



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
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CERTIFIED MAIL: 7009 0820 0000 2807 2030

May 11, 2011

Karla Jensen, Administrator
Helping Hands Home Health
1308 East Center
Pocatello, ID 83201

RE: Helping Hands Home Health, Provider #137102

Dear Ms. Jensen:

Based on the survey completed at Helping Hands Home Health, on April 28, 2011, by our staff, we have determined Helping Hands Home Health is out of compliance with the Medicare Home Health Agency (HHA) **Condition of Participation on Home Health Aide Services (42 CFR 484.36)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction

Karla Jensen, Administrator

May 12, 2011

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for each deficiency cited;

- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health agency into compliance, and that the home health agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before June 12, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than June 4, 2011.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **May 24, 2011.**

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

We urge you to begin correction immediately.

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

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm

Enclosures

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

Kate Mitchell, CMS Region X Office

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

PRINTED: 05/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2011
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NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201
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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>Karen Robertson, RN, BS, HFS, Team Leader Teresa Hamblin RN, MS, HFS</p> <p>Acronyms used in this report include:</p> <p>CNA - Certified Nurse Assistant DME - Durable Medical Equipment DON - Director of Nursing HHA - Home Health Aide LPN - Licensed Practical Nurse MSW - Masters of Social Work OT - Occupational Therapy POC - Plan of Care PRN - as needed PT - Physical Therapy RN - Registered Nurse SOC - Start of Care ST - Speech Therapy</p>	G 000	<p>RECEIVED MAY 23 2011 FACILITY STANDARDS</p>	
G 114	<p>484.10(e)(1)(i-iii) PATIENT LIABILITY FOR PAYMENT</p> <p>Before the care is initiated, the HHA must inform the patient, orally and in writing, of:</p> <p>(i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA;</p> <p>(ii) The charges for services that will not be covered by Medicare; and</p> <p>(iii) The charges that the individual may have to pay.</p> <p>This STANDARD is not met as evidenced by:</p>	G 114	<p>G114 Patient Liability for Payment</p> <p><u>Plan of Action:</u> Before service begins each client is given: Notification in the Bill of Rights & Responsibilities that the client portion of the bill for Medicare and Medicaid Home Health is \$0.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Karla Jensen</i>	TITLE ADMINISTRATOR	(X6) DATE 5/20/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 114	<p>Continued From page 1</p> <p>Based on staff interview, record review, and review of administrative documents, the agency failed to inform patients in writing of expected financial liability or lack thereof for 11 of 11 patients (#1 - #11) whose records were reviewed. This had the potential to interfere with patients' ability to make informed decisions about accepting or declining agency services based on financial considerations. It also resulted in patients, who may have been told verbally by agency staff about potential financial responsibility, not receiving a written reminder. Findings include:</p> <p>The Administrator provided an undated document "Bill of Rights and Responsibilities." The document, which was included in the packet given to patients at SOC, stated the patient had the right to be informed prior to start of care, of the extent to which payments may be expected from Medicare, Medicaid, or any other federally funded program. It further stated the patient had the right to be informed of the charges that the individual may have to pay. This information would be given orally and in writing to the patient.</p> <p>The following patients' records were reviewed. None of the records included evidence written notice of financial liability or lack thereof, was provided to the patients prior to SOC:</p> <p>Patient #1 whose SOC date was 10/21/10 Patient #2 whose SOC date was 3/26/11 Patient #3 whose SOC date was 4/05/11 Patient #4 whose SOC date was 1/27/11 Patient #5 whose SOC date was 4/13/11 Patient #6 whose SOC date was 3/16/11 Patient #7 whose SOC date was 4/04/11</p>	G 114	<p><u>Plan of Correction:</u> Each RN that admits a client for service will notify the client that they will not have a co-pay with Medicare, Medicaid or any Federally Funded Program for Home Health. Insurance and other forms of payment will be discussed at the admission visit and the insurance clerk will be notified to contact the insurance company for co-pay and deductible amounts. Those figures will be given to the client verbally and in writing, as soon as the insurance company gives the information to the insurance clerk. This will include third payors. <u>Person Responsible:</u> Administrator</p> <p><u>Date of Compliance:</u> June 4, 2011</p> <p>See Exhibit 1</p>		

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G 114	Continued From page 2 Patient #8 whose SOC date was 1/24/11 Patient #9 whose SOC date was 3/01/11 Patient #10 whose SOC date was 8/06/09 Patient #11 whose SOC date was 1/13/11 The DON and Administrator were interviewed together on 4/27/11 between 1:25 PM and 3:25 PM. The DON stated nurses generally try to tell people at SOC if they will have to pay a deductible or co-pay. She confirmed patients were not provided information in writing as to the extent payment might be required or that the agency accepted Medicare payment as payment in full. The agency did not inform patients in writing of the extent to which payment was expected from federally funded programs, and any charges the individual may have been expected to pay.	G 114		
G 143	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 record review and staff interview, it was determined the agency failed to ensure staff coordinated efforts effectively for 1 of 2 sample patients (#5) receiving SN and speech therapy services. This had the potential to result in unmet patient needs. Findings include: 1. Patient #5 was a 77 year old female admitted to the agency on 4/13/11 for care primarily related	G 143	G 143 Coordination of Patient Services <u>Plan of Correction:</u> Speech Therapist was given written notice that she will no longer be working for our agency. A new agency was contracted to provide Speech and some Occupational Therapy for clients receiving services from Helping Hands Home Health. <u>Implementation:</u> The new agency providing service has more than one Speech Therapist and is able to accommodate our agency with back up help. <u>Person Responsible:</u> Administrator <u>Date of Compliance:</u> June 10, 2011	

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G 143	<p>Continued From page 3</p> <p>to a viral infection and difficulty walking. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/13/11 to 6/11/11, included an order for a speech therapy consultation.</p> <p>"INTERDISCIPLINARY PROGRESS NOTES" documented multiple attempts by RN staff to coordinate with a speech therapist to provide services to Patient #5, including notes as follows:</p> <ul style="list-style-type: none"> > 4/13/11 at 3:15 PM documented an RN called a speech therapist to report the referral; > 4/14/11 at 12:30 PM documented an RN made a second phone call and message left with a speech therapist; > 4/14/11 at 5:30 PM documented an RN talked with a speech therapist who stated she could not accept the referral. The speech therapist provided the name and phone number to a second speech therapist; > 4/14/11 at 5:30 PM documented an RN calling and leaving the first message with the second speech therapist; > 4/15/11 at 10:00 AM documented an RN calling and leaving a second message with the second speech therapist; > 4/15/11 at 3:00 PM documented an RN calling and leaving a third message with the second speech therapist. <p>There was no documentation to indicate the RN was able to reach the second speech therapist or</p>	G 143			

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G 143	Continued From page 4 any other speech therapist to provide a consultation for Patient #5. An "INTERDISCIPLINARY PROGRESS NOTE," dated 4/18/11 at 10:30 AM, documented the RN talked with Patient #5 regarding the difficulty contacting the speech therapist. Patient #5 replied she did not need ST. An order was initiated, 4/18/11, to discontinue ST services. During an interview on 4/28/11 at 11:00 AM, an RN confirmed having made multiple attempts to reach a speech therapist. She stated the first speech therapist was not available because she was having a baby and the second speech therapist never returned her telephone calls.	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on record review, staff and patient interview, and home observation, it was determined the agency failed to ensure the documentation of coordination of care between individuals providing patient care for 2 of 11 (#4 and #9) patients whose records were reviewed. This had the potential to interfere with the clarity	G 144	G 144 Coordination of Patient Services <u>Plan of Correction:</u> Speech Therapist was given written notice that she will no longer be working for our agency. A new agency was contracted that will be trained with the agency forms and instructed the proper way to communicate with the staff of Helping Hands Home Health.	

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G 144	<p>Continued From page 5 of the course of care. Findings include:</p> <p>1. Patient #9 was a 23 year old female admitted to the agency for care primarily related to aftercare of a craniotomy. An order for ST to evaluate Patient #9 was initiated on 3/02/11. In a review of the clinical record, no documentation was found in regards to ST evaluating Patient #9.</p> <p>In an interview on 4/27/11 at 1:25 PM, the administrator stated she had talked with a speech therapist who reported Patient #9 had refused ST services and that the speech therapist did not feel Patient #9 needed the services.</p> <p>In an interview on 4/28/11 at 11:00 AM, the RN taking care of Patient #9 stated the speech therapist had called her and told her she had done the evaluation and discharged Patient #9 from ST services. The RN further stated the conversation was not documented.</p> <p>In an interview on 4/28/11 at 1:35 PM, the DON stated she was having a hard time reaching ST. She stated ST had not turned in any documentation related to Patient #9's care.</p> <p>The agency did not ensure communication between SN and ST was documented for Patient #9.</p> <p>2. Patient #4 was a 56 year old male admitted to the agency on 1/27/11 for care primarily related to a decubitus ulcer of the buttocks. According to the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 3/27/11 to 5/25/11, the MSW was to "evaluate and assess for needs."</p>	G 144	<p><u>Implementation:</u> When SN, OT, PT, MSW are required the RN will contact the therapist and give information and history of the client for specific care. The Therapist will be informed to contact the RN when evaluation is done to notify RN of cares to be given. Any needed forms will be given to the Therapist. Each Monday during office meeting the therapy notes will be read for continuity. Weekly communication with therapists will give the clients the excellent care that Helping Hands wants to be known for.</p> <p><u>Person Responsible:</u> Administrator <u>Date of Compliance:</u> June 10, 2011 4</p>	

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G 144	<p>Continued From page 6</p> <p>On 3/27/11, the agency sent a fax was to the physician in reference to the recertification. It stated the MSW was to visit Patient #4 every other week from 3/27/11 to 5/25/11. An email dated 4/03/11 from the MSW to the DON was sent regarding Patient #4 and placed in the clinical record. No other MSW notes or communications were found in the record. The MSW was unavailable for interview.</p> <p>A home visit was made on 4/27/11 at 10:25 AM. When asked about receiving MSW visits, Patient #4 stated he "didn't know what had happened" with the visits and he had not seen the MSW "in awhile."</p> <p>In an interview on 4/27/11 at 1:25 PM, the DON reviewed Patient #4's record and stated she talked with the MSW on 4/25/11 and was told Patient #4 had refused MSW visits. The DON further stated no MSW notes were in the clinical record other than the one email communication referenced above.</p> <p>In an interview on 4/28/11 at 11:00 AM, the supervising RN for Patient #4's care stated the MSW would call if there was a problem, but she had not had much communication with the MSW regarding Patient #4. The RN further stated she did not have good communication with the MSW in general.</p> <p>In an interview on 4/28/11 at 12:30 PM, the LPN caring for Patient #4 stated she had been called by the MSW to discuss Patient #4. The LPN stated there was no documentation of the telephone conversations because she thought the</p>	G 144		

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G 144	Continued From page 7 MSW would document the conversations since he initiated the discussions.	G 144			
G 158	<p>The agency did not ensure that communication between the MSW and SN was documented.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</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 care followed the written POC as established by a physician for 2 of 6 patients (#1 and #4) who were receiving MSW services and whose records were reviewed. This had the potential to negatively impact quality and completeness of patient care. Findings include:</p> <p>1. Patient #4 was a 56 year old male admitted to the agency on 1/27/11 for care primarily related to a decubitus ulcer of the buttocks. According to the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 3/27/11 to 5/25/11, the MSW was to "evaluate and assess for needs."</p> <p>On 3/27/11, a fax was sent to the physician in reference to the recertification and it stated the MSW was to visit Patient #4 every other week from 3/27/11 to 5/25/11.</p> <p>There was no documentation of an MSW visit for the week of 4/10/11. There was also no</p>	G 158	<p>G158</p> <p>Acceptance of Patients, POC, Med Super</p> <p>Intervention:</p> <p>Each week at staff meeting missed visits will be identified and MD will be faxed a notice. Nurses, therapies, social workers, and aides will be in serviced and notified in writing of this requirement</p> <p>Person responsible: DON</p> <p>In Compliance by June 10⁴, 2011</p>		

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G 158	<p>Continued From page 8</p> <p>documentation the physician had been notified of a missed visit. The MSW was unavailable to interview. In an interview on 4/27/11 at 1:25 PM, the DON agreed no visits or calls were made by the MSW to Patient #4 for the week of 4/10/11.</p> <p>In an interview on 4/27/11 at 1:25 PM, the DON reviewed Patient #4's record and stated she talked with the MSW on 4/25/11 and was told Patient #4 had refused MSW visits. She also stated the physician had not been notified of Patient #4's refusal of MSW services or of the missed MSW visits.</p> <p>The agency did not ensure MSW visits were made as ordered by the physician and that the physician was notified of missed visits and Patient #4's refusal of MSW services.</p> <p>2. Patient #1 was a 51 year old male admitted to the agency on 10/21/10 for care primarily related to schizophrenia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 2/18/11 to 4/18/11, included orders for one MSW visit every other week starting the week of 2/21/11. In a review of the record, it was found that one visit was missed by the MSW the week of 2/21/11. There was no documentation the physician had been notified of a missed visit. The MSW was unavailable for interview.</p> <p>In an interview on 4/27/11 at 1:25 PM, the DON reviewed Patient #1's record and stated she agreed that no visit was made the week of 2/21/11 as there was no visit note filed in the chart.</p>	G 158		
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G 158	Continued From page 9 The agency did not ensure the POC was followed by the MSW or that the physician had been informed of Patient #1's refusal of services.	G 158	G159	
G 159	484.18(a) PLAN OF CARE 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. This STANDARD is not met as evidenced by: Based on record review, staff and patient interview, and home observation, it was determined the agency failed to ensure the POC included all pertinent information for 5 of 11 patients (#1, #3, #4, #5, and #7) whose records were reviewed. This had the potential to result in incomplete or uncoordinated patient care. Findings include: 1. Patient #4 was a 56 year old male admitted to the agency on 1/27/11 for care primarily related to a decubitus ulcer of the buttocks. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 3/27/11 to 5/25/11, did not include colostomy or suprapubic catheter supplies, abdominal binder, or heel protectors. A home visit was made 4/27/11 at 10:25 AM. The LPN was observed to change Patient #4's	G 159	Plan of Care Intervention: Nurses will be in serviced on importance Of including all equipment on the plan of care such as colostomy, suprapubic catheter supplies, and oxygen equipment Person Responsible: DON Incompliance by June 10, 2011 4	

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G 159	<p>Continued From page 10</p> <p>colostomy bag, clean around his suprapubic catheter, adjust his abdominal binder, and replace his heel protectors.</p> <p>In an interview on 4/27/11 at 1:25 PM, the DON reviewed the POC for Patient #4 and stated she agreed the POC did not include those supplies and that it should have included them.</p> <p>The agency did not include all pertinent DME on the POC.</p> <p>2. Patient #1 was a 51 year old male admitted to the agency on 10/21/10 for care primarily related to schizophrenia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 2/18/11 to 4/18/11, did not include venipuncture supplies, exam gloves, or alcohol swabs on the POC.</p> <p>A home visit was made 4/26/11 at 10:50 AM. The RN was observed to draw blood using venipuncture supplies, wearing exam gloves, and using alcohol swabs to cleanse Patient #1's skin prior to giving a shot.</p> <p>In an interview on 4/27/11 at 1:25 PM, the DON reviewed the POC for Patient #1 and stated she agreed the POC for the certification period of 2/18/11 to 4/18/11 did not include venipuncture supplies, exam gloves, and alcohol swabs.</p> <p>The agency did not include all pertinent DME on the POC.</p> <p>3. Patient #7 was a 52 year old male admitted to the agency on 4/04/11 for care primarily related to multiple sclerosis. The "HOME HEALTH</p>	G 159		

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G 159	<p>Continued From page 11</p> <p>CERTIFICATION AND PLAN OF CARE," for the certification period of 4/04/11 to 6/02/11, included orders for skilled nursing visits for purposes including performance of urine tests and blood work. Laboratory supplies were not included on the POC.</p> <p>In an interview on 4/27/11 at 1:25 PM, the DON stated she agreed that laboratory supplies were not on the POC.</p> <p>The agency did not include all pertinent DME on the POC.</p> <p>4. Patient #5 was a 77 year old female admitted to the agency on 4/13/11 for care primarily related to a viral infection and difficulty walking.</p> <p>During a home visit on 4/27/11 between 9:00 AM and 10:00 AM, the home health aide who provided bath care for Patient #5 explained her usual bathing process. She explained she wheeled Patient #5 in her wheelchair to the top of the stairs, helped her transfer to a chair lift which she then rode to the bottom the stairs. Patient #5 then transferred from the chair lift to a walker and walked to the shower. The home health aide then helped her transfer to a commode that she used in the shower. She stated Patient #5 did not have a bath bench. The wheelchair, walker, chair lift, and commode were observed in the home.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/13/11 to 6/11/11, did not include the chair lift or commode.</p> <p>The DON was interviewed on 4/27/11 at 1:45 PM.</p>	G 159			

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G 159	<p>Continued From page 12</p> <p>She reviewed Patient #5's record and confirmed relevant equipment was missing from the POC.</p> <p>The plan of care did not include equipment required for aide services.</p> <p>5. Patient #3 was a 60 year old female admitted to the agency on 4/05/11 for care primarily related to pneumonia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/5/11 to 6/03/11, included medication orders for continuous oxygen. It also contained orders for SN to assess respiratory status (related to the pneumonia) and to weigh Patient #3 weekly. The POC did not include oxygen equipment as part of the plan of care. It did not include goals related to Patient #3's respiratory status or reporting parameters or goals related to Patient #5's weight.</p> <p>The DON was interviewed on 4/27/11 at 2:00 PM. She reviewed Patient #3's record and confirmed the findings. She stated they did not usually put oxygen equipment on the POC. She stated there should have been relevant respiratory and weight goals.</p>	G 159		
G 187	<p>484.32 THERAPY SERVICES</p> <p>The qualified therapist prepares clinical and progress notes.</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</p>	G 187	<p>G 187</p> <p>Therapy Services</p> <p><u>Plan of Correction:</u> Therapy Services will include documentation of client service. Documentation will be</p>	

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G 187	Continued From page 13 speech therapist prepared clinical notes for 1 of 2 (#9) sample patients who received ST services and whose records were reviewed. This had the potential to interfere with quality and safety of patient care. Findings include: 1. Patient #9 was a 23 year old female admitted to the agency for care primarily related to aftercare of a craniotomy. An order for ST to evaluate Patient #9 was initiated on 3/02/11. In a review of the clinical record, no documentation was found in regards to ST evaluating Patient #9. In an interview on 4/27/11 at 1:25 PM, the administrator stated she had talked with the speech therapist who reported Patient #9 had refused ST services and that the speech therapist did not feel Patient #9 needed the services. In an interview on 4/28/11 at 11:00 AM, the RN taking care of Patient #9 stated the speech therapist had called her and told her she had done the evaluation and discharged Patient #9 from ST services. The RN further stated there was no documentation referring to that conversation. In an interview on 4/28/11 at 1:35 PM, the DON stated she was having a hard time reaching ST. She stated ST had not turned in any documentation related to Patient #9's care. The speech therapist did not document services provided and communication with Patient #9.	G 187	(continued) reviewed each Monday at weekly nurses meeting to insure the clients service are accommodating their needs. In Service to the Therapies will include teaching proper communication including missed visits or refused visit documentation. When in services are completed by the Therapist they will bring verification of the In service to the office staff for filing in personnel files. With open communication, all of the staff will be able to provide excellent service and comply with Medicare regulations. The QA nurse will monitor charts for proper communication to maintain compliance. <u>Person Responsible:</u> Administrator <u>Date of Compliance:</u> June 10/2011 4		
G 189	484.32 THERAPY SERVICES The qualified therapist participates in in-service programs.	G 189	G189 Therapy Services		

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G 189	Continued From page 14 This STANDARD is not met as evidenced by: Based on personnel record review, it was determined the agency failed to ensure 1 of 1 speech therapist participated in in-services. This had the potential to result in patients receiving care from an under-qualified speech therapist. Findings include: When asked, the agency was unable to provide any evidence the speech therapist had participated in in-service programs. The DON and Administrator were interviewed on 4/28/11 at 2:00 PM and both stated they had been trying unsuccessfully to get in touch with the speech therapist. The DON agreed no evidence of participation in in-services by the speech therapist were kept in the speech therapist's employee record or the agency's in-service participation record.	G 189	G189 Therapy Services Intervention: All therapies will be notified in writing That they will be responsible to attend In-service that is appropriate for their Discipline and they must bring in a copy Of these in-service hours to the Home Health Agency Person Responsible: DON Compliance by: 6/10/11		
G 200	The agency did not have evidence of the speech therapist's participation in in-service programs. 484.34 MEDICAL SOCIAL SERVICES The social worker participates in discharge planning and in in-service programs. This STANDARD is not met as evidenced by: Based on personnel record review, it was determined the agency failed to ensure 1 of 1 MSW participated in in-service programs. This had the potential to result in an under-qualified MSW. Findings include: The agency was unable to provide any evidence	G 200	G200 Medical Social Services Intervention: The medical social workers working with the Home Health agency will be notified in writing that they are responsible for attending in-services appropriate for their discipline and they are to bring copies of these in-services to the agency. Person Responsible: DON Incompliance by: June 10, 2011		

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G 200	Continued From page 15 the MSW had participated in in-service programs. The DON and Administrator were interviewed on 4/28/11 at 2:00 PM and both stated they had been trying to get in touch with the MSW, but had been unable to. The DON agreed no evidence of participation in in-services by the MSW were kept in the MSW's employee record or the agency's in-service participation record.	G 200			
G 202	The agency did not have evidence of MSW participation in in-service programs. 484.36 HOME HEALTH AIDE SERVICES This CONDITION is not met as evidenced by: Based on record review, policy review, staff interview, and observation during a home visit, it was determined the agency failed to ensure complete and clear written instruction to, and supervision of, home health aides. It also failed to ensure home health aides provided care in accordance with the written plan of care. These negative systemic agency practices seriously impeded the ability of the agency to provide services of adequate quality. Findings include:	G 202	G202 Home Health Aide Services Intervention: Nurses will be in-serviced on how to accurately and completely fill out an Aide Plan of Care. They will schedule a nursing visit at the same time as the Aide makes their first visit if possible, or very soon after to assess the home situation, equipment and instruct the aide and family on the plan of care for the aide service. Person Responsible: DON Incompliance by: June 10, 2011 4		
G 203	1. Refer to G 224 as it relates to the agency's failure to ensure complete and clear written patient care instructions for home health aides. 2. Refer to G 225 as it relates to the agency's failure to ensure home health aides followed the written plan of care. 3. Refer to G 203 as it relates to incomplete RN supervision of aide staff. 484.36(a) HOME HEALTH AIDE SERVICES	G 203			

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G 203	<p>Continued From page 16</p> <p>Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. They are closely supervised to ensure their competence in providing care. For home health services furnished (either directly or through arrangements with other organizations) after August 14, 1990, the HHA must use individuals who meet the personnel qualifications specified in §484.4 for "home health aide".</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 home health aides were closely supervised to ensure competence in providing care for 2 of 6 patients (#3 and #4) who received home health aide services and whose records were reviewed. This had the potential to negatively impact quality and safety of patient care. Findings include:</p> <p>1. Patient #3 was a 60 year old female admitted to the agency on 4/05/11 for care primarily related to pneumonia. RN visit notes, dated 4/07/11 at 12:10 PM and 4/20/11 at 4:00 PM, documented having provided aide supervision. A box was checked indicating the home health aide was following the POC.</p> <p>However, aide documentation did not indicate the plan of care was followed. The "HHA/HOMEMAKER CARE PLAN," dated 4/05/11, included an assignment for the home health aide to provide Patient #3 with a bath of</p>	G 203	<p>G203 Home Health Aide Services Intervention: Nurses will be in-serviced on the need to review the aide plan of care when doing supervisory visits and the need to read over the aide visits to see if there are changes that need to be made to the plan of care. Person Responsible: DON Incompliance by: June 10, 2011 4</p>	

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G 203	<p>Continued From page 17</p> <p>choice (tub/shower, bed bath, or chair bath). There was no documentation a bath had been provided during aide visits on 4/04/11, 4/07/11, 4/08/11, 4/11/11, 4/13/11, 4/15/11, 4/18/11 or 4/20/11.</p> <p>The DON was interviewed on 4/27/11 at 2:00 PM. She stated that aide supervision consisted of asking patients if they were satisfied with aide services. She further stated "we need to have them review aide notes."</p> <p>The RN did not thoroughly assess the aide's performance.</p> <p>2. Patient #4 was a 56 year old male admitted to the agency on 1/27/11 for care primarily related to a decubitus ulcer of the buttocks. RN visit notes, dated 4/09/11 at 2:00 PM, 4/15/11 at 1:00 PM, and 4/23/11 at 1:00 PM, documented having provided aide supervision. A box was checked indicating the home health aide was following the aide POC.</p> <p>However, aide documentation did not indicate the plan of care was followed. The "HHA/HOMEMAKER CARE PLAN," reviewed 3/27/11, included an assignment for the home health aide to provide Patient #4 with a bath of choice (tub/shower, bed bath, or chair bath). There was no documentation a bath had been provided during aide visits on 3/30/11, 4/05/11, 4/14/11, or 4/21/11. The aide POC also included the assignment for the home health aide to put antibiotic ointment and gauze around Patient #4's suprapubic catheter site after a bath of choice. There was no documentation the suprapubic catheter care was completed during aide visits on</p>	G 203			

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G 203	Continued From page 18 3/31/11, 4/03/11, 4/12/11, 4/14/11, 4/19/11, or 4/21/11.	G 203		
G 224	In an interview on 4/27/11 at 2:00 PM, the DON stated that aide supervision consisted of asking patients if they were satisfied with aide services. She further stated "we need to have them review aide notes." The RN did not thoroughly assess the aide's performance. 484.36(c)(1) ASSIGNMENT & DUTIES OF 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, policy review, staff interview, and observation during a home visit, it was determined the agency failed to ensure complete, clear, and updated written patient care instructions for home health aides for 5 of 6 patients who received home health aide services (#3, #4, #5, #6, and #8) whose records were reviewed. This had the potential to interfere with patient safety, coordination of patient care, and the ability to meet patient needs. Findings include: 1. Patient #5 was a 77 year old female admitted to the agency on 4/13/11 for care primarily related to a viral infection and difficulty walking.	G 224	G224 Assignment & Duties of Home Health Aide Intervention: Nurses will be in-serviced on the need to include all equipment the aide will need to use while they are in the patient's home caring for the patient. This equipment will be listed on the plan of care and also on the Aide Plan of Care. They will also be in-serviced on the importance of writing the aide care plan so that the aide doesn't need to make decisions or assessments for the patient. The instructions need to be plain and clear what the aide will need to do to provide care for the patient that the nurse determines the patient needs. Person Responsible: DON Compliance by: June 11, 2011 4	

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G 224	<p>Continued From page 19</p> <p>During a home visit on 4/27/11 between 9:00 AM and 10:00 AM, the home health aide who provided bath care to Patient #5 explained her usual process for bathing Patient #5. She explained she wheeled Patient #5 in her wheelchair to the top of the stairs, helped her transfer to a chair lift which she rode to the bottom the stairs. She then helped her transfer to the walker and supervised her walking to the shower and transfer to a commode that she used in the shower. This process was not observed because Patient #5 requested a sponge bath in her wheelchair instead of the "usual" shower downstairs during the observation visit.</p> <p>The "HHA/HOMEMAKER CARE PLAN," dated 4/13/11, had a section to list pertinent equipment. The care plan did not include the wheelchair, walker, chair lift, or commode. It did not include necessary sequencing to guide the aide on how to shower Patient #5.</p> <p>There was an assignment for the home health aide to take vital signs PRN. It did not say how the home health aide was to determine if vital signs were needed. The reporting parameters were general: report increase or decrease in vital signs. Specific parameters were not included</p> <p>There was an assignment for the home health aide to exercise Patient #5 PRN according to the PT/OT care plan. There was no documentation to indicate the PT/OT planned on having the aide assist Patient #5 with a planned exercise program or that the aide had been trained in an exercise program specific to Patient #5.</p> <p>The home health aide was interviewed</p>	G 224		
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G 224	<p>Continued From page 20</p> <p>Immediately after the home visit on 4/27/11 at 10:00 AM. When asked how she knew the sequencing necessary to bathe Patient #5, she stated Patient #5's daughter had been present and explained the process to her. When asked how she knew when to take Patient #5's vital signs, she stated she took Patient #5's temperature once because she knew she had an infection.</p> <p>The DON was interviewed on 4/27/11 at 1:45 PM. She reviewed Patient #5's record and confirmed equipment and specific guidance was missing from the aide POC. She stated the chair lift should have been on the aide POC. She also confirmed vital signs were ordered PRN and it was intended to mean to take vital signs per patient or nurse request. She confirmed there were no specific reporting parameters for the vital signs. She stated the assignment for the aide to assist in an exercise program did not belong on the aide POC.</p> <p>The written aide POC did not include equipment needed, directions on sequencing of the bath, or specific guidelines for taking and reporting vital signs. It included an exercise assignment that was not relevant to Patient #5.</p> <p>2. Patient #8 was an 85 year old female admitted to the home health agency on 1/24/11 for care primarily related to muscle weakness and a history of falls. A "NURSING VISIT RECORD," dated 2/18/11, stated Patient #8 continued to shower with assistance with a new shower bench. A shower bench was not included on the "HHA/HOMEMAKER CARE PLAN," dated 1/24/11, or on any subsequent updates to the</p>	G 224		

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NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201	
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G 224	<p>Continued From page 21 care plan.</p> <p>There was an assignment on the "HHA/HOMEMAKER CARE PLAN," dated 1/24/11, for the home health aide to take vital signs PRN. It did not say how the home health aide was supposed to determine if vital signs were needed. There were no reporting parameters for the vital signs.</p> <p>There was also an assignment on the plan for the home health aide to exercise Patient #8 PRN according to the PT/OT care plan. There was no documentation to indicate the PT/OT planned on having the aide assist Patient #8 with a planned exercise program or that the aide had been trained in an exercise program specific to Patient #8.</p> <p>The DON was interviewed on 4/27/11 at 2:15 PM. She reviewed Patient #8's record and confirmed the shower bench was not listed on the aide POC. She also confirmed vital signs were ordered PRN and it was intended to mean to take vital signs per patient or nurse request. She confirmed there were no specific reporting parameters for the vitals. She stated the assignment for the aide to assist Patient #8 with an exercise program did not belong on the aide POC.</p> <p>The written aide plan of care did not include the bath bench or clear guidelines for taking and reporting vital signs. It included an exercise assignment that was not relevant to Patient #8.</p> <p>3. Patient #3 was a 60 year old female admitted to the agency on 4/05/11 for care primarily related</p>	G 224		

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G 224	<p>Continued From page 22</p> <p>to pneumonia. The "HHA/HOMEMAKER CARE PLAN," dated 4/05/11, documented Patient #3 had a dialysis fistula on the right upper arm. It did not provide the home health aide with guidance as to whether the fistula could get wet or required covering.</p> <p>The "HHA/HOMEMAKER CARE PLAN," dated 4/05/11, included an assignment for the home health aide to take vital signs PRN. It did not say how the home health aide was to determine if vital signs were needed. There were no reporting parameters for the vital signs.</p> <p>The plan also included an assignment for the home health aide to exercise Patient #3 PRN according to the PT/OT care plan. There was no documentation to indicate the PT/OT planned on having the aide assist Patient #3 with a planned exercise program or that the aide had been trained in an exercise program specific to Patient #3.</p> <p>The DON was interviewed on 4/27/11 at 2:00 PM. She stated she (the DON) had been taught to avoid a fistula and thought the aide should avoid it. She confirmed there was no guidance on the POC related to the fistula and there should have been. She confirmed there was no specific guidance related to taking or reporting vital signs. She stated the exercise assignment did not belong on the aide POC.</p> <p>The written aide plan of care did not include guidance related to Patient #3's fistula or clear guidelines for taking and reporting vital signs. It included an exercise assignment that was not relevant to Patient #3.</p>	G 224		

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G 224	<p>Continued From page 23</p> <p>4. Patient #6 was an 82 year old male admitted to the agency on 3/16/11 for care primarily related to a stroke. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/16/11 to 5/14/11, listed equipment needed, including a tub/shower bench and grab bars. The "HHA/HOMEMAKER CARE PLAN" did not include the equipment.</p> <p>The "HHA/HOMEMAKER CARE PLAN" included an assignment for the home health aide to take vital signs PRN. It did not say how the home health aide was supposed to determine if vital signs were needed. There were no reporting parameters for the vital signs.</p> <p>The plan also included an assignment for the home health aide to exercise Patient #6 PRN according to the PT/OT care plan. There was no documentation to indicate the PT/OT planned on having the aide assist Patient #6 with a planned exercise program or that the aide had been trained in an exercise program specific to Patient #6.</p> <p>The DON was interviewed on 4/27/11 at 2:20 PM. She reviewed Patient #6's record and confirmed the findings.</p> <p>The written aide plan of care did not include required equipment or clear guidelines for taking and reporting vital signs. It included an exercise assignment that was not relevant to Patient #6.</p> <p>5. Patient #4 was a 56 year old male admitted to the agency on 1/27/11 for care primarily related to a decubitus ulcer of the buttocks. The</p>	G 224		
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G 224	<p>Continued From page 24</p> <p>"HHA/HOMEMAKER CARE PLAN," reviewed on 3/27/11 by the RN, did not include directions as to how the home health aide should attend to the wound dressing on Patient #4's buttocks.</p> <p>A home visit was made by a surveyor on 4/27/11 at 10:25 AM. During the home visit, Patient #4 stated if his wound dressing got wet while the home health aide was there, the home health aide would remove the wet dressing, cover the wound with a simple dressing and then call the SN. These directions were not included on the aide's POC.</p> <p>In an interview on 4/27/11 at 1:25 PM, the DON stated she agreed directions regarding care of Patient #4's wound dressing were not included on the home health aides's POC.</p> <p>The "HHA/HOMEMAKER CARE PLAN," included an assignment for the home health aide to take vital signs PRN. It did not say how the home health aide was to determine if vital signs were needed. The reporting parameters for the vital signs was to notify the nurse of any high or low vital signs. Specific parameters were not included.</p> <p>The DON was interviewed on 4/27/11 at 2:15 PM. She confirmed vital signs were ordered PRN and it was intended to mean to take vital signs per patient or nurse request. She confirmed there were no specific reporting parameters for the vital signs.</p> <p>The home health aide POC did not include significant and specific information related to patient care.</p>	G 224		

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G 225	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review, staff interview, and review of the CNA job description, it was determined the agency failed to ensure home health aides provided care in accordance with the written plan of care for 4 of 6 patients who received home health aide services (#3, #4, #5, and #6) whose records were reviewed. This resulted in a failure to report a change in patient condition. It also resulted in services ordered in the plan of care not being performed. Findings include:</p> <p>The undated "C.N.A. Job Description," (AKA Home Health Aide job description) stated it was the duty and responsibility of the CNA (or home health aide) to report all changes in the client's condition to the Office Manager/Administrator or the DON as soon as practical and to follow the plan of care. These responsibilities were not completed in the examples that follow:</p> <p>1. Patient #5 was a 77 year old female admitted to the agency on 4/13/11 for care primarily related to a viral infection and difficulty walking. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/13/11 to 6/11/11, included an assignment for the aide to take vital signs PRN and report an increase or decrease. A home health aide progress note,</p>	G 225	<p>G225 Assignment & Duties of Home Health Aide Intervention: The home health aides will be instructed to provide service to the clients by following the aide plan of care. They will be instructed on proper documentation techniques and the importance of notifying the nurse of any changes in the plan of care or problems or falls that the patient may experience. Person Responsible: DON Compliance by: June 11, 2011 4</p>	

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G 225	<p>Continued From page 26</p> <p>dated 4/15/11 at 10:00 AM, documented a temperature of 99.7 degrees. There was no documentation the elevated temperature was reported to the RN.</p> <p>During a home visit on 4/27/11 at 10:00 AM, the home health aide who cared for Patient #5 was interviewed. She confirmed Patient #5's elevated temperature and stated she did not report it to the nurse because Patient #5's daughter was present at the time and knew about it.</p> <p>An elevated temperature was not reported to the RN as required in the aide POC.</p> <p>2. Patient #3 was a 60 year old female admitted to the agency on 4/05/11 for care primarily related to pneumonia. The "HHA/HOMEMAKER CARE PLAN," dated 4/05/11, included an assignment for the home health aide to provide Patient #3 with a bath of choice (tub/shower, bed bath, or chair bath) every visit. There was no documentation of baths in aide visit notes, dated 4/04/11, 4/07/11, 4/08/11, 4/11/11, 4/13/11, 4/15/11, 4/18/11, 4/10/11, or 4/22/11. There was also no documentation as to the reason services were not provided.</p> <p>The DON was interviewed on 4/27/11 at 2:00 PM. She reviewed Patient #3's record and confirmed the findings. The aide was not available for interview.</p> <p>Baths were not provided consistent with the aide POC.</p> <p>3. Patient #6 was an 82 year old male admitted to the agency on 3/16/11 for care primarily related</p>	G 225		

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G 225	<p>Continued From page 27</p> <p>to a stroke. The "HHA/HOMEMAKER CARE PLAN," dated 3/16/11, included an assignment for the home health aide to provide Patient #6 with a bath of choice (tub/shower, bed bath, or chair bath) every visit. There was no documentation of baths in aide visit notes, dated 4/07/11, 4/14/11, and 4/21/11. There was also no documentation as to the reason services were not provided.</p> <p>The DON was interviewed on 4/27/11 at 2:20 PM. She reviewed Patient #6's record and confirmed the findings.</p> <p>Baths were not provided consistent with the aide POC.</p> <p>4. Patient #4 was a 56 year old male admitted to the agency on 1/27/11 for care primarily related to a decubitus ulcer of the buttocks. The "HHA/HOMEMAKER CARE PLAN" reviewed on 3/27/11, included an assignment for the home health aide to provide Patient #4 with a bath of choice (tub/shower, bed bath, or chair bath). There was no documentation of baths in aide visit notes, dated 3/30/11, 4/05/11, 4/14/11, or 4/21/11.</p> <p>The aide POC also included the assignment for the home health aide to put antibiotic ointment and gauze around Patient #4's suprapubic catheter site after a bath of choice. There was no documentation the suprapubic catheter care was completed during aide visits, dated 3/31/11, 4/03/11, 4/12/11, 4/14/11, 4/19/11, or 4/21/11. There was also no documentation as to the reason services were not provided.</p>	G 225			

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G 225	Continued From page 28 The DON was interviewed on 4/27/11 at 1:25 PM. She reviewed Patient #4's record and confirmed the findings. The aide was not available for interview. Patient cares were not provided consistent with the aide POC.	G 225			

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state survey of your agency. The surveyors conducting the survey were: Karen Robertson, RN, BS, HFS, Team Leader Teresa Hamblin RN, MS, HFS Acronyms used in this report include: DME - Durable Medical Equipment DON - Director of Nursing LPN - Licensed Practical Nurse POC - Plan of Care SOC - Start of Care	N 000		
N 039	03.07020. ADMIN.GOV. BODY N039 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: a) The extent to which payment may be expected from third party payors.; and This Rule is not met as evidenced by: Refer to G114	N 039	N 039 Admin.Gov.Body <u>Plan of Action:</u> Notice was written and added to the Bill of Rights & Responsibilities that the client portion of the bill for Medicare and Medicaid Home Health is \$0. <u>Plan of Correction:</u> Each RN tha tadmits a client for service will notify the client that they will not have a co-pay with Medicare, Mediciad or any Federally Funded Program for Home Health. Insurance and other forms of payment will be discussed at the admission visit and the insurance clerk will be notified to contact the insurance company for co-pay and deductible amounts, those figures will be given to the client verbally and in writing, as soon as the insurance company gives the information to the insurance clerk. <u>Person Responsible:</u> Administrator <u>Date of Compliance:</u> June 14, 2011 See Exhibit I	
N 040	03.07020. ADMIN. GOV. BODY N040 04. Patients' Rights. Insure that patients' rights are recognized	N 040	N 040 Patient Liability for Payment	

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Bureau of Facility Standards

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

TITLE

Admin

(X6) DATE

5/20/11

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N 040	Continued From page 1 and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: b) The charges for services that will not be covered by third party payors; and This Rule is not met as evidenced by: Refer to G114	N 040	(continued) <u>Plan of Action:</u> Notice was written and added to the Bill of Rights & Responsibilities that the client portion of the bill for Medicare and Medicaid Home Health is \$0. <u>Plan of Correction:</u> Each RN that admits a client for service will notify the client that they will not have a co-pay with Medicare, Medicaid or any Federally Funded Program for Home Health. Insurance and other forms of payment will be discussed at the admission visit and the insurance clerk will be notified to contact the insurance company for co-pay and deductible amounts, those figures will be given to the client verbally and in writing, as soon as the insurance company gives the information to the insurance clerk. <u>Person Responsible:</u> Administrator <u>Date of Compliance:</u> June 10, 2011	
N 041	03.07020. ADMIN. GOV. BODY N041 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: c) The charges that the patient may have to pay; and This Rule is not met as evidenced by: Refer to G114	N 041	N 041 Patient Liability for Payment <u>Plan of Action:</u> Notice was written and added to the Bill of Rights & Responsibilities that the client portion of the bill for Medicare and Medicaid Home Health is \$0. <u>Plan of Correction:</u> Each RN that admits a client for service will notify the client that they will not have a co-pay with Medicare, Medicaid or any Federally Funded Program for Home Health. Insurance and other forms of payment will be discussed at the admission visit and the insurance clerk will be notified to contact the insurance company for co-pay and deductible amounts, those figures will be given to the client verbally and in writing, as soon as the insurance company gives the information to the insurance clerk. <u>Person Responsible:</u> Administrator <u>Date of Compliance:</u> June 10, 2011	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:	N 062	N 062 Administrator	

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N 062	Continued From page 2 i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G143 and G144	N 062	(continued) <u>Plan of Correction/Implementation:</u> When SN, OT, PT, MSW are required the RN will contact the therapist and give information and history of the client for specific care. The Therapist will be informed to contact the RN when evaluation is done to notify RN of cares to be given. Any needed forms will be given to the Therapist. Each Monday during office meeting the therapy notes will be read for continuity. Weekly communication with therapists will give the clients the excellent care that Helping Hands wants to be known for. <u>Person Responsible:</u> Administrator <u>Date of Compliance:</u> June 10, 2011 4	
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to G224	N 122		
N 126	03.07025.THERAPY SERV. N126 01. Qualified Therapist. A qualified therapist duties include the following: c. Prepares clinical and progress notes, and summaries of care, and This Rule is not met as evidenced by: Refer to G187	N 126	N 126 Therapy Services <u>Plan of Correction:</u> Therapy Services will include documentation of client service. Documentation will be reviewed each Monday at weekly nurses meeting to insure the clients service are accommodating their needs. In Service for the Therapies will include teaching proper communication including missed visits or refused visit documentation. When in services are completed by the Therapist they will bring verification of the In service to the office staff for filing in personnel files. With open communication, all of the staff will be able to provide excellent service and comply with Medicare regulations. The QA nurse will monitor charts for proper communication to maintain compliance. <u>Person Responsible:</u> Administrator <u>Date of Compliance:</u> June 10-2011 4	

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NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 127	Continued From page 3	N 127		
N 127	03.07025.THERAPY SERV. N127 01. Qualified Therapist. A qualified therapist duties include the following: d. Participates in in-service programs. This Rule is not met as evidenced by: Refer to G189	N 127	N127 Therapy Service Intervention: All therapy services providing care For Helping Hands Home Health Will provide written documentation Of the in-services and education They attend to the home health Agency Person Responsible: DON Compliance by: 6/10/2011	
N 144	03.07026.SOC.SERV. N144 02. Social Worker. A social worker performs the following duties: f. Participates in in-service programs, and This Rule is not met as evidenced by: Refer to G200	N 144	N144 Therapy Service Intervention: All therapists will attend educational In-services and provide the Home health agency with Written documentation of these In-services Person responsible: Compliance by 6/10/2011	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G158	N 152	N152 & N155 Plan of Care Intervention: Nurses will be in serviced on Importance of including All equipment needed For patient care on the Plan of care Person Responsible: DON Compliance by: 6/10/11	
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A	N 155		

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N 155	<p>Continued From page 4</p> <p>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, staff and patient interview, and home observation, it was determined the agency failed to ensure the POC included all pertinent information for 5 of 11 patients (#1, #3, #4, #5, and #7) whose records were reviewed. This had the potential to result in incomplete or uncoordinated patient care. Findings include:</p> <p>1. Patient #4 was a 56 year old male admitted to the agency on 1/27/11 for care primarily related to a decubitus ulcer of the buttocks. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 3/27/11 to 5/25/11, did not include colostomy or suprapubic catheter supplies, abdominal binder, or heel protectors.</p> <p>A home visit was made 4/27/11 at 10:25 AM. The LPN was observed to change Patient #4's colostomy bag, clean around his suprapubic catheter, adjust his abdominal binder, and replace his heel protectors.</p> <p>In an interview on 4/27/11 at 1:25 PM, the DON reviewed the POC for Patient #4 and stated she agreed the POC did not include those supplies and that it should have included them.</p>	N 155		

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N 155	<p>Continued From page 5</p> <p>The agency did not include all pertinent DME on the POC.</p> <p>2. Patient #1 was a 51 year old male admitted to the agency on 10/21/10 for care primarily related to schizophrenia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 2/18/11 to 4/18/11, did not include venipuncture supplies, exam gloves, or alcohol swabs on the POC.</p> <p>A home visit was made 4/26/11 at 10:50 AM. The RN was observed to draw blood using venipuncture supplies, wearing exam gloves, and using alcohol swabs to cleanse Patient #1's skin prior to giving a shot.</p> <p>In an interview on 4/27/11 at 1:25 PM, the DON reviewed the POC for Patient #1 and stated she agreed the POC for the certification period of 2/18/11 to 4/18/11 did not include venipuncture supplies, exam gloves, and alcohol swabs.</p> <p>The agency did not include all pertinent DME on the POC.</p> <p>3. Patient #7 was a 52 year old male admitted to the agency on 4/04/11 for care primarily related to multiple sclerosis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 4/04/11 to 6/02/11, included orders for skilled nursing visits for purposes including performance of urine tests and blood work. Laboratory supplies were not included on the POC.</p> <p>In an interview on 4/27/11 at 1:25 PM, the DON stated she agreed that laboratory supplies were not on the POC.</p>	N 155		

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N 155	<p>Continued From page 6</p> <p>The agency did not include all pertinent DME on the POC.</p> <p>4. Patient #5 was a 77 year old female admitted to the agency on 4/13/11 for care primarily related to a viral infection and difficulty walking.</p> <p>During a home visit on 4/27/11 between 9:00 AM and 10:00 AM, the home health aide who provided bath care for Patient #5 explained her usual bathing process. She explained she wheeled Patient #5 in her wheelchair to the top of the stairs, helped her transfer to a chair lift which she then rode to the bottom the stairs. Patient #5 then transferred from the chair lift to a walker and walked to the shower. The home health aide then helped her transfer to a commode that she used in the shower. She stated Patient #5 did not have a bath bench. The wheelchair, walker, chair lift, and commode were observed in the home.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/13/11 to 6/11/11, did not include the chair lift or commode.</p> <p>The DON was interviewed on 4/27/11 at 1:45 PM. She reviewed Patient #5's record and confirmed relevant equipment was missing from the POC.</p> <p>The plan of care did not include equipment required for aide services.</p> <p>5. Patient #3 was a 60 year old female admitted to the agency on 4/05/11 for care primarily related to pneumonia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/5/11 to 6/03/11, included medication orders for continuous oxygen. The POC did not include oxygen equipment as part of</p>	N 155		

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N 155	Continued From page 7 the plan of care. The DON was interviewed on 4/27/11 at 2:00 PM. She reviewed Patient #3's record and confirmed the findings. She stated they did not usually put oxygen equipment on the POC. The plan of care did not included pertinent DME on the POC.	N 155			