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

April 22, 2014

Lori Asay, Administrator
Intermountain Home Care Of Cassia
1031 E Main Street
Burley, ID 83318-2029

RE: Intermountain Home Care Of Cassia, Provider #137016

Dear Ms. Asay:

This is to advise you of the findings of the Medicare/Licensure survey at Intermountain Home Care Of Cassia, which was concluded on April 11, 2014.

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

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

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

After you have completed your Plan of Correction, return the original to this office by **May 5, 2014**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt
Enclosures

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 137016 | A. BUILDING _____ B. WING _____ | C 04/11/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| INTERMOUNTAIN HOME CARE OF CASSIA | 1031 E MAIN STREET BURLEY, ID 83318 |

| (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<br><br>The following deficiency was cited during the complaint investigation survey at your agency. The survey was conducted from 4/09/14 through 4/11/14. Surveyors conducting the investigation were:<br><br>Gary Guiles, RN, HFS, Team Leader<br>Don Sylvester, BSN, RN, HFS<br><br>Acronyms include:<br><br>lpm - liters per minute<br>O2 sat - oxygen saturation level<br>POC - plan of care<br>PT - physical therapy<br>RN - registered nurse | G 000 | | |
| G 159 | 484.18(a) PLAN OF CARE<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and medical record review, it was determined the agency failed to ensure the POC for 1 of 6 patients (#1), whose records were reviewed, was complete and provided specific direction to staff. This had the potential to result in unmet patient needs. | G 159 | Plan of care to be developed in consultation with the physician according to patient specific assessments and needs. Plan of care to contain all pertinent diagnoses, types of services, and required equipment.<br><br>Nurse Manager to:<br>Educate staff regarding including oxygen and oxygen equipment in the plan of care as well as interventions to monitor effectiveness of oxygen therapy and parameters to notify the physician as directed by the physician. Initial education began 4/11/14.<br><br>Include discussion of patient specific need to monitor oxygen therapy and parameters to notify physician during weekly interdisciplinary team meeting. | 5/13/14<br><br>4/29/14 |

RECEIVED
MAY - 5 2014
FACILITY STANDARDS

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

[signature] RN MSN | Nurse Manager | 5/2/2014

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

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| G 159 | Continued From page 1<br>Findings include:<br><br>Patient #1's medical record documented a 70 year old female who was admitted for home health services on 8/30/13. Her diagnoses included atrial fibrillation and diabetes. She was transferred to an acute care hospital on 10/01/13 and did not return to the agency's care.<br><br>The "RN ADMIT" note for Patient #1, dated 8/30/13 at 11:41 AM, contained a diagnosis of "OTHER DEPENDENCE ON MACHINES, SUPPLEMENTAL OXYGEN." The note stated she was on continuous oxygen.<br><br>Patient #1's POC for the certification period 8/30/13-10/28/13 did not contain an order for oxygen including a flow rate, although the POC did state "Teach home oxygen therapy safety precautions." The POC did not direct staff to monitor Patient #1's O2 sats. Also, the POC did not direct staff to notify the physician if Patient #1's O2 sats dropped below a specific level.<br><br>An "RN HOME HEALTH PRN VISIT" note, dated 8/31/13 at 2:14 PM, stated Patient #1 was receiving 3 lpm of oxygen and her O2 sat was 97-98%. The RN documented Patient #1 had oxygen flowing at 5 lpm on 9/01/13, 6 lpm on 9/03/13, 6 lpm on 9/05/13, 6 lpm on 9/07/13, 5 lpm on 9/09/13, 6 lpm on 9/12/13, 4-6 lpm on 9/16/13, 2-4 lpm on 9/20/13, and she was not receiving oxygen on 9/24/13. No O2 sats were documented by the RN after 8/31/13.<br><br>PT visit notes documented Patient #1 was on 6 lpm of oxygen on 9/03/13, 6 lpm of oxygen on 9/12/13, 4 lpm of oxygen on 9/20/13, and 4 lpm of oxygen on 9/27/13. The PT visit notes | G 159 | An audit of the medical record of patients receiving oxygen therapy will determine if oxygen orders including flow rate, interventions to monitor, parameters to notify the physician, and equipment are included in the plan of care. Audit indicators to be collected on 100% of patients receiving oxygen therapy that are discussed during weekly interdisciplinary team meeting Audit began 4/29/14.<br><br>Audit results to be at 90% compliance. | 6/13/14 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| INTERMOUNTAIN HOME CARE OF CASSIA | 1031 E MAIN STREET BURLEY, ID 83318 |

