



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
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June 11, 2014

Rod Jacobson, Administrator
Bear Lake Memorial Hospital Home Health
164 South 5th Street
Montpelier, ID 83254

RE: Bear Lake Memorial Hospital Home Health, Provider #137069

Dear Mr. Jacobson:

This is to advise you of the findings of the Medicare/Licensure survey, which was concluded at your agency on May 22, 2014.

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

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

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

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

Rod Jacobson, Administrator
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June 23, 2014, and keep a copy for your records.

Also, enclosed is a similar form stating no licensing deficiencies were cited at your agency. This form is for your records only. It is not necessary to return the form.

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

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pt

Enclosures

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

PRINTED: 06/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 465 WASHINGTON STREET MONTPELIER, ID 83254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your home health agency from 5/19/14 through 5/22/14. The surveyors conducting the recertification were: Gary Guiles, RN, HFS, HFS Team Leader Don Sylvester, BSN, RN Acronyms include: PICC - Peripherally Inserted Central Catheter POC-Plan of Care PT - Physical Therapy	G 000			
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records, agency policies, and Centers for Disease Control guidelines, it was determined the agency failed to ensure standards of practice had been developed and implemented relating to hand hygiene. This had the potential to increase patients' risk of infection. Findings include: 1. Patient #2's medical record documented a 32 year old female who was admitted for home health services on 12/03/13. She was currently a patient as of 5/22/14. Her diagnosis was pregnancy with intractable nausea and vomiting.	G 121	See Addendum #1 The Supervising RN will work with the Home Health Director to obtain a policy/procedure for Hand Hygiene for all Home Health staff. An inservice will be held to train all personnel on the new policy on 6/26/14. A record of acknowledgement by the employee will be placed in each personnel file. This policy will be reviewed yearly..cont	8/1/14	

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



TITLE

Admin

(X6) DATE

6-18-14

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 121	Continued From page 1 Patient #2 had a PICC line through which she received 3 liters of fluids a day. Her POC for the certification period 4/2/14-5/31/14 called for the RN to change her PICC line dressing 1 time a week. On 5/20/14 beginning at 12:44 PM, a visit was made to Patient #2's home to observe the RN. The RN proceeded to change the PICC line dressing. The RN performed hand hygiene and arranged supplies for the dressing change. She then proceeded to put on gloves, remove the old dressing, put on a mask, change into sterile gloves, cleanse the arm, remove the gloves and put on new sterile gloves, place a new dressing on the arm, remove the gloves, clean up her area, and then wash her hands. The RN did not perform hand hygiene 3 times between performing tasks and donning gloves. The RN was interviewed on 5/20/14 at 1:20 PM. She confirmed she did not perform hand hygiene prior to donning gloves. She stated had not been taught to perform hand hygiene between performing tasks and donning gloves. The Centers for Disease Control's "Guideline for Hand Hygiene in Health-Care Settings," published 10/25/02, stated persons should "Decontaminate hands before donning sterile gloves...after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient [and] Decontaminate hands after removing gloves." The RN did not follow CDC Guidelines for hand hygiene.	G 121	Continued from page 1 This will be monitored by the Supervising RN and the personnel file staff annually. This will be done to ensure all personnel understand the correct policy/procedure for hand washing.	8/1/14	

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G 121	Continued From page 2 2. The agency had a policy that was not dated, titled "HAND WASHING." The policy contained a procedure for hand washing but it did not address other forms of hand hygiene nor did it direct staff as to when to perform hand hygiene. A policy stating when hand hygiene should be performed was not present. The agency's Director was interviewed on 5/20/14 at 2:45 PM. She stated the agency did not have a policy that directed staff when to perform hand hygiene. The agency failed to define the standard of care for staff regarding hand hygiene.	G 121	See Addendum #1	8/1/14	
G 160	484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the plan of care after the evaluation visit for 3 of 8 patients (#1, #6, and #13) who received therapy services and whose records were reviewed. This resulted in plans of care that were initiated without physician approval. Findings include: 1. Patient #1's medical record documented a 69 year old female who was admitted for home health services on 4/15/14. She was currently a patient as of 5/21/14 Her diagnoses included pain in her sacrum and knee.	G 160	See Addendum #2 Admitting RN/PT will obtain and document frequency of visits and general care to be provided by therapy services for approval for the plan of care by the physician. This information will be included on the Physicians Telephone Order for the physicians signature to initiate care. This will be monitored by the RN/PT at admit and the person preparing the plan of care 485. This will ensure that no visits are made by therapies without physician approval.	8/1/14	

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G 160	Continued From page 3 Patient #1's POC for the certification period 4/15/14-6/13/14 ordered PT services "For consultation and evaluation with treatment. Treatment orders to follow." A "Physical Therapy Evaluation and Plan of Care," dated 4/22/14, documented the therapist evaluated Patient #1 on that date. The document requested orders for the therapist to visit Patient #1 1-2 times a week for 8 weeks. The physician signed the plan authorizing further visits on 4/29/14. However, the medical record documented a PT visit was made on 4/24/14. This visit was made prior to physician approval. The Director of the agency was interviewed on 5/20/14 beginning at 9:15 AM. She confirmed the 4/24/14 PT visit was made to Patient #13 without physician authorization. She stated she was not aware the agency needed to obtain orders for visits that occurred after the evaluation but prior to physician approval of the therapy plan. The physician was not consulted to approve Patient #1's POC. 2. Patient #6's medical record documented a 78 year old female who was admitted for home health services on 4/16/14 following a total hip replacement. She was currently a patient as of 5/21/14 Patient #6's POC for the certification period 4/16/14-6/14/14 ordered PT services "For consultation and evaluation with treatment. Treatment orders to follow." A "Physical Therapy Evaluation and Plan of	G 160	See addendum #2 and text on page 3 of 6	8/1/14	

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G 160	<p>Continued From page 4</p> <p>Care," dated 4/18/14, documented the therapist evaluated Patient #6 on that date. The document requested orders for the therapist to visit Patient #6 2-3 times a week for 6-8 weeks. The physician signed the plan authorizing further visits on 4/29/14. However, the medical record documented PT visits were made on 4/22/14 and 4/25/14. These visits were made prior to physician approval.</p> <p>The Director of the agency was interviewed on 5/21/14 beginning at 2:00 PM. She confirmed the 4/22/14 and 4/25/14 PT visits were made to Patient #13 without physician authorization.</p> <p>The physician was not consulted to approve Patient #6's POC.</p> <p>3. Patient #13's medical record documented a 73 year old female who was admitted for home health services on 4/07/14. She was currently a patient as of 5/21/14 Her diagnoses included hydrocephaly and weakness.</p> <p>Patient #13's POC for the certification period 4/07/14-6/05/14 ordered PT services "For evaluation and treatment. Treatment orders to follow."</p> <p>A "Physical Therapy Evaluation and Plan of Care," dated 4/09/14, documented the therapist evaluated Patient #13 on that date. The document requested orders for the therapist to visit Patient #13 2 times a week for 7 weeks. The physician signed the plan authorizing further visits on 4/22/14. However, the medical record documented PT visits on 4/14/14, 4/18/14, and 4/21/14. These visits were made prior to physician approval.</p>	G 160	See Addendum #2 and text on page 3 of 6	8/1/14	

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G 160	Continued From page 5 The Director of the agency was interviewed on 5/21/14 beginning at 1:30 PM. She confirmed the PT visits were made to Patient #13 without physician authorization. The physician was not consulted to approve Patient #13's POC.	G 160	See addendum #2 and text on page 3 of 6	8/1/14	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2014
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL HOME HE/	STREET ADDRESS, CITY, STATE, ZIP CODE 465 WASHINGTON STREET MONTPELIER, ID 83254
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N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>No deficiencies were cited during the Idaho state licensure survey of your home health agency from 5/19/14 through 5/22/14.</p> <p>The surveyors conducting the review were:</p> <p>Gary Guiles, RN, HFS, HFS Team Leader Don Sylvester, BSN, RN</p>	N 000		
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FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Admin

(X6) DATE

6-19-14