

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 11, 2011

Sheryl Rickard, Administrator
Bonner General Hospital Home Health
PO Box 1448
Sandpoint, ID 83864

RE: Bonner General Hospital Home Health, Provider #137032

Dear Ms. Rickard:

This is to advise you of the findings of the Medicare/Licensure survey at Bonner General 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.

Sheryl Rickard, Administrator
August 11, 2011
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **August 23, 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,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm
Enclosures

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

PRINTED: 08/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
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NAME OF PROVIDER OR SUPPLIER BONNER GENERAL HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 602 NORTH THIRD AVENUE SANDPOINT, ID 83864
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G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare re-certification survey of your agency. Surveyors conducting the re-certification were: Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS BS - blood sugar DME - Durable Medical Equipment MD - Medical Doctor POC - Plan of Care Pt - patient RN - Registered Nurse TIF-Transfer to Inpatient Facility	G 000		
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, observation, and staff interview, it was determined the agency failed to ensure plans of care covered all pertinent information for 5 of 14 patients (#1, #3, #11, #13 and #14) whose records were reviewed. This had the potential to negatively impact quality, coordination, and completeness of patient care.	G 159		<ul style="list-style-type: none"> Staff education specific to inclusion of all DME/supplies on Home Health Certification and Plan of Care (485) will be conducted on 8/23/11 (see attached agenda - Exhibit A) Staff education specific to addressing all comprehensive assessment findings and interventions will be conducted on 8/23/11 (see attached agenda - Exhibit A) This will provide education and tools for staff to document according to the standard. A minimum of 15 clinical records will be audited quarterly for compliance with this standard. This will be monitored by the Clinical Manager or designee with results forwarded to the Quality Manager. Additional education will be provided as needed based on findings of internal audits.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nonie Howell</i>	TITLE Chief Financial Officer	(X6) DATE 08/16/2011
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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 159	<p>Continued From page 1</p> <p>Findings include:</p> <p>1. Patient #3 was a 61 year old female who was admitted to the agency for skilled nursing services related to Multiple Sclerosis on 12/08/04. The "Recert/Followup Assessment," completed by an RN on 6/30/11 at 8:19 AM, documented Patient #3 ate fewer than two meals a day, and had a weight loss of more than 10 pounds in a 6 month period. The most recent weight for Patient #3 was 95 pounds on 7/12/11. The "Recert/Followup Assessment" also included information that Patient #3 was on oxygen on an "as needed" basis, and she required treatment for a stage 2 pressure ulcer on her sacrum twice weekly. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 7/05/11 to 9/02/11, stated Patient #3 was on a mechanical soft diet. Safety measures related to aspiration precautions were not included in the POC. Additionally, no interventions were listed to improve Patient #3's nutritional status to promote wound healing and health related to her diseases processes.</p> <p>During a home visit on 7/26/11 at 11:00 AM, upon the entry of the RN and surveyor into the house, Patient #3 was at the dining table and had just experienced a severe choking episode. The RN measured Patient #3's blood oxygen level, and vital signs, then assisted Patient #3 with putting her nasal cannula oxygen on and increased the flow from 1.5 liters to 2. Patient #3 again experienced a choking episode during preparation for wound care when she was on her back. At that time, Patient #3 was lying flat.</p> <p>The RN Case Manager was interviewed on</p>	G 159	<p>G 159</p> <ul style="list-style-type: none"> • Related to patient #3 (only active patient on service at time of receipt of Survey Statement of Deficiencies). <p>See attached documentation:</p> <ul style="list-style-type: none"> • Physician was contacted to SLP swallow re-evaluation (see attached for order and progress note). This resulted in no change to current plan of care and patient was not found to be at risk for aspiration. (See Exhibit F) • Patient has again declined nutritional consultation (please see attached progress note) and continued to take 700 calorie shakes twice daily in addition to meals. RN instituted calorie count 7/29/11. (See Exhibit B, C, D, E. 	

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G 159	<p>Continued From page 2</p> <p>7/28/11 at 8:15 AM. She reviewed Patient #3's record and confirmed the "HOME HEALTH CERTIFICATION AND PLAN OF CARE" included orders for weights, but did not include frequency. The RN stated she weighed Patient #3 upon her request, which was approximately every two months. The RN stated Patient #3 had anorexia and often did not want to know what her weight was. The RN stated a nutritional analysis had been done in the past, but she was unable to provide documentation of the consultation. The RN stated she had provided instruction to Patient #3 to increase her protein in her diet, as well as, to drink a nutritional shake every afternoon, although it was not included on the POC. The RN stated Patient #3 was evaluated for swallowing problems and possible aspiration when she had been hospitalized during the spring for pneumonia. She stated Patient #3 had "Aspiration Precautions" included in prior POC's but felt it was no longer a precaution that needed to be included in her current POC.</p> <p>Patient #3's POC did not include the nutritional shakes the RN instructed her to drink. It did not include safety measures to address aspiration. Additionally, the POC did not include consultations necessary to accurately assess Patient #3's current nutritional status and swallowing ability, and recommend interventions to address them.</p> <p>2. Patient #13 was an 88 year old female who was admitted to the agency on 4/05/11 for skilled nursing services related to therapeutic drug monitoring and monthly catheter changes. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/04/11 to</p>	G 159		

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G 159	<p>Continued From page 3</p> <p>8/02/11, under section 14 (DME and Supplies,) contained "N/A" indicating no Durable Medical Equipment or catheter changing supplies would be required. Under section 18, "Activities Permitted," indicated Patient #13 could use a walker, however it was not clear if she had a walker. The "Recert/Followup Assessment," dated 6/03/11 described Patient #1 as requiring a catheter change monthly.</p> <p>In an interview on 7/26/11 at 4:00 PM, the Manager reviewed Patient #13's medical record and confirmed catheter supplies, gloves, and walker were not listed on the POC.</p> <p>Patient #13's POC did not include necessary DME and supplies.</p> <p>3. Patient #14 was a 64 year old female who was admitted to the agency on 5/23/11 for physical and occupational therapy primarily related to a genetic muscular disorder. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 5/23/11 to 7/21/11, under section 14 (DME and Supplies,) contained "N/A" indicating no Durable Medical Equipment or supplies would be required. However, section 18, "Activities Permitted," included a walker and wheelchair.</p> <p>In an interview on 7/26/11 at 3:35 PM, the Manager reviewed Patient #14's medical record and confirmed DME such as a walker and wheelchair was not listed as DME on the POC.</p> <p>Patient #14's POC did not include all DME she needed for ambulation.</p>	G 159		

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G 159	<p>Continued From page 4</p> <p>4. Patient #1 was an 86 year old female who was admitted to the agency on 7/07/11 for physical therapy and skilled nursing services related to a knee replacement. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 7/07/11 to 9/04/11, under section 14 (DME and Supplies,) contained "N/A" indicating no Durable Medical Equipment or supplies would be required, although a walker was included under section 18, "Activities Permitted."</p> <p>During a home visit on 7/26/11 at 9:00 AM, Patient #1 was observed using a walker with the Physical Therapist while walking outside. In the home, Patient #1 was observed using a cane during ambulation from the living area to the kitchen.</p> <p>In an interview on 7/27/11 at 8:30 AM, the Physical Therapist reviewed Patient #1's record and confirmed the DME section did not include a walker or cane. The Physical Therapist stated he had included the use of a walker in the POC under section 18, "Activities Permitted." He confirmed the cane had not been included in the activities or the DME section of the POC.</p> <p>Patient #1's POC did not include all required DME.</p> <p>5. Patient #11's medical record documented a 51 year old male with diagnoses of chronic ulcer of left heel and mid-foot and diabetes with neurological manifestations. His right leg had been amputated below the knee. He was admitted for home health care on 6/13/11 and was currently a patient as of 7/28/11. He was</p>	G 159			

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G 159	<p>Continued From page 5</p> <p>admitted for nursing care of the ulcers. Physician orders were used to communicate with the physician. A "Physician's Modified Order," dated 6/13/11 at 4:30 PM, stated Patient #11 was not taking his Metformin (a diabetic medication) and had discontinued it on his own. The order also stated Patient #11 was "...taking Novolog insulin per sliding scale with no blood sugar range." Another order, dated 6/18/11 at 1:35 PM, stated Patient #11 "...gives his own sliding scale-'if I eat some cake-I just take another couple of units [of insulin] as I need it' But has no order for sliding scale." Patient #11's POC, completed 6/14/11, stated the RN was to "...instruct on diabetic management...medication management..." The POC did not include a specific plan to encourage Patient #11 to care for his diabetes in a systematic way. The POC did not include a plan to decrease Patient #11's noncompliance with diabetes management. A nursing "Progress Report," dated 6/15/11 at 10:48 AM, stated "Pt declines RN set up med planner. States he's taking meds as ordered except for Metformin. States it is too big of a pill. Advised of risks of not taking Metformin and not checking blood sugars. Advised him of need to check BS daily to give MD info he can use to determine need for meds. Suggested he take it at least once a day @ random times, recording them." A plan to address Patient #11's continued noncompliance with diabetic management was not documented through 7/25/11.</p> <p>The RN Case Manager for Patient #11 was interviewed on 7/28/11 at 9:00 AM. She stated Patient #11 continued to refuse to monitor his blood glucose levels and to follow a sliding scale insulin regimen. She confirmed a specific plan to</p>	G 159			

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G 159	Continued From page 6 monitor his blood glucose levels and to increase his compliance for diabetes management had not been developed.	G 159			
G 163	The agency did not develop a plan to manage Patient #11's diabetes. 484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patient POC's were reviewed by attending physicians at least every 60 days or more frequently as warranted by the patients condition, for 3 of 3 patients (#9, #12, and #14) reviewed who were identified by the agency as on services for 60 or more days. This resulted in patients remaining on service when discharge was warranted, patient services being put on hold without physician knowledge or orders to do so, and decreased physician oversight. Findings include:	G 163	G 163 • Staff education specific to this standard "The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer...." will occur on 8/23/11. Please see attached agenda – Exhibit A). • Policies: Case Conference, Home Health Multidisciplinary; On Hold Status, and Discharge or Transfer of Patients from Home Health Services revised on 8/15/11 (See attached Exhibit H, I, J) • 100% of all clinical records will be monitored weekly for compliance with this standard by Clinical Manager or designee with results forwarded quarterly to the Quality Manager. • This will allow for timely identification of untimely or unsent documentation to physician. • Additional education will be provided based on internal audit results.	8/23/11 8/15/11	

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G 163	<p>Continued From page 7</p> <p>A current active patient census was requested during the entrance conference with the Manager on 7/25/11 at 4:00 PM. Three patients on the list as active patients had exceeded the 60 day POC review requirement. They include:</p> <p>1. Patient #9 was a 75 year old female admitted to the agency on 5/13/11 for skilled nursing primarily related to wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the period 5/13/11 to 7/11/11 included orders for nursing visits as follows: one visit for one week, then two to three times weekly for two weeks for wound vac dressing changes. The orders were for three weeks of nursing visits total.</p> <p>The first documented nursing visit was on 5/13/11. Two more visits were noted in the record, on 5/16/11 and 5/20/11. In the visit notes on 5/20/11, the RN documented her plan for the next visit would be 5/24/11 to determine if the wound vac would be continued. The record did not contain documentation of nursing visits the third week, although on a "Communication Note" dated 5/25/11, the RN documented a phone conversation with Patient #9. The RN wrote Patient #9's wound vac device was working well without problems, and she planned to call Patient #9 after her physician's appointment on 5/27/11. There was no documentation that the two or three visits that had been ordered for the third week had been made. The documentation did not reflect a change in the POC.</p> <p>According to the active patient census provided on 7/25/11, Patient #9 would have been in a second certification period, from 7/12/11 to</p>	G 163			

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G 163	<p>Continued From page 8</p> <p>9/08/11. There was no record of a 60 day summary or POC review by the physician.</p> <p>In an interview on 7/27/11 at 9:35 AM, Patient #9's Case Manager stated "I didn't discharge her, and I need to. I have no excuse." The Case Manager did not offer any further information regarding the missed visits or lack of documentation.</p> <p>In an interview on 7/27/11 at 3:30 PM, the Manager stated Patient #9's record had been updated that day to reflect a discharge effective 5/27/11. She stated the Case Manager had failed to document a physician order on 5/27/11 to discharge Patient #9. The Manager stated the OASIS and discharge assessment for Patient #9 had not been completed at the time the order had been received. The Manager confirmed Patient #9 was on the 7/25/11 census as being an active patient.</p> <p>Patient #9's condition changed and home health services were no longer necessary, however, Patient #9 was not discharged. As a result, Patient #9 was identified as an active patient for over 60 days. The failure to discharge was also not identified after 60 days as a summary and POC had not been prepared for physician review.</p> <p>2. Patient #12 was an 80 year old female, admitted to the agency on 4/17/11 for nursing services related to Herpes zoster, also known as shingles. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the period from 4/17/11 to 6/15/11 contained physician orders for skilled nursing visits one to two times weekly for six weeks for dressing changes.</p>	G 163		

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G 163	Continued From page 9 The admission visit was documented on 4/17/11, and the comprehensive assessment was completed at that time. Patient #12 was seen again on 4/20/11, and the Case Manager wrote in her notes of a plan to visit on 4/25/11. According to the active patient census provided on 7/25/11, Patient #12 would have been in a second certification period, from 6/16/11 to 8/14/11. There was no record of a 60 day summary and POC, or other communication, sent to the physician for review. In an interview on 7/28/11 at 3:05 PM, Patient #12's Case Manager stated that after a conversation with Patient #12's daughter on 4/27/11, she placed Patient #12 on hold. The Case Manager stated she had not contacted the physician for orders to place Patient #12 on hold or to discontinue care. In an interview on 7/27/11 at 4:15 PM, the Manager reviewed the record and confirmed there was no documentation after the 4/20/11 nursing visit. In a second interview was completed with the Manager on 7/28/11 at 9:10 AM. The Manager stated the Case Manager had failed to obtain a physician order on 4/27/11 to place Patient #12 on hold or discharge. The Manager stated the OASIS and discharge assessment for Patient #12 had not been completed. The Manager confirmed Patient #12 was on the 7/25/11 census as being an active patient, and she had not been aware that Patient #12's status had changed.	G 163		

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(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 163	Continued From page 10 Agency staff did not complete a 60 day summary and provide it and the POC to the physician for review as required. 3. Patient #14 was a 64 year old female admitted to the agency on 5/23/11 for physical and occupational therapy related to a genetic muscular disease. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the period 5/23/11 to 7/21/11 included orders for physical therapy for two to three times a week for six weeks, and to contact the physician for further orders. The orders for occupational therapy were two to three visits over 14 days, and to contact the physician for further orders. An OASIS C Transfer Assessment form, dated 6/13/11 indicated Patient #14 was transferred to an in-patient facility, and the last therapy visit was 6/10/11. In an interview on 7/27/11 at 3:35 PM, the Manager reviewed Patient #14's record and confirmed the transfer on 6/13/11. She stated the practice of the agency was to place a patient on a "hold" status when a TIF had been completed for the remainder of the certification period. She provided a copy of the "OASIS C Discharge Assessment," which was completed 7/25/11 at 5:00 PM, and stated the discharge OASIS should have been completed by 7/21/11, as well as, a discharge summary for the physician. Agency staff and her physician did not review Patient #14's POC every 60 days or sooner as her condition warranted.	G 163		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE	G 164		

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G 164	<p>Continued From page 11</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</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 agency staff promptly alerted the physician of 1 of 3 patients (#12) reviewed who was identified by the agency as on service for 60 or more days, to changes in patient's condition that suggested a need to alter the POC. This resulted in services to a patient being put on hold, without physician knowledge or orders. Findings include:</p> <p>Patient #12 was an 80 year old female, admitted to the agency on 4/17/11 for nursing services related to Herpes zoster, also known as shingles. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the period from 4/17/11 to 6/15/11 contained physician orders for skilled nursing visits one to two times weekly for six weeks for dressing changes.</p> <p>The admission visit was documented on 4/17/11, and the comprehensive assessment was completed at that time. Patient #12 was seen again on 4/20/11, and the Case Manager wrote in her notes of a plan to visit on 4/25/11.</p> <p>According to the active patient census provided on 7/25/11, Patient #12 would have been in a second certification period, from 6/16/11 to 8/14/11. There was no record of a 60 day summary and POC, or other communication, sent to the physician for review.</p>	G 164	<p>G 164</p> <ul style="list-style-type: none"> • See Plan of Correction for 484.18 G163 • Policies updated (See attached Exhibits H, I, J) completed 8/15/11 and staff will be educated on 8/23/11 (see agenda – Exhibit A). (Plan of Correction the same as for 484.18 G163). 	<p>8/23/11</p> <p>8/15/11</p>
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G 164	Continued From page 12 In an interview on 7/28/11 at 3:05 PM, Patient #12's Case Manager stated that after a conversation with Patient #12's daughter on 4/27/11, she placed Patient #12 on hold. The Case Manager stated she had not contacted the physician for orders to place Patient #12 on hold or to discontinue care. In an interview on 7/27/11 at 4:15 PM, the Manager reviewed the record and confirmed there was no documentation after the 4/20/11 nursing visit. In a second interview on 7/28/11 at 9:10 AM, the Manager stated the Case Manager had failed to obtain a physician order on 4/27/11 to place Patient #12 on hold or discharge. The Manager stated the OASIS and discharge assessment for Patient #12 had not been completed. The Director confirmed Patient #12 was on the 7/25/11 census as being an active patient, and she had not been aware that Patient #12's status had changed. Agency staff did not alert the physician to changes that suggested a need to change Patient #12's POC.	G 164			
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress	G 236	G 236 • Please see Plan of Correction for 484.18 G163 and 484.18 G164 in addition, please see Case Conference Home Health Multidisciplinary Policy revision (See attached – Exhibit H) • This process will allow timely identification of documentation needs.	8/23/11	

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G 236	<p>Continued From page 13</p> <p>notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, it was determined the agency failed to ensure clinical records were complete for 4 of 14 patients, (#9, #10, #12 and #14) whose records were reviewed. This failure had the potential for incorrect patient information being passed to health care providers. Findings include:</p> <p>1. Patient #9 was a 75 year old female admitted to the agency on 5/13/11 for skilled nursing primarily related to wound care. The POC for certification period 5/13/11 to 7/11/11 included orders for nursing visits as follows: one visit for one week, then two to three times weekly for two weeks for wound vac dressing changes. The orders were for a total of three weeks of nursing visits.</p> <p>The first nursing visit was the admission on 5/13/11. Two more visits were noted in the record, on 5/16/11 and 5/20/11. In the visit notes on 5/20/11, the RN documented her plan for the next visit would be 5/24/11 to determine if the wound vac would be continued. A "Communication Note" on 5/25/11, the RN documented a phone conversation with Patient #9. The RN wrote Patient #9's wound vac device was working well without problems, and she planned to call Patient #9 after her physician's appointment on 5/27/11. The record did not contain documentation of further contact with Patient #9 after 5/25/11. There was no</p>	G 236	<p>G 236 cont.</p> <ul style="list-style-type: none"> • A minimum of 15 clinical records will be reviewed quarterly to ensure this standard is met. Clinical Manager or designee will be responsible to monitor this. Results will be forwarded to Quality Manager quarterly. • Additional education will be provided as needed based on internal audit results. 		

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G 236	<p>Continued From page 14</p> <p>documentation that the two or three visits that had been ordered for the third week had been made.</p> <p>In an interview on 7/27/11 at 9:35AM, Patient #9's Case Manager stated "I didn't discharge her, and I need to." The Case Manager did not offer any further information regarding the missed visits or lack of documentation.</p> <p>In an interview on 7/27/11 at 3:30 PM, the Manager stated Patient #9's record had been updated that day to reflect a discharge effective 5/27/11. She stated the Case Manager had failed to document a physician order to discharge Patient #9, and as a result, the OASIS and discharge assessment and summary had not been completed at the time the order had been received.</p> <p>The patient record was incomplete, and had not been maintained to include orders, progress notes, and discharge summary.</p> <p>2. Patient #12 was an 80 year old female, admitted to the agency on 4/17/11 for nursing services related to Herpes zoster, also known as shingles. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the period from 4/17/11 to 6/15/11 contained physician orders for skilled nursing visits one to two times weekly for six weeks for dressing changes.</p> <p>The admission visit was documented on 4/17/11, and the comprehensive assessment was completed at that time. Patient #12 was seen again on 4/20/11, and the Case Manager wrote in her notes of a plan to visit on 4/25/11. There was</p>	G 236		

