



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

March 28, 2011

Carl Hanson, Administrator
Minidoka Home Health Agency
1224 8th Street
Rupert, ID 83350

RE: Minidoka Home Health Agency, Provider #137062

Dear Mr. Hanson:

This is to advise you of the findings of the Medicare/Licensure survey at Minidoka Home Health Agency, which was concluded on March 16, 2011.

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

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

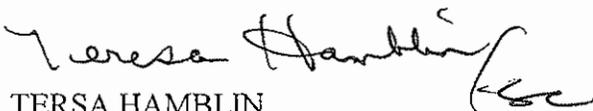
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date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

Carl Hanson, Administrator
March 28, 2011
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **April 10, 2011**, and keep a copy for your records.

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

Sincerely,



TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm
Enclosures

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350
--	--

(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>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the survey were:</p> <p>Teresa Hamblin RN, MS, HFS, Team Leader Gary Guiles, RN, HFS Karen Robertson, RN, BS, HFS</p> <p>Acronyms used in this report include:</p> <p>DME - Durable Medical Equipment mg - milligrams O2 - Oxygen POC - Plan of Care RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care</p>	G 000	<p style="text-align: center;">RECEIVED APR 08 2011 FACILITY STANDARDS</p>	
G 159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</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 the plan of care covered all pertinent information for 6 of 15 patients (#2, #4, #9, #10, #14, and #15) whose records were reviewed. This had the potential to result in incomplete or uncoordinated care.</p>	G 159		<p>484.18 Based on the findings of G159 Plan of Care, the following action was taken: Staff were in-serviced on the updated changes on the policy for the PLAN OF CARE. Compliance will be monitored by the Home Health Director.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Care Hamblin</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-1-11</i>
--	-----------------------------------	--------------------------------

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: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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 159	<p>Continued From page 1</p> <p>Findings include:</p> <p>1. Patient #14 was a 67 year old male who was admitted to the agency on 11/01/10 for care primarily related to emphysema. The "Home Health Certification (485)," for certification period 3/01/11 to 4/29/11, included orders for oxygen at 6 to 7 liters via nasal cannula. It did not state whether the oxygen was continuous or intermittent. Oxygen equipment was not listed as relevant DME.</p> <p>An RN 60 day summary to the physician, dated 2/24/11, stated a hospital bed had been ordered because Patient #14 was having trouble sleeping while lying flat. The hospital bed was not included on the plan of care in the list of DME for the certification period 3/01/11 to 4/29/11.</p> <p>During an interview on 3/15/11 at 3:25 PM, the Director reviewed Patient #14's record and confirmed the findings.</p> <p>The plan of care did not include complete oxygen orders and pertinent DME.</p> <p>2. Patient #15 was an 85 year old male who was admitted to the agency on 8/24/10 primarily for therapeutic drug monitoring. The "Home Health Certification (485)" for certification period 2/20/11 to 4/20/11, included orders for oxygen 3 to 4 liters via nasal cannula. It did not indicate whether oxygen was to be used continuously or as needed. Oxygen equipment was not listed on the plan of care as required equipment under DME.</p> <p>During an interview on 3/16/11 at 10:10 AM, the Director reviewed Patient #15's record and confirmed oxygen equipment was missing from</p>	G 159			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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 159	<p>Continued From page 2</p> <p>the POC and the oxygen order should have been listed as continuous.</p> <p>Further, the same "Home Health Certification (485)" included orders for Methadone for pain management and for SN to assess pain management. It also included diagnoses of congestive heart failure and emphysema and orders for SN to assess heart and lungs. It did not include corresponding goals related to pain or cardio-respiratory status.</p> <p>The "Home Health Certification (485)" also listed dressing supplies under DME. However, there was no indication Patient #15 received wound care.</p> <p>During an interview on 3/16/11 at 10:10 AM, the Director reviewed Patient #15's record and confirmed there was no wound care to explain dressing supplies on the POC and goals were missing related to pain and cardio-respiratory status.</p> <p>The plan of care included incomplete physician orders for oxygen, was missing relevant DME/supplies and clinical goals related to pain and cardio-respiratory status, and included unnecessary wound care supplies.</p> <p>3. Patient #4 was a 67 year old female who was admitted to the agency on 1/12/11 for care after surgery. The "Home Health Certification (485)," for certification period 1/12/11 to 3/12/11, included a diagnosis of diabetes and goals to maintain blood glucose levels between 80 and 250. It did not include an intervention to monitor blood glucose levels. During an interview on 3/15/11 at 9:50 AM, the Director reviewed Patient</p>	G 159			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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 159	<p>Continued From page 3</p> <p>#4's record and confirmed the findings.</p> <p>The plan of care did not include pertinent interventions related to a diagnosis of diabetes.</p> <p>4. Patient #10 was an 80 year old female who was admitted to the agency on 1/12/11 for care related to difficulty walking. The "Home Health Certification (485)," for certification period 1/12/11 to 3/12/11, included a diagnosis of diabetes and goals to maintain blood glucose levels between 80 and 250. It did not include an intervention to monitor blood glucose levels. During an interview on 3/15/11 at 2:00 PM, the Director reviewed Patient #10's record and confirmed the findings.</p> <p>The plan of care did not include pertinent interventions related to a diagnosis of diabetes.</p> <p>5. Patient #2 was a 35 year old female who was admitted to the agency on 9/22/10 for care primarily related to multiple sclerosis. A Hoyer lift was included on the "AIDE PLAN OF CARE," dated 1/18/11, signed by the RN Case Manager. The "Home Health Certification (485)" for the certification period of 1/20/11 to 3/20/11, did not include a Hoyer lift under "DME and Supplies."</p> <p>In an interview on 3/15/11 at 9:10 AM, the Director stated the Hoyer lift was pertinent to Patient #2's care and agreed it was not on the POC.</p> <p>The POC did not include required equipment.</p> <p>6. Patient #9 was an 85 year old female who was admitted to the agency on 2/18/11 for care primarily related to hypertension and chronic kidney disease. A walker was included on the</p>	G 159			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350	
(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 159	Continued From page 4 "AIDE PLAN OF CARE," dated 2/22/11, signed by the RN Case Manager. The "SKILLED NURSING VISIT REPORT" for 2/21/11 at 3:45 PM, 2/24/11 at 9:30 AM, and 3/08/11 at 10:00 AM included documentation Patient #9 was using a walker. During a home visit on 3/16/11 at 11:00 AM, Patient #9 was observed using her walker. "The "Home Health Certification (485)" for the certification period of 2/18/11 to 4/18/11 did not include walker under "DME and Supplies." In an interview on 3/15/11 at 3:10 PM, the Director agreed the walker was not on the POC.	G 159		
G 236	The POC did not include required equipment. 484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure complete and accurate documentation for 2 of 15 sample patients (#9 and #14) whose records reviewed. This had the potential to interfere with clarity, coordination, and safety of care. Findings include:	G 236	484.48 Based on the findings of G236 Clinical Records , the following action was taken: Visit staff were in-serviced on the current policy for <u>NURSING PROGRESS NOTE</u> . Compliance will be monitored by the Home Health Director.	040111

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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 5</p> <p>1. Patient #14 was a 67 year old male who was admitted to the agency on 11/01/10 for care primarily related to emphysema. The "Home Health Certification (485)," for certification periods 3/01/11 to 4/29/11, included goals for oxygen saturations greater than 84% while Patient #14 was on 7 to 8 liters of oxygen. An RN visit note, dated 2/02/11 at 10:50 AM, did not include Patient #14's oxygen saturation level. During an interview on 3/15/11 at 4:15 PM, the RN Case Manager stated she took oxygen saturations every visit, that Patient #14 was on telehealth and her findings would have been electronically transmitted to the physician. She stated she forgot to write the results in Patient #14's record.</p> <p>The clinical record did not contain relevant clinical information obtained during a nursing visit.</p> <p>2. Patient #9 was an 85 year old female who was admitted to the agency on 2/18/11 for care primarily related to hypertension and chronic kidney disease. She also had a history of congestive heart failure with a written goal on the POC for no weight gain of 2 to 3 pounds in one day or 4 to 5 pounds in five days.</p> <p>The "SN Start of Care/Resumption of Care," dated 2/18/11 at 4:20 PM, documented Patient #9's weight as 166 pounds. The "SKILLED NURSING VISIT REPORT" dated 2/21/11 at 3:45 PM, documented Patient #9's weight as 186 pounds. The twenty pound weight difference in three days would have been a critical change in Patient #9's condition if the SOC weight was accurate.</p> <p>In an interview on 3/16/11 at 2:40 PM, the RN Case Manager stated that the weight of 166</p>	G 236			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350
--	--

(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 6 pounds documented on the "SN Start of Care/Resumption of Care" was a "typo" and the weight of 186 was accurate.	G 236		
G 337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>This STANDARD is not met as evidenced by: Based on record review, home visit, patient interview, and staff interview, it was determined the agency failed to ensure a comprehensive drug assessment was completed at the appropriate time for 1 of 3 sample patients (#9) whose medications were reviewed during home visits. This had the potential to negatively impact quality and coordination of patient care. Findings include:</p> <p>1. Patient #9 was an 85 year old female who was admitted to the agency on 2/18/11 for care primarily related to hypertension and chronic kidney disease.</p> <p>During a home visit on 3/16/11 at 11:00 AM, medications were reviewed with Patient #9, compared to her prescription bottles, and personal medication schedule. The following medications were on the "Home Health Certification (485)" for the certification period of 2/18/11 to 4/18/11 under "Medications":</p>	G 337	<p>484.55 Based on the findings of G337 Clinical Records, the following action was taken: Visit staff were in-serviced on the updated policy for MEDICATION RECORD. Compliance will be monitored by the Home Health Director.</p>	040111

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350
--	--

(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 337	<p>Continued From page 7</p> <p>-- "Isosorbide Mononitrate Oral Tablet Extended Release 24 hour 30 MG 1 po qday at noon." The prescription bottle in the home was for 60 mg daily (30 mg more than the dose listed on the POC). This was the same dose that Patient #9 reported taking daily.</p> <p>-- "Hydrochlorothiazide Oral Tablet 25 MG ONE TAB PO QDAY." There was no hydrochlorothiazide prescription bottle in the home and Patient #9 stated she did not take this medication.</p> <p>-- Patient #9 reported using Biofreeze topical cream for aching muscles. This was not on the medication list.</p> <p>In an interview on 3/16/11 at 11:45 AM during the home visit, the RN Case Manager confirmed the above findings and stated she was not aware of these differences. In a follow up interview on 3/16/11 at 2:40 PM, the same RN Case Manager reported her original drug assessment was Isosorbide 30 mg 2 tablets daily. She stated she was unsure why the medication was different on the POC.</p> <p>The home drug review did not match the POC.</p>	G 337		
-------	--	-------	--	--

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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 000	<p>16.03.07 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state survey of your agency. The surveyors conducting the survey were:</p> <p>Teresa Hamblin RN, MS, HFS, Team Leader Gary Guiles, RN, HFS Karen Robertson, RN, BS, HFS</p> <p>Acronyms used in this report include:</p> <p>DME - Durable Medical Equipment POC - Plan of Care RN - Registered Nurse SN - Skilled Nursing</p>	N 000		
N 155	<p>03.07030. PLAN OF CARE</p> <p>N155 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:</p> <p>c. Types of services and equipment required;</p> <p>This Rule is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the agency failed to ensure the plan of care covered all required equipment for 4 of 15 patients (#2, #9, #14, and #15) whose records were reviewed. This had the potential to result in incomplete or uncoordinated care. Findings include:</p> <p>1. Patient #14 was a 67 year old male who was admitted to the agency on 11/01/10 for care</p>	N 155		<p>N 155 Refer to G159</p>

