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 27, 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:

On March 14, 2012, a follow-up visit of your facility, Alliance Home Health Of Idaho, was conducted to verify corrections of deficiencies noted during the survey of January 31, 2012.

We were able to determine that the Condition of Participation for **Oganization, Services, and Administration (42 CFR 484.14); Acceptance of Patients, Plan of Care, and Medical Supervision (42 CFR 484.18); and Evalualtion of the Agency's Program (42 CFR 484.52)** are now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Home

Health 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 6, 2012**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626.

Sincerely,

Teresa Hamblin for Gary Guiles

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm
Enclosures
ec: Kate Mitchell, CMS Region X Office

545 W. 465 N. Suite 100
Providence, UT 84332-8004
Ph. #: 435-753-3133
Fax #: 435-753-3542

04/03/12

To Sylvia Creswell and Gary Guiles
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009

Dear Sylvia and Gary:

Here is the hard copy of the Federal and State Plan of Corrections for Alliance Home Health of Idaho, LLC, located at 440 East Clark Street, Suite A, Pocatello, Idaho 83201. Please call me if you have any questions.

Thank you;

Teresa Dixon RN

Teresa Dixon RN, Alliance Home Health Administrator
Phone #: 208-478-6677
Fax #: 208-478-2618
Cell #: 208-251-1406
e-mail: tdixon@alliancehhh.com

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING _____ B WING _____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	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
{G000}	INITIAL COMMENTS The following deficiencies were cited during the follow up survey at your agency. Surveyors conducting there-visit were: Gary Guiles, RN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS The following acronyms were used in this report. mcg = microgram mg = milligram MSW = Medical Social Worker OT = Occupational Therapist PT = Physical Therapist PTA = Physical Therapy Assistant RN = Registered Nurse SLP = Speech Language Pathologist	{G000}		
{G143}	484.14 (g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in 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 care was coordinated between staff for 3 of 9 patients (#2, #4, and #5) who had more than one service ordered and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. findings include: 1. Patient #2's medical record documented a 44	{G143}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Teresa Dixon RN Administrator | 04-03-12

