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

March 21, 2012

Stephanie Godinez, Administrator
Crest Home Health
700 W Ironwood Dr Ste 210
Coeur D'Alene, ID 83814

RE: Crest Home Health, Provider #137070

Dear Ms. Godinez:

This is to advise you of the findings of the Medicare/Licensure survey at Crest Home Health, which was concluded on March 9, 2012.

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

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

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

After you have completed your Plan of Correction, return the original to this office by **April 3, 2012**, and keep a copy for your records.

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

Sincerely,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm
Enclosures

CREST HOME HEALTH

BRING THE HEALING HOME

April 2, 2012

Idaho Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

RECEIVED
APR -3 2012
FACILITY STANDARDS

RE: Crest Home Health, Provider #13707 Medicare/Licensure Survey

Dear Ms. Costa & Ms. Creswell

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS - 2567 listing Medicare deficiencies and Plan of Correction from the Medicare/Licensure Survey for Crest Home Health, which was concluded on March 9, 2012.

If you have any questions, please write or contact us at 208-765-4343. Thank you for the opportunity.

Sincerely,

Stephanie Godinez, RN
Administrator
Crest Home Health

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

PRINTED: 03/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137070	A. BUILDING _____ B. WING _____	C 03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH	700 W IRONWOOD DR STE 210 COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your Home Health Agency. The following surveyors conducted the survey: Suzi Costa RN, HFS, Team Leader Rebecca Lara RN, BA, HFS Acronyms used in this report include: POC = Plan of Care PT/INR = Prothrombin Time/International Normalized Ratio RN = Registered Nurse	G 000	**G 173: 484.30 (a) DUTIES OF THE REGISTERED NURSE** Agency Administrator will educate all professional employees by 03/29/2012 on required documentation as it relates to initiation of the plan of care and necessary revisions at the time of initial assessment and throughout length of service regardless of pay source. Agency Administrator and/or designee will audit 100% of new admission charts to ensure it contains a written Plan of Care for all patients regardless of pay source to include private pay patients through 06/30/2012 and then 10% of admissions for the following 3 months. Policy 200.34 (Attachment A)	03/29/2012
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure patient plans of care were initiated and revised when necessary for 1 of 4 patients, (#9) who had labs drawn in the home and whose records were reviewed. A failure to initiate and revise a POC as needed had the potential to lead to inadequate patient care and negative patient outcomes. Findings include: 1. Patient #9 was an 87 year old male admitted to the agency on 8/24/11 for PT/INR blood draws related to a diagnosis of atrial fibrillation (irregular heart rate that may cause poor blood flow to the body.) A fax cover sheet titled "CREST HOME	G 173		

RECEIVED
APR 04 2012
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D. Conner RN, Administrator — TITLE — (X6) DATE: 04/04/12

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

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

PRINTED: 03/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137070	A. BUILDING _____ B. WING _____	C 03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH	700 W IRONWOOD DR STE 210 COEUR D'ALENE, ID 83814

(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 173	Continued From page 1 HEALTH," dated 8/24/11 and untimed, documented the physician ordered a PT/INR to be drawn by the agency nurse on 8/24/11. Subsequent PT/INRs were ordered by the physician and drawn by the agency RN on the following dates: 9/16/11, 11/03/11, 12/16/11, 1/20/12 and 3/01/12. A written POC was not found in Patient #9's record. In an interview on 3/08/12 at 8:45 AM, the agency Administrator confirmed Patient #9's record did not contain a written POC. The Administrator stated she did not think a written POC was necessary for Patient #9 because he was a private pay patient who was receiving limited services. The RN did not initiate a written POC for Patient #9.	G 173	G 331: 484.55(a)(1) INITIAL ASSESSMENT VISIT Agency Administrator will educate all professional employees by 03/29/2012 on required documentation as it relates to completion of initial comprehensive assessment visit to determine the immediate care and support needs of the patient regardless of pay source. Agency Administrator will educate all professional employees by 03/29/2012 regarding regularly reevaluating the patient's needs as indicated and makes necessary revisions.	03/29/2012
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the initial SOC comprehensive assessment was completed by an RN for 1 of 4 patients, (#9) who had labs drawn in the home and whose records were reviewed. This failure had the potential to negatively impact patient outcomes due to an incomplete initial assessment. Findings include:	G 331	Agency Administrator and/or designee will audit 100% of new admission charts to ensure it contains a comprehensive assessment for all patients regardless of pay source to include private pay patients through 06/30/2012 and then 10% of admissions for the following 3 months. Policy 200.30 (Attachment B)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137070	A. BUILDING _____ B. WING _____	C 03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH	700 W IRONWOOD DR STE 210 COEUR D'ALENE, ID 83814