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|---|---|---|---|---|
| G 159 | Continued From page 2<br>documented Patient #1's O2 sat dropped to 81% on 9/20/13, 80% on 9/25/13, and 81% on 9/27/13. The Mayo Clinic website, accessed on 4/21/14 stated, "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under 90 percent are considered low."<br><br>The PT notes did not document the physician or RN were notified of the drops in O2 sats. The PT notes did not document any action was taken when Patient #1's O2 sat dropped.<br><br>The Nurse Manager was interviewed on 4/10/14 beginning at 9:45 AM. She reviewed Patient #1's medical record and confirmed the POC did not include oxygen orders or direction to staff regarding O2 sats. She also confirmed the oxygen flow rates and O2 sats that were documented for Patient #1.<br><br>Patient #1's POC was not complete. | G 159 | | |

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | OAS001290 | A. BUILDING: _____ B. WING _____ | C 04/11/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| N 000 | 16.03.07 INITIAL COMMENTS<br><br>The following Idaho state licensure deficiency was cited during the complaint investigation survey at your agency. The survey was conducted from 4/09/14 through 4/11/14. Surveyors conducting the investigation were:<br><br>Gary Guiles, RN, HFS, Team Leader<br>Don Sylvester, BSN, RN, HFS | N 000 | RECEIVED<br>MAY - 5 2014<br>FACILITY STANDARDS | |
| N 167 | 03.07030.PLAN OF CARE<br><br>N167 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:<br><br>o. Other appropriate items.<br><br>This Rule is not met as evidenced by:<br>Refer to G159. | N 167 | Plan of care to be developed in consultation with the physician according to patient specific assessments and needs. Plan of care to contain all pertinent diagnoses, types of services, and required equipment.<br><br>Nurse Manager to:<br>Educate staff regarding including oxygen and oxygen equipment in the plan of care as well as interventions to monitor effectiveness of oxygen therapy and parameters to notify the physician as directed by the physician. Initial education began 4/11/14.<br><br>Include discussion of patient specific need to monitor oxygen therapy and parameters to notify physician during weekly interdisciplinary team meeting.<br><br>An audit of the medical record of patients receiving oxygen therapy will determine if oxygen orders including flow rate, interventions to monitor, parameters to notify the physician, and equipment are included in the plan of care. Audit indicators to be collected on 100% of patients receiving oxygen therapy that are discussed during weekly interdisciplinary team meeting Audit began 4/29/14.<br><br>Audit results to be at 90% compliance. | 5/13/14<br><br>4/29/14<br><br>6/13/14 |

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Nurse Manager — 5/2/2014

IDAHO DEPARTMENT OF
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April 22, 2014

Lori Asay, Administrator
Intermountain Home Care Of Cassia
1031 E Main Street
Burley, ID 83318-2029

RE: Intermountain Home Care of Cassia, Provider #137016

Dear Ms. Asay:

On **April 11, 2014**, a complaint survey was conducted at Intermountain Home Care Of Cassia. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006256**

**Allegation #1:** Caregivers were not trained to assist patients' with intravenous lines (IV).

**Findings #1:** An unannounced visit was made to the home health agency on 4/09/14 through 4/11/14. Six medical records were reviewed. Staff were interviewed.

Medical records of 4 patients with IV lines were reviewed. Two of the records documented caregiver competency with IV lines. One record documented agency staff managed the IV line.

One patient's record documented a 53 year old female who was admitted on 9/20/13 and was discharged on 10/24/13. Her diagnoses included cellulitis of foot, hypertension and diabetes mellitus type II. Her medical record contained a physician's order dated 9/20/13, that stated, "SN (skilled nurse) to teach patient and or caregiver to administer medication and perform line flushes." The comprehensive assessment, dated 9/20/13, stated "Patient's 13 year old granddaughter...is primary assistance with infusions, is willing to learn to perform wound care."

None of the nursing progress notes indicated problems with the IV or administration of medication. Nor did progress notes indicate the caregiver had any problems with IV care or medication administration.

On 4/10/14 at 11:00 AM, the RN Case Manager, stated she gave written instructions and performed demonstrations of IV administration of medication and line care to the patient and caregiver. She stated written instructions, "Caring for Your IV Line" were given to the patient and caregiver. She stated she observed the patient and caregiver on several visits. She stated the caregiver was able to perform IV administration of medication and line care. She stated the caregiver was proficient at these tasks. She stated at no time during the admission, did the patient or caregiver call for assistance with the administration of medication and line care or indicate there was a problem.

No evidence was found to indicate that patients were unable to perform IV line care or assist with administration of medication.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** Nurses did not conduct assessments of wounds or perform appropriate wound care and dressing changes.

**Findings #2:** An unannounced visit was made to the home health agency on 4/09/14 through 4/11/14. Six medical records were reviewed. Staff were interviewed.

One medical record reviewed documented wounds that required care. This patient's record documented a 53 year old female who was admitted on 9/20/13 and was discharged on 10/24/13. Her diagnoses included cellulitis of right foot, hypertension and diabetes mellitus type II.

Her record contained physician orders for wound care as follows: "cleanse with normal saline or wound cleanser. Apply medi honey to wound bed, cover with non-adhesive absorbent dressing, secure with paper tape." Nursing visit notes were documented on, 9/20/13, 9//21/13, 9/22/13, 9/23/13, 9/24/13, 9/25/13, 9/26/13, 9/27/13, 9/30/13, 10/02/13, 10/04/13, 10/10/13, 10/18/13 and discharge 10/24/13. Skilled Nursing visit notes documented patient assessments and wound care at the frequency ordered by the physician. After discharge the patient was to receive out-patient wound care and IV line care through a hospital.

The nursing visit note dated 9/26/13 at 2:57 PM, stated the wound drainage was pink serosanguineous (containing blood and blood serum). No pus was noted. The same visit note stated the physician requested the patient be scheduled for amputation of her toes. The note stated the patient had been diagnosed with osteomyelitis of her toe.

On 4/10/14 at 11:00 AM, the patient's RN Case Manager reviewed her notes. She stated, the patient received a complete assessment and wound care as ordered.

Based on the above information it was determined wound care was completed consistent with physician orders.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** The agency retaliated against patients for complaints to the agency.

**Findings #3:** An unannounced visit was made to the home health agency on 4/09/14 through 4/11/14. Six medical records were reviewed. Staff were interviewed.

A grievance log was reviewed. One grievance was logged between 5/01/13 and 4/09/14. The grievance related to home health aide services.

There was no documentation that the complaint investigated by surveyors was reported to the agency. The agency had a process to document and investigate grievances. This was followed for the grievance noted above. No evidence was found of retaliation against patients for voicing concerns.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** The agency did not inform patients of pending discharge.

**Findings #4:** An unannounced visit was made to the home health agency on 4/09/14 through 4/11/14. Six medical records were reviewed. Staff were interviewed.

Four medical records of discharged patient were reviewed. All of the medical records contained documentation the patients' were notified of pending discharge.

One medical record reviewed documented a 53 year old female who was admitted on 9/20/13 and was discharged on 10/24/13. Her diagnoses included cellulitis of right foot, hypertension and diabetes mellitus type II.

A 10/22/13 Case Communication Report, documented by the RN Case Manager, stated the RN called the patient to review the outcome of the patient's 10/21/13 doctor appointment. The patient told the RN she was sent to the out-patient PT Department for wound care, but did not know if that was to be ongoing or just a one time visit.

The report stated the RN contacted the physician's office and was informed the patient's last dose of IV medication would be on 10/23/13, and she was to be discharged after that. The RN documented she phoned the patient and reviewed the plan for her to get any further IV dressing changes done through out-patient IV therapy. The RN instructed the patient on the days to go for the IV dressing changes. The Report further stated the patient verbalized understanding. A nursing discharge summary, dated,10/24/13, documented notification of service termination; patient/family and physician.

A communication note by the Nurse Manager, dated 10/25/13 at 6:19 PM, stated she spoke with the patient by phone on 10/22/13, and the patient verbally understood the discharge, and that she would be seen through out-patient services

On 4/10/13 at 3:45 PM, the Nurse Manager was interviewed. She stated the patient verbally understood the discharge, and that she would be seen through out-patient services for wound care and IV line care.

No evidence was found to indicate that patients were not informed of discharge as soon as possible.

**Conclusion #4:** Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt