IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
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November 28, 2012

Merrilee Stevenson, Administrator
Idaho Home Health & Hospice
826 Eastland Drive
Twin Falls, Idaho 83301

RE: Idaho Home Health & Hospice, Provider #137014

Dear Ms. Stevenson:

This is to advise you of the findings of the Medicare/Licensure survey at Idaho Home Health & Hospice, which was concluded on November 16, 2012.

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 agency into compliance, and that the 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.

After you have completed your Plan of Correction, return the original to this office by **December 10, 2012**, 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,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137014	A. BUILDING _____ B. WING _____	11/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO HOME HEALTH & HOSPICE	826 EASTLAND DRIVE TWIN FALLS, ID 83301

(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	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency. Surveyors conducting the recertification were: Susan Costa, RN, HFS, Team Leader Gary Gulles, RN, HFS Aimee Hastriter, RN, HFS Libby Doane, RN, HFS	G 000	For the patient affected by the deficient practice, revenue cycle was notified to non-bill all visits outside of the verbal start of care date, the patients Idaho physician was notified and the Plan of Care (POC) and all subsequent orders were submitted for correct signature. An internal Risk Management report was generated and a review by the compliance department was conducted.	12/06/12
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 followed a physicians' written plan of care for 1 of 18 patients (#6) whose records were reviewed. This resulted in unauthorized treatments and had the potential to result in unmet patient needs. Findings include: Patient #6 was a 73 year old female who was admitted to the agency on 10/04/12 with diagnoses of cellulitis of her right foot, diabetes, chronic kidney disease, and required wound care daily. The physician ordering the services for Patient #6 was not authorized to do so, as evidenced by the following: a. Patient #6 received home health services, although the physician ordering services was not licensed in the state of Idaho. The physician responsible for Patient #6's care and orders on	G 158	The Director of Nursing (DON) educated all Branch Managers, Team Leaders, Office Managers, Office Assists, Outcome Coordinator's (OC) and clinicians on the following: Necessity of obtaining all orders for care to assure all care and treatment is authorized by the physician licensed in the state of Idaho. Education included review of Policy 5.011 The Role of the Physician as follows: the agency accepts orders from a Doctor of Medicine (including Psychiatry and Ophthalmology), Doctor of Podiatry and/or Doctor of Osteopathy, whom are licensed, and authorized to practice medicine per Idaho state regulation. Included in the education was education to the office manager's on the procedure for physician licensure verification. Clinicians were instructed to contact the patient's Idaho physician for all Plan of Care and supplemental orders. For those patients who do not have an Idaho physician,	12/06/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maurice Swenson — TITLE: Administrator — (X6) DATE: 12/7/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137014	A. BUILDING _____ B. WING _____	11/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO HOME HEALTH & HOSPICE	626 EASTLAND DRIVE TWIN FALLS, ID 83301

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G 158	Continued From page 1 the "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 10/04/12 to 12/02/12, was a physician who was licensed in another state. According to the 42 CFR 42 484.4, a physician is defined as "A doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed." During an interview on 11/15/12 at 3:30 PM, the Home Health Team Leader confirmed Patient #6's physician was not licensed in the state of Idaho. The agency did not ensure the medical management of Patient #6 was by a physician that was licensed in the state.	G 158	Continued from page 1. Idaho Home Health will not accept the out of state referral. On 12/04/12 a sweep of the Idaho Home Health EMR was conducted, all out of state physicians were removed from the Idaho data base. In addition, a restriction was initiated so out of state physicians could not be accessed for the purpose of generating an order. Monitoring for compliance will be accomplished by; beginning December 6, 2012 and for two consecutive months, the DON or designee including oversight from Outcome Coordinator's will review 100% of admissions to ensure the Plan of Care is authorized by an Idaho physician. To assure 100% compliance the Branch Manager or Team Leader will review all subsequent orders to assure an Idaho Physician is listed on the order, in addition Office Managers will assess orders for correct signature prior to accepting returned orders back into the clinical record, any orders identified that do not adhere to policy 5.011 will be reviewed by the DON prior to being received back into the patient chart.	12/06/12

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001280	A. BUILDING _____ B. WING _____	11/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO HOME HEALTH & HOSPICE	826 EASTLAND DRIVE TWIN FALLS, ID 83301

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Idaho state licensure survey of your agency. Surveyors conducting the review were: Susan Costa,RN,HFS Team Leader Gary Gulles, RN, HFS Aimee Hastriter, RN, HFS Libby Doane, RN, HFS	N 000		
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G168 as it relates to patient care following a written plan of care established, implemented and reviewed by a physician licensed in the state.	N 152		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/7/12