Bureau of Facility Standards

Carl Hansen

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

TITLE
Administrator

(X6) DATE
4-1-11

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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 155	<p>Continued From page 1</p> <p>primarily related to emphysema. The "Home Health Certification (485)," for certification periods 3/01/11 to 4/29/11, included orders for oxygen at 6 to 7 liters via nasal cannula. Oxygen equipment was not listed as relevant DME.</p> <p>An RN 60 day summary to the physician, dated 2/24/11, stated a hospital bed had been ordered because Patient #14 was having trouble sleeping while lying flat. The hospital bed was not included in the list of DME for the certification period 3/01/11 to 4/29/11.</p> <p>During an interview on 3/15/11 at 3:25 PM, the Director reviewed Patient #14's record and confirmed the findings.</p> <p>The plan of care did not include pertinent DME.</p> <p>2. Patient #15 was an 85 year old male who was admitted to the agency on 8/24/10 primarily for therapeutic drug monitoring. The "Home Health Certification (485)," included orders for oxygen 3 to 4 liters via nasal cannula. Oxygen equipment was not listed on the plan of care as required equipment under DME. Dressing supplies were listed under DME, however, there was no indication Patient #15 received wound care.</p> <p>During an interview on 3/16/11 at 10:10 AM, the Director reviewed Patient #15's record and confirmed oxygen equipment was missing from the POC and there was no wound care needed to explain dressing supplies on the POC.</p> <p>The plan of care was missing relevant DME/supplies and included unnecessary supplies.</p> <p>3. Patient #2 was a 35 year old female who was</p>	N 155		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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 155	Continued From page 2 admitted to the agency on 9/22/10 for care primarily related to multiple sclerosis. A Hoyer lift was included on the "AIDE PLAN OF CARE," dated 1/18/11, signed by the RN Case Manager. The "Home Health Certification (485)" for the certification period of 1/20/11 to 3/20/11 did not include a Hoyer lift under "DME and Supplies." In an interview on 3/15/11 at 9:10 AM, the Director stated the Hoyer lift was pertinent to Patient #2's care and agreed it was not on the POC. The POC did not include required equipment. 4. Patient #9 was an 85 year old female who was admitted to the agency on 2/18/11 for care primarily related to hypertension and chronic kidney disease. A walker was included on the "AIDE PLAN OF CARE," dated 2/22/11, signed by the RN Case Manager. The "SKILLED NURSING VISIT REPORT" for 2/21/11 at 3:45 PM, 2/24/11 at 9:30 AM, and 3/08/11 at 10:00 AM included documentation Patient #9 was using a walker. During a home visit on 3/16/11 at 11:00 AM, Patient #9 was observed using her walker. "The "Home Health Certification (485)" for the certification period of 2/18/11 to 4/18/11 did not include walker under "DME and Supplies." In an interview on 3/15/11 at 3:10 PM, the Director agreed the walker was not on the POC. The POC did not include required equipment.	N 155		
N 161	03.07030.PLAN OF CARE N161 01. Written Plan of Care. A written plan of care shall be developed and implemented for each	N 161	N 161 Refer to G337	4/01/11

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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 161	<p>Continued From page 3</p> <p>patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:</p> <p>i. Medication and treatment orders;</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the plan of care covered all pertinent information for 2 of 15 patients (#14 and #15) whose records were reviewed. This had the potential to result in incomplete or uncoordinated care. Findings include:</p> <p>1. Patient #14 was a 67 year old male who was admitted to the agency on 11/01/10 for care primarily related to emphysema. The "Home Health Certification (485)," for certification period 3/01/11 to 4/29/11, included orders for oxygen at 6 to 7 liters via nasal cannula. It did not state whether the oxygen was continuous or intermittent.</p> <p>During an interview on 3/15/11 at 3:25 PM, the Director reviewed Patient #14's record and confirmed the findings.</p> <p>The plan of care included incomplete oxygen orders.</p> <p>2. Patient #15 was an 85 year old male who was admitted to the agency on 8/24/10 primarily for therapeutic drug monitoring. The "Home Health Certification (485)," for certification period INSERT DATE included orders for oxygen 3 to 4 liters via nasal cannula. It did not indicate whether oxygen was to be used continuously or</p>	N 161		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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 161	Continued From page 4 as needed. During an interview on 3/16/11 at 10:10 AM, the Director reviewed Patient #15's record and stated the oxygen should have been listed as continuous. The plan of care included incomplete physician orders for oxygen.	N 161		
N 168	03.07030.02. PLAN OF CARE N168 02. Goals of Patient Care. The goals of patient care must be expressed in behavioral terms that provide measurable indices for performance. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the plan of care covered pertinent goals for 1 of 15 patients (#15) whose records were reviewed. This had the potential to interfere with evaluation of interventions. Findings include: Patient #15 was an 85 year old male who was admitted to the agency on 8/24/10 primarily for therapeutic drug monitoring. The "Home Health Certification (485)" included orders for Methadone for pain management and for SN to assess pain management. It also included diagnoses of congestive heart failure and emphysema and orders for SN to assess heart and lungs. It did not include corresponding goals related to pain or cardio-respiratory status. During an interview on 3/16/11 at 10:10 AM, the Director reviewed Patient #15's record and confirmed goals were missing related to pain and	N 168	N 168 Refer to G159	4/01/11

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER MINIDOKA HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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 168	Continued From page 5 cardio-respiratory status. The plan of care did not include relevant goals.	N 168		
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 health services. This Rule is not met as evidenced by: Refer to G 236 as it relates to the failure of the agency to ensure complete and accurate documentation.	N 174	N 174 Refer to G236	4/01/11