



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

CERTIFIED MAIL: 7012 1010 0002 0836 1383

July 26, 2013

Robert Collette, Administrator
Aspen Home Health Services
3470 Washington PKWY
Idaho Falls, ID 83404

RE: Aspen Home Health Services, Provider #137081

Dear Mr. Collette:

Based on the survey completed at Aspen Home Health Services, on July 12, 2013, by our staff, we have determined Aspen Home Health Services is out of compliance with the Medicare Home Health Agency (HHA) **Condition of Participation of Acceptance of Patients, Plan of Care, & Medical Supervision (42 CFR 484.18)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Aspen Home Health Services, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction 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;

Robert Collette, Administrator
July 26, 2013
Page 2 of 2

- 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 each form.

Such corrections must be achieved and compliance verified by this office, before August 26, 2013. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than August 14, 2013.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **August 8, 2013.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/

Enclosures

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



Aspen Home Health and Hospice

PO Box 3881
Idaho Falls, ID 83403

Via US Postal Service

August 2, 2013

Sylvia Creswell, Co-Supervisor
Non-Long Term Care
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83705

Re: Plan of Correction – Aspen Home Health Services
Medicare Provider No.13-7081

Dear Sylvia:

Enclosed you will find our Credible Allegations in response to the survey conducted July 12, 2013..

Please extend our thanks to Ms. Doane and her colleagues who were helpful and professional throughout the survey..

If there is any other information I can provide just let me know.

Best Regards:

Robert Collette

/s
enclosure (1)

RECEIVED

AUG - 5 2013

FACILITY STANDARDS

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your home health agency. The surveyors conducting the recertification were:</p> <p>Libby Doane, BSN, RN, HFS - Team Lead Sylvia Creswell, LSW, HFS, Supervisor Suzi Costa, RN, HFS Don Sylvester, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ALF - Assisted Living Facility BIPAP - Bi-level Positive Airway Pressure, a device for treating sleep apnea BLE - Bilateral Lower Extremities CAD - Coronary Artery Disease CHF - Congestive Heart Failure CKD - Chronic Kidney Disease CPAP - Continuous Positive Airway Pressure, a device for treating sleep apnea cm - Centimeter CVA - Cerebral Vascular Accident, Stroke DME - Durable Medical Equipment HHA - Home Health Aide HTN - Hypertension IV - Intravenous LPN - Licensed Practical Nurse mcg - micrograms mg - milligrams ml/hr - milliliters per hour NS - Normal Saline OASIS - Outcome and Assessment Information Set OT - Occupational Therapy O2 - oxygen POC - Plan of Care</p>	G 000	<p>Please refer to the attached Appendix I for all plans of correction.</p> <p style="text-align: right;">RECEIVED AUG - 5 2013 FACILITY STANDARDS</p>	

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

TITLE

(X6) DATE

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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	Continued From page 1 PT - Physical Therapy RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care ST - Speech Therapy UTI - Urinary Tract Infection < - less than > - more than	G 000	Please refer to the attached Appendix I for all plans of correction.		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on record review, staff interview, and patient interview during home visits, it was determined the agency failed to ensure staff maintained liaison to effectively coordinate efforts for 3 of 8 patients (#2, #3, and #4) for whom home visits were conducted. This had the potential to negatively impact quality and continuity of patient care. Findings include: 1. Patient #2 was a 76 year old female who was admitted to the agency on 2/31/12 for skilled nursing care related to diabetes, HTN and CAD. Patient #2 resided in an ALF and received daily SN visits for assistance with insulin administration. In addition, Patient #2 was currently receiving Hospice services as of 3/15/13 with a diagnosis of "Unspecified Debility". The Home Health POC for the certification period 4/30/13 to 6/28/13 included the application of a	G 143			

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 143	<p>Continued From page 2</p> <p>Fentanyl Patch, 50 mcg every 72 hours for pain. The dosage had been increased from 37 mcg to 50 mcg on 5/07/13. SN daily visit notes for the certification period 4/30/13 to 6/28/13 and 6/29/13 to 8/27/13 were reviewed and documented Patient #2 as reporting no pain. There was no documentation to support why the Fentanyl Patch dosage had been increased.</p> <p>A home visit to Patient #2 was conducted on 7/09/13 at 4:30 PM to observe nursing care by an LPN. Patient #2 was noted to have a special alternating pressure mattress, frame to keep the blankets off her feet, and she was wearing heel protectors. The POC for the certification period 4/30/13 to 6/28/13 and 6/29/13 to 8/27/13 were reviewed and did not include those items as DME.</p> <p>During an interview on 7/10/13 at 3:00 PM, the Home Health RN Case Manager, the Hospice Case Manager, and the Clinical Director reviewed Patient #2's medical record. The Home Health RN Case Manager confirmed the medical record did not document Patient #2 as having pain over a 2 month period. The Hospice nurse stated she had increased the Fentanyl dosage, as Patient #2 continued to have pain. The Home Health RN Case Manager stated the orders for the heel protectors, the alternating pressure mattress, and the foot frame for the bed were a part of the Hospice orders, and she did not review the Hospice record for Patient #2. She confirmed they had not been included as DME on the POC.</p> <p>The Hospice and Home Health Case Managers did not ensure coordination of care for Patient #2.</p>	G 143	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013	
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 143	<p>Continued From page 3</p> <p>2. Patient #4 was a 75 year old male who was admitted to the agency on 12/28/12 for skilled nursing care related to diabetes, HTN, and atrial fibrillation (an abnormal heartbeat). Patient #4 resided in an ALF and received daily SN visits for assistance with diabetic testing and insulin administration.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/26/13 to 8/24/13, stated finger stick blood sugar results <60 or >350 were to be reported to the physician. In addition, the POC included instructions for the SN to instruct/reinforce diet, skin care, and diabetic foot care.</p> <p>On 7/10/13 at 12:00 PM, a home visit was made to observe nursing care provided to Patient #4. A "BLOOD SUGAR LOG," in Patient #4's medical record for July 2013 was maintained for Patient #4 by the ALF. Instructions on the log noted the target blood sugar level was to be 70-120. On 7/04/13 at 8:00 AM, Patient #4's blood sugar was documented as 55. There was no documentation the home health nurse had reviewed the blood sugar log, acknowledged the low blood sugar, or if Patient #4 had been re-evaluated or retested.</p> <p>On 7/10/13 at 12:00 PM, a home visit was made to observe nursing care provided to Patient #4. The RN reviewed the blood sugar log and noted the low blood sugar result on 7/04/13. She stated the ALF staff was responsible for obtaining the blood sugar results and they would be responsible for alerting the nurse that came in to give the insulin of the abnormal results. The RN and ALF staff were unable to find documentation in Patient #4's medical record to indicate the</p>	G 143	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 143	<p>Continued From page 4</p> <p>Home Health Agency or the physician had been notified of the hypoglycemia episode. The RN confirmed the physician had not been notified of the hypoglycemia.</p> <p>Patient #4's toenails were yellow, thick, long, and curling downward. The RN offered to trim his toenails and Patient #4 declined. The RN was unable to determine when Patient #4's nails had been last trimmed.</p> <p>During an interview on 7/10/13 at 4:55 PM, the Clinical Director stated Patient #4 was eligible for quarterly visits to a podiatrist for nail trimming and a diabetic foot assessment.</p> <p>Effective Coordination of care did not occur between the RN and the Clinical Director.</p> <p>The Home Health Case Manager did not ensure coordination of care with the ALF for Patient #4.</p> <p>3. Patient #3 was a 77 year old male admitted to the agency on 6/18/13 for diagnoses including muscle weakness (generalized), hypoxemia, HTN and CKD. He was receiving SN, HHA and PT services. His medical record for certification period of 6/18/13 through 8/16/13 was reviewed.</p> <p>A home visit to Patient #3 was conducted on 7/09/13 at 10:00 AM, to observe care by an HHA. The HHA was observed giving Patient #3 a bath with a basin of water, soap, and washcloth. Patient #3's groin area was noted to be dark red, dry, and flakey. After the bath the HHA was observed applying Calmoseptine, a barrier cream, to Patient #3's groin, lower abdomen and upper thighs. The cream was not included on the</p>	G 143	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 143	Continued From page 5 POC for certification period of 6/18/13 through 8/16/13. A physician order for the use of the creme was not found in Patient #3's medical record. The RN case manager for Patient #3 was interviewed on 7/11/13 beginning at approximately 9:30 AM. She confirmed the HHA did not communicate the appearance of Patient #3's skin or the use of the cream. The RN also confirmed she had not observed Patient #3' groin and lower abdomen and was not aware of the condition of his skin and use of the cream. The use of the cream and the condition of Patient #3's skin was not coordinated with the RN case manager and physician.	G 143	Please refer to the attached Appendix I for all plans of correction.	
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on staff and patient interview, review of medical records and agency policies, and observation it was determined the agency failed to ensure POCs were completely developed, followed, and updated. These failures had the potential to result in unmet patient needs and negatively impact the continuity, safety, and quality of patient care. Findings include: 1. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with POCs. 2. Refer to G159 as it relates to the failure of the	G 156		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 156	Continued From page 6 agency to ensure the POC included all pertinent diagnoses, types of services and equipment required. 3. Refer to G164 as it relates to the failure of the agency to notify the physician with changes in patients' conditions. 4. Refer to G165 as it relates to the failure of the agency to ensure drugs and treatments were administered by staff only upon a physician's order. The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs.	G 156	Please refer to the attached Appendix I for all plans of correction.		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, patient and staff interview, and observation it was determined the agency failed to ensure care followed a physician's written plan of care for 5 of 16 patients (#3, #4, #5, #14, #16) whose records were reviewed. This resulted in unauthorized treatments as well as omissions of care and had the potential to result in unmet patient needs. Findings include: 1. Patient #16 was a 75 year old male living in an ALF and admitted to the agency on 1/11/13 with diagnoses of paralysis, muscle weakness and	G 158			

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 158	<p>Continued From page 7</p> <p>dysphagia. He was receiving SN, HHA, PT, OT, ST and social work services. His medical record for the certification period 1/11/13 through 3/11/13 was reviewed.</p> <p>An RN "Visit Note Report" from 2/19/13 at 4:24 PM documented that Patient #16 had a size 16 French indwelling Foley catheter that contained "malodorous" urine and sediment. The RN documented that she notified the physician and received an order to remove the catheter. The RN removed the catheter and left instructions for the staff at the ALF to call the agency if Patient #16 had not voided between 9:00 PM and 11:00 PM that night.</p> <p>A "PHYSICIAN VERBAL ORDER" from 2/19/13 at 2:13 PM instructed to remove the Foley catheter and monitor his urine output. The order stated if Patient #16 was not able to void use a "straight cath." A straight cath, or straight catheter, is a tube placed through the urethra temporarily to drain the bladder of urine and is then removed.</p> <p>An RN "Visit Note Report" from 2/19/13 at 10:25 PM documented a second RN had returned to the ALF with a report that Patient #16 was unable to void. She documented Patient #16 was voicing discomfort related to being unable to urinate. She documented she placed a size 18 French indwelling catheter and Patient #16 stated he felt more comfortable after that. There was no order for the placement of an 18 French indwelling catheter.</p> <p>The agency policy "PHYSICIAN'S ORDERS," reviewed 3/15/00, stated "The nurse may use his/her own judgement in increasing the size of</p>	G 158	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 158	<p>Continued From page 8</p> <p>the catheter or bulb when necessary, provided the physician has given prior permission in the signed written orders."</p> <p>The Clinical Director reviewed the record and was interviewed on 7/11/13 at approximately 1:45 PM. She confirmed there was no order for the placement of the indwelling catheter.</p> <p>Treatment of Patient #16 did not follow the physician's order.</p> <p>2. Patient #5 was a 71 year old male living in an ALF and admitted to the agency on 5/30/13 with diagnoses of left middle finger injury, CVA, and pain for which he was receiving SN services. His medical record for the certification period of 5/30/13 through 7/28/13 was reviewed.</p> <p>A "Physician Orders Details" form from a wound care clinic dated 6/24/13, unsigned, documented the wound care orders for Patient #5's left middle finger, including how to clean the wound and what dressing ointment to apply. The order form also contained orders for the treatment of a wound to Patient #5's left fourth finger, including how to clean the wound and what dressing and ointment to apply. There was no documentation to indicate Patient #5 had a wound to his left fourth finger or that dressings had been applied as ordered.</p> <p>The RN case manager was interviewed via telephone on 7/11/13 at 12:20 PM. She confirmed the orders from the wound clinic were the orders skilled nursing followed to apply dressings to Patient #5's left middle finger. She confirmed Patient #5 had a small wound to his lower left fourth finger and she had not applied a dressing</p>	G 158	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 158	<p>Continued From page 9</p> <p>to it. She stated she was unaware of the order for wound care to the left fourth finger. The Clinical Director, who was present at the time of the interview, confirmed that the order for wound care on the fourth finger was on the same page as the wound care orders for the left third finger.</p> <p>Wound care orders for Patient #5 were not followed.</p> <p>3. Patient #14 was an 87 year old female admitted to the agency on 12/13/12 with diagnoses of a hip injury, Alzheimer's dementia, and diabetes for which she was receiving SN services. Her medical record for the certification period of 12/13/12 through 2/10/13 was reviewed. Her POC, electronically signed by the physician on 1/03/13, included orders for wound care to both shins.</p> <p>An RN "Visit Note Report," dated 12/21/12 at 11:38 documented a skin tear to Patient #14's right elbow. The RN case manager documented she cleaned and dressed the wound. There was no documentation to indicate the physician had been notified or that an order had been received for the treatment of the skin tear.</p> <p>An RN "Visit Note Report," dated 12/28/13 at 9:59 AM, documented Patient #14 had a new wound to her right knee and a wound to her left ankle. The RN case manager documented she cleaned both wounds with normal saline and applied a hydrocolloid and Tegaderm dressing. There was no order for the treatment of the wounds to the right knee and left ankle found in Patient #14's medical record.</p>	G 158	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 158	<p>Continued From page 10</p> <p>An RN "Visit Note Report," dated 1/04/13 at 9:44 AM documented wound care had again been provided to Patient #14's left ankle, right knee and right elbow. The wound care included cleansing the wounds with normal saline and applying hydrocolloid and Tegaderm dressings. There was no order for the wound care in Patient #14's medical record.</p> <p>The Clinical Director reviewed the record and was interviewed on 7/11/13 at 12:50 PM. She confirmed there was no order for the wound care treatment to Patient #14's right elbow, left ankle and right knee.</p> <p>Patient #14 received wound care without an order.</p> <p>4. Patient #4 was a 75 year old male who was admitted to the agency on 12/28/12 for skilled nursing care related to diabetes, HTN, and atrial fibrillation (an abnormal heartbeat). Patient #4 resided in an ALF and received daily SN visits for assistance with diabetic testing and insulin administration.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/26/13 to 8/24/13, stated finger stick blood sugar results <60 or >350 were to be reported to the physician. In addition, the POC included instructions for the SN to instruct/reinforce diet, skin care, and diabetic foot care.</p> <p>On 7/10/13 at 12:00 PM, a home visit was made to observe nursing care provided to Patient #4. A "BLOOD SUGAR LOG," in Patient #4's medical record for July 2013 was maintained for Patient</p>	G 158	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 158	<p>Continued From page 11</p> <p>#4 by the ALF. Instructions on the log noted the target blood sugar level was to be 70-120. On 7/04/13 at 8:00 AM, Patient #4's blood sugar was documented as 55. There was no documentation the home health nurse had reviewed the blood sugar log, acknowledged the low blood sugar, or if Patient #4 had been re-evaluated or retested.</p> <p>On 7/10/13 at 12:00 PM, a home visit was made to observe nursing care provided to Patient #4. The RN reviewed the blood sugar log and noted the low blood sugar result on 7/04/13. She stated the ALF staff was responsible for obtaining the blood sugar results and they would be responsible for alerting the nurse who came in to give the insulin of abnormal results. The RN and ALF staff were unable to find documentation in Patient #4's medical record to indicate the Home Health Agency or the physician had been notified of the hypoglycemia episode. The RN confirmed the physician had not been notified of the hypoglycemia.</p> <p>Patient #4's toenails were yellow, thick, long, and curling downward. The RN offered to trim his toenails, and Patient #4 declined. The RN was unable to determine when Patient #4's nails had been last trimmed.</p> <p>During an interview on 7/10/13 at 4:55 PM, the Clinical Director stated Patient #4 was eligible for quarterly visits to a podiatrist for nail trimming and a diabetic foot assessment.</p> <p>Patient #4 was not re-evaluated after a low blood sugar result and diabetic foot and nail care was not provided as directed in the POC.</p>	G 158	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 158	<p>Continued From page 12</p> <p>5. Patient #3 was a 77 year old male admitted to the agency on 6/18/13 for diagnoses including muscle weakness (generalized), hypoxemia, HTN and CKD. He was receiving SN, HHA and PT services. His medical record for certification period of 6/18/13 through 8/16/13 was reviewed.</p> <p>During home visit on 7/09/13 starting at 10:00 AM, surveyors observed Tubigrips (tubular elastic compression bandages) applied to Patient #3's BLE by the HHA.</p> <p>A "PHYSICIAN VERBAL ORDER" dated 6/27/13 at 10:05 AM, stated "...APPLY MEDI PLEX BORDER AND TUBIGRIP" to Patient #3's BLE.</p> <p>A "PHYSICIAN VERBAL ORDER" dated 7/03/13 at 2:36 PM, stated to "APPLY TED HOSE" to BLE.</p> <p>A "PHYSICIAN VERBAL ORDER" from 7/08/13 at 3:58 PM, ordered to "PLACE TED HOSE TO BLE AS WELL."</p> <p>An RN "Visit Note Report" from 7/08/13 at 4:09 PM documented Patient #3's physician's office was contacted and new orders received which included Patient #3 was to "CONTINUE WITH TED HOSE TO BLE."</p> <p>The RN case manager for Patient #3 was interviewed on 7/11/13 beginning at approximately 9:30 AM. She confirmed the RN "Visit Note Report" from 7/08/13 at 4:09 PM documented Patient #3 was to continue with ted hose to BLE. She stated Patient #3 had refused ted hose and Tubigrips continued to be used instead. She stated she had not document this.</p>	G 158	Please refer to the attached Appendix I for all plans of correction.		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013	