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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING _____ B WING _____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	**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-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G143}	Continued From page 1 year old female who was admitted for home health care on 2/25/12. She was currently a patient as of 3/14/12. Her diagnoses included acute respiratory failure, pneumonia, and bipolar disorder. An untimed physician order, dated 2/25/12, requested a speech therapy evaluation. As of 3/14/12, there was no documentation present in Patient #2's record that the evaluation had been completed. Patient #2's RN Case Manager was interviewed on 3/13/12, beginning at 1:55PM. She stated she was certain the Speech Therapist had visited Patient #2 and had evaluated her swallowing. The Office Manager was interviewed on 3/13/12 at 2:30PM. She stated she had not received documentation by the Speech Therapist. Patient #2's RN Case Manager was interviewed again on 3/14/12, beginning at 9:00AM. She stated she had contacted the Speech Therapist. She stated the Speech Therapist had been out of town and had not conducted an evaluation of Patient #2. Coordination of care had not occurred between the RN Case Manager and the Speech Therapist. 2. Patient #4's medical record documented a 73 year old female who was admitted for home health care on 3/01/12. She was currently a patient as of 3/14/12. Her diagnoses included emphysema, anxiety disorder, and depression. A physical therapy evaluation and plan for Patient #4 were dated 3/02/12 at 5:40 PM. The plan called for therapy visits once a week for 1 week	{G143}	The RN Case Manger will initiate communication with the attending physicians, other staff members and therapists to coordinate optimal care for the patient. A new face sheet has been completed that will include the therapies and any other services the physician orders for the care of the patient. Once the disciplines have been ordered and contacted, the RN Case Manager will check these off on the form and document the date/time of contact. The Office Manager will then follow up with this process to make sure the appropriate contacts have been made (see copy of new form). The Director of Nursing will be responsible for monitoring compliance with this. Chart reviews will be conducted at least quarterly to monitor compliance with the above. The Quality Assurance Manager will monitor compliance for this.	03/14/12 03/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING _____ B WING _____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	**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-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 143}	Continued From page 2 and 3 times a week for 8 weeks. The plan stated verbal orders affirming the plan were obtained by the PT. Subsequent therapy visits were documented on 3/07/12, 3/08/12 and 03/09/12. A "COMPREHENSIVE ADULT NURSING ASSESSMENT," dated 3/05/12, stated Patient #4 had been hospitalized on 3/02/12 for elevated blood pressure and had returned to her home on 3/04/12. An untimed order, dated 3/05/12, stated to resume home health orders for nursing and physical therapy"...per previous orders of 3/01/12. The PT who provided services to Patient #4 was interviewed on 3/13/12 at 5:40 PM. He stated he called the physician's office on 3/02/12. He stated the office was closed and he did not speak with the physician or his representative. He stated he left a message on the physician's answering machine. Patient #4's RN Case Manager was interviewed on 3/14/12, beginning at 9:00 AM. She stated she spoke with the PT about Patient #4's condition on 3/02/12. She stated she thought the PT had obtained orders to continue therapy. She stated she did not realize the physician had not approved the therapy plan. Coordination of care had not occurred between the RN Case Manager and the PT. 3. Patient #5 was a 93 year old male who was admitted to the agency on 3/03/12 for care related to weakness. A verbal physician's order dated 3/04/12 at 2:00 PM, included an order for an MSW to visit Patient #5 to assist with	{G143}	All physician orders will be written with the date and time of the order by the disciplines who received the physician orders. The DON and QA Manager will be responsible for monitoring compliance with this. All Therapists have been provided education related to reporting changes in patient condition to the physician, documenting the changes, receiving orders, documenting those orders and sending them in for signature. Education has also been provided to the Therapies and Nursing staff related to the necessity of communicating/coordinating patient needs, changes and/or concerns between the disciplines. Making sure that the communication and coordination of cares is documented for the date and time completed. This education was provided by the Administrator and the DON. The Administrator will be responsible for monitoring compliance and chart reviews will be conducted at least quarterly by the QA Manager to also monitor compliance.	03/14/12 03/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING _____ B WING _____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	**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-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 143}	Continued From page 3 advanced directives. Patient #5's record was reviewed. As of 3/13/12, there was no documentation an MSW had contacted Patient #5 for an evaluation. The RN Case Manager for Patient #5 was interviewed on 3/13/12 at 3:00 PM. When asked about the MSW order, she excused herself to talk to the MSW, came back and said the MSW was not aware there was a signed physician's order for the MSW visit. Coordination of care between the RN Case Manager and MSW had not occurred, resulting in a delay in providing services.	{G143}	The RN Case Manager is responsible for management of the patients cares. He/She will notify all disciplines of the need for specific services. The specific disciplines will be responsible for notifying the physician about the POC, receiving the verbal order for approval of the POC and relating that information to the RN Case Manager. If the RN Case Manager has not received this information from the ordered disciplines He/She will call and receive report and document this on a separate form or on the IDG notes. The DON and QA Manager will be responsible for monitoring compliance with this.	03/15/12
{G144}	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure documentation showed effective coordination of patient care for 2 of 9 patients (#44 and #7) who had more than one service ordered and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. Findings include: 1. Patient #4's medical record documented a 73 year old female who was admitted for home health care on 3/01/12. She was currently a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING _____ B WING _____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	**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-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 144}	Continued From page 4 patient as of 3/14/12. Her diagnoses included emphysema, anxiety disorder, and depression. A physical therapy evaluation and plan for Patient #4, dated 3/02/12 at 5:40 PM, called for therapy visits once a week for 1 week and 3 times a week for 8 weeks. A progress note by the PTA, dated 3/09/12, stated Patient #4 complained of painful urination and low grade fever. The note stated Patient #4 thought she had a urinary tract infection. The PTA documented notifying the PT and the RN of the urinary symptoms. The PTA was interviewed on 3/14/12 beginning at 11:45 AM. She stated she informed the PT of Patient #4's urinary complaints but did not speak with the RN. She stated she thought the PT informed the RN but did not know if this occurred. Coordination of care was not documented between the RN and the PTA. 2. Patient #7's medical record documented an 88 year old female admitted to the agency on 2/08/12 for care after fracturing her femur and having hip replacement surgery. A "FACE-TO-FACE ENCOUNTER Referral Form," included physician orders for physical therapy and occupational therapy. Patient #7's record was reviewed. No documentation was found to indicate occupational therapy services were initiated. The RN Case Manager was interviewed on 3/13/12 at 2:35 PM. She stated the reason occupational therapy was not initiated was because the physician did not mean to order the	{G144}	The Physical Therapist is responsible for supervision and coordination of care with the Physical Therapy Assistant. The Physical Therapy Assistant will provide physical therapy services to clients in their homes, follow the physician's Plan of Care as established by the PT with MD approval. The PTA will document all services, changes, needs and client progress. The PT and PTA will report changes/concerns to the RN Case Manager on the day of the observed change in the patient's condition and coordinate cares appropriately. This coordination will be documented and placed in the patient's chart. Any orders obtained will also be signed by the MD and filed in the patient's chart. Education related to the above was given by the DON and QA Manger. Compliance will be monitored by the Director of Nursing and Administrator with chart reviews being conducted at least quarterly.	03/20/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING_____ B WING_____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	**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-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 144}	Continued From Page 5 services. She stated she talked with the physician over the phone to clarify but did not document the coordination with the physician or other team members. Coordination between an RN, physician, and team members was not documented.	{G144}	Alliance Home Health will conduct IDT (Interdisciplinary Team) meetings every two weeks to coordinate cares with all disciplines involved with patient cares. This coordination of cares will be documented on the IDT Care Plan. All disciplines will be represented at the Care Conferences (IDT) or will provide the RN Case Manger with report either verbal or written to be added to the IDT notes. The RN Case Manger is responsible for making sure these IDT notes are documented appropriately for all disciplines. The Director of Nursing will monitor compliance with this and chart reviews will be conducted at least quarterly with reports given to the Administrator (see up-dated chart review form).	03/20/12
{G160}	484.18 (a) PLAN OF CARE 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 additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on staff interview and medical record review, it was determined the agency failed to ensure staff consulted a physician to approve plans of care for 2 of 11 patients (#4 and #5) whose records were reviewed. This resulted in services being provided to patients without physician approval. Findings include: 1. Patient #4's medical record documented a 73 year old female who was admitted for home health care on 3/01/12. She was currently a patient as of 3/14/12. Her diagnoses included emphysema, anxiety disorder, and depression. An untimed order, dated 3/01/12, stated "PT to evaluate and treat." A physical therapy evaluation and plan of care, dated 3/02/12 at 5:40 PM, called for therapy visits once a week for 1 week and 3 times a week for 8 weeks. The plan stated verbal orders affirming the plan were obtained by the PT. Subsequent physical therapy visits were documented on 3/07/12, 3/08/12, and 03/09/12.	{G160}	Alliance Home Health's professional staff will promptly alert the physician for any changes in the patient's status that indicates a need to alter the present POC. Chart reviews will be conducted at least quarterly to monitor compliance. The Director of Nursing services will be responsible for compliance.	03/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING_____ B WING_____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	**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-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G160}	Continued From page 6 The PT who provided services to Patient #4 was interviewed on 3/13/12 at 5:40 PM. He stated he called the physician's office on 3/02/12. He stated the office was closed and he did not speak with the physician or his representative. He stated he left a message on the physician's answering machine and did not receive a return call to confirm approval of the plan of care. The PT did not consult the physician to approve additions to the plan of care. 2. Patient #5 was a 93 year old male who was admitted to the agency on 3/03/12 for care related to weakness. A "HOME HEALTH FACE SHEET/INTAKE FORM," dated 3/01/12, indicated referral from the physician for physical therapy services following discharge from the hospital. A physician's initial order, dated 3/02/12, was present in Patient #5's record to arrange home health services. Patient #5's record was reviewed. There were no specific physician orders for the agency to provide skilled nursing services. Three RN nursing notes were present in Patient #5's record: 3/03/12 at 10:00 AM 3/07/12 at 1:40 PM 3/12/12 at 9:55 AM The RN Case Manager was interviewed on 3/13/12 at 3:00 PM. She reviewed Patient #5's Record and confirmed physician orders for skilled nursing had not been obtained prior to the visits listed above. She stated there was a mix-up in communication between her and the admitting	{G160}	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 have completed their assessment of the patient, the physician will be notified of the Plan of Care. A verbal order will be obtained by the appropriate discipline and approval for the POC will be obtained from the physician to continue cares. Documentation of this will be completed, stated as a verbal order for POC with the date and time included. The Director of Nursing and Administrator will be responsible for monitoring compliance. Chart reviews will be conducted at least quarterly to monitor compliance. Nursing and Therapy staff has been educated by the DON regarding obtaining verbal orders to approve the POC after the initial or assessment visit has been completed. This will include frequency of visits, skilled services that are needed to be provided. On-going education will be the responsibility of the Director of Nursing.	03/15/12 03/20/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING _____ B WING _____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	**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-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G160}	Continued From page 7 weekend RN. The miscommunication resulted in a delay in obtaining orders. The physician was not consulted to approve the addition of nursing visits prior to initiation of nursing services.	{G160}	All disciplines will complete an evaluation visit, then consult the physician to approve the additions and/or modification to the POC. The Administrator and Director of Nursing will be responsible for compliance and chart reviews will be conducted at least quarterly to monitor this.	03/15/12
{G164}	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 medical record review, it was determined the agency failed to ensure staff promptly alerted the physician to the need to alter the plan of care for 1 of 11 patients (#2), whose medical records were reviewed. This resulted in the inability of the physician to modify the plan of care in response to the patient's changing condition. Findings include: Patient #2's medical record documented a 44 year old female who was admitted for home health care on 2/25/12. She was currently a patient as of 3/14/12. Her diagnoses included acute respiratory failure, pneumonia, and bipolar disorder. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 2/25/12, stated she took 22 medications including, Seroquel 800 mg daily (antipsychotic), Tamazepam 30 mg daily (for sleep), Ativan 1 mg every 6 hours as needed (anti-anxiety), Tizanidine 4 mg every 6 hours as needed (for muscle spasms), Ropinirole 0.5 mg daily (anti-spasmodic), Endocet 10.325 mg two times a day as needed (narcotic), Fentanyl patch	{G164}	All Nursing personnel and Therapists will promptly alert the physician of any changes in the patient's condition that suggests a need to alter the plan of care. Education was provided to all of the clinical staff related to notifying the physician and receiving orders as needed related to necessary changes in the patient's plan of care. The Director of Nursing and Administrator provided this education to nursing and therapy staff. The Administrator and DON will be responsible for monitoring compliance. Chart reviews will be conducted at least quarterly for this and a report will be submitted to the Administrator.	03/20/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING_____ B WING_____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	**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-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G164}	Continued From page 8 100 mcg every 3 days (narcotic), and Citalopram 40 mg (antidepressant). Patient #2's RN Case Manager was interviewed on 3/13/12, beginning at 1:55 PM. When asked about the number of psychotropic medications Patient #2 was taking, she stated the patient often appeared very sedated. The RN Case Manager stated the previous week Patient #2 had almost fallen because she was so sedated. The RN Case Manager stated she had not alerted the physician of Patient #2's sedation or the increased likelihood of falls. The RN did not notify the physician of the need to review Patient #2's medication regimen.	{G164}	Modifications or additions to the patient's Plan of Care shall be made as needed. All medications will be reviewed by the RN Case Manager, with the patient and/or primary caregiver upon admission to Home Health. These medications will be documented on the medication sheet, entered in the initial or supplemental orders and given to the physician for review and approval. Changes noted in the patient's condition will be related to the physician and orders obtained as necessary. Education has been provided for the RN Case Managers related to the above. Chart reviews will be conducted at least quarterly to monitor compliance. The Administrator and DON will be responsible for compliance.	03/15/12 03/20/12
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF THE HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure written patient care instructions were prepared by the RN prior to the provision of aide services for 1 of 3 sample patients (#7) who received aide services. This resulted in aide services being provided without appropriate written care instructions. Findings include: Patient #7 was an 88 year old female who was admitted to the agency on 2/08/12 for care after	G 224	**POLICY** All Home Health aide services will be started only as ordered by the physician and the RN Case Manager has completed the Aide Specific Plan of Care. The Aide Specific POC will be discussed with the patient and/or primary caregiver. A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse. All home health aide staff will follow the identified plan. The Care Plan will be available to all persons involved in client care, including contracted providers. Home Health Aide services will not be provided until the aide has received a copy of the Care Plan and discussed the cares with the RN Case Manager. The DON and RN Case Manager will be responsible for compliance. Chart reviews will be conducted at least quarterly to monitor this.	03/20/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING _____ B WING _____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	**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-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 224	Continued From page 9 fracturing her femur and having hip replacement surgery. An "AIDE/HOMEMAKER CARE PLAN," was initiated on 2/16/12. Home Health Aide progress notes were present in Patient #7's record for 2/09/12 and 2/13/12 indicating the care was initiated prior to a written plan of care by the RN. The Home Health Aide was interviewed by telephone on 3/14/12 at 9:00 AM. She confirmed she did not have a written plan of care when she began providing services to Patient #7. She stated the RN Case Manager had given her verbal instructions. Written patient care instructions for the home health aide were not prepared by the RN prior to the initiation of cares.	G 224	Separate education was provided to the Home Health Aides of Alliance Home Health. No Aide services will be started until the Aide receives a copy of the Aide Specific Plan of Care as prepared by the RN. The DON and Administrator provided this education and will be responsible for monitoring compliance.	03/15/12 & 03/20/12
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the home health aide provided care in accordance with the written plan of care prepared by the RN for 1 of 3 patients (#7) who received aide services whose records were reviewed. This resulted in unauthorized aide services and had the potential to interfere with patient safety. Findings include: Patient #7 was an 88 year old female who was	G 225	If the Home Health Aide is assigned to perform delegated nursing functions, such as simple dressing changes to a non-infected dry wound, or special exercises, the Home Health Aide must be oriented to the procedure by a Registered Nurse (or therapist) and the nurse must document return demonstration and /or other evidence of competency. The Home Health Aide cannot be responsible for performing any procedure that is not assigned writing by the Registered Nurse/Therapist or that is beyond his/her ability. The Home Health Aide tasks must be related to the physical care needs of the client. The Home Health Aide Care Plan shall be reviewed and updated by the Registered Nurse minimally at least every 60 days or as changes require.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137115	A BUILDING _____ B WING _____	R 03/14/12

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH OF IDAHO	**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-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 10 admitted to the agency on 2/08/12 for care after fracturing her femur and having hip replacement surgery. An "AIDE/HOMEMAKER CARE PLAN," was initiated on 2/16/12. Home Health Aide progress notes indicated the aide assisted Patient #7 with "Exercise-per PT/OT/SLP" on 2/28/12, 3/07/12, and 3/08/12. Patient #7's record was reviewed. The care plan did not include guidance for the aide to assist Patient #7 with exercises. The Home Health Aide who provided services to Patient #7 was interviewed by telephone on 3/14/12 at 9:00 AM. When asked about providing exercise assistance, the Home Health Aide explained Patient #7 requested help doing her daily exercise program and asked her to hold the therapy band for her, count for her, hold the ball for her, and place a towel between her legs. She denied receiving any instruction for the RN or PT regarding exercises. Aide services were provided that were not included in the aide plan of care.	G 225	Education was provided to the RN Case Managers and the Certified Nursing Assistants by the DON and Administrator related to completion of the Aide Specific Care Plan and importance of accurate documentation of cares required to provide services to each patient. The DON and RN Case Manager will be responsible for compliance. Aide specific chart reviews will be conducted at least monthly on 10% of the charts to monitor compliance.	03/20/12