(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 331	Continued From page 2 1. Patient #9 was an 87 year old male admitted to the agency on 8/24/11 for PT/INR blood draws related to a diagnosis of atrial fibrillation (irregular heart rate that may cause poor blood flow to the body.) A "SKILLED NURSING NOTE," dated 8/24/11 at 2:45 PM, documented an initial RN visit. The note indicated a physical assessment was completed by the RN that included vital signs and a partial review of systems. The note also documented a PT/INR was drawn by the RN at the time of the visit. There was no comprehensive assessment found in Patient #9's record. In an interview on 3/08/12 at 8:45 AM, the Administrator stated she did not think a comprehensive assessment was necessary for Patient #9 because he was a private pay patient who was receiving limited services. She also stated a nursing assessment was performed during each home visit. The Administrator confirmed the RN did not complete a comprehensive assessment for Patient #9. The RN failed to complete a comprehensive assessment for Patient #9.	G 331		

PRINTED: 03/20/2012
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001140	A. BUILDING ______ B. WING ______	C 03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH	700 W IRONWOOD DR STE 210 COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to G331 as it relates to the failure of the agency to ensure a comprehensive assessment was completed for all patients.	N 093	**<u>Please refer to Plan of Correction:</u>** **<u>G 331: 484.55(a)(1) INITIAL ASSESSMENT VISIT</u>**	03/29/2012
N 094	03.07024. SK. NSG. SERV. N094 01. Registered Nurse. A. registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: b. Initiates the plan of care and makes necessary revisions; This Rule is not met as evidenced by: Refer to G173 as it relates to the failure of the agency to ensure comprehensive plans of care were initiated for all patients.	N 094	**<u>Please refer to Plan of Correction:</u>** **<u>G 173: 484.30 (a) DUTIES OF THE REGISTERED NURSE</u>** RECEIVED APR 04 2012 FACILITY STANDARDS	03/29/2012

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] RN, Administrator 4/4/12 TITLE (X6) DATE

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DEBRA RANSOM, R.N.,R.H.I.T., Chief
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3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

March 21, 2012

Stephanie Godinez, Administrator
Crest Home Health
700 W Ironwood Dr Ste 210
Coeur D'Alene, ID 83814

Provider #137070

Dear Ms. Godinez:

On **March 9, 2012**, a complaint survey was conducted at Crest Home Health. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004753

Allegation #1: The agency discharged a patient without an explanation.

Findings #1: An unannounced survey was conducted at the agency from 3/06/12 through 3/09/12. Surveyors reviewed twelve patient records, including six records of discharged patients and six records of current patients. Also reviewed were incident reports, complaint/grievance logs, agency policies and administrative documents. Surveyors interviewed agency staff as well.

One discharge record documented an 82 year old female who was admitted to the agency for care related to end stage renal disease and generalized muscle weakness. The "OASIS Discharge Assessment," dated 9/07/10 and completed by a registered nurse, documented "pt has had a decline in physical status. She is unable to speak walk/bear wt and is not eating." Documentation on the discharge assessment also included, "pt's spouse has declined a Medical Social Worker (MSW) referral, Skilled Nursing Facility (SNF) placement, hospice, MD appointment or Emergency Room (ER) visit." The RN also documented that she informed the patient and the patient's spouse that she was required to refer the patient to Adult Protective Services (APS) because she was not receiving medical attention. Documentation also indicated the patient was unable to verbalize a response, but the patient's spouse verbalized understanding.

A "COMPLAINT LOG," dated 9/08/10 and completed by the agency Administrator, stated the patient was on service for skilled nursing and physical therapy. Documentation included the following concern: "patient has shown a recent rapid decline in function over the last few weeks and is now unable to walk or bear weight, talk, and per spouse is not eating now." Under the comment section of the entry, it was documented that the the patient's decline in status and the agency's recommendations were discussed with the patient and the patient's husband. The "Additional Follow-up," section stated it was explained to the patient and family that the patient was no longer appropriate for home health due to safety concerns. Follow-up documentation also stated the reasons for referral to APS were explained to the patient and the patient's husband.

The agency Administrator was interviewed on 3/08/12 at 9:30 AM. The Administrator stated it was the practice of the agency to discharge a patient from the agency if the patient was assessed to be unsafe in the home. She stated the patient was discharged from the agency related to a significant decline in her physical condition and safety concerns. The Administrator stated the agency encouraged the patient and family to allow the agency to coordinate a referral/appointment for the patient with the physician or the ER. The agency also offered to coordinate referrals for hospice and/or transfer to a SNF. The Administrator stated the husband refused all referrals. She stated the husband was then told the agency would discharge the patient from home health services and refer the patient to APS for evaluation.

No evidence could be found that the agency discharged a patient without explanation to the patient and family. Due to this lack of sufficient evidence, the allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The agency refused to provide a copy of the discharge documents.

Findings #2: One discharge record documented an 82 year old female who was admitted to the agency on 7/24/10 for care related to end stage renal disease and generalized muscle weakness. The patient was discharged from the agency on 9/07/10. The "OASIS Discharge Assessment," dated 9/07/10 and completed by a registered nurse, documented the patient's husband became upset when the RN was unable to leave the original discharge assessment at his request. Documentation also included the husband was informed he was not listed as the power of attorney for the patient. He was advised he would need to complete a release of information and once he had done so, a copy of the discharge assessment would be provided.

A "COMPLAINT LOG," dated 9/08/10, documented under the "Additional Follow-up" section that the patient's husband requested the nurse leave the original discharge assessment in the home

at the time of the visit on 9/07/12. The complaint log documented the RN stated, ".... i advised him that I needed to take it with me as we have to file it at the office. I told him that we could get a copy to them but that we had to go through process of requesting records."

The agency Administrator was interviewed on 3/08/12 at 9:30 AM. She stated the agency had attempted to reach the patient's documented power of attorney, but they were unsuccessful at the time. The Administrator also said it was not the practice of the agency to leave an original discharge summary in the patient's home, but a copy of the summary would have been provided if the patient's husband had agreed to complete the consent/release of medical information process.

Due to insufficient evidence, the allegation that the agency refused to provide a copy of the discharge documents to the patient's husband could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The agency discharged a patient when services were still required.

Findings #3: One discharge record documented an 82 year old female who was admitted to the agency for care related to end stage renal disease and generalized muscle weakness. The patient was discharged from the agency before the certification period ended because the agency stated the patient was no longer safe in the home. The "OASIS Discharge Assessment," completed by a registered nurse, documented "pt has had a decline in physical status. She is unable to speak walk/bear wt and is not eating." Documentation on the discharge assessment also included, "pt's spouse has declined a Medical Social Worker (MSW) referral, Skilled Nursing Facility (SNF) placement, hospice, Medical Doctor (MD) appointment or Emergency Room (ER) visit." The RN also documented that she informed the patient and the patient's family that she was required to refer the patient to Adult Protective Services (APS) because she was not receiving medical attention. Documentation also indicated the patient was unable to verbalize a response, but the patient's spouse verbalized understanding.

A "COMPLAINT LOG," dated 9/08/10 and completed by the agency Administrator, stated the patient was on service for skilled nursing and physical therapy. Documentation included the following concern: "patient has shown a recent rapid decline in function over the last few weeks and is now unable to walk or bear weight, talk, and per spouse is not eating now." The "Additional Follow-up," section stated it was explained to the husband that the patient was no longer appropriate for home health due to safety concerns.

