



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

December 8, 2011

Greg Lake, Administrator
Idahealth Home Care
2867 E Copperpoint Dr
Meridian, ID 83642

RE: Idahealth Home Care, Provider #137091

Dear Mr. Lake:

This is to advise you of the findings of the Medicare/Licensure survey at Idahealth Home Care, which was concluded on December 1, 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 and State Form 2567.

Greg Lake, Administrator
December 8, 2011
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **December 21, 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: 12/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2011
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NAME OF PROVIDER OR SUPPLIER IDAHEALTH HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2867 E COPPERPOINT DR MERIDIAN, ID 83642
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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
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G 000	INITIAL COMMENTS The following deficiencies were cited during a recent recertification survey of your home health agency. The surveyors conducting the recertification were: Teresa Hamblin, RN, MS, HFS, Team Leader Rebecca Lara, RN, BA, HFS Acronyms used in this report include: CNA = Certified Nursing Assistant CPR = Cardiopulmonary Resuscitation OT = Occupational Therapist PT = Physical Therapist QA = Quality Assurance	G 000		
G 116	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements. This STANDARD is not met as evidenced by: Based on staff interview and review of patient	G 116	G 116 Action Taken to Correct Deficiency: The Admission Packet has been updated to include the correct telephone number. How the Action will improve the processes that led to the deficiency: It will correct the incorrect phone number. Completion Date: 12/13/2011	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Greg B. Jahn</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/15/2011</i>
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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 116	Continued From page 1 admission information, it was determined the agency failed to ensure patients were provided with the telephone number of the Idaho home health complaint hotline. This had the potential to interfere with the ability of patients to file complaints with the Idaho State agency. Findings include: Upon arrival at the agency on 11/28/11, a copy of the admission packet was provided to surveyors. Admission information included the telephone number for the Utah State hotline to file complaints. It did not include the telephone number for the Idaho State hotline. The Administrator was interviewed on 11/28/11 at 11:15 AM. He acknowledged the admission packet did not include the Idaho State hotline number. He described it as "a mistake." The agency did not ensure patients were informed of the Idaho State hotline telephone number to file complaints.	G 116	Monitoring: The Administrator or his designee will review 20% of the new admissions to ensure that the new admission packet has been utilized for the next six weeks. Person Responsible for implementing the plan of correction: Administrator.		
G 131	484.14(b) GOVERNING BODY The governing body adopts and periodically reviews written bylaws or an acceptable equivalent. This STANDARD is not met as evidenced by: Based on staff interview and review of bylaws, the agency failed to ensure the governing body reviewed the written bylaws on a periodic basis. This had the potential to interfere with the overall operation of the agency. Findings include: Upon request, the Administrator provided a copy	G 131	G 131 Action Taken to Correct Deficiency: The written bylaws have been reviewed by the governing body. How the Action will improve the processes that led to the deficiency: An annual checklist has been developed to ensure review.		

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G 131	Continued From page 2 of the agency's bylaws, dated 12/14/2000. When asked on 12/01/11 at 12:30 PM for the last date the bylaws were reviewed, the Administrator stated he did not know but would check with the corporate office. After talking to the corporate office, the Administrator stated the corporate office informed him the bylaws were reviewed by an attorney a couple of years prior. He further stated there was no documentation of the attorney review or any other review since the year 2000.	G 131	Completion Date: 12/20/2011	
G 135	The agency did not ensure periodic review by the governing body of written bylaws. 484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, ensures the accuracy of public information materials and activities. This STANDARD is not met as evidenced by: Based on staff interview and review of patient information handouts, brochures, and employee information, it was determined the agency failed to ensure accuracy of public information materials as it related to services the agency offered. This resulted in the public being informed of the availability of speech therapy services without the actual availability of a speech therapist. Findings include: The Administrator provided, upon request, a copy of a patient admission packet. The packet included a section related to an overview of the agency and the services the agency offered. The	G 135	Monitoring: A annual checklist has been developed which will audit for compliance. Person Responsible for implementing the plan of correction: The Administrator. G 135 Action Taken to Correct Deficiency: Recruiting has been initiated for a speech therapist. How the Action will improve the processes that led to the deficiency: When hired staffing will match services advertised. Completion Date: 12/20/11	

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G 135	<p>Continued From page 3</p> <p>information documented the agency offered speech therapy services. The Administrator also provided the agency's brochure, titled "Aspen Home Care." The brochure stated agency services included language skills, swallowing techniques, and skills (services typically provided by speech therapists).</p> <p>The Administrator provided a list of employees and contract staff. There were no speech therapists included on the current list.</p> <p>The Administrator and Director of Nursing were interviewed together during the entrance conference on 11/28/11 between 9:30 AM and 10:15 AM. The Administrator stated the agency did not have a speech therapist on staff either as an employee or contracted staff. The Administrator confirmed the information provided in the patient packet and brochure did not match the agency's actual availability of services.</p>	G 135	<p>Monitoring:</p> <p>The annual checklist devised will include a check of current staff employed to ensure that all services advertised are able to be provided.</p> <p>Person Responsible for implementing the plan of correction:</p> <p>Administrator.</p>	
G 141	<p>484.14(e) PERSONNEL POLICIES</p> <p>Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of personnel documents, it was determined the agency failed to ensure qualifications of 3 or 3 home health</p>	G 141	<p>G 141</p> <p>Action Taken to Correct Deficiency:</p> <p>The following has been updated and or completed on all home health aides utilized by the company:</p> <ol style="list-style-type: none"> 1. Evidence of criminal background checks. 2. Evidence of completion of a certification training program. 3. Current CPR card. 4. Skills Checklist. 	

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G 141	Continued From page 4 aides (C, D, and E) were kept current in personnel records. This resulted in home health aide services without verification of qualifications. It had the potential to negatively impact quality and safety of patient care. Findings include: Employee files were obtained and reviewed in coordination with the Administrator and Director of Nursing on 12/01/11. Home Health aide files for Staff C, D, and E, hired 9/26/11, did not include evidence of criminal background checks, evidence of completion of a certification training program, current CPR or completion of a skills checklist. The Administrator was interviewed on 12/01/11 at 1:30 PM. He stated the home health aides were contracted staff. He stated the agency kept track of the home health aide in-service hours but did not keep track of any other employee information. He stated he could get the information. The job description of the Home Health aide included the following requirements: - Successful completion of a formal certification training program and/or written skills test and competency evaluation; - Licensure as required by state law; - Current CPR certification. The agency did not keep current qualifications of home health aides.	G 141	Also a checklist has been implemented for employee file audits to include the above. How the Action will improve the processes that led to the deficiency: The checklist will be completed annually to maintain compliance. Completion Date: 12/20/11 Monitoring: The checklist will be completed annually on employee files to ensure continued compliance. Person Responsible for implementing the plan of correction: The Administrator.	
G 142	484.14(f) PERSONNEL HOURLY/PER VISIT CONTRACT	G 142	G 142 Action Taken to Correct Deficiency:	

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G 142	<p>Continued From page 5</p> <p>If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following:</p> <ol style="list-style-type: none"> (1) Patients are accepted for care only by the primary HHA. (2) The services to be furnished. (3) The necessity to conform to all applicable agency policies, including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA. (6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. (7) The procedures for payment for services furnished under the contract. <p>This STANDARD is not met as evidenced by: Based on review of written contracts and staff interview, it was determined the agency failed to ensure written contracts were complete for 1 of 2 sample contracts (#1) that were reviewed. This had the potential to interfere with quality and coordination of patient care. Findings include:</p> <p>Upon request, the Administrator provided copies of the only two contracts the agency reportedly had with employees and employee groups. One contract was with an OT. It delineated all of the contractual requirements. The second contract was with a group that provided home health aide services. It did not contain the following</p>	G 142	<p>The contract has been updated to include:</p> <ol style="list-style-type: none"> 1. That patients were accepted for care only by the primary agency. 2. A description of the services to be furnished. 3. The necessity for the home health aides to conform to all applicable agency policies, including personnel qualifications. 4. The manner in which services would be coordinated and evaluated by the primary agency. 5. The procedure for submitting clinical notes and progress notes and scheduling visits. 6. The procedure for periodic patient evaluations. 7. The procedure for payment of services furnished under contract. 8. The requirements for licensure, CPR and in-services. 	

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G 142	Continued From page 6 information: - That patients were accepted for care only by the primary agency; - A description of the services to be furnished; - The necessity for the home health aides to conform to all applicable agency policies, including personnel qualifications; - The manner in which services would be coordinated and evaluated by the primary agency; - The procedure for submitting clinical notes and progress notes and scheduling visits; - The procedure for periodic patient evaluations; - The procedure for payment for services furnished under contract; - The requirements for licensure, CPR and in-services. The Administrator and surveyor reviewed the contracts together on 12/01/11 beginning at 2:00 PM. The Administrator confirmed the elements missing in the one contract.	G 142	How the Action will improve the processes that led to the deficiency: The new contract includes the aforementioned criteria. Completion Date: 12/20/11 Monitoring: The Administrator will review any existing or new contracts to ensure continued compliance. Person Responsible for implementing the plan of correction: Administrator		
G 153	A written contract was incomplete. 484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and	G 153	G 153 Action Taken to Correct Deficiency:		

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G 153	Continued From page 7 plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. This STANDARD is not met as evidenced by: Based on review of administrative documents and staff interview, it was determined the agency failed to ensure the group of professional personnel reviewed the agency's policies annually. This had the potential to result in outdated policies that did not meet patient needs. Findings include: Surveyors requested evidence of the last agency evaluation that included a review of agency policies. The Administrator provided minutes from the last four quarterly meetings (last quarter of 2010 through 3rd quarter of 2011). None of the quarterly reports documented a review of agency policies. The Administrator was interviewed on 12/01/11 at 12:15 PM. He stated the QA group reviewed policies as the need arose but did not review specific policies on an annual basis. He stated the meeting minutes did not document the actual review of policies.	G 153	A professional group has reviewed the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. This annual review has been added to our annual checklist. How the Action will improve the processes that led to the deficiency: The annual checklist will ensure continued compliance. Completion Date: 12/20/11 Monitoring: The annual checklist will be completed. Person Responsible for implementing the plan of correction: The Administrator.		
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,	G 159			

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G 159	<p>Continued From page 8</p> <p>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, observation, patient interview, and staff interview, it was determined the agency failed to ensure a plan of care was developed related to diabetes for 2 of 2 patients (#5 and #12) who had a diagnosis of diabetes. This had the potential to result in missed opportunity to identify blood sugar levels that could negatively impact health and recovery and require coordination with a physician. Findings include:</p> <p>1. Patient #5 was an 81 year old male who was admitted to the agency on 10/14/11 for care related to a below-the-knee amputation, secondary to diabetic complications. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Form 485)," for certification period 10/14/11 to 12/12/11, included orders for skilled nursing services, occupational therapy, physical therapy, sliding scale insulin and diabetic precautions as a safety measure. It did not include diabetes as a relevant diagnosis. There were no specific interventions listed for oversight of the diabetes. The POC stated Patient #5's wife managed his diabetic medication and monitored his blood glucose levels.</p> <p>The Director of Nursing and Administrator were interviewed together on 11/30/11 at 3:15 PM.</p>	G 159	<p>G 159</p> <p>Action Taken to Correct Deficiency: Licensed staff have been inserviced in regards to completion of the 485 to include the diagnosis of diabetes and to indicate what measures are in place for monitoring (if needed).</p> <p>How the Action will improve the processes that led to the deficiency: Staff will be aware of the need for including the diagnosis on the 485 for diabetic patients and to ensure appropriate monitoring is in place.</p> <p>Completion Date: 12/20/11</p>		

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G 159	<p>Continued From page 9</p> <p>They reviewed Patient #5's record and confirmed the diagnosis was missing. They explained they might include interventions on the plan of care if a patient were a newly diagnosed diabetic that needed teaching. In the case of Patient #5, the Director of Nursing, stated the wife monitored Patient #5's diabetes so they were not monitoring it.</p> <p>The plan of care did not include diabetes as a relevant diagnosis with associated diabetic monitoring.</p> <p>2. Patient #12 was an 83 year old female who was admitted to the agency on 9/30/11 for care after gallbladder surgery (cholecystectomy). The "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Form 485)," for certification period 11/29/11 to 1/27/12, including a diagnosis of diabetes, orders for skilled nursing, physical therapy and occupational therapy. The POC also included orders for sliding scale insulin, diabetic supplies, and diabetic precautions. There were no specific interventions related to assessment of diabetic status, such as monitoring of blood glucose levels.</p> <p>A visit to Patient #12's home was made on 11/30/11 beginning at 9:00 AM to observe care an RN provided to Patient #12. There was no assessment observed of Patient #12's diabetic status. The surveyor prompted the RN to assess the blood glucose. Patient #12's husband reported a blood sugar of 160 that morning and expressed concern about becoming exhausted in the care of his wife. He inquired if there was additional help he could access that would be paid by Medicare.</p>	G 159	<p>Monitoring:</p> <p>The Director of Nursing will review all 485's on diabetic patients to ensure that the diagnosis is present and appropriate monitoring is in place. She will perform this audit weekly for the next six weeks or longer if compliance is not noted.</p> <p>Person Responsible for implementing the plan of correction:</p> <p>The Director of Nursing.</p>	

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G 159	Continued From page 10 The RN was interviewed during the home visit. When asked about diabetic care the agency provided, she stated the agency did not monitor the diabetes. She stated Patient #12's husband oversaw his wife's diabetic care. The Director of Nursing and Administrator were interviewed together on 11/30/11 at 3:15 PM. When asked for an agency policy about diabetic care, they were not able to provide one. The Director of Nursing stated Patient #12's husband managed his wife's diabetes. She described an incident (documented in an RN note, dated 11/28/11 at 10:45 AM) that Patient #12's husband accidentally gave Patient #12 the wrong dosage of insulin, had to call the physician for guidance, gave his wife glucose and stayed up with his wife for the remainder of the night to monitor her.	G 159		
G 212	The plan of care was incomplete. 484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAINING The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. This STANDARD is not met as evidenced by: Based on review of personnel records and staff interview, it was determined the agency failed to ensure 3 of 3 home health aides (C, D, and E) met competency evaluation requirements. This had the potential to allow home health aides who had not met competency requirements to provide services on behalf of the agency. Findings	G 212	G 212 Action Taken to Correct Deficiency: Competency evaluations have been completed on employees c,d and e. and the competency evaluation has been added to the annual employee checklist mentioned under G 141. How the Action will improve the processes that led to the deficiency: The annual checklist will help to ensure compliance with the competency requirement. Completion Date: 12/20/11 Monitoring:	

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

PRINTED: 12/07/2011
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER IDAHEALTH HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2867 E COPPERPOINT DR MERIDIAN, ID 83642	
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G 212	Continued From page 11 include: Employee files were reviewed. Home Health aide files for Staff C, D, and E, hired 9/26/11, did not include evidence of competency evaluations. The Administrator and the Director of Nursing were interviewed during an entrance conference on 11/28/11 beginning at 9:30 AM. When asked about aide competency evaluations, they both stated home health aide services were contracted with an outside agency and they did not keep track of paperwork related to aide competency requirements. The Administrator was interviewed again on 12/01/11 at 1:30 PM. He stated the agency kept track of the home health aide in-service hours but did not have other employee information. The agency did not ensure home health aides met competency evaluation requirements prior to providing care.	G 212	The checklist will be completed annually on all employees. Person Responsible for implementing the plan of correction: The Administrator.	
G 244	484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review. This STANDARD is not met as evidenced by: Based on review of administrative documents and staff interview, it was determined the agency failed to ensure an annual evaluation included an overall policy review. This had the potential to result in outdated policies that did not meet patient needs. Findings include:	G 244	G 244 Action Taken to Correct Deficiency: The annual evaluation of the overall policies has been completed and this review has been added to the annual checklist. How the Action will improve the processes that led to the deficiency: The annual checklist will help to ensure that the review is completed. Completion Date: 12/20/11	

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G 244	<p>Continued From page 12</p> <p>Surveyors requested evidence of the last agency evaluation that included a review of agency policies. The Administrator provided minutes from the last four quarterly QA meetings (last quarter of 2010 through 3rd quarter of 2011). None of the quarterly reports documented a review of agency policies.</p> <p>The Administrator was interviewed on 12/01/11 at 12:15 PM. He stated the QA group reviewed policies as the need arose but did not review specific policies on an annual basis. He stated the meeting minutes did not document the actual review of policies.</p> <p>The agency did not ensure the annual evaluation included an overall policy review.</p>	G 244	<p>Monitoring:</p> <p>The annual checklist will be completed to ensure compliance.</p> <p>Person Responsible for implementing the plan of correction:</p> <p>Administrator.</p>	
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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, Team Leader Rebecca Lara, RN, BA, HFS	N 000		
N 027	03.07020. ADMIN. GOV. BODY N027 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.ix. A patient has the right to be advised of the availability of the toll-free HHA hotline in the state. When the agency accepts a patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the state, the hours of its operation and that the purpose of the hotline is to receive complaints or questions about local HHAs. This Rule is not met as evidenced by: Refer to G 116.	N 027	N 027 Please see G 116	
N 050	03.07021. ADMINISTRATOR N050 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:	N 050	N 050 Please see G 141	



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

STATE FORM

5899

HO6011

TITLE

Administrator

(X6) DATE

12/15/2011

If continuation sheet 1 of 10

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N 050	Continued From page 1 d. Insuring that personnel employed shall be qualified to perform their assigned duties and that agency practices are supported by written personnel policies. This Rule is not met as evidenced by: Refer to G 141.	N 050		
N 051	03.07021. ADMINISTRATOR N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations. This Rule is not met as evidenced by: Refer to G 141.	N 051	N 051 Please see G 141	
N 054	03.07021. ADMINISTRATOR N054 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:	N 054	N 054 Please see G 142	

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N 054	Continued From page 2 h. Insuring that if personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: i. A patient is accepted for care only by the primary home health agency; This Rule is not met as evidenced by: Refer to G 142.	N 054			
N 055	03.07021. ADMINISTRATOR N055 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: h. Insuring that if personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: ii. The services that are to be furnished; This Rule is not met as evidenced by: Refer to G 142.	N 055	N 055 Please see G 142		
N 056	03.07021. ADMINISTRATOR N056 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:	N 056	N 056 Please see G 142		

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N 056	Continued From page 3 h. Insuring that if personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: iii. The necessity to conform to all applicable HHA patient care policies including personnel qualifications; This Rule is not met as evidenced by: Refer to G 142.	N 056		
N 057	03.07021. ADMINISTRATOR N057 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: h. Insuring that if personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: iv. The responsibility for participating in developing plans of care; This Rule is not met as evidenced by: Refer to G 142.	N 057	N 057 Please see G 142	
N 058	03.07021. ADMINISTRATOR N058 03. Responsibilities. The	N 058	N 058 Please see G 142	

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N 058	Continued From page 4 administrator, or his designee, shall assume responsibility for: h. Insuring that if personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: v. The manner in which services will be controlled, coordinated, and evaluated by the primary agency; This Rule is not met as evidenced by: Refer to G 142.	N 058		
N 059	03.07021. ADMINISTRATOR N059 03.Responsibilities. The administrator, or his designee, shall assume responsibility for: h. Insuring that if personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: vi. The procedures for submitting clinical and progress notes, scheduling of visits, and periodic patient evaluation; This Rule is not met as evidenced by: Refer to G 142.	N 059	N 059 Please see G 142	

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N 062	Continued From page 5	N 062		
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G 143 and G 144.	N 062	N 062 Please see G 143 and G 144	
N 111	03.07024.03.SK.NSG.SERV. N111 03. Home Health Aide. A home health aide must have completed the supplemental skills checklist approved by the Idaho State Board of Nursing and must be included on the Idaho State Board of Nursing's Home Health Aide Registry. Duties of a home health aide include the following: a. The performance of simple procedures as an extension of therapy services; This Rule is not met as evidenced by: Refer to G 212.	N 111	N 111 Please see G 212	
N 153	03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each	N 153	N 153 Action Taken to Correct Deficiency:	

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N 153	<p>Continued From page 6</p> <p>patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:</p> <p style="padding-left: 40px;">a. All pertinent diagnoses;</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 a plan of care included a relevant diagnosis for 1 of 12 (#5) whose records were reviewed. This had the potential to result in incomplete patient care.</p> <p>Patient #5 was an 81 year old male who was admitted to the agency on 10/14/11 for care related to a below-the-knee amputation, secondary to diabetic complications. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Form 485)," for certification period 10/14/11 to 12/12/11, included orders for skilled nursing services, occupational therapy, physical therapy, sliding scale insulin and diabetic precautions as a safety measure. It did not include diabetes as a relevant diagnosis. There were no specific interventions listed for oversight of the diabetes. The Plan of Care stated Patient #5's wife managed his diabetic medication and monitored his blood glucoses.</p> <p>The Director of Nursing and Administrator were interviewed together on 11/30/11 at 3:15 PM. They reviewed Patient #5's record and confirmed the diagnosis was missing. They explained they might include interventions on the plan of care if a patient were a newly diagnosed diabetic that needed teaching. In the case of Patient #5, the Director of Nursing, stated the wife monitored Patient #5's diabetes so they were not monitoring it.</p>	N 153	<p>Staff have been educated to include diabetes as a diagnosis on the 485 when indicated.</p> <p>How the Action will improve the processes that led to the deficiency:</p> <p>Diabetes will be included on the 485 when indicated.</p> <p>Completion Date: 12/20/11</p> <p>Monitoring:</p> <p>The Director of Nursing will review the 485's of all diabetic patients to ensure that it is listed. This will be performed for the next six weeks or longer if compliance is not noted.</p> <p>Person Responsible for implementing the plan of correction: The Director of Nursing.</p>	

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N 153	Continued From page 7 The plan of care did not include diabetes as a relevant diagnosis with associated diabetic monitoring.	N 153		
N 193	03.07040.AGENCY EVALUATION N193 040. AGENCY EVALUATION. A group of professional personnel, which includes at least one (1) physician, one (1) registered nurse, and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one (1) member of the group is neither an owner nor an employee of the agency. This Rule is not met as evidenced by: Refer to G 153.	N 193	N 193 Please see G 153	
N 195	03.07040.02 AGENCY EVAL. N195 02. Evaluation Criteria and Purpose. The evaluation consists of an overall policy and administrative review and a clinical record review and assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. This Rule is not met as evidenced by: Refer to G 244.	N 195	N 195 Please see G 244	

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N 199	<p>Criminal History and Background Check</p> <p>009.CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.</p> <p>01. Compliance with Department ' s Criminal History and Background Check. A home health agency must comply with IDAPA 16.05.06, " Criminal History and Background Checks. " (3-26-08)</p> <p>02. Direct Patient Access Individuals. These rules apply to employees and contractors hired or contracted with after October 1, 2007, who have direct patient access. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must complete an application before having access to patients. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any patient without a clearance by the Department. Once the notarized application is completed the individual can only work under supervision until the individual has been fingerprinted. The individual must have his fingerprints submitted to the Department within twenty-one (21) days of completion of the notarized application. (3-26-08)</p> <p>This Rule is not met as evidenced by: Based on review of personnel records and staff interview, it was determined the agency failed to ensure completion of criminal background checks for 5 of 8 sample employees (C, D, E, G, and H) hired after October 2007. This had the potential to allow employees access to patients who may have had disqualifying crimes. Findings include:</p>	N 199	<p>N 199</p> <p>Action Taken to Correct Deficiency:</p> <p>Employees C,D,E,G AND H have had background checks initiated, and background checks have been added to the employee file checklist.</p> <p>How the Action will improve the processes that led to the deficiency:</p> <p>The checklist will help to maintain compliance.</p> <p>Completion Date:</p> <p>12/20/11</p> <p>Monitoring:</p> <p>The checklist will be completed on hire and annually.</p> <p>Person Responsible for implementing the plan of correction:</p> <p>The Administrator</p>	

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N 199	Continued From page 9 Personnel records were reviewed. Employee files for staff hired after October 2007 did not have evidence of qualifying background checks on the following staff: Staff C, a home health aide, hired 9/26/11; Staff D, a home health aide, hired 9/26/11; Staff E, a home health aide, hired 9/26/11; Staff G, a physical therapist, hired 9/21/09; Staff H, an occupational therapist, hired 9/01/09. The Administrator was interviewed on 12/01/11 beginning at 1:30 PM. He confirmed he did not have background checks on the home health aides (Staff C, D, and E) or the PT (Staff G). He had a background check, dated 8/12/05, for the OT (Staff H) completed over 4 years prior to the hire date with the agency. Prior to survey exit, the Administrator was able to obtain evidence of background checks on the aides that had been held at the contract agency. However, the background checks were not qualifying background checks. They were conducted by "Affordable Searches" rather than the Idaho Department of Health and Welfare. The agency did not have required background checks on employees.	N 199		