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 158 G 159	<p>Continued From page 13</p> <p>Treatment of Patient #3 did not follow the physician's order.</p> <p>484.18(a) PLAN OF CARE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records and policies, patient and staff interview, and observation, it was determined the agency failed to ensure the plan of care included all pertinent information for 7 of 16 patients (#1, #2, #3, #4, #6, #8, and #13) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include:</p> <p>1. The agency policy "PLAN OF CARE 485," last reviewed by the agency February of 2007, stated the "patients [sic] plans of care is established by the doctor, agency RN staff and therapist. It will include at least:...Types of services and equipment required." The agency failed to ensure the POC contained all pertinent information as follows:</p> <p>a. Patient #1 was a 63 year old male admitted to the agency on 6/03/13 for diagnoses including</p>	G 158 G 159	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 14</p> <p>abnormal gait, CVA, and aphasia. He was receiving SN, HHA, PT, OT, ST and social worker services. His medical record for the certification period of 6/03/13 through 8/01/13 was reviewed.</p> <p>During a home visit with PT on 7/09/13 beginning at 1:15 PM, it was noted Patient #1 used a hemi walker to assist with ambulation. Patient #1's significant other stated they had the hemi walker for "awhile," and they had received it sometime after starting care with the home health agency. The hemi walker was not included as DME on the POC.</p> <p>The Clinical Director was interviewed on 7/11/13 beginning at 12:20 PM. She confirmed the hemi walker did not appear on Patient #1's POC as DME.</p> <p>Patient #1's POC did not include all pertinent medical equipment.</p> <p>b. Patient #13 was a 65 year old female admitted to the agency on 5/28/13 with diagnoses of muscle weakness, CHF, HTN, asthma and chronic pain, for which she received services from SN and PT. Her medical record for the certification period of 5/28/13 through 7/26/13 was reviewed.</p> <p>An RN "Visit Note Report" from 6/04/13 at 7:26 AM documented that Patient #13 had been instructed to elevate her legs in her new power recliner to reduce edema. The power recliner was not listed on the POC as DME.</p> <p>The RN case manager for Patient #13 was interviewed via telephone on 7/11/13 at 1:35 PM.</p>	G 159	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 15</p> <p>She confirmed Patient #13 had a power recliner. She stated that Patient #13 was non weight bearing and used a lift to move her from the bed to her power recliner where she spent most of her time. The RN confirmed that the recliner had not been added to the POC as DME.</p> <p>Patient #13's POC did not include all pertinent medical equipment.</p> <p>c. Patient #2 was a 76 year old female who was admitted to the agency on 2/31/12 for skilled nursing care related to diabetes, HTN and CAD. Patient #2 resided in an ALF and received daily SN visits for assistance with insulin administration. In addition, Patient #2 was currently receiving Hospice services as of 3/15/13 with a diagnosis of "Unspecified Debility".</p> <p>A home visit to Patient #2 was conducted on 7/09/13 at 4:30 PM to observe nursing care by an LPN. Patient #2 was noted to have a special alternating pressure mattress, a bed frame to keep the blankets off her feet, and was wearing heel protectors. The POC did not include those items as DME.</p> <p>During an interview on 7/10/13 at 3:00 PM, the RN Case Manager and the Clinical Director reviewed Patient #2's medical record. The RN Case Manager stated the orders for the heel protectors, the alternating pressure mattress, and the foot frame for the bed was a part of the Hospice orders. She confirmed they had not been included as DME on the POC.</p> <p>The POC for Patient #2 did not include all pertinent information.</p>	G 159	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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	Continued From page 16 d. Patient #4 was a 75 year old male who was admitted to the agency on 12/28/12 for skilled nursing care related to diabetes, HTN, and atrial fibrillation (an abnormal heartbeat). Patient #4 resided in an ALF and received daily SN visits for assistance with diabetic testing and insulin administration. Patient #4's POC for the certification period 6/26/13 to 8/24/13 included wound care supplies and O2 precautions. There was no documentation in the medical record Patient #4 had an existing wound or was on oxygen therapy. During an interview on 7/10/13 at 4:55 PM, the Clinical Director reviewed Patient #4's medical record and confirmed there was no documentation of an existing wound or oxygen therapy. The POC was not accurate and patient specific. e. Patient #6 was a 72 year old male who was admitted to the agency on 10/22/12 for skilled nursing care related to paraplegia, diabetes, and wound care. Patient #6 received twice weekly nursing visits for assessment and treatment of wounds on his coccyx and right lower leg. A home visit was conducted on 7/09/13 at 1:00 PM to observe nursing care provided by an RN. An additional wound was noted in the perianal area. Patient #6's wife stated it had been there "a couple of weeks," and resulted as a skin tear while on the shower bench. During the home visit the RN cleansed the perianal area and applied a dressing. During the visit, it was noted Patient #6	G 159	Please refer to the attached Appendix I for all plans of correction.		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 17</p> <p>had a BIPAP machine. His wife stated he had been on a CPAP machine for sleep apnea, but it had become worse and he was changed to the BIPAP. The CPAP and BIPAP were not on the POC for the certification period 7/06/13 to 9/03/13.</p> <p>In an interview on 7/10/13 at 4:35 PM, the Clinical Director reviewed Patient #6's record and contacted Patient #6 and his wife by phone. They confirmed the skin tear had occurred "a couple of weeks" prior to the home visit. Patient #6's wife verified he used BIPAP for sleep apnea.</p> <p>On 7/11/13 while reviewing Patient #6's medical record, it was noted the RN that made the home visit on 7/09/13 at 1:00 PM had not documented the skin tear in the perianal area, nor had she notified the physician for wound care orders. This was confirmed with the Clinical Director during an interview on 7/10/13 at 4:35 PM.</p> <p>The POC for Patient #6 was not accurate and had not been updated to include pertinent information.</p> <p>f. Patient #3 was a 77 year old male admitted to the agency on 6/18/13 for diagnoses including muscle weakness (generalized), hypoxemia, HTN and CKD. He was receiving SN, HHA and PT services. His medical record and POC for certification period of 6/18/13 through 8/16/13 were reviewed. Patient #3's POC did not include all pertinent information as follows:</p> <p>i. The RN SOC Assessment dated 6/18/13 at 12:58 PM, documented Patient #3's gastrointestinal assessment as "CONSTIPATION"</p>	G 159	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 18 and "ANOREXIA." The "NUTRITIONAL ASSESSMENT FINDING" section of the assessment indicated Patient #3 had an illness or condition which made him change the kind and/or amount of food he ate; ate fewer than 2 meals per day, ate few fruits and vegetables, or milk products; and had lost or gained over 10 lbs. in the last 6 months without wanting to. It also documented Patient #3's nutritional status as "PATIENT IS AT A HIGH NUTRITIONAL RISK" and his usual nutritional intake pattern as "VERY POOR - NEVER EATS A COMPLETE MEAL. RARELY EATS MORE THAN 1/3 OF ANY FOOD OFFERED, EATS 2 SERVINGS OR LESS OF PROTEIN (MEAT OR DAIRY PRODUCTS) PER DAY. TAKES FLUIDS POORLY. DOES NOT TAKE A LIQUID DIETARY SUPPLEMENT, OR IS NPO AND/OR MAINTAINED ON CLEAR LIQUIDS OR IV FOR MORE THAN 5 DAYS." The SOC Assessment further documented "PT. EATS VERY POORLY AND DOES NOT DRINK MUCH BECAUSE IT IS DIFFICULT TO TRANSFER USING 2 CANES TO GET TO THE BATHROOM."</p> <p>Patient #3's POC for the certification period 6/18/13 through 8/16/13 included "SN for observation and assessment of gastrointestinal status and to intervene to minimize complications." However, specific needs, goals, and interventions related to Patient #3's nutritional status were not included on the POC.</p> <p>The Clinical Director reviewed the record and POC and was interviewed on 7/10/13 at approximately 10:45 AM. She confirmed Patient #3's nutritional needs were not addressed.</p>	G 159	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 19</p> <p>ii. Patient #3's RN SOC Assessment dated 6/18/13 at 12:58 PM, stated he had 3+ edema on BLE. It also stated Patient #3 had stopped taking his medication. A REQUEST FOR PHYSICIAN ORDERS form, signed on 6/18/13 by the RN who completed the assessment, did not include a request for orders to address Patient #3's edema. Patient #3's POC for the certification period of 6/18/13 through 8/16/13, developed based on the findings of the 6/18/13 assessment, did not include needs, goals, and interventions related to the edema.</p> <p>The Clinical Director and RN case manager for Patient #3 were interviewed together on 7/11/13 at 9:30 AM. The Clinical Director confirmed the POC developed at SOC did not include interventions related to Patient #3's edema.</p> <p>iii. The RN SOC Assessment from 6/18/13 at 12:58 PM recommended under the DME section that Patient #3 have an "ELEVATED TOILET SEAT." The elevated toilet seat was not included as DME on the POC.</p> <p>A PT "ADD ON EVALUATION" from 6/24/13 at 1:39 PM documented under the recommended DME section "ELEVATED TOILET SEAT." The elevated toilet seat was not included as DME on the POC.</p> <p>During a home visit with a HHA on 7/09/13 beginning at 10:38 AM, Patient #3 stated "I have a hard time getting up off of the toilet." An elevated toilet seat was not observed in Patient #3's bathroom.</p> <p>The Clinical Director was interviewed on 7/10/13</p>	G 159	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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	Continued From page 20 beginning at 10:45 AM. She confirmed the elevated toilet seat did not appear on Patient #3's POC as DME. Patient #3's POC did not include all pertinent information. g. Patient #8 was a 64 year old female admitted to the agency on 5/07/13 for diagnoses including non infectious lymphedema, left hip injury, unspecified venous insufficiency, ulcer of other part of lower limb, CHF unspecified, HTN muscle weakness (generalized), Atrial Fibrillation and Morbid Obesity. She was receiving SN services. Her medical record for the certification period of 7/06/13 to 9/03/13 was reviewed. During a home visit with SN on 7/10/13 beginning at 1:00 PM, it was observed Patient #8 had a bed side commode. An RN "Visit Note Report" from 5/07/13 beginning at 2:59 PM, documented Patient #8 had a "BED SIDE COMMUNE" listed as DME available. The bed side commode was not listed on the POC for certification period of 7/06/13 to 9/03/13. The RN case manager for Patient #8 was interviewed via telephone on 7/10/13 at 10:10 AM. She confirmed Patient #8 had a bed side commode and it had not been added to the POC. Patient #8's POC did not include all pertinent medical equipment.	G 159	Please refer to the attached Appendix I for all plans of correction.		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the	G 164			

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 164	<p>Continued From page 21</p> <p>physician to any changes that suggest a need to alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on review of agency policies, clinical records, and staff interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 7 of 16 patients (#1, #2, #3, #4, #5, #6, and #14) whose records were reviewed. This resulted in missed opportunity for physicians to alter the plan of care to meet patient needs. Findings include:</p> <p>The agency policy "PLAN OF CARE 485," dated 12/01/97 and reviewed by the agency January 2013, stated "If the patient's condition changes are severe enough to change or alter the plan of care, the physician will be alerted by the staff." Agency staff failed to adhere to the policy as follows:</p> <p>1. Patient #1 was a 63 year old male admitted to the agency on 6/03/13 for diagnoses including abnormal gait, CVA, and aphasia. He was receiving SN, HHA, PT, OT, ST and social worker services. His medical record for the certification period of 6/03/13 through 8/01/13 was reviewed and included the following events:</p> <p>- An RN "Visit Note Report," dated 6/19/13 at 11:31 AM, documented Patient #1 "keeps falling" and refused to wait for his significant other to help him. It was unclear if Patient #1 had fallen during the SN visit or at another time. There was no documentation that the physician had been</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 164	<p>Continued From page 22</p> <p>notified that Patient #1 had been falling.</p> <p>- An RN "Visit Note Report," dated 6/21/13 at 12:01 PM, documented Patient #1 was weak and his significant other stated he had been falling. There was no documentation that the physician had been notified that Patient #1 had been falling.</p> <p>- An RN "Visit Note Report," dated 7/03/13 at 7:40 AM, documented the RN had arrived just after Patient #1 had gotten up to use the bathroom without assistance and fallen. The RN documented Patient #1 had sustained 3 abrasions from the fall that were then cleaned and dressed by the RN. There was no documentation to indicate the physician had been notified of Patient #1's fall or subsequent injuries.</p> <p>- A Physical Therapy Assistant "Visit Note Report," dated 7/03/13 at 10:47 AM, documented Patient #1's significant other stated Patient #1 had fallen twice in the "last few days" from getting out of bed without assistance. There was no documentation to indicate the physician had been notified of Patient #1's falls.</p> <p>The Clinical Director reviewed the record and was interviewed on 7/11/13 at 1:00 PM. She stated it was the practice of the agency to notify the physician for all falls, including unwitnessed falls. She confirmed there was no documentation to indicate the physician had been notified of Patient #1's falls or subsequent injuries.</p> <p>Patient #1's physician was not notified of changes in his condition.</p> <p>2. Patient #5 was a 71 year old male living in an</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 164	<p>Continued From page 23</p> <p>ALF and admitted to the agency on 5/30/13 with diagnoses of left middle finger injury, CVA, and pain for which he was receiving SN services. His medical record for the certification period of 5/30/13 through 7/28/13 was reviewed.</p> <p>In a "Client Coordination Note Report" from 6/03/13, untimed, the RN documented that, based on the weekend RN assessment, "Patient #5 needs to be seen by a physician today." The note documented Patient #5's finger was "SWOLLEN DEEP PURPLE SUTURE LINE DEHISING [sic]." The note stated the RN would notify the caregiver at the ALF of the need for "FURTHER MEDICAL CARE TODAY." There was no documentation to indicate the physician had been notified of the change in Patient #5's wound.</p> <p>An RN "Visit Note Report," dated 6/04/13 at 11:03 AM, documented Patient #5 had necrotic tissue on the inner part of his left middle finger. The note stated that Patient #5 was going to see the physician the next day and "WILL WAIT TO [see] WHAT [doctor] SAYS..." There was no documentation to indicate the physician had been notified of the change in Patient #5's wound.</p> <p>The Clinical Director reviewed the record and was interviewed on 7/11/13 at 12:20 PM. She stated the RNs who had provided care to Patient #5 and documented the notes should have called the physician to notify him of changes to the wound as soon as they were discovered instead of waiting for him to follow up with the physician later.</p> <p>Patient #5's physician was not notified of changes</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013	
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 164	<p>Continued From page 24 in his condition.</p> <p>3. Patient #14 was an 87 year old female admitted to the agency on 12/13/12 with diagnoses of a hip injury, Alzheimer's dementia and diabetes for which she was receiving SN services. Her medical record for the certification period of 12/13/12 through 2/10/13 was reviewed. Her POC, electronically signed by the physician on 1/03/13, included orders for wound care to both shins.</p> <p>An RN "Visit Note Report," dated 12/21/12 at 11:38 documented a skin tear to Patient #14's right elbow. The RN documented she cleaned and dressed the wound. There was no documentation to indicate the physician had been notified and an order had been received for the treatment of the skin tear.</p> <p>An RN "Visit Note Report," dated 12/28/13 at 9:59 AM documented Patient #14 had a new wound to her right knee and a wound to her left ankle. The RN documented she cleaned both wounds with normal saline and applied a hydrocolloid and Tegaderm dressing. There was no documentation to indicate the physician had been notified of the new wounds.</p> <p>The Clinical Director reviewed the record and was interviewed on 7/11/13 at 12:50 PM. She confirmed there was no documentation to indicate Patient #14's physician had been notified of her new wounds.</p> <p>Patient #14's physician was not notified of changes in her condition.</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 164	<p>Continued From page 25</p> <p>4. Patient #4 was a 75 year old male who was admitted to the agency on 12/28/12 for skilled nursing care related to diabetes, HTN, and atrial fibrillation (an abnormal heartbeat). Patient #4 resided in an ALF and received daily SN visits for assistance with diabetic testing and insulin administration.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/26/13 to 8/24/13, stated finger stick blood sugar results <60 or >350 were to be reported to the physician.</p> <p>A "BLOOD SUGAR LOG," for July 2013 was maintained for Patient #4 by the ALF. Instructions on the log noted the target blood sugar level was to be 70-120, and if low, to give a pop, juice, or frosting to bring the blood sugar up. The instructions further stated the blood sugar was to be retested, and the patient was to be provided with a half a peanut butter sandwich and a glass of milk. On 7/04/13 at 8:00 AM, the blood sugar was documented as 55. There was no indication in Patient #4's medical record the agency nurse reviewed the blood sugar log, acknowledged the low blood sugar, or if Patient #4 was retested.</p> <p>On 7/10/13 at 12:00 PM, a home visit was made to observe nursing care provided to Patient #4. The RN reviewed the blood sugar log and noted the low blood sugar result on 7/04/13. The RN and ALF staff was unable to find documentation in Patient #4's medical record to indicate the physician had been notified of the hypoglycemia episode. The RN confirmed the physician had not been notified of the hypoglycemia.</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013	
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 164	<p>Continued From page 26</p> <p>The physician had not been notified for out of parameter blood sugar results.</p> <p>5. Patient #6 was a 72 year old male who was admitted to the agency on 10/22/12 for skilled nursing care related to paraplegia, diabetes, and wound care. Patient #6 received twice weekly nursing visits for assessment and treatment of wounds on his coccyx and right lower leg.</p> <p>A home visit was conducted on 7/09/13 at 1:00 PM to observe nursing care provided by an RN. An additional wound was noted in the perianal area. Patient #6's wife stated it had been there "a couple of weeks," and had resulted from a skin tear while on the shower bench. During the home visit the RN cleansed the perianal area and applied a dressing.</p> <p>In an interview on 7/10/13 at 4:35 PM, the Clinical Director reviewed Patient #6's record and contacted Patient #6 and his wife by phone. They confirmed the skin tear had occurred "a couple of weeks" prior to the home visit.</p> <p>While reviewing Patient #6's medical record on 7/11/13 at 11:45 AM, it was noted the RN who was observed during the home visit on 7/09/13 at 1:00 PM had not documented the skin tear in the perianal area, nor had she notified the physician for wound care orders. This was confirmed with the Clinical Director.</p> <p>The physician had not been notified for additional wound care orders for a new wound.</p> <p>6. Patient #2 was a 76 year old female who was</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 164	<p>Continued From page 27</p> <p>admitted to the agency on 2/31/12 for skilled nursing care related to diabetes, HTN and CAD. Patient #2 resided in an ALF and received daily SN visits for assistance with insulin administration. In addition, Patient #2 was currently receiving Hospice services as of 3/15/13 with a diagnosis of "Unspecified Debility".</p> <p>a. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/29/13 to 8/27/13, included parameters of when to notify her physician for low or high blood pressure. The physician was not notified of the following vital signs which were outside of the identified parameters:</p> <p>i. 5/28/13, blood pressure 98/62. Nursing note stated the physician was not notified as Patient #2 was not symptomatic.</p> <p>ii. 6/04/13 at 5:45 PM, blood pressure 99/63. Nursing note stated the physician was not notified as Patient #2 was not symptomatic.</p> <p>iii. 7/02/13 at 5:30 PM, blood pressure 99/60. Nursing note stated the physician was not notified as Patient #2 was not symptomatic.</p> <p>iv. 6/14/13 at 5:37 PM, blood pressure 98/61. Nursing note stated the physician was not notified as Patient #2 was not symptomatic.</p> <p>b. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/29/13 to 8/27/13, stated finger stick blood sugar results of <60 or >250 were to be reported to the physician. The physician was not notified of the following blood sugar results which were outside</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 164	<p>Continued From page 28 of the identified parameters:</p> <p>i. 5/30/13 at 7:51 AM, blood sugar 57. Nursing note stated the physician was not notified as Patient #2 was not symptomatic.</p> <p>ii. 5/31/13 at 8:10 AM, blood sugar 280. Nursing note stated the physician was not notified as Patient #2 was not symptomatic.</p> <p>During an interview on 7/10/13 at 3:00 PM, the RN Case Manager and the Clinical Director reviewed Patient #2's medical record. The RN Case Manager stated Patient #2 was on Hospice services, therefore it was not necessary to contact the physician for low blood pressure results. She confirmed the parameters were on the POC, and stated they would need to be adjusted for Patient #2's needs. The RN Case Manager stated Patient #2 was no longer having routine blood sugar testing, and stated the POC would need to be revised to instruct the nursing staff of what readings they would need to report to the physician.</p> <p>The physician had not been notified for out of parameter blood sugar and blood pressure results.</p> <p>7. Patient #3 was a 77 year old male admitted to the agency on 6/18/13 for diagnoses including muscle weakness (generalized), hypoxemia, HTN and CKD. He was receiving SN, HHA and PT services. His medical record for certification period of 6/18/13 through 8/16/13 was reviewed. Patient#3's physician had not been notified of the need to update his POC as follows:</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 164	<p>Continued From page 29</p> <p>i. During a home visit on 7/09/13 starting at 10:00 AM, surveyors observed Tubigrips (tubular elastic compression bandages) applied to Patient #3's BLE by the HHA.</p> <p>A "PHYSICIAN VERBAL ORDER" dated 6/27/13 at 10:05 AM stated "...APPLY MEPILEX BORDER AND TUBIGRIP" to Patient #3's BLE.</p> <p>A "PHYSICIAN VERBAL ORDER" dated 7/03/13 at 2:36 PM stated to "APPLY TED HOSE" to BLE.</p> <p>A "PHYSICIAN VERBAL ORDER" from 7/08/13 at 3:58 PM ordered to "PLACE TED HOSE TO BLE AS WELL."</p> <p>An RN "Visit Note Report" from 7/08/13 at 4:09 PM, documented Patient #3's physician's office was contacted and new orders received which included Patient #3 was to "CONTINUE WITH TED HOSE TO BLE."</p> <p>The RN case manager for Patient #3 was interviewed on 7/11/13 at approximately 9:30 AM. She confirmed the RN "Visit Note Report" from 7/08/13 at 4:09 PM documented Patient #3 was to continue with ted hose to BLE. She stated Patient #3 refused the ted hose and Tubigrips continued to be used instead.</p> <p>Patient #3's physician had not been notified of the need to alter his POC to include the use of the Tubigrips in lieu of ted hose.</p> <p>ii. A home visit to Patient #3 was conducted on 7/09/13 at 10:00 AM, to observe care by an HHA. The HHA was observed giving Patient #3 bath with soap, a basin of water and washcloth.</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013	
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 164	Continued From page 30 Patient #3's groin area was noted to be dark red, dry, and flaky. After the bath the HHA was observed applying Calmoseptine, a barrier cream, to Patient #3's groin, buttocks, and upper thighs. The cream was not included on the POC for certification period of 6/18/13 through 8/16/13. A physician order for the use of the creme was not found in Patient #3's medical record. The RN case manager for Patient #3 was interviewed on 7/11/13 approximately 9:30 AM. She confirmed the HHA did not communicate the appearance of Patient #3's skin or the use of the cream. The RN also confirmed she had not observed Patient #3' groin and lower abdomen and was not aware of the condition of his skin and use of the cream.	G 164	Please refer to the attached Appendix I for all plans of correction.	
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on review of agency policies, medical record review and staff interview, it was determined the agency failed to ensure physician orders were obtained prior to the administration of medications for 3 of 16 patients, (#3, #4, and #12) whose records were reviewed. This resulted in unauthorized medication administration and had the potential to negatively impact patient safety. Findings include:	G 165		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013	
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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	<p>Continued From page 31</p> <p>A policy, titled "MEDICATIONS," dated 12/01/97, and reviewed 02/07, noted "drugs and treatments will be administered by agency staff only as ordered by the physician."</p> <p>1. Patient #4 was a 75 year old male who was admitted to the agency on 12/28/12 for skilled nursing care related to diabetes, HTN, and atrial fibrillation (an abnormal heartbeat). Patient #4 resided in an ALF, and received daily SN visits for assistance with diabetic testing and insulin administration. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/26/13 to 8/24/13 included Humalog Insulin per sliding scale twice daily. The times of the administration were not specific. The POC further included Lantus Insulin 30 units daily in section #10, "Medications". The POC contained a conflicting order under section #21, "Orders of Discipline and Treatments," which noted Lantus Insulin 25 units daily.</p> <p>On 7/10/13 at 12:00 PM, a home visit was made to observe nursing care provided to Patient #4. The RN reviewed the medical record and confirmed the orders for Lantus were conflicting. The RN stated Patient #4 was taking Lantus 25 units daily at noon. She stated the sliding scale schedule was to be followed with the 8:00 AM and the 12:00 PM blood sugar results.</p> <p>During the home visit to Patient #4 on 7/10/13, the RN noted dry and flaky skin on both of his legs and feet and used barrier cream on his legs. Barrier cream was not on the POC. Patient #4's toenails were yellow, thick, long, and curling downward. The RN offered to trim his toenails</p>	G 165	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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	<p>Continued From page 32 and Patient #4 declined. The RN was unable to determine when Patient #4's nails had been last trimmed.</p> <p>During an interview on 7/10/13 at 4:55 PM, the Clinical Director stated Patient #4 was eligible for quarterly visits to a podiatrist for nail trimming and a diabetic foot assessment.</p> <p>Insulin orders and the times of administration were unclear, and had not been clarified with the physician. Barrier cream was used although it was not on Patient #4's POC.</p> <p>2. Patient #12 was an 85 year old male, admitted to the agency on 2/13/13 for nursing and therapy services related to a UTI, IV antibiotic administration, dementia, and HTN.</p> <p>A "Visit Note Report," (which was also the SOC comprehensive assessment) dated 2/13/13, documented the nurse administered IV antibiotics, then a continuous IV infusion of NS (Normal Saline) at 100 ml/hr. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/13/13 to 4/13/13 did not include orders for continuous IV fluids.</p> <p>During an interview on 7/10/13 at 4:10 PM, the RN Case Manager for Patient #12 stated the IV fluids had been discontinued the following day, as Patient #12 was residing in an Assisted Living Facility and continuous IV fluids were not allowed in that environment. She confirmed the IV NS had not been included on the POC.</p> <p>3. Patient #3 was a 77 year old male admitted to</p>	G 165	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 33 the agency on 6/18/13 for diagnoses including muscle weakness (generalized), hypoxemia, HTN and CKD. He was receiving SN, HHA and PT services. His medical record for certification period of 6/18/13 through 8/16/13 was reviewed. On a home visit on 7/09/13 starting at 10:00 AM, surveyors observed the application of a barrier cream, Calmoseptine, to Patient #3's groin, buttocks, and upper thighs by an HHA. The HHA stated she got the barrier cream for Patient #3. During an interview on 7/10/13 beginning at 10:45 AM, the Clinical Director reviewed Patient #3's record and confirmed there was not a physician order for the barrier cream.	G 165	Please refer to the attached Appendix I for all plans of correction.	
G 172	Barrier cream was applied to Patient #3 without a physician's order. 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 3 of 16 patients (#3, #4 and #6) 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 #4 was a 75 year old male who was admitted to the agency on 12/28/12 for skilled	G 172		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 172	<p>Continued From page 34</p> <p>nursing care related to diabetes, HTN, and atrial fibrillation (an abnormal heartbeat). Patient #4 resided in an ALF, and received daily SN visits for assistance with diabetic testing, and insulin administration.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/26/13 to 8/24/13, stated finger stick blood sugar results <60 or >350 were to be reported to the physician. In addition, the POC included instructions for the SN to instruct/reinforce diet, skin care, and diabetic foot care.</p> <p>A "BLOOD SUGAR LOG," for July 2013 was maintained for Patient #4 by the ALF. Instructions on the log noted the target blood sugar level was to be 70-120, and if low, to give a pop, juice, or frosting to bring the blood sugar up. The instructions further stated the blood sugar was to be retested, and the patient was to be provided with a half a peanut butter sandwich and a glass of milk. On 7/04/13 at 8:00 AM, the blood sugar was documented as 55. There was no indication in Patient #4's medical record the agency nurse reviewed the blood sugar log, acknowledged the low blood sugar, or if Patient #4 was re-evaluated or retested. The medical record did not indicate the ALF staff had been educated/instructed regarding Patient #4's dietary needs, or appropriate interventions</p> <p>On 7/10/13 at 12:00 PM, a home visit was made to observe nursing care provided to Patient #4. The RN reviewed the blood sugar log and noted the low blood sugar result on 7/04/13. The RN and ALF staff was unable to find documentation in Patient #4's medical record to indicate the</p>	G 172	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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)
G 172	<p>Continued From page 35</p> <p>physician had been notified of the hypoglycemia episode . The RN confirmed the physician had not been notified of Patient #4's hypoglycemia on 7/04/13.</p> <p>During the home visit to Patient #4 on 7/10/13, the RN noted dry and flaky skin on both of his legs and feet and used barrier cream on his legs. Barrier cream was not on the POC for the certification period 6/26/13 to 8/24/13. Patient #4's toenails were yellow, thick, long, and curling downward. The RN offered to trim his toenails and Patient #4 declined. The RN was unable to determine when Patient #4's nails had been last trimmed.</p> <p>During an interview on 7/10/13 at 4:55 PM, the Clinical Director stated Patient #4 was eligible for quarterly visits to a podiatrist for nail trimming and a diabetic foot assessment.</p> <p>Patient #4's blood sugar had not been retaken after a low result had been obtained. Patient #4 was not re-assessed for the need of diabetic foot care.</p> <p>2. Patient #6 was a 72 year old male who was admitted to the agency on 10/22/12 for skilled nursing care related to paraplegia, diabetes, and wound care. Patient #6 received twice weekly nursing visits for assessment and treatment of wounds on his coccyx and right lower leg.</p> <p>A home visit was conducted on 7/09/13 at 1:00 PM to observe nursing care provided by an RN. An additional wound was noted in the perianal area. Patient #6's wife stated it had been there "a couple of weeks," and resulted as a skin tear</p>	G 172	<p>Please refer to the attached Appendix I for all plans of correction.</p>

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013	
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 172	<p>Continued From page 36</p> <p>while on the shower bench. During the home visit the RN cleansed the perianal area and applied a dressing.</p> <p>In an interview on 7/10/13 at 4:35 PM, the Clinical Director reviewed Patient #6's record and contacted Patient #6 and his wife by phone. They confirmed the skin tear had occurred "a couple of weeks" prior to the home visit. During the visit, it was noted Patient #6 had a BIPAP machine. His wife stated he had been on a CPAP machine for sleep apnea, but it had become worse and he was changed to the BIPAP. The CPAP and BIPAP were not on the POC for the certification period 7/06/13 to 9/03/13.</p> <p>On 7/11/13 while reviewing Patient #6's medical record, it was noted the RN that had made the home visit on 7/09/13 at 1:00 PM had not documented the skin tear in the perianal area, nor had she notified the physician for wound care orders. This was confirmed with the Clinical Director.</p> <p>The RN did not re-evaluate Patient #6's nursing needs.</p> <p>3. Patient #3 was a 77 year old male admitted to the agency on 6/18/13 for diagnoses including muscle weakness (generalized), hypoxemia, HTN and CKD. He was receiving SN, HHA and PT services. His medical record for certification period of 6/18/13 through 8/16/13 was reviewed. A SOC assessment completed by the RN on 6/18/13 at 12:58 PM noted Patient #3 had 3+ edema to BLE and had stopped taking his medication.</p>	G 172	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 172	<p>Continued From page 37</p> <p>An RN "Visit Note Report" dated 6/21/13 beginning at 12:36 PM, documented Patient #3 had open blisters on BLE and scabs on each thigh. It also stated Patient #3 had 2+ pitting edema to BLE and had stopped taking all medications 2 months prior without telling his physician. The RN requested and received an order from the physician on 6/21/13 for Lasix (a diuretic) and Potassium Chloride (for Potassium replacement while on Lasix). Patient #3's health status was not regularly re-evaluated by SN as follows:</p> <p>i. A home visit to Patient #3 was conducted on 7/09/13 at 10:00 AM, to observe care by a HHA. The HHA was observed giving Patient #3 a bath with soap, a basin of water and washcloth. Patient #3's groin, buttocks, and upper thighs were noted to be dark red, dry, and flaky. After the bath the HHA was observed applying Calmoseptine, a barrier cream, to Patient #3's groin, buttocks, and upper thighs. The cream was not included on the POC for certification period of 6/18/13 through 8/16/13. A physician order for the use of the creme was not found in Patient #3's medical record.</p> <p>The RN case manager for Patient #3 was interviewed on 7/11/13 starting at approximately 9:30 AM. The RN case manager confirmed she had not observed Patient #3' groin and buttocks and was not aware of the condition of his skin in these areas or the use of the cream.</p> <p>ii. The RN SOC Assessment dated 6/18/13 at 12:58 PM, documented Patient #3's gastrointestinal assessment as "CONSTIPATION"</p>	G 172	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 172	<p>Continued From page 38 and "ANOREXIA." The "NUTRITIONAL ASSESSMENT FINDING" section of the assessment indicated Patient #3 had an illness or condition which made him change the kind and/or amount of food he ate; ate fewer than 2 meals per day, ate few fruits and vegetables, or milk products; and had lost or gained over 10 lbs. in the last 6 months without wanting to. It also documented Patient #3's nutritional status as "PATIENT IS AT A HIGH NUTRITIONAL RISK" and his usual nutritional intake pattern as "VERY POOR - NEVER EATS A COMPLETE MEAL. RARELY EATS MORE THAN 1/3 OF ANY FOOD OFFERED, EATS 2 SERVINGS OR LESS OF PROTEIN (MEAT OR DAIRY PRODUCTS) PER DAY. TAKES FLUIDS POORLY. DOES NOT TAKE A LIQUID DIETARY SUPPLEMENT, OR IS NPO AND/OR MAINTAINED ON CLEAR LIQUIDS OR IV FOR MORE THAN 5 DAYS." The SOC Assessment further documented "PT. EATS VERY POORLY AND DOES NOT DRINK MUCH BECAUSE IT IS DIFFICULT TO TRANSFER USING 2 CANES TO GET TO THE BATHROOM."</p> <p>Patient #3's medical record for certification period of 6/18/13 through 8/16/13 was reviewed. Further assessment findings related to the type and amount of food/fluid consumed by Patient #3, was not documented.</p> <p>The RN case manager for Patient #3 was interviewed on 7/11/13 starting at approximately 9:30 AM. She confirmed that during SN visits she did not ask Patient #3 or his wife about the type and amount of food/fluid he consumed.</p> <p>iii. An RN "Visit Note Report" dated 7/08/13</p>	G 172	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 172	Continued From page 39 beginning at 3:58 PM, noted Patient #3 had lost 30+ lbs in the past two weeks due to diuresis. Patient #3's weight documented at the time of the 6/18/13 SOC assessment was 240 lbs. No further documentation of his weight was found in his medical record. It was unclear how the 30+ weight loss was determined. The RN case manager for Patient #3 was interviewed on 7/11/13 starting at approximately 9:30 AM. She confirmed there was no further documentation of Patient #3's weight. Comprehensive re-evaluations of Patient #3's nursing needs related to his skin, nutritional intake, and weight were not completed.	G 172	Please refer to the attached Appendix I for all plans of correction.	
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure nursing notes including complete and consistent information regarding the health status of 1 of 16 (Patients #3) whose records were reviewed. This had the potential to compromise continuity of care and assessment of patients' progress. Finding include: 1. Patient #3 was a 77 year old male admitted to the agency on 6/18/13 for diagnoses including	G 176		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 176	<p>Continued From page 40</p> <p>muscle weakness (generalized), hypoxemia, HTN and CKD. He was receiving SN, HHA and PT services. His medical record for certification period of 6/18/13 through 8/16/13 was reviewed.</p> <p>A SOC assessment completed by the RN on 6/18/13 at 12:58 PM noted Patient #3 had 3+ edema to BLE and had stopped taking his medication.</p> <p>An RN "Visit Note Report" dated 6/21/13 beginning at 12:36 PM, documented Patient #3 had open blisters on BLE and scabs each each thigh. It also stated Patient #3 had 2+ pitting edema to BLE. The visit report did not include documentation of the size of the wounds, nor did it indicate pictures of the wound had been taken.</p> <p>RN "Visit Note Report" documents for visits completed on 6/24/13, 6/27/13, and 7/01/13 were reviewed. None of the visit notes documented the size of the wounds on Patient #3's BLE. The size of the wounds were not documented until an RN visit on 7/08/13. A Wound Assessment Tool was used during the visit. The assessment showed the wound on Patient #3's left lower leg was 6.4 cm long and 5 cm wide. The wound on his right lower leg was documented as 6 cm long and 5.2 cm wide. Pictures were also taken at that time.</p> <p>In addition, the RN "Visit Note Report" dated 6/21/13 beginning at 12:36 PM, documented Patient #3 had scabs on each thigh. Patient #3's medical record for certification period of 6/18/13 through 8/16/13 did not include further documentation regarding the scabs.</p>	G 176	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 176	Continued From page 41 RN progress notes did not provide complete and consistent data regarding the status of Patient #3's wounds.	G 176	Please refer to the attached Appendix I for all plans of correction.	
G 337	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 record review, policy review, observations during home visits, staff interview and patient interview, it was determined the agency failed to ensure the drug review was comprehensive for 2 of 16 patients (#4 and #6,) whose records were reviewed. Failure to obtain an accurate patient medication list or to evaluate the list for duplicative therapy, drug interactions, or significant side effects had the potential to place patients at risk for adverse events or negative drug interactions. Findings include: A policy, titled "MEDICATIONS," dated 12/01/97, and revised 2/07, noted "All medications will be recorded in patient 's clinical record including over-the-counter medications. Agency staff will check all medications to identify possible ineffective drug therapy, adverse reactions, significant side effects, drug allergies, and contraindicated medications and promptly report any problems to the physician. Medications will be reviewed and updated by Licensed Nurse of the agency."	G 337		

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013	
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 42</p> <p>1. Patient #6 was a 72 year old male who was admitted to the agency on 10/22/12 for skilled nursing care related to paraplegia, diabetes, and wound care. Patient #6 received twice weekly nursing visits for assessment and treatment of wounds on his coccyx and right lower leg.</p> <p>A home visit was conducted on 7/09/13 at 1:00 PM to observe nursing care provided by an RN. At the time of the home visit, the RN was not noted to review medications with Patient #6 or his family. After the observation of nursing care, Patient #6's wife reviewed his medications with the surveyor. The following concerns were noted with the home medication regime for Patient #6 as compared to what was ordered on his POC for the certification period 6/19/13 to 8/17/13:</p> <p>a. Humalog Insulin, sliding scale. The medication and sliding scale administration orders was not on Patient #6's POC, although Patient #6's wife stated he had been on that routine for more than one year.</p> <p>b. Promethazine, 25 mg. The prescription had a fill date of 7/25/11, and the expiration date of the medication was listed as 7/25/12. The medication had expired 11 months prior to the home visit date.</p> <p>c. Calcium 500 mg. Patient #6's wife stated he was taking Calcium 600 mg with D 3 one tablet daily. The POC had not been updated to include the change in supplement.</p> <p>d. Sulfamethoxazole-Trimethoprin 400-80 mg. Patient #6's wife stated the physician had changed the dosage to 1/2 tablet daily on</p>	G 337	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404	
(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 43</p> <p>7/02/13. The POC had not been updated to include the change in dosage.</p> <p>e. Coumadin 2 mg. The medication sheet contained dosage of 1 tablet every other day. Patient #6's wife stated the dosage had been changed 6/26/13 to 1 tablet on Monday, Wednesday, Friday, Saturday and Sunday. Tuesday and Thursday no Coumadin was to be given. The POC had not been updated to include the change in Coumadin dosages.</p> <p>f. Multivitamin, 1 daily. Patient #6's wife stated he had been taking a multivitamin daily for more than 1 year. The multivitamin was not included on the POC.</p> <p>g. Bactroban topical ointment. Patient #6's wife stated he no longer used that medication, as he was sensitive to it. The POC had not been updated to remove the medication.</p> <p>In an interview on 7/10/13 at 4:35 PM, the Clinical Director reviewed Patient #6's record and contacted Patient #6 and his wife by phone. Patient #6's wife verified the sliding scale insulin, Calcium, Sulfamethoxazole-Trimethoprin and multivitamin dosages with the Clinical Director.</p> <p>Medications had not been reviewed and updated to reflect Patient #4's current medication routine.</p> <p>2. Patient #4 was a 75 year old male who was admitted to the agency on 12/28/12 for skilled nursing care related to diabetes, HTN, and atrial fibrillation (an abnormal heartbeat). Patient #4 resided in an ALF, and received daily SN visits for assistance with diabetic testing and insulin</p>	G 337	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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

PRINTED: 07/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404		
(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 44 administration.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/26/13 to 8/24/13 included Humalog Insulin per sliding scale twice daily. The times of the administration were not specific. The POC further included Lantus Insulin 30 units daily in section #10, "Medications". The POC contained a conflicting order under section #21, "Orders of Discipline and Treatments," which noted Lantus Insulin 25 units daily.</p> <p>On 7/10/13 at 12:00 PM, a home visit was made to observe nursing care provided to Patient #4. The RN reviewed the medical record and confirmed the orders for Lantus were conflicting. The RN stated Patient #4 was taking Lantus 25 units daily at noon. She stated the sliding scale schedule was to be followed with the 8:00 AM and the 12:00 PM blood sugar results.</p> <p>Medications were not thoroughly reviewed, nor was the physician notified of the discrepancy in the medication orders.</p>	G 337	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

Aspen Home Health
Blackfoot Home Health
Medicare Provider # 13-7081
State License Number HH183
July 12, 2013 Survey
HCFA-Identified Deficiencies Credible Allegation

Appendix I

Aspen Home Health
 Blackfoot Home Health
 Medicare Provider # 13-7081
 State License Number HH183
 July 12, 2013 Survey

HCFA-Identified Deficiencies Credible Allegation

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
G143	<p>Special staff inservices have been scheduled to review the findings of the survey and to do continued teaching and education. These inservices are mandatory and will include all staff in all offices. The final inservice will be concluded prior to August 14th, 2013.</p> <p>Teachings and instructions will include the importance of communications between clinicians who may be providing services for different providers concurrently, and also the importance of documenting these communications.</p> <p>In the case of Patient #2, this individual's pain was being well managed by the hospice clinician. Better documentation of the communications between the home health clinicians and the hospice clinicians in the home health chart who have painted a clearer picture of the patient's status.</p> <p>The staff will also be taught and instructed on the importance of including all relevant information in their clinical documentation.</p> <p>In the case of Patient #4, the physician had verbally asked the clinicians to not send daily notifications of out-of-range blood sugar levels because significant fluctuations in blood sugar levels with this individual were the norm. Better documentation of this instruction to the clinicians would have helped clarify the clinical record.</p> <p>Finally, the inservices will provide continuing emphasis on the need to have physician orders in place prior to providing any services, regardless of the scope or significance.</p>	Deanna Baird RN Clinical Staff	Ongoing Monthly QA	August 14, 2013
G156	Please see POC for G158, G159 and G165	N/A	N/A	N/A

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
G158	<p>Special staff inservices have been scheduled to review the findings of the survey and to do continued teaching and education. These inservices are mandatory and will include all staff in all offices. The final inservice will be concluded prior to August 14th, 2013.</p> <p>The staff will be re-inserviced regarding the need to adequately communicate any patient condition changes or potential needs to the on call staff, and to give/get complete report on all active patients prior to going on call.</p> <p>During the inservices the importance of reading and understanding all physician orders prior to initiating care will be emphasized.</p> <p>As indicated under G143, the inservices will also provide continuing emphasis on the need to have physician orders in place prior to providing any services, regardless of the scope or significance as well as the importance of including all relevant information in their clinical documentation.</p> <p>Finally, the inservices will also continue to stress the importance of providing feedback to physicians if a patient cannot tolerate what is ordered in the plan of care, and to seek alternative orders if appropriate.</p> <p>It should be noted here that the summary statement of deficiencies indicates Patient #5 had unsigned orders for wound care, when in fact the orders had been signed electronically as found in the electronic medical record.</p>	Deanna Baird RN Clinical Staff	Ongoing Monthly QA	August 14, 2013

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
G159	<p>Special staff inservices have been scheduled to review the findings of the survey and to do continued teaching and education. These inservices are mandatory and will include all staff in all offices. The final inservice will be concluded prior to August 14th, 2013.</p> <p>All clinical staff will be reminded during this inservice of the importance to include a complete and accurate record of all DME equipment being used in the home in every patient's medical record.</p> <p>Additional instructions will be given regarding the importance of documenting all concerns, patient challenges or changes in condition in the medical record, communicating the same to the physicians, and seeking additional physician orders whenever appropriate to address said concerns, challenges or changes..</p>	Deanna Baird RN Clinical Staff	Ongoing Monthly QA	August 14, 2013
G164	<p>Special staff inservices have been scheduled to review the findings of the survey and to do continued teaching and education. These inservices are mandatory and will include all staff in all offices. The final inservice will be concluded prior to August 14th, 2013.</p> <p>Instructions will be given regarding the importance of documenting all concerns, patient challenges or changes in condition in the medical record, communicating the same to the physicians, and seeking additional physician orders whenever appropriate to address said concerns, challenges or changes</p> <p>Additional teaching will be provided regarding the need to set appropriate parameters for BS and BP during the admission process, and to follow agency guidelines whenever observations fall outside these set parameters.</p>	Deanna Baird RN Clinical Staff	Ongoing Monthly QA	August 14, 2013

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
G165	<p>Special staff inservices have been scheduled to review the findings of the survey and to do continued teaching and education. These inservices are mandatory and will include all staff in all offices. The final inservice will be concluded prior to August 14th, 2013.</p> <p>Teaching during these inservices will include medication documentation in the medical record, the importance of consistency in administering medications according to POC and physician orders, and the importance of communicating all medication changes to the physician.</p>	Deanna Baird RN Clinical Staff	Ongoing Monthly QA	August 14, 2013
G172	<p>Special staff inservices have been scheduled to review the findings of the survey and to do continued teaching and education. These inservices are mandatory and will include all staff in all offices. The final inservice will be concluded prior to August 14th, 2013</p> <p>Teaching during these inservices will include further instructions regarding clinical staff interactions with ALF staff and ALF procedures, and steps to take when VS or BS are outside established norms.</p> <p>Please also see POCs submitted under G 159 and G164..</p>	Deanna Baird RN Clinical Staff	Ongoing Monthly QA	August 14, 2013
G176	<p>Special staff inservices have been scheduled to review the findings of the survey and to do continued teaching and education. These inservices are mandatory and will include all staff in all offices. The final inservice will be concluded prior to August 14th, 2013</p> <p>Teaching during these inservices will include reminding the staff of the importance of documenting wound measurements in the medical record and including wound photos where available and appropriate,</p>	Deanna Baird RN Clinical Staff	Ongoing Monthly QA	August 14, 2013

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
G337	<p>Special staff inservices have been scheduled to review the findings of the survey and to do continued teaching and education. These inservices are mandatory and will include all staff in all offices. The final inservice will be concluded prior to August 14th, 2013</p> <p>Teaching during these inservices will include reminding the staff of the importance of regularly reviewing patients medications with patients and/or their spouses/caregivers and updating the medical record to reflect any changes or modifications, thereby ensuring an accurate and complete POC.</p>	Deanna Baird RN Clinical Staff	Ongoing Monthly QA	August 14, 2013

Bureau of Facility Standards

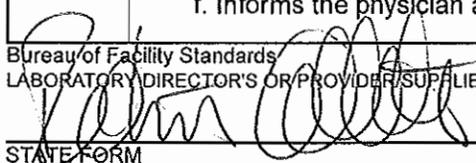
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404
---	--

(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 state licensure survey of your home health agency. The surveyors conducting the survey were: Libby Doane, BSN, RN, HFS - Team Leader Sylvia Creswell, LSW, HFS Susan Costa, RN, HFS Don Sylvester, RN, HFS	N 000	Please refer to the attached Appendix II for all plans of correction.	
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to G172.	N 093		
N 098	03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: f. Informs the physician and	N 098		

RECEIVED
AUG - 5 2013
FACILITY STANDARDS

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



TITLE
Administrator

(X6) DATE
8/2/2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
--	---	---	--

NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404
--	--

(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 098	Continued From page 1 other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G176.	N 098	Please refer to the attached Appendix II for all plans of correction.	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G158.	N 152		
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 G159.	N 155		
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency	N 172		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASPEN HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3470 WASHINGTON PKWY IDAHO FALLS, ID 83404
---	--

(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 172	Continued From page 2 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 G164.	N 172	Please refer to the attached Appendix II for all plans of correction.	
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 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 G165.	N 173		

Aspen Home Health
Blackfoot Home Health
Medicare Provider # 13-7081
State License Number HH183
July 12, 2013 Survey
State-Identified Deficiencies Credible Allegation

Appendix II

Aspen Home Health
Blackfoot Home Health
Medicare Provider # 13-7081
State License Number HH183
July 12, 2013 Survey

State-Identified Deficiencies Credible Allegation

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
N 093	Please see response to Federal ID G172	N/A	N/A	N/A
N 098	Please see response to Federal ID G176	N/A	N/A	N/A
N 152	Please see response to Federal ID G158	N/A	N/A	N/A
N 155	Please see response to Federal ID G159	N/A	N/A	N/A
N 172	Please see response to Federal ID G164	N/A	N/A	N/A
N 173	Please see response to Federal ID G165	N/A	N/A	N/A