The agency Administrator was interviewed on 3/08/12 at 9:30 AM. The Administrator stated that due to the rapid decline in the patient's status she was not appropriate for home health

services at the time of discharge. She also said the agency felt the patient required medical services that the home health was unable to provide, and for that reason, they attempted to refer the patient to various services, including the treating physician, the ER, hospice and/or a SNF. The administrator stated the husband refused the referral for services, which necessitated the referral to APS.

No evidence could be found to support the agency discharged a patient when home health services were still required. Therefore, the allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Susan Costa/sc

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm

IDAHO DEPARTMENT OF
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March 21, 2012

Stephanie Godinez, Administrator
Crest Home Health
700 W Ironwood Dr Ste 210
Coeur D'Alene, ID 83814

Provider #137070

Dear Ms. Godinez:

On **March 9, 2012**, a complaint survey was conducted at Crest Home Health. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004942

Allegation #1: Agency did not provide on-call nursing services.

Findings #1: An unannounced recertification survey and complaint investigation was made to the agency on March 6 through March 9, 2012. During the investigation, surveyors reviewed twelve patient records, including six records of discharged patients and six records of current patients. Administrative documents were reviewed, including incident reports and documentation of patient complaints and grievances. Home visits were made to observe care provided to patients by nursing, physical therapy, occupational therapy and home health aide staff.

One record reviewed was that of a patient who had received skilled nursing services as well as other disciplines. The record contained documentation from the on-call nurses after responding to calls from the patient's family on two occasions. Each entry by the on-call nurses indicated the family had declined visits during the off hours.

The Administrator stated an answering service refers calls from patients to the on-call staff. She stated the agency provides nursing on-call coverage for evenings, nights, and weekend hours.

She stated her staff has been instructed to communicate any patient calls or home visits with the appropriate case managers in the mornings after taking call.

The Administrator provided time logs from the answering service as well as on-call staff response times to calls. There was no evidence that staff had not responded to patient and family calls.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Nursing staff was incompetent with caring for the patient's colostomy.

Findings #2: An unannounced recertification survey and complaint investigation was made to the agency on March 6 through March 9, 2012. During the investigation, surveyors reviewed twelve patient records, including six records of discharged patients and six records of current patients. Administrative documents were reviewed, including incident reports and documentation of patient complaints and grievances. Home visits were made to observe care provided to patients by nursing, physical therapy, occupational therapy and home health aide staff.

One record reviewed was that of a patient who had received skilled nursing visits. The record documented the patient had an ostomy and was noted to have a rash on the area surrounding the stoma. The admission assessment and nursing notes included documentation that education was provided to the patient and family regarding wound and ostomy care. The nursing visit that day was noted to be three hours in length. A nursing visit note three days later indicated the stoma was normal in appearance with tape irritation on the surrounding skin. The nursing note stated the spouse was observed to perform the changing of the appliance, with minimal teaching/assistance required.

The agency nursing staff training and qualifications were reviewed. There was documentation of inservices provided by a nurse consultant wound and ostomy therapist. The staff records indicated all nursing staff had attended the inservices and were current with qualification and competency records.

The allegation that nursing staff was incompetent with caring for an ostomy could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The agency terminated patient services.

Findings #3: An unannounced recertification survey and complaint investigation was made to

the agency on March 6 through March 9, 2012. During the investigation, surveyors reviewed twelve patient records, including six records of discharged patients and six records of current patients. Administrative documents were reviewed, including incident reports and documentation of patient complaints and grievances. Home visits were made to observe care provided to patients by nursing, physical therapy, occupational therapy and home health aide staff.

One record reviewed was that of a patient that had received skilled nursing, physical and occupational therapy services after being discharged from a hospital. The record contained documentation the family of the patient requested termination of services before the certification period ended. The record indicated the patient was planning to relocate to another state and the agency had attempted to facilitate transfer to another agency for the patient.

A "COMPLAINT FORM," completed by the agency Administrator documented a phone call by the patient's family member requesting termination of services. Included in the documentation was the notation the patient was discharged per request, and the physician had been notified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm