



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey & Certification

January 27, 2012

Mary Lou Long, RN, MSN, NHA
Director Community Services, Home Care & Hospice
190 East Bannock Street
Boise, ID 83712

Re: St Lukes Home Care and Hospice
CMS Certification Number: 13-7034

Re: Plan of Correction Received

Dear Ms. Long:

The Centers for Medicare and Medicaid Services (CMS) has received St Lukes Home Care and Hospice's voluntarily submitted plan of correction following the December 16, 2011, sample validation survey. CMS appreciates the time and effort of you and staff in developing and implementing the plan of correction. Please contact me at (206) 615-2432 if you need further information.

Sincerely,

Kate Mitchell, Health Insurance Specialist
Survey, Certification and Enforcement Branch - Seattle

cc: Idaho Bureau of Facility Standards
file



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

January 3, 2012

Mike Reno, Administrator
St. Luke's Magic Valley Home Health
601 Poleline Road
Twin Falls, ID 83301

CMS Certification Number: 13-7034

Re: Results of Sample Validation Survey

Dear Mr. Reno:

The Centers for Medicare and Medicaid Services (CMS) is confirming the results of the sample validation survey, completed by the Idaho Bureau of Facility Standards (State survey agency) on December 16, 2011, at St. Luke's Magic Valley Home Health.

CMS finds that your home health agency is in compliance with all the Medicare Conditions of Participation and will continue to be certified as meeting Medicare requirements. We have forwarded a copy of this letter and the findings from the survey to the Joint Commission.

It is not a requirement to submit a plan of correction; however, under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable if requested.

You may therefore wish to submit your plans for correcting the deficiencies cited. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving 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;
- All plans of correction must demonstrate how the home health agency has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Seattle Regional Office
2201 Sixth Avenue, RX-48
Seattle, WA 98121

Plan of Correction elements cont.

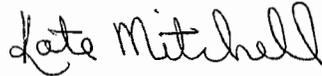
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Please send a copy of your plan of correction within 10 days receipt of this letter to CMS and the State survey agency. **If you choose to not submit a plan a correction, please sign and date the first page of each Form CMS-2567 and return to CMS.**

Kate Mitchell, Division of Survey and Certification
Centers for Medicare and Medicaid Services
2201 Sixth Avenue, Mail Stop RX-48
Seattle, Washington 98121

We thank you for your cooperation, and look forward to working with you on a continuing basis in the administration of the Medicare program. Please contact me at (206) 615-2432 if you need additional information.

Sincerely,



Kate Mitchell, Health Insurance Specialist
Division of Survey and Certification - Seattle

Enclosure

cc: Idaho Bureau of Facility Standards
CMS Central Office
Joint Commission

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

January 4, 2012

Tina Peer, Administrator
St. Luke's Magic Valley RMC Home Health
601 Poleline Road
Twin Falls, ID 83301

RE: St. Luke's Magic Valley RMC Home Health, provider #137034

Dear Ms. Peer:

This is to advise you of the findings of the Validation/Licensure survey at St. Luke's Magic Valley RMC Home Health which was concluded on December 16, 2011.

A copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567 was forwarded to you by the CMS Region X office on January 3, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

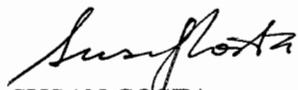
1. Action that will be taken to correct each specific deficiency cited.
2. Description of how the actions will improve the processes that led to the deficiency cited.
3. Procedure for implementing the acceptable plan of correction for each deficiency cited.
4. A completion date for correction of each deficiency cited must be included (2 month rule)
5. Monitoring and tracking procedures to ensure the POC is effective in bringing the provider into compliance, and that the provider remains in compliance with the regulatory requirements.
6. For each deficiency, the title of the person responsible for implementing the acceptable plan of correction
7. If a POC for a citation refers to another citation's POC, the referenced POC addresses the regulatory issues or problems identified in the basic deficiency statement.
8. Sign and date the form(s) in the space provided at the bottom of the first page.

Tina Peer, Administrator
January 4, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **January 17, 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 call or write 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/srm

Enclosures

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office



St. Luke's Home Care
 190 E. Bannock St.
 Boise, Idaho 83712
 Phone: (208) 381-2138 Fax: (208) 381-2133

RECEIVED

JAN 23 2012

FACILITY STANDARDS

CONFIDENTIALITY NOTICE

The document(s) accompanying this telecopy transmission contains confidential information belonging to the sender, which is privileged. The information is intended only for the use of the individual or entity named below. If you have received this correspondence in error, please: i) safeguard the information and notify the sender immediately to arrange for the return of the information; OR ii) immediately shred or otherwise destroy the communication and notify the sender. Confidential information should not be disposed of in open waste receptacles or through other means that are not secure.

To: Sylvia Creswell, Facility Standards

Fax #: 208-364-1888

From: Home Care & Hospice Sharon Barrett Hill 381-4696

Date: Per Fax Header Time: 1610

Comments: Validation Survey Action Plan

Pages: 35 (including cover sheet)

(Please call if you do not receive all the pages sent)

Confidential Health Information

This facsimile contains Protected Health Information that is of a sensitive and confidential nature. It is being faxed to you with the authorization of the patient or under circumstances where authorization is not required. You are required to maintain this information in a secure and confidential manner and are prohibited from re-disclosing it without first obtaining the patient's consent or as otherwise permitted by law. Unauthorized re-disclosure may subject you to federal and state law penalties.



January 20, 2012

Kate Mitchell, Division of Survey and Certification
Center for Medicare and Medicaid Services
2201 Sixth Avenue, Mail Stop RX-48
Seattle, Washington 98121

Sylvia Creswell, Supervisor
Idaho Bureau of Facility Standards – DHW
P.O. Box 83720
Boise, ID 83720-0036

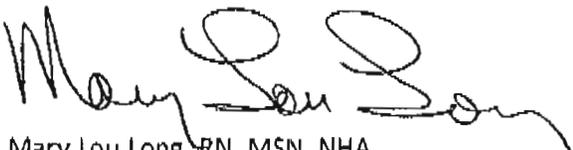
RE: St. Luke's Magic Valley Home Health

Dear Ms. Mitchell and Ms. Creswell:

Enclosed is our Plan of Correction for our validation survey completed on December 16, 2011. Because we are a Joint Commission accredited organization and currently have deemed status, we understand a Plan of Correction is not required. However, we have determined it appropriate to respond to the deficiencies cited.