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G 236	<p>Continued From page 15</p> <p>no further documentation in Patient #12's record to indicate further visits were made. There was no documentation in Patient #12's record to explain missed visits.</p> <p>In an interview on 7/28/11 at 3:05 PM, Patient #12's Case Manager stated after a conversation with Patient's daughter on 4/27/11 she placed Patient #12 on hold. The Case Manager stated she had not contacted the physician for orders to place Patient #12 on hold or to discontinue care.</p> <p>In an interview on 7/27/11 at 4:15 PM, the Manager reviewed the record and confirmed there was no documentation after the 4/20/11 nursing visit.</p> <p>In a second interview on 7/28/11 at 9:10 AM, the Manager stated the case manager had failed to obtain a physician order on 4/27/11 to place Patient #12 on hold or discharge. The Manager stated the OASIS and discharge assessment for Patient #12 had not been completed. The Manager confirmed Patient #12 was on the 7/25/11 census as being an active patient, and she had not been aware that Patient #12's status had changed.</p> <p>The patient record was incomplete, and had not been maintained to include orders, progress notes, and discharge summary.</p> <p>3. Patient #14 was a 64 year old female admitted to the agency on 5/23/11 for physical and occupational therapy related to a genetic muscular disease. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the period 5/23/11 to 7/21/11 included orders for</p>	G 236		

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G 236	<p>Continued From page 16</p> <p>physical therapy for two to three times a week for six weeks, and to contact the physician for further orders. The orders for occupational therapy were two to three times over 14 days, and to contact the physician for further orders.</p> <p>An OASIS C Transfer Assessment form, dated 6/13/11 indicated Patient #14 was transferred to an in-patient facility, and the last therapy visit was 6/10/11.</p> <p>In an interview on 7/27/11 at 3:35 PM, the Manager reviewed Patient #14's record and confirmed the transfer on 6/13/11. She stated the practice of the agency was to place a patient on a "hold" status when a TIF had been completed for the remainder of the certification period. She confirmed the discharge assessment should have been documented by 7/21/11.</p> <p>The patient record did not include a discharge summary.</p> <p>4. Patient #10's medical record documented an 88 year old female with diagnoses of lung cancer and phlebitis of her legs. She was admitted for home health care on 5/02/11 and was currently a patient as of 7/25/11. A "Physician's Modified Order," dated 5/31/11, ordered occupational therapy and speech therapy evaluations to be completed by 6/10/11. The evaluations were not done. On 6/20/11, a "Physician's Modified Order," ordered occupational therapy and speech therapy evaluations to be completed by 7/01/11. The occupational therapy evaluation was conducted on 6/29/11. The speech therapy evaluation was conducted on 7/01/11. An explanation for the delay in evaluations was not</p>	G 236		

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G 236	Continued From page 17 documented in the medical record. The agency Manager was interviewed on 7/28/11 at 11:05 AM. She stated she had spoken with the RN about Patient #10. The Manager stated she thought Patient #10's family had been reluctant to allow the therapists to visit Patient #10. She also stated she did not believe the therapists were notified of the orders to visit Patient #10 in a timely manner. She stated she was not completely certain of the reason for the delays because the medical record did not contain documentation explaining the delays. The agency did not maintain a complete clinical record for Patient #10. The agency did not ensure documentation for patient medical records was complete and accurate.	G 236			
G 341	484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, it was determined the facility failed to ensure a comprehensive assessment was done at the time of discharge for 3 of 3 patients (#9, #12 and #14) reviewed who were identified by the agency as being on service for 60 days or more. This failure led to the patient's status being unclear to HHA personnel. Findings include: The following patients had been included on the	G 341	G 341 • Please see Plan of Correction for 484.18 G163 and G164.	8/23/11	

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G 341	<p>Continued From page 18</p> <p>list of current active patients when the census had been requested during the entrance conference 7/25/11 at 4:00 PM. The patients were identified as being on service for 60 or more days.</p> <p>1. Patient #9 was a 75 year old female admitted to the agency on 5/13/11 for skilled nursing primarily related to wound care. The POC for certification period 5/13/11 to 7/11/11 included orders for nursing visits as follows: one visit for one week, then two to three times weekly for two weeks for wound vac dressing changes. The orders were for a total of three weeks of nursing visits.</p> <p>The first nursing visit was the admission on 5/13/11. Two visits on week #2 were made, 5/16/11 and 5/20/11. There was no documentation that the two or three visits that had been ordered for the third week had been made. The record did not contain an updated comprehensive assessment.</p> <p>In an interview on 7/27/11 at 9:35 AM, Patient #9's Case Manager stated "I didn't discharge her, and I need to." The Case Manager did not offer any further information regarding the lack of documentation in Patient #9's record that could explain if she was an active or discharged patient.</p> <p>In an interview on 7/27/11 at 3:30 PM, the Manager stated Patient #9's record had been updated that day to reflect a discharge effective 5/27/11. She stated the case manager had failed to document a physician order to discharge Patient #9, and as a result, the OASIS and discharge comprehensive assessment and</p>	G 341		

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G 341	<p>Continued From page 19 summary for the physician had not been completed at the time the order had been received.</p> <p>The discharge assessment of Patient #9 was not completed at discharge.</p> <p>2. Patient #12 was an 80 year old female, admitted to the agency on 4/17/11 for nursing services related to Herpes zoster, also known as shingles. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the period from 4/17/11 to 6/15/11 contained a physician order for skilled nursing visits for dressing changes one to two times weekly for six weeks.</p> <p>The admission visit was on 4/17/11, and the comprehensive assessment was completed at that time. Patient #12 was seen again on 4/20/11, and the Case Manager wrote in her notes of a plan to visit on 4/25/11. There was no further documentation in Patient #12's record to indicate further visits were made. The record did not contain an updated comprehensive assessment.</p> <p>In an interview on 7/28/11 at 3:05 PM, Patient #12's Case Manager stated after a conversation with Patient #12's daughter on 4/27/11, she placed Patient #12 on hold. The Case Manager stated she had not contacted the physician for orders to place Patient #12 on hold or to discontinue care.</p> <p>In an interview on 7/27/11 at 4:15 PM, the Manager reviewed the record and confirmed there was no documentation after the 4/20/11 nursing visit, and she had not been aware that</p>	G 341		
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G 341	<p>Continued From page 20</p> <p>Patient #12's status had changed.</p> <p>Agency staff had not completed a discharge assessment of Patient #12 to reflect her current status.</p> <p>3. Patient #14 was a 64 year old female admitted to the agency on 5/23/11 for physical and occupational therapy related to a genetic muscular disease. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the period 5/23/11 to 7/21/11 included orders for physical therapy for two to three times a week for six weeks, and to contact the physician for further orders. The orders for occupational therapy were two to three times over 14 days, and to contact the physician for further orders. The record did not contain an updated comprehensive assessment.</p> <p>An OASIS C Transfer Assessment form, dated 6/13/11 indicated Patient #14 was transferred to an in-patient facility, and the last therapy visit was 6/10/11.</p> <p>In an interview on 7/27/11 at 3:35 PM, the Manager reviewed Patient #14's record and confirmed the transfer on 6/13/11. She provided a copy of the "OASIS C Discharge Assessment," which was completed 7/25/11 at 5:00 PM, and stated the discharge OASIS as well as a discharge summary for the physician should have been completed by 7/21/11.</p> <p>A discharge assessment of Patient #14 not completed at discharge.</p>	G 341		

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N 000	16.03.07 INITIAL COMMENTS Surveyor: 00023 The following deficiencies were cited during the state licensure survey of your agency. Surveyors conducting the on site visit were: Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS BS - blood sugar MD - Medical Doctor POC - Plan of Care Pt - patient RN - Registered Nurse	N 000		
N 075	03.07022. DIRECTOR N075 02. Responsibilities. The director or designee shall be responsible for assuring that: e. The total plan of treatment is reviewed by the attending physician as often as the severity of the patient's condition requires and shall be reviewed at least every sixty (60) days; This Rule is not met as evidenced by: Surveyor: 00023 The agency failed to ensure the total plans of treatment were reviewed by the attending physician at least every 60 days. Refer to G163 as it relates to the agency's failure to provide physicians with an updated POC at least every 60 days.	N 075	N 075 • Please see Plan of Correction for 484.18 G163 and G164.	8/23/11
N 174	03.07031.01 CLINICAL RECORDS	N 174	N 174 • Please see Plan of Correction for 484.18 G163 and G164.	8/23/11

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Bureau of Facility Standards

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

TITLE
Chief Financial Officer
(X6) DATE
09/02/11

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BONNER GENERAL HOSPITAL HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 602 NORTH THIRD AVENUE SANDPOINT, ID 83864		
(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 174	Continued From page 1 N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services. This Rule is not met as evidenced by: Surveyor: 00023 The agency failed to ensure complete clinical records were documented. Refer to G236 as it relates to the lack of documentation to describe the care provided to patients.	N 174		