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

October 18, 2011

Mary Lou Long, Administrator
St Lukes RMC Home Care
190 East Bannock
Boise, ID 83712

RE: St Lukes RMC Home Care, Provider #137028

Dear Ms. Long:

This is to advise you of the findings of the complaint survey at St Lukes RMC Home Care, which was concluded on October 17, 2011.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health into compliance, and that the home health remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

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

October 31, 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,

KAREN ROBERTSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

KR/srm
Enclosures

St Luke's
Boise · Meridian

Nationally Recognized for Nursing Excellence

October 31, 2011

Sent via facsimile to (208) 364-1888

Sylvia Creswell
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720

Re: CMS Certification Number: 13-7028

Dear Ms. Creswell:

This letter is in follow-up to your correspondence and Statement of Deficiencies dated October 18, 2011, advising us of your findings relative to the Complaint Survey completed earlier this month at St. Luke's Homecare.

Enclosed you will find our Plan of Correction describing procedures we have implemented and/or begun to implement in response to the processes cited as deficiencies.

Thank you for allowing us the opportunity to respond to your findings. If you have any questions or concerns, please feel free to contact me at (208) 381-3595.

Sincerely,

D Severe, RN

Danika A. Severe, RN
Manager, Accreditation

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137028	A. BUILDING _____ B. WING _____	C 10/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES RMC HOME CARE	325 WEST IDAHO BOISE, ID 83712

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G 000	INITIAL COMMENTS	G 000		

The following deficiencies were cited during the complaint investigation of your Home Health Agency. The following surveyors conducted the complaint investigation:

Karen Robertson, RN, BS, HFS, Team Leader
Aimee Hastriter, RN, BS, HFS

Acronyms used in this report include:

ALF - Assisted Living Facility
ER - Emergency Room
IM - Intramuscular
L - Liters
O2 - Oxygen
POC - Plan of Care
RN - Registered Nurse
SN - Skilled Nursing
SOC - Start of Care
x - times

G 158 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER

Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it was determined the agency failed to ensure care was provided in accordance with the established plan of care for 2 of 2 patients (#5 and #7) with diabetes, whose records were reviewed. This resulted in a lack of diabetic management and had the potential to negatively impact patient

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FACILITY STANDARDS

Action Plan Responsible Party: Jennifer Mensik, Administrator Nursing and Patient Care; Marylou Long, Director Community Services; Sharon Barrett-Hill, Clinical Nurse Specialist

G 158 Process Improvements and Action Plan Implementation:

✓ All nurses will attend an education session with the Clinical Educator and/or Clinical Nurse Specialist regarding the development of the plan of care (POC) and methods to review the POC as part of each skilled nursing visit. During the education session each nurse will have individualized assessment of one of their own POC and subsequent documentation. Education will be completed by November 30, 2011.

CEO 3PM 10/31/11

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

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 158	Continued From page 1 progress towards reaching discharge goals. Findings include: 1. Patient #7 was a 64 year old male admitted to the agency on 8/15/11 for physical therapy due to weakness and rehabilitation needs. The medical record contained physician orders, dated 9/15/11, for a resumption of care with specific orders for treatment related to cellulitis and diabetic ulcers. The agency was to notify the physician if blood glucose, blood pressure, pulse, respiratory rate, temperature, pain, or oxygen saturation level were outside of established parameters. Staff failed to monitor blood glucose levels or vital signs during the following visits: - On 9/17/11, the medical record did not contain documentation of a blood glucose level or an oxygen saturation level. - On 9/18/11, the medical record did not contain documentation of a blood glucose level or oxygen saturation level. - On 9/19/11, the medical record did not contain documentation of a blood glucose level or oxygen saturation level. - On 9/22/11, the medical record did not contain documentation of a blood glucose level or oxygen saturation level. - On 9/26/11, the medical record did not contain documentation of a blood glucose level, blood pressure, or oxygen saturation level. - On 9/29/11, the medical record did not contain documentation of a blood glucose level, blood pressure, pulse, respiratory rate, or oxygen saturation level. - On 10/03/11, the medical record did not contain documentation of a blood glucose level, blood	G 158	QAPI Integration: ✓ Each nurse will complete 3 self-audits by November 30th and each month thereafter x 4 months total. ✓ The PI/Education Manager or designee will concurrently audit 20 charts per month x 4 months to assess compliance following the plan of care. ✓ Beginning April 1, 2011 the PI/Education Manager or designee will perform quarterly audits of a minimum of 20 charts will assess compliance with following the plan of care.	

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G 158	Continued From page 2 pressure, pulse, respiratory rate, or oxygen saturation level. - On 10/06/11, the medical record did not contain documentation of a blood glucose level, respiratory rate, or oxygen saturation level. - On 10/10/11, the medical record did not contain documentation of a blood glucose level, temperature, or oxygen saturation level. The Care Coordinator for Patient #7, RN C, was interviewed on 10/13/11 at 2:05 PM. He stated he did not routinely review the diabetic flowsheet for Patient #7 and was not monitoring Patient #7's diabetes. He stated the nursing staff at the Assisted Living Facility where Patient #7 resided checked his blood glucose levels and administered his medication. He stated that because Patient #7 was not an insulin-dependent diabetic the impact of the diabetes on wound healing was not as critical as it could be for other patients. RN C stated for wound care only patients, such as Patient #7, he typically always assesses temperature. However, completing blood pressure, respiratory rate, pulse, and obtaining an oxygen saturation level were done as needed and not necessarily routine. He reviewed Patient #7's medical record and confirmed blood glucose levels and vital signs had not been monitored at each visit. The Clinical Educator was interviewed on 10/13/11 at 3:10 PM. She stated that for focused visits (i.e., wound care only) it was the agency's standard of practice to always assess temperature but not necessarily other vital signs. She stated the pre-formatted POC for wound care included vital sign parameters automatically. She stated if diabetes was noted as a diagnosis,	G 158		

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G 158	Continued From page 3 blood glucose parameters would also be included on the POC. The Clinical Educator confirmed that if parameters were included on the POC, it was expected the parameters would be monitored at nursing visits. If the RN felt not all vital signs needed to be obtained for each visit, the instructions were to be detailed in the POC. Blood glucose levels and vital signs were not routinely monitored for Patient #7 in accordance with the POC. 2. Patient #5 was a 62 year old female admitted to the agency on 10/06/11 for care primarily related to stoma care. Her medical record contained physician orders, dated 10/06/11, for nursing staff to provide stoma care and teaching. In addition, nursing was to instruct the patient regarding diabetic foot care and was to notify the physician if blood glucose, blood pressure, pulse, respiratory rate, temperature, pain, or oxygen saturation level were outside of established parameters. An admission assessment was completed by RN B on 10/06/11. RN B documented in the endocrine section of the assessment that Patient #5 had "EARLY D.M. [diabetes mellitus]." The assessment did not include additional information to explain what it meant for Patient #5 to be an early diabetic. There was no glucose level documented and no documentation regarding whether or not Patient #5 monitored her blood glucose levels or how often they were checked. There was no documentation of the completion of a diabetic foot exam, or discussion with Patient #5 related to education of a foot exam.	G 158		

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G 158	Continued From page 4 Nursing visit notes, completed by RN B on 10/07/11 and 10/10/11, did not include an assessment of Patient #5's blood glucose levels or documentation of education provided related to diabetic foot care. RN B was interviewed on 10/13/11 at 9:35 AM. He stated he obtained the information regarding the early diabetes from transfer paper work sent by the hospital upon referral to home care. He stated because he did not have specific orders related to monitoring blood glucose levels this was not something he had addressed with Patient #5. He stated he was not sure if she checked her blood glucose levels but verified with Patient #5 that she was not taking insulin. He confirmed the orders related to blood glucose and diabetic foot exam teaching were a standard part of the POC for diabetic patients. However, he stated Patient #5 did not require that level of diabetic management. Diabetes was not monitored in accordance with the POC.	G 158		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency nursing staff failed to prepare clinical notes with complete documentation of the assessments and	G 176	Action Plan Responsible Party: Jennifer Mensik, Administrator Nursing and Patient Care; Marylou Long, Director Community Services; Sharon Barrett-Hill, Clinical Nurse Specialist Process Improvements and Action Plan Implementation: ✓ Standardized assessment and documentation criteria, based on patient populations and disease specific care, will be developed by October 31, 2011. Patient care staff will be educated regarding the assessment expectations and criteria by November 30, 2011.	

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G 176	Continued From page 5 communications for 4 of 8 sample patients (#2, #5, #7, and #8) whose records were reviewed. Failure to prepare complete and accurate clinical notes and document communication had the potential to interfere with coordination and safety of patient care. Findings include: 1. Patient #2 was a 71 year old female admitted to the agency on 8/07/11 for care primarily related to lung cancer. On 8/07/11 at 7:27 PM, Patient #2 was discharged from an ER with a prescription for "oxygen via nasal cannula at 3 L nasal cannula." RN F made her first visit to Patient #2 on 8/08/11 at 1:22 PM. RN F documented, "pt [patient] now using 2 L of O2 per NC [nasal cannula] continuously." Patient #2 was documented as using 2 L O2 continuously via nasal cannula on 8/10/11 at 10:29 AM, 8/17/11 at 10:30 AM, 8/19/11 at 10:50 AM, 8/23/11 at 12:05 PM, and 8/24/11 at 11:52 AM. On 8/15/11 at 11:36 AM, RN F documented "no O2; pt [patient] weaned self off O2." On 10/17/11 at 9:25 AM, RN F was interviewed. She stated Patient #2 had been sent home from the ER on 3 L O2, but when she visited Patient #2 the next day (8/08/11), Patient #2 was on only 2 L O2. RN F stated she provided education to Patient #2 and her family regarding the importance of wearing the oxygen as prescribed by her physician. RN F stated that Patient #2 expressed her dislike of the oxygen and complained about having to wear it throughout the visit. RN F stated Patient #2 and family were frequently adjusting the oxygen and not using it as ordered. RN F reviewed Patient #2's medical	G 176	QAPI Integration: ✓ Each nurse will complete 3 self-audits by November 30th and each month thereafter x 4 months total. ✓ The PI/Education Manager or designee will concurrently audit 20 charts per month x 4 months to assess assessment and documentation compliance. ✓ Beginning April 1, 2011 the PI/Education Manager or designee will perform quarterly audits of a minimum of 20 charts will assess compliance with standardized assessment and documentation criteria.	

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G 176	Continued From page 6 record and agreed she did not document the education provided about the proper dose of oxygen. RN F stated she informed Patient #2's physician about the incorrect use of the oxygen, but stated that communication was not documented. On 8/08/11 at 1:22 PM, RN F documented that Patient #2 complained of "blistering to groin from Foley cath [catheter]." On 8/17/11 at 10:30 AM, RN F documented "blisters in groin area have healed." No assessment of the blistering was documented on any of the nursing visit notes. On 10/17/11 at 9:25 AM, RN F reviewed Patient #2 medical record and stated no assessment was done of the blisters because Patient #2 refused to let RN F look at them. RN F stated she did not document Patient #2's refusal of an assessment. RN F stated Patient #2 and her daughter told her what the blisters looked like. The agency did not thoroughly document assessments or communication in regards to Patient #2. 2. Patient #5 was a 62 year old female admitted to the agency on 10/06/11 for care primarily related to stoma care. On 10/04/11, a referral from Patient #5's physician was documented in the "Physician Order List" and included orders to "Assess: Incision/wound care: stoma." On 10/07/11 at 10:00 AM, an assessment was completed by RN A. Documentation related to Patient #5's ostomy was directed at changing the ostomy bag and educating Patient #5 on care of the ostomy appliance. No documentation was	G 176		

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G 176	Continued From page 7 found of the stoma's appearance (color, size, shape), output, or the appearance of the surrounding skin. On 10/10/11 at 10:20 AM, an assessment was completed by RN A. Documentation related to Patient #5's ostomy was directed at changing the ostomy bag and education on the ostomy appliance. Patient #5 was documented as having a bowel movement, but was not further described as to solidity, color, odor, or amount. No documentation was found of the stoma's appearance (color, size, shape) or the appearance of the surrounding skin. The record did not show documentation of a lung assessment performed on Patient #5. In an interview on 10/13/11 at 9:40 AM, RN A reviewed Patient #5's medical record. He stated the stoma was new. He stated he did assess Patient #5's stoma and surrounding skin while changing the ostomy bag. He stated he agreed he did not document the stoma's size, color or the surrounding skin's appearance and should have. The agency did not thoroughly document assessments for Patient #5. 3. Patient #7 was a 64 year old male admitted to the agency on 8/15/11 for physical therapy due to weakness and rehabilitation needs. The medical record contained physician orders, dated 9/15/11, for a resumption of care with specific orders for treatment related to cellulitis and diabetic ulcers. On 9/14/11, an order was received for SN to administer "Ertapenem 1 gram IM daily x 7 days." Ertapenem, an antibiotic, was documented as	G 176		

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G 176	Continued From page 8 given on 9/17/11 and 9/19/11 by an agency RN. In an interview on 10/13/11 at 2:05 PM, RN C stated Patient #7 lived in an ALF that employed two RNs. RN C stated the ALF and the home health agency agreed to share the responsibility for administering Patient #7's Ertapenem IM medication. RN C stated that Patient #7 did receive the medication for seven days as ordered, but the ALF performed five of the injections. RN C stated the agreement with the ALF was not documented in the record and should have been. Throughout the medical record, including the nursing notes below, Patient #7 was documented as having cellulitis on the front of his lower left leg. He was also documented as having three diabetic ulcers on his left foot. The following inaccuracies related to these wounds were noted in nursing notes on the following dates: -- 9/15/11 at 9:42 AM: "cellulitis on elbow to wrist front of lower left leg." -- 9/17/11 at 10:45 AM: "cellulitis on elbow to wrist front of lower left leg." -- 9/19/11 at 11:30 AM: "No open areas noted to left foot with diabetic foot check. Wound on Rt [right] foot improving." -- 9/19/11 at 11:30 AM: "cellulitis on elbow to wrist front of lower left leg." -- 9/22/11 at 11:11 AM: "cellulitis on elbow to wrist front of lower left leg." -- 10/03/11 at 9:30 AM: "No open areas noted to left foot with diabetic foot check. Wound on Rt [right] foot has no improvement." -- 10/06/11 at 11:00 AM: "Completed wound care to Right foot."	G 176		

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G 176	Continued From page 9 In an interview on 10/13/11 at 2:05 PM, RN C stated Patient #7's cellulitis was on the front of his lower left leg. RN C stated he had "no idea how wrist to elbow" got documented. He stated the "cut and paste" function was frequently used to pull information forward from previous documentation and the inaccuracy had not been noticed. RN C reviewed Patient #7's medical record and agreed that the nursing assessments on 9/19/11 and 10/03/11 were incorrect as the wound was on the left foot, not the right foot. On 9/15/11 at 9:42 AM, RN C documented Patient #7 had edema in the cardiovascular section of the nursing note, but not where or how severe the edema was. On 10/13/11 at 2:05 PM, RN C was interviewed. RN C reviewed Patient #7's medical record and agreed that he did not document any description of the edema on 9/15/11. RN C stated he did assess the edema's location and severity. He stated he "typically" documented a note describing the edema at the end of the cardiovascular section and must have forgotten. The agency did not thoroughly document assessments for or communications related to Patient #7. 4. Patient #8 was an 83 year old male admitted to the agency on 8/06/11 for care primarily related to cellulitis of his left leg. The "PLAN OF CARE," for certification period 8/06/11 to 10/04/11, included orders for SN to assess for signs and symptoms of edema and for SN to perform "wound care as ordered."	G 176		

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G 176	Continued From page 10 A SOC assessment was completed on 8/06/11 at 12:15 PM by RN D. RN D documented Patient #8 had edema, but did not document where or the severity. Also, "Wound 1" was assessed, but wound care was not documented as performed. On 8/09/11 at 9:27 AM, an assessment was completed by RN E. "Wound 2" was documented as "cellulitis on inner aspect of lower left leg." "Wound 2" was not documented 8/06/11 on the SOC assessment. Also, no assessment of edema was documented. In an interview on 10/14/11 at 8:40 AM, RN D stated he did complete wound care on "Wound 1." He also stated he did assess Patient #8's left leg cellulitis. RN D reviewed Patient #8's medical record and stated he agreed he did not document the wound care provided or the cellulitis on the left leg. In an interview on 10/14/11 at 9:25 AM, RN E stated she did assess Patient #8's edema. She reviewed Patient #8's medical record and stated she agreed she did not document her assessment of Patient #8's edema. The agency did not thoroughly document assessments for Patient #8.	G 176		

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ST LUKES RMC HOME CARE	325 WEST IDAHO BOISE, ID 83712

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the complaint investigation of your Home Health Agency. The following surveyors conducted the complaint investigation: Karen Robertson, RN, BS, HFS, Team Leader Aimee Hastriter, RN, BS, HFS The following abbreviations are used in this report: POC - Plan of Care	N 000	Action Plan Responsible Party: Jennifer Mensik, Administrator Nursing and Patient Care; Marylou Long, Director Community Services; Sharon Barrett-Hill, Clinical Nurse Specialist Process Improvements and Action Plan Implementation: ✓ All nurses will attend an education session with the Clinical Educator and/or Clinical Nurse Specialist regarding the development of the plan of care (POC) and methods to review the POC as part of each skilled nursing visit. During the education session each nurse will have individualized assessment of one of their own POC and subsequent documentation. Education will be completed by November 30, 2011. QAPI Integration: ✓ Each nurse will complete 3 self-audits by November 30th and each month thereafter x 4 months total. ✓ The PI/Education Manager or designee will concurrently audit 20 charts per month x 4 months to assess compliance following the plan of care. ✓ Beginning April 1, 2011 the PI/Education Manager or designee will perform quarterly audits of a minimum of 20 charts will assess compliance with following the plan of care.	
N 097	03.07024. SK. NSG. SERV. N097 01.Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: e. Prepares clinical and progress notes, and summaries of care; This Rule is not met as evidenced by: Refer to G 176 as it relates to the agency's failure to ensure nursing staff thoroughly documented assessments and communications.	N 097		
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	N 152		

RECEIVED NOV 02 2011 FACILITY STANDARDS

CEO 3pm 10/31/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137028	A. BUILDING _____ B. WING _____	C 10/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES RMC HOME CARE	325 WEST IDAHO BOISE, ID 83712

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N 152	Continued From page 1 includes: This Rule is not met as evidenced by: Refer to G 158 as it relates to the agency's failure to ensure care was provided in accordance with the POC.	N 152	Action Plan Responsible Party: Jennifer Mensik, Administrator Nursing and Patient Care; Marylou Long, Director Community Services; Sharon Barrett-Hill, Clinical Nurse Specialist Process Improvements and Action Plan Implementation: ✓ Standardized assessment and documentation criteria, based on patient populations and disease specific care, will be developed by October 31, 2011. Patient care staff will be educated regarding the assessment expectations and criteria by November 30, 2011. QAPI Integration: ✓ Each nurse will complete 3 self-audits by November 30th and each month thereafter x 4 months total. ✓ The PI/Education Manager or designee will concurrently audit 20 charts per month x 4 months to assess assessment and documentation compliance. ✓ Beginning April 1, 2011 the PI/Education Manager or designee will perform quarterly audits of a minimum of 20 charts will assess compliance with standardized assessment and documentation criteria.	

St Luke's
Boise · Meridian

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November 4, 2011

Karen Robertson RN, BSN
Health Facility Surveyor
Bureau of Standards
Boise, Idaho
Fax 208-364-1888

Dear Ms. Robertson:

Please accept this letter as an addendum correction to St Luke's Home Care Plan of Correction submitted on October 31, 2011. The following excerpt has been revised with the correct date.

Addendum to tags: G158, G176, N97, N152
The following is corrected:

- ✓ Beginning **April 1 2012,** the PI/Education Manager or designee will perform quarterly audits of a minimum of 20 charts **to assess ongoing** compliance with standardized assessment and documentation criteria.

Should you have any additional questions please contact me. Thank you for the opportunity to provide correction on the oversight.

Kind regards,

DSevere RN

Danika Severe, RN,
Manager, Accreditation

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
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Boise, ID 83720-0009
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October 18, 2011

Mary Lou Long, Administrator
St Lukes RMC Home Care
190 East Bannock
Boise, ID 83712

Provider #137028

Dear Ms. Long:

On **October 17, 2011**, a complaint survey was conducted at St Lukes RMC Home Care. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005209

Allegation #1: The home health agency failed to follow orders related to oxygen management.

Finding #1: An unannounced survey of the home health agency was conducted on 10/11/11 through 10/17/11. The medical records of three patients, who required oxygen, were reviewed and nine staff members of the home health agency were interviewed with the following results:

The medical records of three patients, who required oxygen, were reviewed. All plans of care included physician orders for oxygen use and for oxygen saturation levels to be monitored.

Two of the three medical records included documentation of appropriate oxygen use, per physician orders. However, one record contained documentation of a patient with an order for oxygen at 3 liters nasal cannula, but who was documented as being on 2 liters nasal cannula. On one visit, nursing staff documented the patient as having weaned themselves off the oxygen. There were no documented orders from the patient's physician for the patient to try to wean themselves off the oxygen.

The Care Coordinator Registered Nurse was interviewed regarding the oxygen use of this patient. The Registered Nurse stated the patient did not like wearing the oxygen and was trying to turn down the oxygen or turn it off. The Registered Nurse stated she educated the patient multiple times regarding using the oxygen as ordered by the physician, but the patient continued to inappropriately use the oxygen.

It could not be determined the agency did not follow orders related to oxygen management. Therefore, the allegation was unsubstantiated and no deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The home health agency nurses failed to provide thorough assessments.

Finding #2: An unannounced survey of the home health agency was conducted on 10/11/11 through 10/17/11. Eight patients' records were reviewed, one home visit was conducted, and nine staff members of the home health agency were interviewed with the following results:

A home visit was conducted on 10/13/11 at 10:45 AM. During that time the Registered Nurse was observed to perform a thorough assessment of the patient. Additionally, nine agency staff members were interviewed. All staff stated comprehensive assessments were conducted in accordance with patients' plans of care.

Four records for current patients and four records of discharged patients were reviewed. All eight records included documentation of assessments. However, not all assessment findings were included in the records and assessments related to blood glucose levels and vital signs were not completed in accordance with the plans of care for two patients.

Additionally, one record documented the patient as having skin issues, but no assessments of the skin issues were documented. In an interview with the Care Coordinator Registered Nurse for the patient, the Registered Nurse stated the patient had refused to let the Registered Nurse assess the skin due to the location of the skin problem. However, documentation related to the patient's refusal was not documented in the record.

The agency did not assess blood glucose levels and vital signs in accordance with patients' plans of care and the agency failed to keep documentation related to assessments and refusals of care. Therefore, the allegation was substantiated and deficiencies were cited.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #3: The home health agency failed to appropriately manage patient grievances related to nursing services.

Finding #3: An unannounced survey of the home health agency was conducted on 10/11/11 through 10/17/11. The complaint/grievance log was reviewed and nine staff members of the home health agency were interviewed with the following results:

The complaint/grievance log book from 7/14/11 to 10/11/11 was reviewed. The log included documentation of two nursing complaints. One complaint documented a patient and patient's family being dissatisfied with the nurse providing services. The complaint was investigated and a different,

more established nurse was assigned as the patient's nurse. However, the patient and family expressed dissatisfaction with the second nurse and a second complaint was filed with the agency. The second complaint was investigated and documented that an individual in management spoke with the patient's daughter. The investigation documented the patient was looking for services, like cooking and cleaning, that could not be provided by a home health agency and that the facility did not feel they would be able to satisfy the patient's needs. Therefore, the home health agency discharged the patient.

It could not be determined that the agency did not manage patient grievances appropriately. Therefore, the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

KAREN ROBERTSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

KR/srm