We appreciated the professionalism and courtesy of the surveyors. If you have any questions, please call Mary Lou Long at 208-381-3946 or Tina Peer at 208-814-7608.

Sincerely,



Mary Lou Long, RN, MSN, NHA
Director Community Services, Home Care and Hospice

cc: JoDee Aiverson
James Angle
Amy Bearden

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALT		STREET ADDRESS, CITY, STATE, ZIP CODE 601 POLELINE ROAD 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) COMPLETE DATE
N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Validation survey of your agency. The surveyors conducting the survey were: Susan Costa, RN, HFS, Team Leader Almea Hastriter, RN, BSN, HFS Acronyms used in this report include: SN - Skilled Nurse	N 000		
N 091	03.07024. SK.NSG.SERV. N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G 170 as it relates to the failure of the agency to ensure nursing services were provided in accordance with the plan of care	N 091	N 091 RN Team Leader and OASIS Review Nurse provided education to staff on reviewing the plan of care prior to the visit and then following the POC as written with emphasis on pediatric and diabetic plans. Audit 20 charts a month for 3 months and then 20 charts per quarter to identify if the plan of care is being followed with a goal of 90% compliance.	Education completed 12/21/11.
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G 159 as it relates to the failure of the agency to ensure the POC included DME and	N 155	N 155 OASIS Review Nurse will review 100% of plans of care daily before sent out for signature. 100% of POCs will have supplies and durable medical equipment included if indicated.	Education completed at staff meeting on 1/11/12

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JAN 23 2012
FACILITY STANDARDS

Bureau of Facility Standards

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

[Handwritten Signature]

TITLE

CHIEF EXECUTIVE OFFICER 1/23/2012

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALT		STREET ADDRESS, CITY, STATE, ZIP CODE 601 POLELINE ROAD 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) COMPLETE DATE
N 155	Continued From page 1 supplies.	N 155		
N 160	03.07030.PLAN OF CARE N160 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: h. Nutritional requirements; This Rule is not met as evidenced by: Refer to G 159 as it relates to the failure of the agency to include patients' nutritional needs on the POC.	N 160	N160 OASIS Review Nurse reviews 100% of plans of care daily before sent out. 100% of plans of care will have nutrition needs included. N 172 The Clinical Instructor reviewed the case manger orientation document called Home Health/Hospice Telephone Triage which contains a list of typical events that would require notification to the physician.	Education completed at staff meeting on 1/11/12
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G 164 as it relates to the failure of the agency to alert the physician to changes that suggested a need to alter the plan of care.	N 172	N 172 and N 173 Audit 20 charts a month for 3 months and then 20 charts per quarter to identify patient events and whether physician was notified with goal of 90% compliance. N172:Team leader will also make home visits with all staff starting February 1st to ensure the physician is notified in a timely manner with goal of 100% compliance.	Education completed at staff meeting on 1/11/12
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's	N 173	N 173 RN Team Leader and OASIS Review Nurse provided education to staff on reviewing the plan of care prior to the visit and then following the plan of care as written with emphasis on lab orders and wound care plans.	Education completed at staff meeting on 12/21/11.

Jan. 4. 2012 2:50PM

No. 5062 P. 6/9

PRINTED: 01/03/2012
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0A9001380	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2011
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALT		STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLELINE ROAD 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) COMPLETE DATE
N 173	Continued From page 2 countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G 185 as it relates to the failure of the agency to ensure patient medications were reviewed and ordered by the physician.	N 173		
N 186	03.07031.03.CLINICAL REC. N186 03. Clinical and Progress Notes, and Summaries of Care, Clinical and progress notes must be written or dictated on the day service is rendered and incorporated into the clinical record within seven (7) days. Summaries of care reports must be submitted to the attending physician at least every sixty (60) days. This Rule is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure progress notes were not entered into the medical record within seven days for 1 of 16 sample patients (#8) whose records were reviewed. Failure to promptly enter progress notes into the clinical record impaired coordination of patient care. Findings include: Patient #8 was a 5 year old female admitted to the agency on 10/03/11 for care related to a congenital heart anomaly and feeding difficulties. Her "HOME HEALTH CERTIFICATION AND	N 186	N 186 Staff will complete visit notes on the same day of the visit and OASIS visits within 2 days (new standard of care). Audit 20 charts a month for 3 months and then 20 charts per quarter to identify if charting is being done per required time lines with goal of 90%.	Education provided at staff meetings on 12/21/11 and 1/11/12

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALT		STREET ADDRESS, CITY, STATE, ZIP CODE 601 POLELINE ROAD 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) COMPLETE DATE
N 186	<p>Continued From page 3</p> <p>PLAN OF CARE," for the certification period of 10/03/11 to 12/01/11, contained orders for SN services 1-2 times a week throughout the certification period. Her medical record contained a physician's order, dated 10/04/11, for a speech therapy evaluation. The physician ordered speech therapy 2 times a week for a total of 5 weeks.</p> <p>The Case Manager for Patient #8 documented in the "Patient Activity" section of the record that on 10/04/11 she left a message for the Speech Therapist regarding the referral order. On 10/17/11, the Case Manager documented she contacted the Speech Therapist and was notified that a visit was planned for 10/18/11, if interpretive services were secured. Review of nursing and speech therapy visit notes revealed no further communication between the Case Manager and the Speech Therapist. In addition, the speech therapy visit notes for 10/18/11, 10/20/11, 10/25/11, and a second visit dated 10/25/11, were not entered into the medical record until 11/12/11.</p> <p>The Case Manager for Patient #8 was interviewed on 12/15/11 at 3:20 PM. She stated she had contacted the Speech Therapist on 10/17/11 to determine when the next visit was scheduled, but had not spoken with her since that time. She confirmed the speech therapy visit notes were not being entered into the computer system in a timely manner. The Case Manager stated she did leave a message for the Speech Therapist regarding the missing visit notes but did not hear back from her.</p> <p>Speech therapy progress notes were not entered into Patient #8's medical record within seven days of each visit.</p>	N 186		

Jan. 4. 2012 2:51PM

No. 5062 P. 8/9

PRINTED: 01/03/2012
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CAS001350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2011	
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 POLELINE ROAD 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) COMPLETE DATE

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

PRINTED: 01/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 601 POLELINE ROAD 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 Validation survey of your agency. The surveyors conducting the survey were: Susan Costa, RN, HFS, Team Leader Aimee Hastriter, RN, BSN, HFS Acronyms used in this report include: DME - Durable Medical Equipment mcg - microgram mg - milligram LPN - Licensed Practical Nurse OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy RN - Registered Nurse SN - Skilled Nurse	G 000	 G 144 Staff were educated regarding documentation of coordination and requirements for who documents and events that would trigger coordination and documentation. Audit 20 charts a month for 3 months and then 20 charts every quarter to identify if coordination is being done and documented with a goal of 90% compliance.	Education completed 1/20/12.	
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure documentation of coordination of care between disciplines providing care to 2 of 14 sample patients (#8 and #16) who received care from more than one discipline. This had the potential to interfere with the quality and effectiveness of patient care. Findings include:	G 144			

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

TITLE

(X6) DATE

[Signature]

CHIEF EXECUTIVE OFFICER 1/23/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2011
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NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLELINE ROAD TWIN FALLS, ID 83301
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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 144	<p>Continued From page 1</p> <p>1. Patient #8 was a 5 year old female admitted to the agency on 10/03/11 for care related to a congenital heart anomaly and feeding difficulties. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 10/03/11 to 12/01/11, contained orders for SN services 1-2 times a week throughout the certification period. Her medical record contained a physician's order, dated 10/04/11, for a speech therapy evaluation. The physician ordered speech therapy 2 times a week for a total of 6 weeks.</p> <p>The Case Manager for Patient #8 documented in the "Patient Activity" section of the record that on 10/04/11 she left a message for the Speech Therapist regarding the referral order. On 10/17/11, the Case Manager documented she contacted the Speech Therapist and was notified that a visit was planned for 10/18/11, if interpretive services were secured. Review of nursing and speech therapy visit notes revealed no further communication between the Case Manager and the Speech Therapist.</p> <p>The Case Manager for Patient #8 was interviewed on 12/16/11 at 3:20 PM. She stated she had contacted the Speech Therapist on 10/17/11 to determine when the next visit was scheduled, but had not spoken with her since that time. She confirmed the speech therapy visit notes were not being entered into the computer system in a timely manner. The Case Manager stated she did leave a message for the Speech Therapist regarding the missing visit notes but did not hear back from her. She confirmed this contact was not documented. She stated she</p>	G 144		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 601 POLELINE ROAD 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 144	<p>Continued From page 2</p> <p>had e-mailed the Speech Therapist on 12/05/11 regarding continuing therapy into the new certification period, but had not heard back from her.</p> <p>The medical record did not contain documentation of coordination of care between the Case Manager and the Speech Therapist for Patient #8.</p> <p>2. Patient #16 was a 15 year old female admitted to the agency on 8/23/11 for care related to a pressure ulcer. Patient #16 had spina bifida (the incomplete development of the spinal cord and its coverings), was confined to a wheelchair, and wore a back brace. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 11/22/11 through 1/20/12, contained orders for SN visits 1 time a week for 9 weeks, PT 1 time a week for 6 weeks, and an OT evaluation.</p> <p>Communication between disciplines was documented in the "Patient Activity" section of the medical record. On 11/22/11, the Occupational Therapist documented notifying the Case Manager a visit was scheduled for 11/28/11. The Case Manager documented communication with the Occupational Therapist on 12/08/11 and indicated the OT evaluation would occur on 12/08/11. Patient #16's medical record did not contain evidence of an OT evaluation as of 12/16/11 and there were no additional communication notes to explain the delay of the evaluation.</p> <p>The Case Manager for Patient #16 was interviewed on 12/15/11 at 4:33 PM. She</p>	G 144			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMG HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLELINE ROAD 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 144	Continued From page 3 reviewed Patient #16's medical record and explained the communication between herself and the Occupational Therapist. She stated Patient #16's family was overwhelmed with various obligations over the holiday and chose to wait to begin treatment with the Occupational Therapist on 12/08/11. She confirmed this information had not been documented. The Case Manager confirmed the Occupational Therapist did complete an evaluation of Patient #16 on 12/08/11, however she had not had any communication from him regarding the results of the evaluation. She confirmed the visit note was not yet in the medical record. She stated she would have expected to hear from him, but communication between staff was somewhat more difficult with contracted employees.	G 144		
G 159	The facility failed to ensure the medical record contained documentation of the coordination of care between disciplines providing patient care. 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 and staff interview, it was determined the agency failed to ensure plans	G 159	G 159 OASIS Review Nurse will review 100% of plans of care before they are sent out. 100% of plans of care will have supplies and durable medical equipment included if indicated.	Education completed 1/11/12.

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 601 POLELINE ROAD 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 159	<p>Continued From page 4</p> <p>of care covered all pertinent information, including DME and supplies, for 5 of 16 patients (#2, #4, #7, #10, and #13) whose records were reviewed. This had the potential to negatively impact quality, coordination, and completeness of patient care. Findings include:</p> <p>1. Patient #2 was a 91 year old male who was admitted to the agency on 7/01/11 after being hospitalized for a fractured hip. He was to receive SN, OT, and PT services. The "PLAN OF CARE," for the certification period 7/01/11 to 8/28/11, listed only alcohol preps as the DME and supplies needed. Patient #2 was to receive Lovenox injections daily for five days for the prevention of blood clots. Alcohol wipes would be used to cleanse the skin just prior to the injection. The comprehensive assessment completed by an RN on 7/01/11 at 12:30 PM, included information that Patient #2 had a bedside commode and used a walker for ambulation.</p> <p>During an interview on 12/15/11 at 3:45 PM, the RN who completed the comprehensive assessment, reviewed the record and confirmed the bedside commode and walker were not included on the POC as DME. The RN stated she thought when she entered the information into the electronic medical record during the comprehensive assessment it would be automatically be entered into the POC.</p> <p>Patient #2's POC did not include necessary DME and supplies.</p> <p>2. Patient #7 was a 4 year old male admitted to the agency on 12/10/11. Patient #7 had been hospitalized for complications related to a</p>	G 159			

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G 159	<p>Continued From page 5</p> <p>progressive neurological disease which caused strokes. His "PLAN OF CARE" for the certification period 12/10/11 to 2/07/12, listed a feeding pump and oxygen as the DME and supplies needed. The comprehensive assessment completed by an RN on 12/10/11 at 11:00 AM, included information that Patient #7 used a hospital bed, an oxygen concentrator provided his oxygen, and had a portable suction machine, a wheelchair, and a walker.</p> <p>During an interview on 12/16/11 at 11:10 AM, the Home Health Team Lead reviewed Patient #7's record and confirmed the hospital bed, oxygen concentrator, suction machine, wheelchair, and walker had not been listed on the POC as DME.</p> <p>The agency did not include DME supplies on the POC.</p> <p>3. Patient #10 was a three month old male who was admitted to the agency on 11/23/11. Patient #10's diagnoses included bronchopulmonary dysplasia (also known as chronic lung disease, with scarring of the lung tissue and airways,) history of aspiration, and a blood clot in his heart that required daily injections of Lovenox, a blood thinning medication. Patient #10 received SN visits and PT services. The "PLAN OF CARE," for the certification period 11/23/11 to 1/21/12, indicated "NO SUPPLIES" in the DME section. The comprehensive nursing assessment, dated 11/23/11 at 12:20 PM, included information that Patient #10 was on oxygen by nasal cannula, as well as, an apnea monitor. The items were not included in the DME section of the POC.</p> <p>During an interview on 12/16/11 at 11:10 AM, the</p>	G 159			

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G 159	<p>Continued From page 6</p> <p>Home Health Team Lead reviewed Patient #10's record and confirmed the oxygen via nasal cannula and the apnea monitor were not on the POC.</p> <p>The agency did not include DME supplies on the POC.</p> <p>4. Patient #4 was a 73 year old female admitted to the agency on 11/08/11 for care related to sprained ankles and broken ribs sustained as a result of a fall. According to the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/08/11 through 1/06/12, Patient #4 was diabetic and used insulin, as well as, oral medications to treat her diabetes. The POC indicated SN was to teach Patient #4 diabetic foot care and monitor her feet for lesions. The POC did not indicate if Patient #4's diabetes was under control, who would be responsible to monitor blood glucose levels, what the blood glucose parameters were, or if additional diabetic education was warranted.</p> <p>The Home Health Team Lead reviewed Patient #4's medical record on 12/13/11 at 4:07 PM. She confirmed that beyond the guidance to teach diabetic foot care and monitor for lesions, the POC did not contain direction to staff regarding additional needed education or blood glucose monitoring.</p> <p>The RN caring for Patient #4 was interviewed on 12/14/11 at 8:00 AM. She stated she had reviewed Patient #4's physician's notes prior to providing care. She stated that based on the records she determined Patient #4's diabetes was controlled. She confirmed that this</p>	G 159			

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G 159	<p>Continued From page 7</p> <p>Information was not documented. She also confirmed that acceptable blood glucose parameters was not a topic discussed with Patient #4.</p> <p>Patient #4's POC did not include pertinent information related to the diagnosis of diabetes.</p> <p>5. Patient #13 was an 80 year old female admitted to the agency on 8/10/11 for care related to congestive heart failure. Her comprehensive assessment was completed by an RN on 8/10/11. The RN documented a blood glucose reading and noted that Patient #13 had "IMPAIRED FASTING GLUCOSE." The RN documented Patient #13 did not take medications to control her blood sugars, rather she "WATCHES WHAT SHE EATS." The RN also documented that Patient #13 had neuropathy to both lower extremities. According to the National Diabetes Information Clearinghouse in 2/2009, at diabetes.niddk.nih.gov, diabetic neuropathies are a family of nerve disorders caused by diabetes. People with diabetes can, over time, develop nerve damage throughout the body. The nerve damage can result in pain, tingling, or numbness.</p> <p>Patient #13's POC did not include guidance to staff related to the "IMPAIRED FASTING GLUCOSE." The POC did not include direction related to necessary education or monitoring related to impaired fasting glucose.</p> <p>The RN who completed the comprehensive assessment for Patient #13 was interviewed on 12/16/11 at 9:24 AM. She was unable to fully explain what was meant by the diagnosis of "impaired fasting glucose." She stated that</p>	G 159			

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G 159	Continued From page 8 Patient #13 did not actually have diabetes, but did have blood glucose issues. She stated she obtained this information by reviewing Patient #13's medical history. She confirmed that she reviewed Patient #13's diet and blood sugar levels at every visit. She stated she was not aware that the information related to blood sugar monitoring was not on the POC. The Home Health Team Lead was interviewed on 12/16/11 at 9:40 AM. She reviewed Patient #13's POC and confirmed there were no orders to address education and monitoring related to blood glucose levels and stated she would have expected this to be included in the POC.	G 159		
G 164	The facility failed to ensure the POC included all medical equipment and direction to staff related to all pertinent diagnoses. 484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency staff failed to alert the physician to changes that suggested a need to alter the plan of care in 4 of 16 patients (#4, #5, #6, and #10) whose records were reviewed. This had the potential to negatively impact patient care and outcomes. Findings include: 1. Patient #6 was an 80 year old female who was admitted to the agency on 11/18/11 after	G 164	G 164 The Clinical Instructor reviewed the case manager orientation document called Home Health/Hospice Telephone Triage which contains a list of typical events that would require notification to the physician. Audit 20 charts a month for 3 months and then 20 charts per quarter to identify patient events and whether physician was notified with goal of 90% compliance. Team leader will also make home visits with all staff starting February 1st to ensure the physician is notified in a timely manner with a goal of 100% compliance.	Educated completed at staff meeting on 12/21/11.

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G 184	<p>Continued From page 9</p> <p>discharge from a hospital related to a fractured arm and pelvis. A referral order, dated 11/14/11, stated "initiate HC [Home Care] services, SN TO ADMIT TO HH [Home Health] SERVICES. PT TO EVAL [evaluate] AND TREAT." The comprehensive assessment was completed on 11/18/11 by a Physical Therapist. The record did not contain documentation of an RN visit.</p> <p>In an interview on 12/13/11 at 9:05 AM, the LPN who had received the referral stated she noticed on 11/17/11 that Patient #8 had not yet been seen by an RN. The LPN stated she gave the referral to her supervisor. The LPN stated her supervisor then gave the referral to an RN who visited Patient #8.</p> <p>In an interview on 12/13/11 at 9:15 AM, the RN who evaluated Patient #8 stated, after a discussion with Patient #8 and her family, it was decided only PT and OT services were needed. The RN stated she contacted PT directly after meeting with Patient #8 and the comprehensive assessment was completed by PT on 11/18/11. The RN stated she did not notify Patient #8's physician regarding the change in plan for therapy only services. The RN stated she did not document her initial visit with Patient #8 on 11/17/11.</p> <p>The agency failed to notify the physician that skilled nursing services were no longer needed.</p> <p>2. Patient #10 was a three month old male who was admitted to the agency on 11/23/11. Patient #10's diagnoses included bronchopulmonary dysplasia (a chronic lung disease, with scarring of the lung tissue and airways,) history of aspiration,</p>	G 184			

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G 164	<p>Continued From page 10</p> <p>and a blood clot in his heart that required daily injections of Lovenox, a blood thinning medication. Patient #10 was to receive SN and PT services. The "PLAN OF CARE" for the certification period 11/23/11 through 1/21/12, indicated nursing visits would be 1-2 times weekly</p> <p>In a nursing note dated 12/01/11 at 1:30 PM, the RN documented Patient #10's mother was not present during the visit and the great aunt was taking care of him. The RN noted Patient #10 had a weight gain of seven ounces in the eight days since admission. A rapid gain of weight could have indicated fluid buildup around Patient #10's heart and lungs causing harm. The RN did not document an assessment of Patient #10, such as listening to his heart and lungs, obtaining an oxygen saturation level to ensure he was getting enough oxygen, looking for signs of swelling, assessing how hard he was working to breathe, in order to rule out this potentially negative fluid buildup.</p> <p>In addition, the RN documented, "I DONT SEE THE DIURIL [a medication to decrease fluid build up in the body], CAFFEINE [used in infants to stimulate regular breathing patterns], OR NACL [sodium chloride]. ASSUME THESE WERE CANCELED BUT WILL WAIT TO DISCUSS WITH MOM." The RN also noted the great aunt stated Patient #10 was no longer using supplemental oxygen via the nasal cannula.</p> <p>The medical record did not contain documentation that Patient #10's physician was notified of the rapid weight gain or that the medication changes were clarified with Patient #10's mother or physician.</p>	G 164		

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G 164	<p>Continued From page 11</p> <p>In addition, the RN also documented Patient #10's great aunt had difficulty with the apnea monitor (a device which alarmed if Patient #10 stopped breathing) leads not working, and the company was unable to supply new leads until the following week. The RN documented she instructed the great aunt to use tape to secure the monitor leads until that time. The record indicated Patient #10 died that evening.</p> <p>During an interview on 12/16/11 at 11:10 AM, the Home Health Team Lead reviewed Patient #10's medical record and confirmed it appeared the RN did not communicate the weight gain to the physician, and did not document clarification of the changes in medication or oxygen.</p> <p>The agency did not alert the physician to Patient #10's weight gain as well as to confirm medication changes.</p> <p>3. Patient #4 was a 73 year old female admitted to the agency on 11/08/11 for care related to sprained ankles and broken ribs sustained as a result of a fall. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/08/11 through 1/08/12, contained orders for SN and PT visits 1-2 times a week during the certification period, and OT evaluation.</p> <p>On 11/15/11 the Occupational Therapist documented, in the "Patient Activity" section of the medical record, the Physical Therapist notified him that Patient #4 "DID NOT THINK SHE NEEDED OCCUPATIONAL THERAPY BUT</p>	G 164			

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G 164	<p>Continued From page 12</p> <p>WOULD BE OK WITH JUST PHYSICAL THERAPIST [sic]." The Occupational Therapist documented that it was decided the Physical Therapist would screen Patient #4 carefully and educate Patient #4 if OT was needed. The Physical Therapist documented on 11/16/11 that the team (which include PT, OT, and SN) was notified of Patient #4's request to hold off on OT until she was stronger. There was no documentation in the medical record that the physician was notified of this alteration in the POC.</p> <p>The Home Health Team Lead reviewed Patient #4's medical record on 12/13/11 at 3:00 PM and confirmed the physician was not notified that Patient #4 was not receiving OT services as ordered.</p> <p>The agency failed to notify the physician of changes in patient needs which altered the POC.</p> <p>4. Patient #5 was a 95 year old female admitted to the agency on 10/27/11 for care related to an abrasion on her trunk which required dressing changes. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/27/11 to 12/25/11, included orders for SN visit 1-2 times a week for 9 weeks.</p> <p>Documentation from a SN visit on 11/21/11 indicated a change to Patient #5's medication regimen. The RN documented Patient #5 was started on Clotrimazole Lozenges (a medication to treat oral yeast infections) but was refusing to take them. The RN also documented, "PATIENT DOES HAVE WHITE BLOTCHYNESS [sic] TO TONGUE." The RN noted, in the</p>	G 164		

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G 164	Continued From page 13 "POC/Synopsis" section of the visit note, that Patient #5 was "STARTED ON A NEW MED [medication] FOR THE WHITE PATCHES ON HER TONGUE HOWEVER REFUSES TO TAKE IT AT THE TIME..." The medical record did not contain documentation that the physician was notified of Patient #5's refusal to take the prescribed medication. In addition, the medical record did not contain documentation of any follow up evaluation of the white patches on Patient #5's tongue during subsequent SN visits. Patient #5 and her caregiver were interviewed following a home visit on 12/13/11 at 12:40 PM. Patient #5 stated she was prescribed the lozenges for the white patches in her mouth. She recalled her doctor talking to her about a yeast infection. She stated she stopped taking the lozenges because she felt they caused her side effects (which she stated she couldn't recall). The RN who cared for Patient #5 was interviewed on 12/13/11 at 4:24 PM. She stated she recalled Patient #5 mentioning a yeast infection, but that Patient #5 believed the yeast infection was actually on the skin in her armpit. The RN stated she evaluated the armpit, which looked normal, but did not assess the white patches on Patient #5's tongue. She stated she did not connect that the yeast infection may have actually been in Patient #5's mouth rather than in her armpit as Patient #5 believed. She confirmed there was no additional evaluation or documentation of an assessment of Patient #5's tongue. Nursing staff failed to notify the physician Patient #5 had discontinued prescribed medications.	G 164			
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN	G 165			

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G 165	<p>Continued From page 14 ORDERS</p> <p>Drugs and treatments are administered by agency staff only as ordered by the physician.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure care was only provided as ordered by a physician for 2 of 16 sample patients (#11, and #13) whose records were reviewed. This had the potential to result in provision of care without a physician's approval and authorization. Findings include:</p> <p>1. Patient #13 was an 80 year old female admitted to the agency on 8/10/11 for care related to congestive heart failure. The comprehensive assessment was completed by an RN on 8/10/11. The RN documented "BMP [basic metabolic panel - a lab test to evaluate blood chemistry levels] PER MD [medical doctor] PERFORMED PER AGENCY PROTOCOL." Patient #13's medical record did not contain orders for a BMP lab draw due on 8/10/11.</p> <p>The Home Health Team Lead reviewed Patient #13's medical record and confirmed there was no order documented for the BMP lab drawn on 8/10/11.</p> <p>Patient #13 had lab work drawn without a physician's order.</p> <p>2. Patient #11 was an 88 year old female admitted to the agency on 11/26/11 for care related to a 2nd degree burn. The "HOME HEALTH CERTIFICATION AND PLAN OF</p>	G 165	<p>G 165 RN Team Leader and OASIS Review Nurse provided education to staff on reviewing the plan of care prior to the visit and then following the plan of care as written with emphasis on lab orders and wound care.</p> <p>Audit 20 charts a month for 3 months and then 20 charts per quarter to ensure the plan of care is being followed with goal of 90% compliance.</p>	<p>Education completed at staff meeting on 12/21/11.</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLELINE ROAD 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 165	Continued From page 15 CARE,* for the certification period of 11/26/11 to 01/24/12, contained orders for SN visits for dressing changes. The dressing was to be changed on 11/26/11 and then twice during the following week. According to the dressing change order, the wound was to be cleansed with normal saline, the area around the wound was to be patted dry, and then a Repicare dressing was to be applied. The RN documented in the nursing visit notes for 11/28/11 and 12/02/11, that the wound was cleansed with normal saline, and an Adaptic dressing (a Vaseline Impregnated gauze dressing) was applied, covered with Teffe, and taped in place. The dressing changes were not completed as ordered on 11/28/11. The Home Health Team Lead was interviewed on 12/15/11 at 11:20 AM. She reviewed Patient #11's medical record and confirmed there was no order for the Adaptic dressing used on 11/28/11 and 12/02/11. Dressing changes were provided to Patient #11 without a physician's order.	G 165			
G 170	The facility failed to ensure all treatments were provided only as ordered by the physician. 484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on staff interview, observation, and record review, it was determined the agency failed to	G 170			

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NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 601 POLELINE ROAD 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 170	<p>Continued From page 16</p> <p>ensure skilled nursing services were provided in accordance with the plan of care for 5 of 16 patients (#2, #3, #4, #7, and #12), whose records were reviewed. This had the potential to negatively impact quality and completeness of patient care. Findings include:</p> <p>1. Patient #2 was a 91 year old male who was admitted to the agency on 7/01/11 after being hospitalized for a fractured hip. He was to receive PT and OT services, and SN visits to monitor his anti-coagulant therapy to prevent blood clots. The "PLAN OF CARE," for the certification period 7/01/11 to 8/28/11, indicated the SN would instruct Patient #2 to record his blood pressure and weight in a log which would be reviewed with the RN at each visit.</p> <p>SN visit notes for 7/01/11, 7/02/11, 7/03/11, 7/04/11, 7/07/11 and 7/12/11 did not contain documentation related to instructing Patient #2 to keep a blood pressure and weight log. None of the visits contained documentation that a log was kept or that this information was reviewed with Patient #2.</p> <p>In an interview on 12/15/11 at 3:45 PM, the RN who cared for Patient #2 stated the software program the agency used would automatically incorporate information from the comprehensive assessment to design the POC. She stated the orders to instruct Patient #2 regarding a blood pressure and weight log, and then to review it at each visit were automatically entered into the POC. She stated she was unaware the POC contained the orders and did not provide this instruction or monitoring.</p>	G 170	<p>G 170 RN Team Leader and OASIS Review Nurse provided education to staff on reviewing the plan of care prior to the visit and then following the plan of care as written with emphasis on pediatric and diabetic care plans.</p> <p>Audit 20 charts a month for 3 months and then 20 charts per quarter to ensure the plan of care is being followed with a goal of 90% compliance.</p>	<p>Education completed at staff meeting on 12/21/11.</p>	

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NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 661 POLELINE ROAD TWIN FALLS, ID 83301		
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G 170	<p>Continued From page 17</p> <p>The agency did not ensure nursing staff followed Patient #2's POC.</p> <p>2. Patient #7 was a 4 year old male (Patient #3's twin brother), admitted to the agency on 12/10/11. Patient #7 had been hospitalized for complications related to a progressive neurological disease which caused strokes. Patient #7 was on oxygen and had a feeding pump for nutrition administration. The "PLAN OF CARE," for the certification period 12/10/11 to 2/07/12, indicated the SN would assess vital signs, such as blood pressure and oxygen saturation levels, and weights at each visit.</p> <p>SN visits made on 12/10/11 and 12/13/11 did not contain documentation that weights, blood pressures, or oxygen saturation levels had been obtained.</p> <p>In an interview 12/18/11 at 10:20 AM, the Home Health Team Lead reviewed Patient#7's record and confirmed weights, blood pressures, and oxygen saturations had not been monitored at the visits on 12/10/11 and 12/13/11.</p> <p>The agency did not ensure nursing staff followed the POC.</p> <p>3. Patient #3 was a 4 year old male (Patient #7's twin brother), admitted to the agency on 11/04/11. Patient #3 had been hospitalized for complications related to a progressive neurological disease which caused strokes. The "PLAN OF CARE," for the certification period 11/04/11 to 1/02/12, indicated the SN would assess vital signs, such as blood pressure and oxygen saturation levels, and weights every visit.</p>	G 170			

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G 170	<p>Continued From page 18</p> <p>SN visits made on 11/08/11, 11/11/11, 11/16/11, 11/23/11, 12/01/11 and 12/13/11 did not contain documentation that weights, blood pressures, or oxygen saturation levels had been obtained.</p> <p>During a home visit on 12/13/11 at 1:15 PM with Patient #3's Case Manager, it was noted his weight, blood pressure, and oxygen saturation level were not assessed.</p> <p>In an interview 12/16/11 at 10:30 AM, the Home Health Team Lead reviewed Patient#3's record and confirmed weights, blood pressure and oxygen saturation levels were not documented.</p> <p>The agency did not ensure nursing staff followed Patient #3's POC.</p> <p>4. Patient #4 was a 73 year old female admitted to the agency on 11/08/11 for care related to sprained ankles and broken ribs sustained as a result of a fall. According to the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/08/11 to 1/08/12, Patient #4 was diabetic and used insulin, as well as, oral medications to treat her diabetes. The POC indicated SN was to teach Patient #4 diabetic foot care and monitor her feet for lesions. The medical record did not contain documentation that Patient #4 was educated regarding diabetic foot care.</p> <p>During a home visit on 12/13/11 at beginning at 10:50 AM, Patient #4 was observed discussing foot care with the Physical Therapist. Patient #4 stated her toenails needed to be trimmed and since she was not able to do it herself she asked</p>	G 170			

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G 170	<p>Continued From page 19</p> <p>the Physical Therapist who would be able to safely provide this service. The Physical Therapist recommended Patient #4 contact her podiatrist. Following the home visit, Patient #4 was interviewed. She stated that she did not recall being educated by the RN regarding diabetic foot care.</p> <p>The RN who cared for Patient #4 was interviewed on 12/14/11 at 9:00 AM. She confirmed the medical record did not contain documentation that Patient #4 was educated regarding diabetic foot care. She stated it was possible that she provided Patient #4 a hand out regarding foot care and provided the necessary teaching but did not complete the documentation.</p> <p>Patient #4 was not educated regarding diabetic foot care in accordance with the POC.</p> <p>5. Patient #12 was a 68 year old male admitted to the agency on 8/06/11 for care related to diabetes. His "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 8/06/11 to 10/04/11, contained orders for SN to teach diabetic foot care and evaluate Patient #12's feet each visit.</p> <p>The medical record contained documentation of 14 SN visits during the certification period. The RN documented completing an examination of Patient #12's feet on only 6 visits (8/08/11, 8/10/11, 8/12/11, 9/06/11, 9/13/11, and 9/19/11). The medical record did not contain documentation that Patient #12 had been educated on diabetic foot care and evaluate his feet on each visit.</p>	G 170			

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G 170	Continued From page 20 The Home Health Team Lead reviewed Patient #12's record on 12/15/11 at 11:50 AM. She confirmed that there was no documentation Patient #12 had been educated on diabetic foot care. She confirmed that, with the exception of the above dates, there was no documentation that Patient #12's feet had been examined during each visit. Patient #12 did not receive diabetic foot care education or examinations of his feet with each SN visit in accordance with the POC.	G 170		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on review of medical records and staff and patient interview, it was determined the agency failed to ensure the RN re-evaluated the nursing needs for 2 of 16 patients (#5 and #10) whose records were reviewed. This had the potential to result in unmet patient needs and to negatively impact the quality of patient care. Findings include: 1. Patient #10 was a three month old male who was admitted to the agency on 11/23/11. Patient #10's diagnoses included bronchopulmonary dysplasia (a chronic lung disease, with scarring of the lung tissue and airways,) history of aspiration, and a blood clot in his heart that required daily	G 172	G 172 Manager provided education to the nurses regarding the steps to follow when patients are unable/unwilling to follow the plan of care; for example, not taking medications as ordered. Audit 20 charts a month for 3 months and then 20 charts per quarter to identify nurse re-evaluation when the patient is not following the plan of care with goal of 90 % compliance.	Education completed 1/20/12.

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G 172	<p>Continued From page 21</p> <p>Injections of Lovenox, a blood thinning medication. Patient #10 was to receive SN and PT services. The "PLAN OF CARE" for the certification period 11/23/11 through 1/21/12, indicated nursing visits would be 1-2 times weekly</p> <p>In a nursing note dated 12/01/11 at 1:30 PM, the RN documented Patient #10's mother was not present during the visit and the great aunt was taking care of him. The RN noted Patient #10 had a weight gain of seven ounces in the eight days since admission. A rapid gain of weight could have indicated fluid buildup around Patient #10's heart and lungs causing harm. The RN did not document an assessment of Patient #10, such as listening to his heart and lungs, obtaining an oxygen saturation level to ensure he was getting enough oxygen, looking for signs of swelling, assessing how hard he was working to breathe, in order to rule out this potentially negative fluid buildup.</p> <p>In addition, the RN documented, "I DONT SEE THE DIURIL [a medication to decrease fluid build up in the body], CAFFEINE [used in infants to stimulate regular breathing patterns], OR NACL [sodium chloride]. ASSUME THESE WERE CANCELED BUT WILL WAIT TO DISCUSS WITH MOM." The RN also noted the great aunt stated Patient #10 was no longer using supplemental oxygen via the nasal cannula.</p> <p>The medical record did not contain documentation that Patient #10's physician was notified of the rapid weight gain or that the medication changes were clarified with Patient #10's mother or physician.</p>	G 172			

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G 172	<p>Continued From page 22</p> <p>In addition, the RN also documented Patient #10's great aunt had difficulty with the apnea monitor [a device which alarmed if Patient #10 stopped breathing] leads not working, and the company was unable to supply new leads until the following week. The RN documented she instructed the great aunt to use tape to secure the monitor leads until that time. The record indicated Patient #10 died that evening.</p> <p>During an interview on 12/16/11 at 11:10 AM, the Home Health Team Lead reviewed Patient #10's medical record and confirmed it appeared the RN did not communicate the weight gain to the physician, and did not document clarification of the changes in medication or oxygen.</p> <p>The RN did not fully assess the nursing needs for Patient #10.</p> <p>2. Patient #5 was a 95 year old female admitted to the agency on 10/27/11 for care related to an abrasion on her trunk which required dressing changes. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/27/11 to 12/25/11, included orders for SN visit 1-2 times a week for 9 weeks.</p> <p>Documentation from a SN visit on 11/21/11 indicated a change to Patient #5's medication regimen. The RN documented Patient #5 was started on Clotrimazole Lozenges (a medication to treat oral yeast infections) but was refusing to take them. The RN also documented, "PATIENT DOES HAVE WHITE BLOTCHYNESS [sic] TO TONGUE." The RN noted, in the "POC/Synopsis" section of the visit note, that Patient #5 was "STARTED ON A NEW MED</p>	G 172			

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G 172	Continued From page 23 [medication] FOR THE WHITE PATCHES ON HER TONGUE HOWEVER REFUSES TO TAKE IT AT THE TIME..." The medical record did not contain documentation that the physician was notified of Patient #5's refusal to take the prescribed medication. In addition, the medical record did not contain documentation of any follow up evaluation of the white patches on Patient #5's tongue during subsequent SN visits. Patient #5 and her caregiver were interviewed following a home visit on 12/13/11 at 12:40 PM. Patient #5 stated she was prescribed the lozenges for the white patches in her mouth. She recalled her doctor talking to her about a yeast infection. She stated she stopped taking the lozenges because she felt they caused her side effects (which she stated she couldn't recall). The RN who cared for Patient #5 was interviewed on 12/13/11 at 4:24 PM. She stated she recalled Patient #5 mentioning a yeast infection, but that Patient #5 believed the yeast infection was actually on the skin in her amput. The RN stated she evaluated the amput, which looked normal, but did not assess the white patches on Patient #5's tongue. She stated she did not connect that the yeast infection may have actually been in Patient #5's mouth rather than in her amput as Patient #5 believed. She confirmed there was no additional evaluation or documentation of an assessment of Patient #5's tongue. Nursing staff failed to re-evaluate Patient #5's nursing needs related to symptoms of a yeast infection.	G 172			
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT	G 332			

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G 332	<p>Continued From page 24</p> <p>The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the initial patient assessment was completed within 48 hours from physician referral for 1 of 18 patients (#8) whose records were reviewed. This had the potential to result in unmet patient needs. Findings include:</p> <p>Patient #8 was an 80 year old female who was admitted to the agency on 11/18/11 after discharge from a hospital related to a fractured arm and pelvis. A referral order, dated 11/14/11, stated "Initiate HC [Home Care] services. SN TO ADMIT TO HH [Home Health] SERVICES. PT TO EVAL [evaluate] AND TREAT." The comprehensive assessment was completed on 11/18/11 by a Physical Therapist. The record did not contain documentation of an RN visit.</p> <p>In an interview on 12/13/11 at 9:05 AM, the LPN who had received the referral stated she noticed on 11/17/11 (three days after the referral) that Patient #8 had not yet been seen by an RN. The LPN stated she gave the referral information to her supervisor. The LPN stated her supervisor then gave the referral to an RN who visited Patient #8 on 11/17/11.</p> <p>In an interview on 12/13/11 at 9:15 AM, the RN who completed the initial visit with Patient #8 stated, after a discussion with Patient #8 and her family, it was decided only PT and OT services</p>	G 332	<p>G 332 Education by manager to staff regarding the process to follow if patient is unable to have the initial assessment within 48 hours. The physician will be notified and the reason for the delay is documented.</p> <p>Chart of any patient not assessed within 48 hours will be audited for documentation of reason for delay and whether physician was notified. Audits will be done monthly for 3 months and then quarterly with a goal of 95% compliance.</p>	Education completed 1/20/12	

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G 332	Continued From page 25 were needed. The RN stated she contacted PT directly after meeting with Patient #6 and the comprehensive assessment was completed by PT on 11/18/11. The RN stated she did not document her initial visit with Patient #6 on 11/17/11.	G 332		
G 337	The agency did not ensure the initial assessment was performed within 48 hours from the time of referral. 484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on staff and patient interview and record review, it was determined the agency failed to ensure medications were fully assessed during the initial comprehensive assessment for 2 of 8 patients (#5 and #6) visited in their homes, whose records were reviewed. This had the potential to interfere with safety and continuity of patient care. Findings include: 1. Patient #6 was an 80 year old female who was admitted to the agency on 11/18/11 for PT and OT services after suffering a fractured arm and pelvis. During a home visit on 12/13/11 at 10:15 AM, Patient #6 reviewed her current medication list. The following medications were being taken by	G 337	G 337 Education by the Clinical Instructor to the staff on the expectation that the nurse or the therapist must actually look at all the medications the patient is taking in order to reconcile. Team leaders will make home visits with all nurses and therapists starting February 1st to ensure the medication reconciliation process is being followed 100% of the time. Follow-up visits will be made as needed to ensure compliance.	Education completed 1/11/12

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NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 601 POLELINE ROAD 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 337	<p>Continued From page 28</p> <p>Patient #6 although they were not on the POC or medication reconciliation forms:</p> <ul style="list-style-type: none"> -Levothyroxine sodium 50 mcg tablets, once daily -Voltaren 1% gel, applied to joint pain as needed for arthritis. -Cyanocobalamin 1000 mcg/ml injection, once monthly -Vitamin D 1000 unit capsules, once daily - Ensure meal supplement, one can three times daily -Calcium Carbonate-Vitamin D, one tablet three times daily -Tramadol 50 mg tablets, one tablet four times daily as needed for pain. <p>Patient #6's medical record contained a visit note from her physician, dated 11/21/11, complete with a current list of her medications. This list contained the medications documented on the POC for Patient #6 in addition to those noted above. The POC did not contain a complete list of the medications Patient #6 was taking. Therefore a thorough comprehensive assessment of Patient #6's medications was not completed.</p> <p>In an interview on 12/13/11 at 11:30 AM, the Physical Therapist reviewed the medication list for Patient #6. The Physical Therapist, who was present during the home visit with Patient #6 on 12/13/11, stated he questioned patients at each visit about medications, and was surprised that Patient #6 disclosed additional medications. He confirmed the medication list for Patient #6 did not reflect all of the medications she was taking at the time of admission.</p>	G 337			

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

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FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 601 POLELINE ROAD 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 337	<p>Continued From page 27</p> <p>The agency did not have a complete and accurate record of patient medications.</p> <p>2. Patient #5 was a 95 year old female admitted to the agency on 10/27/11 for care related to an abrasion on her trunk which required dressing changes. Her medical record contained a "Medication Log" obtained from Patient #5's physician prior to admission to the agency. The medication log contained a list of medications Patient #5 was taking and indicated the list was last reviewed on 9/14/11. The list contained numerous medications, including Aspirin 81 mg daily. However, the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/27/11 to 12/25/11, did not include Aspirin 81 mg daily as one of the medications Patient #5 took.</p> <p>Patient #5 was interviewed on 12/13/11 at 12:40 PM, following a home visit observation. Patient #5 reviewed her medication list and stated she did take one Aspirin 81 mg tab a day.</p> <p>The RN who cared for Patient #5 was interviewed on 12/13/11 at 4:24 PM. She reviewed the medical record and confirmed Aspirin had been listed in the medical history provided by the physician for Patient #5. She also confirmed that Aspirin was not listed as part of the agency's medication list obtained during the comprehensive assessment.</p> <p>The comprehensive assessment did not include a complete list of the medications Patient #5 was taking.</p> <p>The agency failed to ensure medications were</p>	G 337			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ST LUKES MAGIC VALLEY RMC HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLELINE ROAD 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 337	Continued From page 26 fully assessed during the initial comprehensive assessment.	G 337			