responsible to provide it.</p> <p>d. At the meeting on 12/21/10, the Pocatello Branch Director (who was an LPN) indicated she wanted to evaluate outcomes related patient cares and therapy services. It was documented that she would look at completed chart reviews to "see how well the therapies have been providing cares. Further information will come from this at a later date." There was no documentation this issue was re-visited at subsequent meetings.</p> <p>e. According to the 7/14/11 meeting minutes, "it was determined that extra emphasis was needed to be placed on quality of director patient cares, skilled services that were offered, the quality of documentation to determine the need and results of patient cares. The question was asked by the quality director about how we are doing with</p>	G 153	Professional Advisory Group meetings will include review of minutes from past meetings in order to address issues that have previously been discussed. The Administrator and/or designee will be responsible for conducting this meeting and making sure the documentation is done completely and in a timely manner. Meeting discussions will include quality of services, review of policies and procedures, areas of concern, community interactions and staff qualifications/education.	01/31/12



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 153	Continued From page 21 Documentation in the 10/20/11 meeting minutes indicated the Branch Director for the Pocatello office was "actively looking for a community representative to come to these meetings."  The Administrator, interviewed on 1/31/12 beginning at 12:45 PM, stated the agency had been looking for a replacement but had not found one yet.  The agency failed to ensure the Professional Advisory Group had a least one member of the group who was neither an owner nor an employee of the agency and on an annual basis reviewed the agency's policies, clinical records, personnel qualifications, and program evaluation.	G 153	Alliance Home Health's Professional Advisory Group now has a Community Liaison who is not an employee or owner of the agency.	02/07/12
G 154	484.16(a) ADVISORY AND EVALUATION FUNCTION  The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program.  This STANDARD is not met as evidenced by: Based on staff interview and review of meeting minutes, it was determined the agency failed to ensure the group of professional personnel participated in an agency evaluation. This resulted in a lack of guidance to the agency. Findings include:  Professional Advisory Group meeting minutes	G 154	An agency evaluation will be conducted annually by chosen members of the Professional Advisory Group. The Group was educated on what their duties include, on how to evaluate the Policies and Procedures, the agency's program, maintaining liaison with other health care professionals/providers and with the community. To provide guidance and direction for the Alliance Home Health program and promote best quality of healthcare standards.	01/31/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 154	Continued From page 22 from 4/28/10, 7/06/10, 10/12/10, 12/21/10, 4/24/11, 7/14/11, and 10/20/11 did not contain documentation of an agency evaluation for 2010 or 2011.  The Administrator was interviewed on 1/30/12 at 4:05 PM. She confirmed the agency had not conducted an annual evaluation of the agency's policies, administration, and clinical record review. Therefore the Professional Advisory Group did not have this information to review and provide feedback to the agency.  The agency failed to ensure a group of professional personnel had met to provide guidance to the agency.	G 154	The Professional Advisory Group decided that the meetings will be held at least two times a year and that the annual agency evaluation will be conducted before the end of 2012 and every year thereafter. <i>Annual Evaluation for 2011 Report is completed as of 3/9/12 &amp; will be presented to PAG on or about 4/23/12 to finalize, Administrator is responsible for this. 3/13/12 TO</i>	01/31/12
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  This CONDITION is not met as evidenced by: Based on staff and patient interview and review of medical records, it was determined the agency failed to ensure care was provided in accordance with patients' POCs and failed to ensure physicians were alerted to changes in patient conditions. This resulted in plans of care that did not match the care provided, as well as a lack of input from physicians related to POCs. Findings include:  1. Refer to G 158 as it relates to the failure of the agency to ensure staff followed patients' established POCs.  2. Refer to G 160 as it relates to the failure of the	G 156	All RN Case Managers received education on patient care management related to Home Health services being done ONLY under direct orders from the patient's physician, following the physician ordered POC, notifying the physician of any changes that may require a change in physician ordered POC. The Administrator and DON provided this education and will be responsible for compliance.	02/15/12 & 02/21/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 156	Continued From page 23 agency to ensure physicians were consulted regarding changes to the POC.	G 156	Clinical staff education was provided by the DON and Administrator on Policy and Procedure related to the patient Plan of Care and following Physician orders.	02/15/12 & 02/21/12
G 158	3. Refer to G 164 as it relates to the failure of the agency ensure staff notified physicians to changes in patients' conditions.  The cumulative effect of these negative systemic practices seriously impeded the ability of the agency to provide care of adequate quality. 484.18 ACCEPTANCE OF PATIENTS, POC, 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 staff interview and review of medical records, it was determined the agency failed to ensure care followed a written POC for 4 of 14 patients (#7, #10, #11, and #12) whose records were reviewed. This resulted in the inability of the agency to provide care that had been authorized by a physician. Findings include:  1. Patient #10's medical record documented a 78 year old female who was admitted to home health on 11/29/11 and was currently a patient as of 1/26/12. Her diagnosis included ulcerative colitis and diabetes. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 11/29/11, called for nursing visits 4 times a week for 1 week, 3 times a week for 1 week, and 1 time a week for 1 week. These visits were completed as per the plan on 12/12/11. Nursing visits were also made on 12/16/11 and 12/23/11 which were	G 158	All medications, treatments and services provided to clients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. All medications and treatments, that are part of the client's plan of care, must be ordered by the physician. Physician orders shall be incorporated into the plan of care when skilled care is being provided. Physician orders will be followed as written. Any changes in the POC will be ordered by the physician and implemented by the licensed staff. The Director of Nursing and/or Branch Director will be responsible for ensuring that all staff is educated on policies and procedures related to following physician orders, providing cares in accordance with those orders and notifying the physician with changes in patient condition that may require changes in the orders. <i>The Director of Nursing is responsible for this. 3/13/12 TD</i>	02/21/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>	
(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 158	<p>Continued From page 24 not included in the POC.</p> <p>The discrepancy in nursing visits was confirmed with the Pocatello Branch Director on 1/26/12 at 11:10 AM.</p> <p>2. Patient #11's medical record documented an 89 year old female who was admitted to the home health agency on 11/28/11 and was discharged on 1/04/12. Her diagnoses included a skull fracture and diabetes. She received home health aide services on 11/30/11, 12/02/11, 12/05/11, 12/07/11, 12/09/11, 12/12/11, 12/14/11, 12/16/11, 12/19/11, 12/20/11, 12/23/11, 12/28/11, 12/29/11, and 12/30/11. Her POC, dated 11/28/11, did not mention aide services. Physician orders for aide services were not documented.</p> <p>The Branch Director from the Pocatello office was interviewed on 1/26/12 beginning at 9:35 AM. She reviewed the record and confirmed aide services were not provided according to the POC.</p> <p>3. Patient #12 was an 80 year old female admitted to the agency on 11/28/11. Her medical record contained a physician's order, dated 11/28/11, for an admission to home health for weakness and physical and occupational therapy evaluations and treatment. Her medical record did not contain documentation of an OT evaluation or treatment.</p> <p>The RN Case Manager for Patient #12 was interviewed on 1/26/12 at 10:35 AM and again at 3:30 PM. She explained that she had inadvertently programmed an incorrect phone number for the Occupation Therapist into her work phone. Therefore, the Occupational</p>	G 158	<p>All patients must have written and signed orders for services rendered by Alliance Home Health staff. Aide services must be ordered by the physician and an aide Plan of Care established by the RN Case Manager prior to providing services.</p> <p>Aide specific chart reviews will be conducted weekly for 4 weeks then monthly thereafter (open charts), to ensure that physician orders are being obtained and followed. The Administrator and/or Designee will be responsible for follow-up of this.</p> <p>Chart reviews will be given to the QA Manager for review and problems will be identified by the team to correct areas of deficiency.</p>	<p>02/01/12</p> <p>02/20/12</p> <p>02/27/12</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 158	<p>Continued From page 25</p> <p>Therapist did not receive the message regarding the referral for Patient #12. She stated she did not follow through to ensure Patient #12 was evaluated by the Occupational Therapist. She stated Patient #12's physician was not notified of this oversight.</p> <p>Patient #12 did not receive therapy services in accordance with the physician's POC.</p> <p>4. Patient # 7 was an 82 year old male admitted to the agency on 12/07/11 for home health aide and therapy services. His medical record contained a physician's order, dated 12/13/11, for OT to evaluate and treat. The medical record did not contain documentation of an OT evaluation or treatment.</p> <p>The RN Case Manager for Patient #7 was interviewed on 1/26/11 at 10:35 AM and again at 3:30 PM. She explained that she had inadvertently programmed an incorrect phone number for the Occupational Therapist into her work phone. Therefore, the Occupational Therapist did not receive the message regarding the referral for Patient # 7. She stated she did not follow through to ensure Patient #7 was evaluated by the Occupational Therapist. She stated Patient #7's physician was not notified of this oversight.</p>	G 158	<p>A double-check system has been put into place. If the physician has ordered therapy services the Office Manager will double check with the RN Case Manager to make sure the appropriate therapies have been notified. A face sheet will be faxed to the appropriate therapist notifying them of the referral. The RN Case Manager and/or designee will be responsible for this.</p> <p><i>The RN Case Manager will be responsible for this and <sup>only to</sup> compliance monitored by GA 3/13/12 TO @ least quarterly</i></p>	02/21/12
G 160	<p>484.18(a) PLAN OF CARE</p> <p>If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve</p>	G 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>		
(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 160	<p>Continued From page 26 additions or modification to the original plan.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure physicians were consulted in order to authorize additional orders after initial assessments were completed for 5 of 11 sample patients (#3, #9, #12, #13, and #14) whose records were reviewed. This resulted in the provision of care without physician approval. Findings include:</p> <p>1. Patient #12 was an 80 year old female admitted to the agency on 11/28/11 primarily for physical therapy services related to generalized muscle weakness. Patient #12 also had a diagnosis of congestive heart failure. She was admitted to the hospital on 1/04/12, and discharged from home health services on 1/08/12.</p> <p>Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 11/28/11 through 1/26/12 indicated Patient #12 Was to receive physical therapy visits three times a week for six weeks. The POC was signed by the physician on 1/26/12. Patient #12's medical record also contained a "PHYSICAL THERAPY CARE PLAN." Created by the PT on 12/05/11. The form had a place to indicate if a verbal order for the POC as obtained. This section was left blank.</p> <p>Patient #12's medical record contained 14 physical therapy visit notes between 12/05/11 and 1/04/12. A physician order for these visits was not present.</p>	G 160	<p>Alliance's professional staff will promptly alert the physician to any changes that suggest a need to alter the Plan of Care. For Example: In the event that physician ordered visits have not been made, the MD will be notified and an order for correction to the POC will be obtained or a missed visit note will be completed and sent to the patient's physician. The DON and/or designee will monitor compliance and will report findings to Administrator.</p> <p>Chart reviews on all open charts are being done weekly for 4 weeks and will then be done monthly on at least 10% of the charts. Chart review results are given to the Case Manager for correction. The Director of Nursing and/or designee will monitor compliance.</p> <p><i>The DON will monitor Compliance for this. 3/13/12 TD</i></p>	02/01/12  02/01/12

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

PRINTED: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 160	<p>Continued From page 27</p> <p>The RN Case Manager for Patient #12 was interviewed on 1/26/12 at 10:35 AM. She confirmed the documentation related to the lack of physician approval for the physical therapy visits prior to 1/26/12.</p> <p>2. Patient #9 was a 78 year old male admitted to the agency on 9/02/11 for care related to a hip fracture. He was a current patient as of 1/26/12. His "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period from 9/02/11 through 10/21/11, indicated Patient #9 was to receive nursing visits two times a week for eight weeks. According to this POC, he was to have a physical therapy and speech therapy evaluation and the home health aide was to assist him with personal cares (no visit frequency had been assigned to the home health aide visits). The POC was signed by the physician on 10/26/11.</p> <p>Patient #9's medical record contained a "PHYSICAL THERAPY PLAN OF CARE (POC)." Completed by the PT on 9/06/11 for visits two times a week for six weeks. The form contained a section to document if verbal orders were received for the POC. This section was left blank. However, the physician signed the form on 9/22/11. Patient #9 received physical therapy visits on 9/09/11 and 9/13/11 prior to the physician's approval to the POC. The medical record contained a missed visit note for the visits scheduled during the week from 9/18/11 through 9/24/11 due to Patient #9 not feeling well.</p> <p>From the date of the initial assessment on 9/02/11 until the POC was signed by the</p>	G 160	<p>All Home Health services will be ordered by the Physician and followed by the clinician providing the cares. Once the RN Case Manager and/or therapist has completed their assessment of the patient, the physician will be notified of the Plan of Care. A verbal order will be written after the assessment which will include the number of visits needed by each discipline and the skilled services that are required. EXAMPLE: SNV 2 x week for 3 weeks, 1 x week for 6 weeks for assessment of diagnosis; medication management. PT visits 2 x week for 9 weeks for strengthening. Aide visits 3 x week for 9 weeks for assist with personal cares. The DON and/or designee will monitor compliance</p>	02/15/12

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

PRINTED: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DIFICIENCY 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 160	<p>Continued From page 28 physician, on 10/26/11, Patient #9 received 15 nursing visits and 22 home health aide visits. These visits were completed without documentation of physician approval of the POC.</p> <p>The RN Case Manager for Patient #9 was interviewed on 1/26/12 at 3:30 PM. She confirmed that the PT completed his evaluation on 9/06/11 and created a POC. She also confirmed there was no documentation the physician was notified of the POC and no verbal orders obtained for provision of therapy services after the initial evaluation until the POC was signed by the Physician on 9/22/11. She stated after completing the initial assessment she developed a POC. She stated se did not always contact the physician to notify them of the POC or obtain verbal orders for the subsequent provision of care.</p> <p>The DON was interviewed on 1/30/12 at 10/10 AM. She explained the expected process for obtaining physician approval for the POC following the comprehensive assessment. She stated that following that initial assessment when the RN created the POC he/she was to contact the physician to obtain approval for the established POC. This approval was to be documented in a section of the referral intake form.</p> <p>However, the referral intake form did not contain documentation that the physician was notified of the planned frequency of visits for nursing, therapy, or the home health aide. There was no documentation the physician approved of the wound care or urinary catheter maintenance to be provided. Someone had documented information</p>	G 160	<p>Staff education was provided by the Administrator and DON regarding obtaining verbal orders after the initial evaluation for the POC, including frequency of visits, skilled services to be provided and disciplines providing cares and frequencies. The Administrator and DON will monitor compliance.</p>	02/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 160	<p>Continued From page 29</p> <p>In the section of the referral intake form titled, "Attending Physician Contacted about ordered POC (see below)." There was a line which read "Date/Time: 9/2/11 HH [Home Health] adm [admit]/PT [physical therapy] &amp; ST [speech therapy] orders ([name of PT/name of Speech Therapist]), nursing to care for pressure ulcers &amp; foley [sic] maintenance." Another line read "RN Signature: [initials of a nurse]."</p> <p>The DON was interviewed on 1/30/12 at 10:10 AM. She reviewed this section of Patient #9's medical record and confirmed that the physician did not approve the frequency of visits for nursing or the home health aide, or the wound care and catheter maintenance. She verified the information was not documented by the RN Case Manager who completed the comprehensive assessment.</p> <p>Patient #9's "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the second certification period from 11/01/11 through 12/30/11, indicated nursing was to see Patient #9 one time a week for eight weeks for wound care and urinary catheter maintenance and the home health aide was to assist Patient #9 three times a week for eight weeks. This POC was not signed by the physician until 1/04/12.</p> <p>Patient #9's medical record contained 10 nursing Visits and 27 home health aide visits between the time the POC was developed on 11/01/11 and when the physician signed approval of the POC, on 1/04/12. Nursing staff provided urinary catheter changes and dressing changes during this time frame.</p>	G 160	<p>After the initial assessment and evaluation for home health services, the physician will be notified of the Plan of Care, verbal orders received and written, then submitted for signature. This will be included in the admission process. A supplemental order form will be included in the admission packet to assist the RN Case Manager in documenting the verbal orders for start of care. The DON and/or designee will be responsible for compliance. This will be added to the orientation program for Home Health staff. The Administrator will monitor compliance and chart reviews are being completed to ensure compliance.</p>	02/20/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 160	<p>Continued from page 30</p> <p>The medical record contained a physician order form completed by the RN on 10/28/11. The RN documented a verbal order from the physician for "Re-cert [recertification] Home Health to include wound care, home health aide services, and foley [sic] cath [catheter] maintenance." The physician signed the orders on 11/09/11. However, the verbal order did not indicate the frequency of nursing or CNA visits approved, or the details related to wound care or catheter maintenance.</p> <p>The RN Case Manager reviewed Patient #9's medical record on 1/26/12 at 3:30 PM. She confirmed the documented verbal order for the POC dated 11/01/11 was not complete and therefore the care was provided without physician approval.</p> <p>Care was provided to Patient #9 without physician approval.</p> <p>3. Patient #3's medical record documented an 85 year old female who was admitted to home health on 1/11/12 for low back pain and hypertension. She was currently a patient as of 1/25/12. Her POC, dated 1/11/12, called for physical therapy to evaluate and treat her. The PT visited her on 1/11/12. He wrote a "PHYSICAL THERAPY CARE PLAN," dated 1/11/12, for physical therapy 2 times a week for 1 week and 3 times a week for 7 weeks. The therapy POC was not signed by the physician until 1/25/12. However, visits by the PT were documented on 1/13/12, 1/17/12, 1/19/12, 1/20/12, and 1/23/12.</p> <p>The DON was interviewed on 2/01/12 at 11:05 AM. She reviewed Patient #3's record and confirmed orders for physical therapy were not</p>	G 160	<p>Chart reviews on new admissions will be done by nursing and/or QA team members weekly for 4 weeks, then monthly on at least 10% of the open charts. Reports will be given to the Director of Nursing indicating any deficiencies and needs for correction. The person responsible will correct any deficiencies and will submit these corrections to the DON for approval. The time frame for completion of corrections will be within 48 hours. The DON will report the deficiencies to the Administrator who will present these to the Governing Body at least quarterly.</p>	02/20/12

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

PRINTED: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 160	<p>Continued From page 31 obtained until 1/25/12.</p> <p>The physician did not approve the therapy POC.</p> <p>4. Patient #13's medical record documented a 78 year old female who was admitted to home health on 12/05/11 following the revision of total hip surgery. She was currently a patient as of 1/26/12. Care was provided by the Malad office. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 12/05/11, stated "PT See Plan of Care." The Physical Therapy evaluation, dated 12/05/11, stated the PT planned to see Patient #13 three times a week for 4 weeks. There was no documentation the physician had been notified of this plan and no orders for physical therapy were documented. Visits by the PT were documented on 12/07/11, 12/09/11, 12/12/11, 12/14/11, 12/16/11, and 12/19/11.</p> <p>The Branch Director for the Malad office was interviewed on 1/26/12 beginning at 1:40 PM. She confirmed the documentation and said the POC for therapy had not been approved by the physician.</p> <p>The physician did not approve the therapy POC.</p> <p>5. Patient #14's medical record documented a 77 year old female who was admitted to home health on 7/18/11 for Parkinson's Disease. She was discharged on 10/18/11. Care was provided by the Twin Falls office. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 7/18/11, stated "PT See Plan of Care." the PHYSICAL THERAPY PLAN OF CARE (POC)," written by the PT and dated 7/21/11, stated the</p>	G 160	<p>Orders for Home Health services will be obtained from the Patient's physician prior to performing any cares. Staff education presented on the Policy related to physician orders and provision of cares.</p>	02/15/12 & 02/21/12

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

PRINTED: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 160	Continued From page 32 PT planned to see Patient #14 two times a week for 9 weeks. There was no documentation the physician had been notified of this plan and no orders for physical therapy were documented until 8/12/11. A time stamp stated the plan was faxed to the physician on 7/26/11. It was signed by the physician on 8/12/11. The PT documented visits to Patient #14 on 7/25/11, 7/28/11, 8/02/11, 8/03/11, and 8/09/11. These visits occurred prior to approval by the physician.  The Branch Director for the Twin Falls office was interviewed on 1/26/12 beginning at 4:05 PM. She confirmed the documentation and said the POCD for therapy was not been approved by the physician until 8/12/11.	G 160	All Home Health services will be signed and ordered by the physician prior to offering services. This will be monitored by chart reviews by the RN Case Manger and the DON.	02/27/12
G 164	The physician did not approve the therapy POC prior to providing therapy services. 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 staff interview and review of medical records, it was determined the agency failed to ensure staff notified the physician to changes in the condition of 1 of 2 patients (#1) who were hospitalized while on home health, that suggested a need to alter the plan of care. This resulted in a lack of input from the physician regarding the need to alter home health services. Findings include:	G 164		

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

PRINTED: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 164	<p>Continued From page 33</p> <p>Patient #1's medical record documented a 78 year old male who was admitted to home health on 11/10/11 and was currently a patient as of 1/23/12. His diagnoses included emphysema, hypertension, and depression.</p> <p>Patient #1's medical record documented he was hospitalized on 12/06/11 for an exacerbation of breathing difficulties. He was also hospitalized on 12/22/11 and was discharged on 12/23/11 for hernia surgery. He was again hospitalized on 1/02/12 and discharged on 1/02/12 for increased difficulty breathing. The POC was not changed following any of these hospitalizations. No documentation was present that Patient #1's physician was consulted after these hospitalizations in order to determine if the POC needed to be changed.</p> <p>The DON was interviewed on 1/24/12 beginning at 2:50 PM. She stated the physician was not contacted following Patient #1's hospitalizations in order to determine if the POC needed to be updated.</p> <p>The agency did not contact Patient #1's physician when his condition change in order to determine if the POC needed to be updated.</p> <p>The agency did not contact Patient #1's physician when his condition change in order to determine if the POC needed to be updated.</p>	G 164	<p>Following the initial assessment, a Care Plan shall be developed with the client and/or caregiver. The interventions shall correspond to the problems identified, services needed and the client goals for the episode of care. The Care Plan shall be reviewed, evaluated, and revised (minimally every 60 days <b>and as needed</b>) based upon the client's health status and/or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse or Therapist. All changes will be communicated to appropriate staff members. The Administrator and DON will monitor compliance.</p> <p>Modifications or additions to the initial plan of care shall be made as necessary. The total Plan of Care shall be reviewed by the attending physician and Alliance Home Health personnel as often as the severity of the client's condition requires, but at least one time every 60 days. Physician's signature and date shall be evidence of the review or renewal. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care. The Administrator and/or designee will monitor compliance.</p>	02/15/12  02/20/12
G 229	<p>484.36(d)(2) SUPERVISION</p> <p>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.</p> <p>This STANDARD is not met as evidenced by:</p>	G 229	<p>If the patient is hospitalized, an assessment will be completed for resumption of care and the POC will be revised a new orders obtained to resume cares as needed &amp; per MD orders. The DON will monitor compliance. 3/13/12</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>		
(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 229	<p>Continued From page 34</p> <p>Based on record review, review of facility policies, and interview it was determined the agency failed to ensure home health aide supervisory visits were conducted every 14 days for 1 of 1 sample patients (#7) who received only physical therapy and home health aide services. This had the potential to interfere with quality and safety of patient care. findings include:</p> <p>Patient #7 was an 82 year old male admitted to the agency on 12/07/11 for physical therapy related to weakness. His "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period from 12/07/11 to 2/04/12, included orders for one skilled nursing visit to admit Patient #7 to services, as well as physical therapy visits 3 times a week for 6 weeks, and home health aide visits 2 times a week for 6 weeks. Patient #7 was discharged from the agency on 1/19/12 as his therapy goals had been met.</p> <p>The medical record contained documentation of home health aide and physical therapy visits throughout the admission, However, the medical record did not contain documentation that the Physical Therapist had completed home health aide supervision at any point during Patient #7's admission.</p> <p>The "HOME HEALTH AIDE SUPERVISION" policy, last reviewed in 12/2009, indicated, "When skilled services are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client's residence at least every 2 weeks... to assess relationships and determine whether goals are being met."</p>	G 229	Alliance Home Health shall provide Home Health Aide services under the direction and supervision of a Registered Professional Nurse/Therapist when personal care services are indicated and ordered by the physician. The frequency of supervision will be in response to Medicare regulations and no less than every 14 days. The RN Case Manager will be responsible to ensure that these supervisory visits are done as per policy.	02/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>		
(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 229	Continued From page 35 The RN Case Manager for Patient #7 was interviewed on 1/26/12 at 10:35 AM. She stated that as physical therapy was the only skilled service providing care to Patient #7, it was the Physical Therapist's responsibility to provide home health aide supervision. She confirmed that there was not documentation in the medical record to indicate the home health aide had been supervised by the Physical Therapist.	G 229	Education was provided by the DON to the RN Case Managers about the necessity of supervision of the CNAs. The RN is the Case Manager and must ensure that the supervisory visits are completed at least every 14 days. They are to remind the Physical Therapist or make a non-billable visit and complete the supervision themselves. The DON and Administrator are responsible for maintaining compliance.	02/17/12
G 236	The agency failed to ensure home health aide supervisory visits were completed when the only skilled service provided was physical therapy. <b>484.48 CLINICAL RECORDS</b>  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 discharge summary.  This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure complete and accurately edited medical records were maintained for 7 of 14 patients (#1, #5, #6, #7, #10, #12, and #14) whose medical records were reviewed. This resulted in incomplete information available to staff caring for patients. Findings include:	G 236	All new admissions' clinical records will be reviewed weekly for the next 4 weeks, then 10% of the charts will be reviewed monthly. The DON will be responsible for compliance. The reviews will be given to the DON and QA manager. Any discrepancies found in the charts will be corrected by the appropriate clinical staff. A report of the findings will be given to the Administrator (weekly then monthly).	02/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 236	<p>Continued From page 36</p> <p>1. The agency failed to ensure complete medical records were available as follows:</p> <p>a. Patient #10's medical record documented a 78 year old female who was admitted to home health on 11/29/11, and was currently a patient as of 1/26/12. Her diagnoses included ulcerative colitis and diabetes.</p> <p>Patient #10's medical record was not kept in the main office. The complete medical record was requested from the Pocatello Office Manager on 1/16/12 at 8:30 AM. The medical record was e-mailed from the Twin Falls office. The record was substantially incomplete when it arrived. The form "HOME HEALTH CERTIFICATION AND PLAN OF CARE" was not included. Nursing visit notes for 11/29/11, 11/30/11, 12/01/11, and 12/09/11 were initially sent as the record. Two aide notes were also sent. No progress notes beyond 12/09/11 were included in the record. The record was requested again. Seventeen more nursing notes, dated between 12/05/11 and 1/20/12, were sent with the second transmission, as well as 5 PT notes and 1 SW note.</p> <p>The Office Manager at the parent office, who also was responsible for medical records, was interviewed beginning at 11:15 AM on 1/26/12. She stated branch offices were supposed to e-mail medical records to the parent office. She stated the parent office was to maintain complete medical records for all patients. She stated she had sent several reminders to the branch offices to send their medical records in. She said she had started working for the company seven or eight months ago. She said the availability of medical records from branch offices was a</p>	G 236	<p>Missing documentation will be requested by the office manager of the parent office. If documentation is not provided weekly, she will notify the DON and Branch Director of the parent office. If staff continues to be non-compliant the Administrator will be notified and disciplinary actions will be initiated. This action has been approved by the Governing Body, DON and Parent Office Branch Director.</p>	02/06/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 236	<p>Continued From page 37</p> <p>continuing problem since that time. She also confirmed Patient #10's medical record was not available at the parent office.</p> <p>The Branch Director of the parent office was interviewed beginning at 11:10 AM on 1/26/12. She was asked about the incomplete medical record. She stated she had urged other Branch Directors to send their records to the main office at the Branch Directors' meetings. She stated difficulty getting medical records from branch offices was not a new problem.</p> <p>The agency did not maintain a readily available medical record for Patient #10.</p> <p>b. Patient #1's medical record documented a 78 year old male who was admitted on 11/10/11 and was currently a patient as of 1/23/12. His diagnoses included emphysema, hypertension, and depression. He was served by the parent office in Pocatello. His medical record was requested on 1/23/12 at 2:00 PM. The record was provided promptly but it was incomplete. Only 12 nursing progress notes dated between 11/10/11 and 12.20/11 were contained in the clinical record. The complete medical record was requested from the Pocatello Office Manager. The complete record was provided approximately 20 minutes later. Missing documentation included 4 more nursing progress notes dated between 12/27/11 and 1/17/12, a SW note dated 1/10/12, as well as an updated POC dated 1/09/12. The Pocatello Office Manager stated the missing information had not been filed.</p> <p>The agency did not maintain a readily available medical record for Patient #1.</p>	G 236	<p>Documentation of services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within seven (7) days after the care has been provided. The Administrator and/or designee will monitor compliance. Chart reviews will be completed weekly for four weeks (then Monthly at least 10%) to monitor compliance. The RN Case Manager will review their own charts monthly and PRN to make sure appropriate visit notes are filed in the charts.</p> <p><i>The office Manager will send requests for pt. specific documentation that is missing to the respective offices &amp; cc a copy to the DON &amp; Administrator to monitor compliance weekly. 3/13/12 TD</i></p>	02/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 236	Continued From page 38  c. Patient #14's medical record documented a 78 year old female who was admitted to home health on 7/18/11. She was discharged on 10/18/11. Her diagnosis was Parkinson's Disease. Her medical record was requested from the Pocatello Office Manager at 9:10 AM on 1/26/12. The Office Manager for the parent office in Pocatello stated her record was not present and needed to be retrieved from the Twin Falls office.  Patient #14's medical record was not available at the parent office even though she had been discharged 3 months and 8 days earlier.  d. Patient #7 was an 82 year old male admitted on 12/06/11 for physical therapy and home health aide services for muscular weakness. He was discharged from the agency on 1/19/12. His care was provided from the Idaho Falls office. His medical record was requested for review on 1/23/12. At the time of review on 1/24/12, Patient #7's medical record was substantially incomplete. It contained a face sheet, admission paperwork, home health referral order, order for continuation of physical therapy, the comprehensive admission assessment and the home health aide plan of care. it did not contain the "HOME HEALTH CERTIFICATION AND PLAN OF CARE" or visit notes. The Pocatello Office Manager was notified of the deficiencies the afternoon of 1/24/12.  On 1/25/12 at 8:15 AM, the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," the Physical therapy POC, five physical therapy visit notes from 1/03/12 through 1/13/12 and the physical therapy discharge assessment were	G 236	All nursing and therapy staff have been educated by the DON and Administrator on the fact that all visit notes, POCs, and completed documentation related to patient cares must be filed in the patients' chart and must be in the Pocatello office. The Pocatello office is the CMS certified site for Alliance Home Health of Idaho. Since there are no branches for Home Health, all patient records are filed and maintained in the Pocatello office and must be in the charts within 7 days. Compliance with policy will be monitored by the QA Manager and DON.  Extra education about documentation and keeping all of the records in the Pocatello office, filing all documentation within 7 days was provided by the DON and Administrator. Chart reviews are being done to monitor compliance.	02/01/12  02/20/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 236	<p>Continued From page 39 present on the record. The information was reviewed and the Pocatello Office Manager was notified that information was still missing.</p> <p>On 1/26/12 additional information was provided from the Idaho Falls office to the Pocatello parent office. This included an additional physician order, five home health aide visit notes from 12/15/11 to 12/29/11, the physical therapy evaluation and POC along with 17 physical therapy visit notes from 12/13/11 through 1/18/12.</p> <p>The Branch Director for the Idaho Falls office was interviewed on 1/26/12 at 3:15 PM. She stated it was difficult to coordinate the transfer of medical records between the two offices.</p> <p>The agency did not maintain a readily available complete medical record for Patient #7.</p> <p>e. Patient #12 was an 80 year old female admitted to the agency on 11/28/11 primarily for physical therapy services related to generalized muscle weakness. Patient #12 also had a diagnosis of congestive heart failure. She was listed as a current patient at the time the record was requested for review on 1/23/12. Her medical record was initially reviewed the morning of 1/26/12 and contained a face sheet, admit paperwork, the comprehensive nursing assessment, the physical therapy evaluation, physical therapy POC, and 12 physical therapy visit notes from 12/15/11 to 12/30/11.</p> <p>Patient #12's RN Case Manager was interviewed on 1/26/12 at 10:35. She confirmed the Idaho Falls office had additional information for Patient #12 that was to arrive that afternoon. She</p>	G 236	<p>A new POLICY has been developed by the Administrator and approved by the Governing Body and members of the PAG and is as follows: All clinical records will be filed, maintained and kept current by the Home Health parent office until such time as Alliance receives approval from CMS/State to have branch offices. All documentation from remote offices will be mailed, faxed, or e-mailed to the parent office at least weekly. Copies of documentation may be kept in the remote offices for clinical staff to refer to in order to provide continuity of care. The home health parent office will maintain and store all closed out patient charts.</p> <p>The Director of Nursing and/or designee will monitor compliance from all clinical staff to make sure appropriate paperwork is in the patient charts.</p>	02/06/12 and PAG on 02/08/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>	
(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 236	<p>Continued From Page 40 explained that Patient #12 was admitted to the hospital on 1/04/12 and discharged from home health services on 1/08/12.</p> <p>The afternoon of 1/26/12, the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," the original referral order, and two physical therapy visit notes, dated 1/02/12 and 1/04/12, were submitted for review.</p> <p>On 1/27/12 at 10:05 AM, the Pocatello Office Manger was asked to obtain the "TRANSFER TO INPATIENT FACILITY" and "DISCHARGE ASSESSMENT" for Patient #12. She stated Patient #12 was not entered into the system as discharged and she would need to contact the Idaho Falls office for this documentation. It was faxed to the surveyor's office on 1/27/12 at 3:15 PM.</p> <p>The agency did not maintain a readily available complete medical record for Patient #12.</p> <p>2. The agency failed to ensure corrections/additions to medical records documented the identity of the individual completing the edits and the date the edits were made. Examples are as follows:</p> <p>a. Patient #6 was a 90 year old male admitted to the agency on 12/06/11 for urinary catheter maintenance. He was a current patient as of 1/26/12. Patient #6's "COMPREHENSIVE ADULT NURSING ASSESSMENT," dated 12/06/11, was a 20 page document which contained 2 distinct sets of writing written in different colored ink. The author using the black ink signed the document. The author using the</p>	G 236	<p>All documentation will be completed after the visit is made or the orders are given. All documentation will be filed in the patient's chart within 7 days. The patient data will be entered in the computer system by the Office Manager within 72 hours. The DON will be responsible for maintaining compliance.</p>	02/20/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 236	<p>Continued From page 41</p> <p>Blue ink had written on 7 pages of the document, including adding information to the assessment and plan of care documentation. The author using the blue ink did not sign the document authenticating the author's identity.</p> <p>The DON was interviewed on 1/24/12 at 4:35 PM. She confirmed that she sometimes amended the "COMPREHENSIVE ADULT NURSING ASSESSMENT" forms. She stated that if the RN was in the office a list of edits/additions for the RN to add to the paperwork was created. If the RN was not in the office she made the corrections. She confirmed that the added information was not dated, timed, or authenticated.</p> <p>The Case Manger, who was the RN completing the comprehensive assessment for Patient #6 was interviewed on 1/25/12 at 2:55 PM. She stated in the past the DON added information to her assessment forms. She stated that now the DON created a list of additions and/or edits for her to correct. She reviewed Patient #6's medical record and confirmed the documentation in the blue ink was not dated or authenticated and was not hers.</p> <p>b. Patient #5's medical record documented a 57 year old male who was admitted to home health on 1/02/12 following hip replacement surgery. He was currently a patient as of 1/24/12. Patient #5's "COMPREHENSIVE ADULT NURSING ASSESSMENT," dated 1/07/12, was a 20 page document which contained 2 distinct sets of writing written in different colored ink. The author using the black ink signed the document. The author using the blue ink had written on 8 pages</p>	G 236	<p>Education was provided by the Administrator regarding documentation in the patient chart. Each clinician will be responsible for signing, dating and/or initialing his/her own documentation. The DON position has been changed. The new DON also provided education to the IDT that each separate entry by each separate individual clinician will be initialed and their signature placed at the end of the documentation. The DON and/or her designee will be responsible for compliance.</p>	02/15/12



