



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

August 4, 2011

Rod Jacobson, Administrator
Bear Lake Memorial Hospital Home Health
164 South 5th Street
Montpelier, ID 83254



RE: Bear Lake Memorial Hospital Home Health, Provider #137069

Dear Mr. Jacobson:

This is to advise you of the findings of the Medicare/Licensure survey at Bear Lake Memorial Hospital Home Health, which was concluded on July 28, 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 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 the Form CMS-2567 and State Form 2567.

Rod Jacobson, Administrator
August 4, 2011
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **August 17, 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

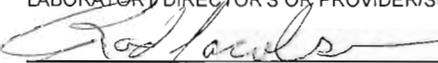
PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254
--	--

(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 Medicare recertification survey of your home health agency.</p> <p>The following surveyor conducted the survey: Teresa Hamblin, RN, MS, HFS</p> <p>The following abbreviations are used in the report: DME = Durable Medical Equipment POC = Plan of Care PT = Physical Therapy RN = Registered Nurse SN = Skilled Nursing TED = Thrombo Embolic Deterrent</p>	G 000		
G 158	<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 a written plan of care for 3 of 10 patients (#2, #3, and #4) whose records were reviewed. This resulted in missed visits, an extra visit, and an unaddressed safety hazard. It had the potential to negatively impact quality of care. Findings include: 1. Patient #2 was a 98 year old male who was admitted to the agency on 6/13/11 for care</p>	G 158	<p>See Addendum I</p> <p>Admitting RN/PT will include teaching for tripping hazards at admit to include electrical cords, O2 tubing, etc. along with fall prevention protocol and keeping pathways clear. SN/PT will document patient/family knowledge and understanding of the teaching. This will be monitored by the person preparing the plan of care 485 at each admit, ROC, recert and PRN... at D/C and at reasonable times when changes occur through the cert.</p>	<p>RECEIVED AUG 15 2011 FACILITY STANDARDS</p> <p>9/30/2011</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>8-11-11</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: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

G 158	<p>Continued From page 1</p> <p>primarily related to joint disease and muscle weakness. The "Home Health Certification (485)," for certification period 6/13/11 to 8/11/11, included orders for safety precautions: keeping pathways clear and fall precautions. Disciplines ordered included SN, PT, and home health aide.</p> <p>During a home visit on 7/26/11 at 8:50 AM, the home environment was observed as well as physical therapy care provided to Patient #2. An electrical cord was observed to be draped in front of the pathway to the bathroom. The electrical cord was for oxygen equipment being used in another room. When the surveyor went to inspect the bathroom, she stepped over the electrical cord to avoid tripping. There was no documentation found in PT or SN visit notes to indicate the potential tripping hazard had been addressed or documentation the home health aide had reported the tripping hazard to SN or PT.</p> <p>During an interview on 7/28/11 at 10:50 AM, the Director stated she agreed that an electrical cord in front of a bathroom entry could be a safety issue. She reviewed Patient #2's record and stated she could not see documentation the safety issue had been addressed.</p> <p>The agency did not address a tripping hazard according to the written plan of care.</p> <p>2. Patient #3 was an 87 year old female who was admitted to the agency on 7/15/11 for care after a femur fracture. The "Home Health Certification (485)," for certification period 7/15/11 to 9/12/11, included orders for home health aide services 2 times per week for 1 week followed by 3 times</p>	G 158	<p>See Addendum I</p> <p>Patient 3) SN will calculate weekly visits for 60 day cert period (days of week Sun-Sat). This will coincide with aide care plan. The person preparing the 485 plan of care will then re-count visits to ensure (continued on next page)</p>	<p>07/28/11</p> <p>07/28/11</p> <p>07/28/11</p> <p>9/30/2011</p>
-------	---	-------	---	--

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

PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 158	Continued From page 2 per week for 8 weeks. There were no documented home health aide visits during the first week when 2 visits were ordered. There were 2 home health aide visits during the second week (7/18/11 and 7/25/11) when 3 visits were ordered. During an interview on 7/28/11 at 10:20 AM, the Director reviewed Patient #3's record. She stated the aide visits were off compared to the orders. The agency did not ensure aide visit frequency followed the written plan of care. 3. Patient #4 was a 58 year old female who was admitted to the agency on 6/29/11 for care related to a malignant lymphoma. The "Home Health Certification (485)," for certification period 6/29/11 to 8/27/11, included orders for home health aide services 2 times per week for 8 weeks beginning the second week. No visits were ordered for the first week of service. An aide visit note documented a visit on 6/29/11 at 11:30 AM, during the first week of service when there were no orders present for an aide visit. During an interview on 7/28/11 at 10:30 AM, the Director reviewed Patient #4's record. She confirmed the extra visit during the first week of care. The agency did not ensure aide visit frequency followed the written plan of care.	G 158	(Continued from previous page) correct number of visits per week, so that no missed visits will occur and to prevent possible harm or injury to patient. See Addendum I	9/30/2011	
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses,	G 159			

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

PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254	
(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 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 plans of care covered all pertinent information for 4 of 10 patients (#2, #3, #8, and #9) whose records were reviewed. This had the potential to negatively impact quality, coordination, and completeness of patient care. Findings include:</p> <p>1. Patient #3 was an 87 year old female who was admitted to the agency on 7/15/11 for care following a femur fracture. The initial RN assessment, dated 7/15/11, documented Patient #3 reported constipation and used docusate sodium per label instructions. The "Home Health Certification (485)," for certification period 7/15/11 to 9/12/11, included a diagnosis of constipation. It did not include the docusate sodium.</p> <p>During an interview on 7/28/11 at 10:20 AM, the Director reviewed Patient #3's record. She stated the docusate sodium should have been included in the POC.</p> <p>The agency did not ensure the POC included all relevant medications.</p> <p>2. Patient #2 was a 98 year old male who was</p>	G 159	<p>See Addendum I</p> <p>Admitting RN will check med sheet against the MD discharge instructions or current MD med sheet, OASIS documentation and also patient's meds in the home including all OTC meds or herbal supplements the patient may be taking. The person entering OASIS into the system will check med sheet to ensure all OASIS med documentation is noted on the med sheet and on the 485 plan of care for MD approval.</p>	9/30/2011

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

PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254		
(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 5 include oxygen equipment or supplies as relevant DME/supplies. During an interview on 7/28/11 at 11:20 AM, the Director reviewed Patient #9's record. She stated oxygen supplies should have been on the POC. The agency did not ensure the POC included all relevant DME/supplies.	G 159	continued from previous page See Addendum I corrections same as	9/30/2011	
G 224	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, observations during home visits, staff interview, and caregiver interview, it was determined the agency failed to ensure the RN prepared written patient care instructions for the home health aide that included all relevant information for 7 of 8 patients (#2, #3, #4, #6, #7, #8, #10) who received home health aide services whose records were reviewed. This had the potential to negatively impact coordination and safety of patient care. Findings include: 1. Patient #6 was a 90 year old male who was admitted to the agency on 6/15/11 for care after prostate surgery. The "Home Health Certification (485)," for certification period 6/15/11 to 8/13/11, included orders for continuous oxygen at 4 liters per minute. The "AIDE CARE PLAN," dated 6/15/11, did not include a plan for oxygen use.	G 224	See Addendum I Patient 6 RN/PT will complete aide care plan to include/describe in full detail the use and instructions for all D.M.E. supplies that will be used during the aide visits including instructions for O2 use; how (continued on next page)	9/30/2011	

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

PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254
--	--

(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 224	<p>Continued From page 6</p> <p>During a home visit on 7/20/11 between 11:10 AM and 11:50 AM, a surveyor observed a home health aide provide care to Patient #6. Patient #6 was sitting in a chair in the dining room area. He removed his oxygen to use his jazzy chair (a motorized scooter) to go to the bathroom for his shower. He was observed to have increased shortness of breath after his shower, at which time, the aide stated Patient #6 was also short of breath during his shower. Patient #6's spouse stated the oxygen tubing was not long enough to reach the bathroom but they could get longer tubing to reach the bathroom. After Patient #6 returned to the kitchen in his jazzy chair, the aide was observed to assist him in re-applying oxygen via nasal canula.</p> <p>The agency did not ensure an RN provided relevant written patient care instructions for the home health aide related to oxygen use.</p> <p>2. Patient #7 was a 58 year old male who was admitted to the agency on 5/14/11 for care primarily related to diabetes and renal disease. The "Home Health Certification (485)," for certification period 5/14/11 to 7/12/11, included orders for continuous oxygen at 4 liters per nasal cannula, and a jazzy chair as relevant DME. The "AIDE CARE PLAN," dated 5/14/11, did not include the jazzy chair or guidance related to oxygen usage. The care plan identified a fistula on Patient #7's left arm (a vascular access device for dialysis). It did not provide guidance as to whether the fistula could get wet or needed to be kept dry.</p> <p>During an interview on 7/28/11 at 11:05 AM, the</p>	G 224	<p>(continued from previous page)</p> <p>often, etc. The person completing the 485 (director or assist director) POC will review Aide care plan for completeness and instructions.</p> <p>See Addendum I</p> <p>SN/PT will complete Aide care plan with full detail on O2 use during ambulation, bathing, at rest, etc. to ensure that all staff knows exactly when when O2 should be worn. Director or assistant Director will monitor at entry of OASIS and POC preparation.</p> <p>See Addendum I</p> <p>Patient 7 RN/PT to complete Aide care plan to include full instruction on wound care, i.e. "can get wet" or "cover to keep dry"; O2 use and instructions for "jazzy chair" or wheelchair use and safety with transfers, repositioning, etc. Person perparing 485 POC will monitor at admit, ROC, recert and PRN at D/C when teaching to the patient/family.</p> <p>See Adendum I</p>	<p>9/30/2011</p> <p>9/30/2011</p> <p>9/30/2011</p>
-------	---	-------	--	--

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

PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254		
(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 224	<p>Continued From page 7</p> <p>Director reviewed Patient #7's record. She confirmed the care plan did not include the jazzy chair, oxygen guidance, or guidance related to the fistula.</p> <p>The agency did not ensure an RN provided written instructions to the home health aide related to relevant DME or instructions related to oxygen or the fistula.</p> <p>3. Patient #3 was an 87 year old female who was admitted to the agency on 7/15/11 for care after a femur fracture. The "Home Health Certification (485)," for certification period 7/15/11 to 9/12/11, included orders for intermittent oxygen at 1 liter per minute and TED hose. The "AIDE CARE PLAN," dated 7/15/11, did not list or provide guidance to the aide related to TED hose or oxygen use.</p> <p>During an interview on 7/28/11 at 10:20 AM, the Director reviewed Patient #3's record. She confirmed the aide care plan did not include guidance for oxygen use or TED hose use.</p> <p>The agency did not ensure an RN provided relevant written patient care instructions for the home health aide related to oxygen use and TED hose.</p> <p>4. Patient #4 was a 58 year old female who was admitted to the agency on 6/29/11 for care related to a malignant lymphoma. The "Home Health Certification (485)," for certification period 6/29/11 to 8/27/11, listed a shower chair and cane as relevant DME. The "AIDE CARE PLAN," dated 6/29/11, did not include the shower chair or cane, which were relevant to caring for Patient</p>	G 224	<p>See Addendum I</p> <p>RN/PT will complete Aide care plan to list all D.M.E. supplies used by the patient or Aide during aide visit to include complete instructions for TED hose use i.e. "On and Off" times, skin care, keeping TED hose wrinkle free, laundry care of hose, O2 use; "continuous or at NOC only", etc. Director preparing 485 POC will monitor for completeness of aide care plan.</p> <p>See Addendum I</p> <p>Aide care plan will include all DME supplies used by the patient/aide during aide visit. Instruction for use to ensure proper, consistent teaching to aide and patient. This will be completed by RN/PT and monitored at the time of preparation of POC 485 by Director or assistant Director.</p>	9/30/2011	9/30/2011

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

PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254		
(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 224	<p>Continued From page 8 #4.</p> <p>During an interview on 7/28/11 at 10:30 AM, the Director reviewed Patient #4's record and confirmed the aide care plan was missing relevant information.</p> <p>The agency did not ensure an RN include relevant DME on the written patient care instructions for the home health aide.</p> <p>5. Patient #2 was a 98 year old male who was admitted to the agency on 6/13/11 for care primarily related to joint disease and muscle weakness.</p> <p>During a home visit on 7/26/11 between 8:50 AM and 9:15 AM, Patient #2 was observed to ambulate with a walker. A foley catheter bag was hanging on the walker. The "Home Health Certification (485)," for certification period 6/13/11 to 8/11/11, listed a walker and hand-held shower as relevant DME. The "AIDE CARE PLAN," dated 6/13/11, did not reference the need for a walker or the hand-held shower. It did not give the aide guidance as to any care related to the foley catheter, whether to empty it or keep it below the level of the bladder.</p> <p>During an interview on 7/28/11 at 10:50 AM, the Director reviewed Patient #2's record. She confirmed the aide care plan did not include relevant DME or guidance related to the foley catheter care.</p> <p>The agency did not ensure an RN included relevant DME or instructions related to the foley catheter on the written patient care instructions</p>	G 224	<p>See Addendum I</p> <p>RN/PT will complete Aide care plan to include reference to the need for for a walker or the hand-held shower, foley catheter. Frequency of use for the walker, teaching and use of the hand-held shower to the patient. Foley cath care instructions i.e. how often to empty, to change to leg bag or down drain bag, positioning of the down drain bag during ambulation or while patient is at rest (to keep below bladder level). Person preparing the POC 485 will monitor Aide care plan, OASIS and Aide care plan.</p> <p>See Addendum I</p>	<p>9/30/2011</p> <p>9/30/2011</p>	

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

PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254
--	--

(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 224	<p>Continued From page 9 for the home health aide.</p> <p>6. Patient #8 was an 80 year old male who was admitted to the home health agency on 4/12/11 for care primarily related to a lung condition. The "Home Health certification (485)," for certification periods 4/12/11 to 6/10/11, included orders for continuous oxygen at 3.5 liters per nasal cannula and precautions for oxygen. The "AIDE CARE PLAN," dated 4/12/11, indicated high risk precautions for oxygen. It did not provide guidance as to whether Patient #8 should have oxygen on during bathing activities.</p> <p>During an interview on 7/28/11 at 11:15 AM, the Director reviewed Patient #8's record and confirmed the information related to oxygen use was incomplete on the Aide POC.</p> <p>The agency did not ensure an RN provided written instructions to the home health aide related to oxygen use.</p> <p>7. Patient #10 was an 86 year old male who was admitted to the agency on 7/19/11 for care after surgery. The "Home Health Certification (485)," for certification period 7/19/11 to 9/16/11, included orders for continuous oxygen at 3 liters per minute. It also listed a walker as relevant DME.</p> <p>The "AIDE CARE PLAN," dated 7/19/11, did not list the walker as relevant DME and did not provide guidance to the home health aide regarding oxygen use.</p> <p>During an interview on 7/28/11 at 11:30 AM, the Director reviewed Patient #10's record. She</p>	G 224	<p>Aide care plan will be complete as it will include 02, liter flow rate (to report to SN if different) precautions for 02 use and guidance as to whether or not patient should wear 02 during bathing. This will be monitored by the person completing the POC 485, OASIS entry. The Aide care plan will be completed by SN/PT.</p> <p>See Addendum I</p> <p>The Aide care plan will be completed by the admit RN or PT to include relevant D.M.E. supplies with complete instructions on how often the 02 should be worn by the patient and instructions on walker use i.e. how often patient should use, etc.</p> <p>This will be monitored by the director or assistant director when OASIS entry and preparation of 485 POC occurs. Also at recert or ROC.</p>	<p>9/30/2011</p> <p>9/30/2011</p>
-------	---	-------	--	-----------------------------------

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

PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254
--	--

(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 224	Continued From page 10 confirmed the care plan was missing relevant information related to oxygen use and the walker. The agency did not ensure an RN provided written instructions to the home health aide related to relevant DME and the use of oxygen.	G 224	see previous page. Same as description on page 9. See Addendum I	9/30/2011
-------	---	-------	---	-----------

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HE/		STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254		
(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	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey of your home health agency. The following surveyor conducted the survey: Teresa Hamblin, RN, MS, HFS The following abbreviations are used in the report: DME = Durable Medical Equipment POC = Plan of Care	N 000	See Addendum I	9/30/2011
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 G 224.	N 122	See tag G224 on federal report for details. See Addendum I For plan of correction	9/30/2011
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:	N 152	See next page. See Addendum I	9/30/2011

RECEIVED
AUG 17 2011
FACILITY STANDARDS

Bureau of Facility Standards

Rod Jacobson
REGISTRAR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Admin

(X6) DATE

8-17-11

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HE/		STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254		
(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 152	Continued From page 1 This Rule is not met as evidenced by: Refer to G 158.	N 152		
N 155	03.07030. PLAN OF CARE 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: c. Types of services and equipment required; This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the written plan of care covered all pertinent equipment and supplies for 3 of 10 patients (#2, #8, and #9) whose records were reviewed. This had the potential to negatively impact quality, coordination, and completeness of patient care. Findings include: 1. Patient #2 was a 98 year old male who was admitted to the agency on 6/13/11 for care primarily related to joint disease and muscle weakness. The "Home Health Certification (485)," for certification period 6/13/11 to 8/11/11, indicated Patient #2 had a urinary catheter that would need to be changed every 2 months. The POC did not include urinary catheter supplies as necessary supplies. During an interview on 7/28/11 at 10:50 AM, the Director reviewed Patient #2's record. She stated the urinary catheter supplies should have been	N 155	See Addendum I All D.M.E. equipment and supplies needed to complete the patient's needs will be added to the OASIS, 485 POC portion of the 485 by the SN/PT. Person preparing the 485 POC, entering OASIS data will monitor to ensure all D.M.E. supplies are listed and included in the care plan with instruction. SN/PT and person monitoring will also check all MD orders to ensure all D.M.E. supplies are noted.	9/30/2011

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HE/			STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254		
(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 included in the POC. The agency did not ensure the POC included all relevant supplies. 2. Patient #8 was an 80 year old male who was admitted to the home health agency on 4/12/11 for care primarily related to a lung condition. The "Home Health Certification (485)," for certification periods 4/12/11 to 6/10/11 and 6/11/11 to 8/09/11, included orders for continuous oxygen. It did not include oxygen equipment or supplies as relevant DME/supplies. During an interview on 7/28/11 at 11:15 AM, the Director reviewed Patient #8's record. She stated oxygen supplies should have been on the POC. The agency did not ensure the POC included all relevant DME/supplies. 3. Patient #9 was a 75 year old male who was admitted to the agency on 6/21/11 after removal of a brain tumor. The "Home Health Certification (485)," for certification period 6/21/11 to 8/19/11, included orders for continuous oxygen. It did not include oxygen equipment or supplies as relevant DME/supplies. During an interview on 7/28/11 at 11:20 AM, the Director reviewed Patient #9's record. She stated oxygen supplies should have been on the POC. The agency did not ensure the POC included all relevant DME/supplies.	N 155	See Addendum I 02 supplies and equipment will be listed by the admit RN/PT on the OASIS, 485 POC in the D.M.E. supplies. Person preparing 485 POC and entering OASIS data will monitor for this completeness.	9/30/2011	
N 161	03.07030.PLAN OF CARE N161 01. Written Plan of Care. A written plan of care shall be	N 161	Same as above.	9/30/2011	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HE/		STREET ADDRESS, CITY, STATE, ZIP CODE 487 WASHINGTON STREET MONTPELIER, ID 83254		
(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>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>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 plans of care covered all pertinent medications for 1 of 10 patients (#3) whose records were removed. This had the potential to negatively impact coordination of patient care. Findings include:</p> <p>Patient #3 was an 87 year old female who was admitted to the agency on 7/15/11 for care following a femur fracture. The initial RN assessment, dated 7/15/11, documented Patient #3 reported constipation and used docusate sodium per label instructions. The "Home Health Certification (485)," for certification period 7/15/11 to 9/12/11, included a diagnosis of constipation. It did not include the docusate sodium.</p> <p>During an interview on 7/28/11 at 10:20 AM, the Director reviewed Patient #3's record. She stated the docusate sodium should have been included in the POC.</p> <p>The agency did not ensure the POC included all relevant medications.</p>	N 161	<p>See Addendum I</p> <p>Admit RN/PT will ensure all meds are entered on the medication sheet from MD orders, OASIS data collection, meds noted at the home during admit, ROC, recert and also PRN D/C. The meds will be entered and submitted to the MD for approval i.e. OTC meds and herbal supplements patient may be taking at home that the MD may not be aware of. Person preparing the 485 POC will monitor medication sheet against 485 POC MD instructions for meds, OASIS entry of documentation for completeness and matching of all documents.</p>	9/30/2011