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

PRINTED: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 242	Continued From page 43 agency's program was appropriate, adequate, effective and efficient.  3. Refer to G 246 as it relates to the agency's failure to ensure an annual agency evaluation was conducted and results of the evaluation were reported to and acted upon by those responsible for the operation of the agency.  4. Refer to G 250 as it relates to the agency's failure to include all health professionals in chart audits representing the scope of the program as part of the quarterly record review.			
G 244	The cumulative effect of these negative systemic practices seriously impeded the ability of the agency to provide services of adequate quality. 484.52 EVALUATION OF THE AGENCY'S PROGRAM  The evaluation consists of an overall policy and administrative review and clinical record review.  This STANDARD is not met as evidenced by: Based on review of meeting minutes, quality assessment documentation, and agency policies, and staff interview, it was determined the agency failed to ensure an annual evaluation including an overall policy, administrative, and clinical record review was completed., this had the potential to result in the failure of the agency to adequately meet patient needs. Findings include:  The agency's "ANNUAL EVALUATION" policy, reviewed in 12/2009, indicated "The Annual agency evaluation is a systematic collection and analysis of information necessary to guide the	G 244	The Administrator is responsible for management of the Annual Agency Evaluation and presenting the results to the Governing Body. The Annual agency evaluation will be completed on or about the middle of December of each year.	02/01/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>	
(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 244	Continued From page 44 agency in future planning for services. The evaluation is completed at the end of the agency's fiscal year." According to the policy, the components of the evaluation included, "a) Organization structure and systems review, b) Policy and procedure review, c) Clinical record review, d) Program review or [sic] appropriateness, adequacy, effectiveness, efficiency of client care."  Professional Advisory Group meeting minutes for the calendar years 2010 and 2011 and Governing Body meeting minutes for calendar year 2011 were reviewed. Quality assurance documentation for October through December of 2011 was reviewed. There was no documentation that an annual agency evaluation was conducted.  The Administrator was interviewed on 1/30/12 at 4:05 PM. She confirmed the agency had not conducted an annual evaluation of the agency's policies, administration, and clinical record review.  The Program Director for QAPI was interviewed on 1/27/12 at 9:00 AM. She stated she was unaware of the requirement for an annual evaluation of the agency's program. She stated she compared her data (such as incident reports, infection rates, record review data, statistics) year to year but did not compile a report with this information for anyone to review.  The agency did not ensure an annual evaluation of the agency's program was completed.	G 244	Chosen members of the PAG that will complete the Annual Agency Evaluation has been chosen and education provided by the Administrator related to the POLICY regarding the responsibilities of the team and the components to be evaluated.	02/01/12
G 245	484.52 EVALUATION OF THE AGENCY'S PROGRAM	G 245		

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

PRINTED: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 245	<p>Continued From page 45</p> <p>The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.</p> <p>This STANDARD is not met as evidenced by: Based on review of agency policies, meeting minutes, quality assurance documentation, and staff interview, it was determined the agency failed to ensure an annual evaluation was performed to assess the extent to which the agency's program was appropriate, adequate, effective and efficient. This failure had the potential to result in missed opportunities to streamline services and improve patient care. Findings include:</p> <p>The agency's 'ANNUAL EVALUATION' policy, reviewed in 12/2009, indicated the purpose of the organization's program meets the needs of the community, provides adequate services, delivers services effectively, and operates efficiently."</p> <p>Professional Advisory Group meeting minutes for calendar years 2010 and 2011 and Governing Body meeting minutes for the calendar year 2011 were reviewed. Quality assurance documentation for the 4<sup>th</sup> quarter of 2011 were reviewed. There was no documentation that an annual agency evaluation was conducted.</p> <p>The Administrator was interviewed on 1/30/12 at 4:05 PM. She confirmed the agency had not conducted an annual evaluation of the agency's policies, administration, and clinical record review to assess the appropriateness, adequacy,</p>	G 245	The Governing Body has approved the members of the PAG that will conduct the Annual Agency Evaluation.	02/01/12

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

PRINTED: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>	
(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 245	Continued From page 46 effectiveness, and efficiency of the program.	G 245		
G 246	<p>The agency failed to complete an agency evaluation.</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM</p> <p>Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency.</p> <p>This STANDARD is not met as evidenced by: Based on review of the agency policies and Professional Advisory Group meeting minutes and staff interview, it was determined the agency failed to ensure an annual agency evaluation was conducted and results of the evaluation were reported to and acted upon by those responsible for the operation of the agency. This failure potentially impeded the agency's ability to improve operation and delivery of services. Findings include:</p> <p>The agency's "ANNUAL EVALUATION" policy, reviewed in 12/2009, indicated "Annually a representative group will review the information and draft a summary report for review and action by the Professional Advisory Committee. After approval the report is submitted to the Governing Body for review and approval.</p> <p>Profession Advisory Group meeting minutes from 4/28/11, 7/14/11, and 10/20/11 did not contain documentation of a review of an agency evaluation which included policy, administration, and clinical record review.</p>	G 246	<p>The policy for the Annual Agency Evaluation was presented to members of the PAG by the Administrator. Data will be gathered throughout the year to present to the team to enable the evaluation process.</p>	02/01/12 and 02/08/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>		
(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 246	Continued From page 47  The Administrator was interviewed on 1/30/12 at 4:05 PM. She confirmed the agency had not conducted an annual evaluation of the agency's policies, administration, and clinical record review and therefore the information was not evaluated and acted upon.	G 246		
G 250	<p>Results of an agency evaluation were not available and therefore not reviewed and acted upon by those responsible for the operation of the agency.</p> <p><b>484.52(b) CLINICAL RECORD REVIEW</b></p> <p>At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of chart audit data and policies, it was determined the agency failed to include all health professionals in chart audits representing the scope of the program as part of the quarterly record review. in addition, the agency failed to conduct record reviews for remote offices. This resulted in an incomplete review and had the potential to negatively impact the utility and effectiveness of the review. Findings include:</p> <p>The agency failed to complete a comprehensive review of medical records as follows:</p> <p>1. The agency had 4 remote offices located in</p>	G 250	A clinical record review will be conducted (weekly- due to survey- then monthly on at least 10% of the open and closed charts) to determine the extent to which Alliance Home Health staff complies with accepted professional standards and principles, federal and state regulations, and accreditation standards. This review will be completed by representatives of appropriate health care disciplines. The Administrator will monitor compliance.	02/20/12

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

PRINTED: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 250	<p>Continued From page 48 Malad, Rexburg, Idaho Falls, and Twin Falls, Idaho. Chart review data gathered by the agency was reviewed. It did not contain evidence of chart review data from any of the remote office locations. The "CLINICAL RECORD REVIEW" policy, last reviewed 12/2009, did not contain direction to staff related to record review to be completed at each office location and how that information was to be incorporated into the agency evaluation as a whole.</p> <p>The Branch Director (a home health aide) for the Idaho Falls and Rexburg offices was interviewed on 1/26/12 at 3:15 PM. She stated either she and/or the Idaho Falls quality assurance personnel completed an admission audit, discharge audit, and random chart audits. She stated an annual audit of 3 – 5 % of their current caseload was completed at the end of the year. she confirmed there was some difficulty getting this information to the parent agency.</p> <p>The Malad Branch Director was interviewed on 1/26/12 beginning at 1:40 PM. She stated she reviewed medical records for completeness and coding. She stated medical record review was not conducted in the Malad office for the agency's quality assurance program.</p> <p>The Program Director for QAPI was interviewed on 1/27/12 at 9:00 AM. She stated that each remote office location did complete record reviews in the same manner as the parent office. She stated she requested clinical record review data from each of the offices at the end of the quarter. She stated she did not always receive the information and confirmed there was not data received from any of the remote office from</p>	G 250	Added to policy: chart reviews will include charts that are sent to the Parent office from the remote sites and/or charting stations.	02/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 250	<p>Continued From page 49</p> <p>October through December of 2011. She stated she relied on the other offices to send the information and that the Administrator was aware this transfer of data had not occurred as required.</p> <p>The agency utilized remote offices which were not represent in the quarterly record review evaluation.</p> <p>2. The agency provided physical therapy, occupational therapy, speech therapy, social work, nursing, and home health aide services. The "CLINICAL RECORD REVIEW" policy, last reviewed 12/2009, indicated the record review would be completed by "representatives of appropriate health care disciplines." The policy indicated the responsibility for the review program was primarily assigned to the DON. However, the policy also indicated the "clinical Record Review Committee is a subcommittee of the Professional Advisory Committee. The membership is composed of [agency name] staff and health related non-[agency name] representatives."</p> <p>The DON was interviewed on 1/30/12 at 10:00 AM. She stated that she was the only one completing the clinical record reviews for the parent office. She stated she would have preferred someone else complete the record review on her own records, however, no other nurse was willing to do this.</p> <p>The agency failed to ensure that all disciplines were appropriately incorporated into the record review process.</p> <p>3. the "CLINICAL RECORD REVIEW" policy last reviewed 12/2009, indicated the one purpose</p>	G 250	<p>The Clinical Record Review subcommittee is the same as the Agency Evaluation Team. This team consist of the Administrator, Medical Director, PT, ST, SW, QA Manager, DON, Office Manager, Professional Volunteer, Human Resources, Billing and Information Manager, Office Manager, RN Case Manager.</p> <p>Discipline specific chart review forms have been established for PT, OT, ST, SW, and Physician. These disciplines have been notified and agree to perform chart reviews. They will conduct these reviews on at least 10% of the Home Health charts monthly. Results of these reviews will be given to the QA Manger upon completion and to the PAG at least twice a year. All of the clinical staff are conducting chart reviews. There is also an aide specific chart review form being used. The Administrator and DON will be responsible for compliance.</p>	<p>02/01/12</p> <p>02/10/12</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>	
(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 250	<p>Continued From page 50</p> <p>Of the clinical record review was to "evaluate the appropriateness, adequacy and effectiveness of services." However, the "Home Health Chart Review Form," used for record review, contained a list of items to determine if the record had complete documentation and that services were provided in accordance with the established POC. There was no specific prompting to evaluate the record as a whole to determine if all the necessary services were offered or if care was adequate and appropriate. The following are examples that had the potential to lead to inadequate review of medical records:</p> <p>a. Under the "Social Work" section, question #53 read "Are goals listed as 'met and unmet' on the Discharge Summary, SW [social work] area?" This type of question related to the completeness of documentation but did not allow the reviewer to evaluate whether or not the patient progressed throughout the admission and, in fact, that goals had been met.</p> <p>b. Coordination of care between all disciplines was not addressed on the "Home Health Chart Review Form." The only location where documentation of coordination of care was specifically addressed was question #50 under the "Social Work" section.</p> <p>c. For therapy services, the form asked for a comparison of the visit schedule with the POC and whether PTA supervisory visits were completed. The "Home Health Chart Review Form" did not include a review of the quality and appropriateness of therapy service provided.</p> <p>d. The "Start of Care" and Recertification"</p>	G 250	Discipline specific chart reviews have been created and includes whether or not the patient progressed towards his/her goals and if there was documentation of coordination of cares between disciplines.	02/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/2012	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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 250	<p>Continued From page 51</p> <p>Sections, questions # 19 and #63 respectively, asked if the patient had surgical wounds. Subsequent questions related to the details of the surgical wound. No other wounds were addressed.</p> <p>e. According to the quality assurance documentation for October through December of 2011, eleven records were reviewed. Four of the records contained visit documentation that did not match the ordered POC. Two of the records were missing physical therapy visit notes. The actions to these deficiencies included referring the issue to the appropriate Case Manager and the lead home health aide. There was no documentation that agency policies and/or systems were reviewed to determine if changes needed to be made to assist staff in improving the quality and completeness of the medical record.</p> <p>The DON was interviewed on 1/30/12 at 10:00 AM. She stated that even though it was not specifically indicated in the record review worksheet, she tried to reviewed records for the appropriateness and effectiveness of services.</p> <p>The Program Director for QAPI was interviewed on 1/27/12 at 9:00 AM. She confirmed that the record review for the Pocatello office was completed by the DON. She stated the DON discussed issues noted during the record review directly with the involved employees. For example, if the skilled nursing visits did not match the POC the DON spoke with the RN Case Manager for the patient to rectify the issue. She</p>	G 250	<p>The chart review form has been up-dated to include the gathering of quality data. There are also discipline specific review forms to assist with the reviews. All of the RN Case Mangers will assist with these reviews as well as therapies, social worker and physician. The DON will assist with this process and report outcomes to the Administrator. Corrections that are needed will be given to the appropriate discipline to complete and the QA Manager will compile a report and give it to the DON.</p>	02/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALLIANCE HOME HEALTH OF IDAHO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201</b>	
(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 250	<p>Continued From page 52</p> <p>Confirmed the agency did not evaluate the record review data in a way so as to evaluate the agency's policies and processes to determine if changes were needed to assist staff providing care to patients and improve accuracy of documentation.</p> <p>The agency failed to ensure the record reviews were adequate to address staff practices and the outcomes of patient care.</p> <p>The agency failed to include all health professionals in chart audits representing the scope of the program as part of the quarterly record review to evaluate provision of patient care in accordance with agency policy.</p>	G 250	<p>All disciplines are being involved in evaluation of charts at least quarterly. There is a comprehensive chart review form and discipline specific review forms. Education was provided by the DON and Administrator to the clinical staff (including contracted staff) related to the chart reviews, their importance in patient cares and quality of services.</p>	02/27/12

PRINTED: 03/22/12  
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  OAS001018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/12
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201	
(X4) 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
N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state licensure survey of your Home Health Agency. The surveyors who conducted the recertification were:</p> <p>Gary Guiles, RN, HFS, Team Leader Aimee Hastriter, RN, BS, HFS</p> <p>Acronyms used in this report include:</p> <p>CEO - Chief Executive Officer CMS - Centers for Medicare and Medicaid Services CNA - Certified Nursing Assistant DON - Director of Nursing LPN - POC - Plan of Care OT - Occupational Therapy PT - Physical therapist PTA - Physical therapy Assistant QAPI - QUALITY Assurance and Performance Improvement RN - Registered Nurse SW - Social Worker</p>	N 000		
N 001	<p>03.07020.01. ADMIN.GOV.BODY</p> <p>020. ADMINISTRATION - GOVERNING BODY.</p> <p>N001 01. Scope. The home health agency shall be organized under a governing body, which shall assume full legal responsibility for the conduct of the agency.</p> <p>This Rule is not met as evidenced by: Refer to G 128 as it relates to the Governing</p>	N 001		

Bureau of Facility Standards

*Debra Dixon* RN Administrator  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03-26-12  
(X6) DATE

PRINTED: 03/22/12  
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  OAS001018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/12
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE AS 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
N 001	Continued From page 1  Body's failure to ensure it assumed responsibility for the agency's operation	N 001	See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 2 of 53 as related to G 123	02/14/12
N 002	03.07020.02. ADMIN.GOV.BODY  N002 02. Structure. The administrative responsibilities of the agency shall be documented by means of a current organizational chart.  This Rule is not met as evidenced by: Refer to G 123 as it relates to the agency's failure to ensure lines of authority for the delegation of responsibility were clearly set forth in writing and were readily identifiable.	N 002	See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 3 of 53 & page 4 of 53 as related to G 123	02/01/12 02/06/12 & 02/20/12
N 047	03.07021.03. ADMINISTRATOR  N047 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:  a. Organizing and coordinating administrative functions of the program, delegating duties, establishing a formal means of accountability on the part of staff members, and maintaining continuing liaison among the governing body, the group of professional personnel and the staff.  This Rule is not met as evidenced by: Refer to G 133 as it relates to the agency's failure to ensure the agency's ongoing functions.	N 047	See Plan of Correction as stated on the Department of Health and Human services CMS POC page 8 of 53, page 9 of 53 & page 10 of 53 as related to G 133	02/01/12 & 02/20/12

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  OAS001018	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  01/31/12
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201	
(X4) 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
N 062	Continued From page 2	N 062	See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 10 of 53 as it relates to G 143	02/01/12
N 062	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 G 143 as it relates to the agency's failure to ensure effective coordination of care was maintained among all disciplines and services providing care.  Refer to G 144 as it relates to the agency's failure to ensure coordination of patient care was clearly documented in clinical records or minutes of case conferences.	N 062	All personnel furnishing services shall maintain a liaison and open communication to coordinate effectively and support the objectives outlined in the patient Plan of Care. This should be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction. All staff received education on this and education is ongoing. The Administrator and DON is responsible for compliance.  The RN Case Manager is responsible for coordination of cares among all disciplines providing services. Interdisciplinary Team meetings are being held every two weeks. All disciplines providing services will document patient care results on the IDT notes or give a report (either verbal or written) to the RN Case Manager who will make sure it is documented on the IDT notes. Therapy services will attend IDT meetings as much as possible or will report cares to the RN to be added to the IDT notes. The Director of Nursing and QA Manager will be responsible for monitoring compliance by conducting chart reviews at least quarterly.	02/15/12  02/15/12
N 119	03.070240.40.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 (60) days.  This Rule is not met as evidenced by:	N 119		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  OAS001018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/12
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREET, SUITE A 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
N 119	Continued From page 3  Refer to G 229 as it relates to the agency's failure to ensure home health aide supervisory visits were conducted every 14 days by a therapist or an RN.	N119	Alliance Home Health shall provide Home Health Aide services under the direction and supervision of a Registered Professional Nurse/Therapist when personal care services are indicated and ordered by the physician. The frequency of CNA supervision will be in response to Medicare regulations and no less than every 14 days. The RN Case Manager will be responsible to ensure that these Supervisory Visits are being conducted according to policy. The DON and QA Manager will be responsible for monitoring compliance by conducting chart reviews at least quarterly on 10% of the open charts.	02/15/12
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 G 158 as it relates to the agency's failure to ensure care followed a written POC.	N 152		02/21/12
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 G 164 as it relates to the agency's failure to ensure staff notified the physician to changes in a patient's condition that suggested a need to alter the plan of care.	N 172		02/15/12 \$ 02/20/12
N 174	03.07031.01 CLINICAL RECORDS  N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home	N 174		See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 24 of 53, page 25 of 53 and page 26 of 53 as it relates to G 158.
			See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 34 of 53. If the Pt. is hospitalized, then discharged an assessment will be completed for resumption of care and the POC will be revised with new orders obtained to resume cares as needed and per MD orders. The DON will monitor compliance.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  OAS001018	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  01/31/12
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE  440 EAST CLARK STREET, SUITE A POCATELLO, ID 83201	
(X4) 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
N 174	Continued from page 4  health services.  This Rule is not met as evidenced by: Refer to G 236 as it relates to the agency's failure to ensure complete and accurately edited medical records were maintained.	N 174	See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 36 of 53, page 37 of 53, page 38 of 53, page 39 of 53, page 40 of 53, page 41 of 53, page 42 of 53 and page 43 of 53 as it relates to G 236.	02/01/12 02/06/12 02/20/12 02/27/12
N 193	03.07040. AGENCY EVALUATION  N193 040. AGENCY EVALUATION. A group of professional personnel, which includes at least one (1) physician, one (1) registered nurse, and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one (1) member of the group is neither an owner nor an employee of the agency.  This Rule is not met as evidenced by: Refer to G 153 as it relates to the agency's failure to ensure a group of professional personnel had at least one member of the group who was neither an owner nor an employee of the agency and on an annual basis reviewed the agency's policies, clinical records, personnel qualifications and overall program evaluation.	N 193	See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 19 of 53, page 20 of 23, page 21 of 53, and page 22 of 53 as it relates to G 153.	01/31/12 02/03/12 02/07/12
N 194	03.07010.01.AGENCY EVAL.  N194 01. Evaluation Timetable. The group of professional personnel meets	N 194		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  OAS001018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/12
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE  440 EAST CLARK STREET, SUITE A 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
N 194	Continued From page 5  As needed to advise the agency and monitor the program. The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel, or a committee of this group, HHA staff, and consumers, or by professional people working outside the agency in conjunction with consumers.  This Rule is not met as evidenced by: Refer to G 154 as it relates to the agency's failure to ensure the group of professional personnel participated in an agency evaluation.	N 194	See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 22 of 53 and page 23 of 53 as it relates to G 154. The Annual evaluation for 2011 Report is completed as of 03/09/12 and will be presented to the Professional Advisory Group on or about 04/23/12 to finalize. The Administrator is responsible for monitoring compliance with this rule.	01/31/12 03/09/12
N 195	03.07040.02 AGENCY EVAL.  N195 02. Evaluation Criteria and Purpose. The evaluation consists of an overall policy and administrative review and a clinical record review and assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient.  This Rule is not met as evidenced by: Refer to G 244 as it relates to the agency's failure to ensure an annual evaluation including an overall policy, administrative, and clinical record review was completed.	N 195	See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 44 of 53 and page 45 of 53 as it relates to G 244.	02/01/12
N 196	03.07040.03 AGENCY EVAL.  Refer to G 245 as it relates to the agency's failure to ensure an annual evaluation was performed to assess the extent to which the agency's program was appropriate, adequate, effective and efficient.		See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 46 of 53 as it relates to G 245.	02/01/12

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  OAS001018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/12
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 440 EAST CLARK STREE, SUITE A POCATELLO, ID 83201	
(X4) 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
N 196	Continued From page 6  N196 03. Evaluation Results. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.  This Rule is not met as evidenced by: Refer to G 246 as it relates to the agency's failure to ensure an annual agency evaluation was conducted and results of the evaluation were reported to and acted upon by those responsible for the operation of the agency.	N 196	See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 47 of 53 as it relates to G 246.	02/01/12 & 02/08/12
N 197	03.07050. CLINICAL REC. REVIEW  N197 050. CLINICAL RECORD REVIEW. The agency shall have a subcommittee to perform an audit of clinical records on at least a quarterly basis to determine the adequacy of services provided in meeting patient's needs. The committee members will represent the scope of the program consisting of health professionals. The review shall consist of at least ten per cent (10%) sampling of both active and closed clinical records representing all services being offered. A written summary of findings and recommendations of the committee shall be utilized in the overall review and self-evaluation of the agency.  This Rule is not met as evidenced by: Refer to G 250 as it relates to the agency's failure to include all health professionals in chart audits representing the scope of the program as part of the quarterly record review. in addition, the agency failed to conduct record reviews for	N 197	See Plan of Correction as stated on the Department of Health and Human Services CMS POC page 48 of 53, page 49 of 53, page 50 of 53, page 51 of 53, page 52 of 53 and page 53 of 53 as it relates to G 250.	02/01/12 02/10/12 02/17/12 02/20/12 02/27/12

PRINTED: 03/22/12  
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  OAS001018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/31/12	
NAME OF PROVIDER OR SUPPLIER  ALLIANCE HOME HEALTH OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE  440 EAST CLARK STREET, SUITE A 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
N 197	Continued From page 7  remote offices	N 197		