



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

December 4, 2014

Donna Cardish, Administrator
Eden Home Health
1480 Midway Avenue, Unit 7
Ammon, ID 83406-4587

RE: Eden Home Health, Provider #137119

Dear Ms. Cardish:

This is to advise you of the findings of the Medicare/Licensure survey at Eden Home Health, which was concluded on November 19, 2014.

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

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

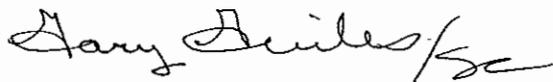
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date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

Donna Cardish, Administrator
December 4, 2014
Page 2 of 2

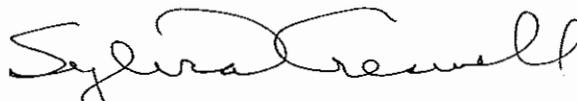
After you have completed your Plan of Correction, return the original to this office by **December 17, 2014**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626, option 4.

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt
Enclosures

TIME RECEIVED
January 23, 2015 12:42:48 PM MST

REMOTE CSID
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39 1

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

PRINTED: 12/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER EDEN HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1480 MIDWAY AVENUE, UNIT 7 AMMON, ID 83406	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiency was cited during the Medicare recertification survey of your home health agency conducted from 11/17/14 - 11/19/14. The surveyors conducting the survey were: Gary Gules, RN, HFS - Team Leader Laura Thompson, RN, BSN, HFS Acronyms used in this report include: OT - Occupational Therapy PT - Physical Therapy SN - Skilled Nursing	G 000	<p>RECEIVED</p> <p>JAN 23 2015</p> <p>FACILITY STANDARDS</p>	
G 113	484.10(e)(1) PATIENT LIABILITY FOR PAYMENT The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. This STANDARD is not met as evidenced by: Based on review of admission paperwork and staff interview, it was determined the agency failed to ensure patients were informed in writing of the extent to which payment could be expected, and the charges the individual might have to pay, for 4 of 10 patients (#1, #4, #6, and #10) whose records were reviewed. This had the potential to interfere with patients'/caregivers' ability to make reasonable, informed decisions about financial matters related to the agency's care and treatment. Findings include:	G 113		
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.

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

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(X6) DATE

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G 113	<p>Continued From page 1</p> <p>The Admission packet and each patient record contained a form, titled Admission Service Agreement Home Health. Section 3 of the form, titled Liability for Payment, stated "I understand and agree to pay deductibles, co-payments, spend downs and any amount due after payment of benefits on my behalf by any and all third party payers." Under this same section on the form, there were checkboxes that may be marked to indicate which insurance coverage the patient may have. The checkbox for Medicare stated "Project 100% covered." For Medicaid it stated "Project 100% covered after meeting spend down and/or other requirements", with no area to specify a breakdown of costs to the patient. The area for private insurance, under this section, stated the patient's anticipated payment amounts per visit will be provided in writing when the insurance company informed the organizations of the patient's financial liability. There was an area to be filled out by the agency of the percentage to be paid by insurance, and the specific amounts the patients were responsible for on the form.</p> <p>1. Patient #10 was a 71 year old male admitted to the agency on 5/22/14, for SN and PT services related to hypotension (low blood pressure). The Admission Service Agreement, signed and dated 5/22/14, was left blank under the section Liability for Payment. There was no information regarding Patient #10's financial liability.</p> <p>During an interview on 11/19/14 at 2:45 PM, the Administrator confirmed the form was left blank with no information about Patient #10's financial liability. She stated she was unaware of how patients admitted to the agency were informed of their possible financial liability prior to care being initiated in the home.</p>	G 113	

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G 113	<p>Continued From page 2</p> <p>During an interview on 11/19/14 at 2:55 PM, the Clinical Manager confirmed Patient #10's Admission Service Agreement was left blank with no information about financial liability. She stated that upon admission she had the patient sign the form. Then once the insurance company had sent the information, she stated she would tell them the costs verbally. The Clinical Manager confirmed she did not give this information to the patient or caregiver in writing before care was initiated.</p> <p>During an interview on 11/19/14 at 3:05 PM, the Office Manager confirmed the Admission Service Agreement was left blank with no information regarding Patient #10's financial liability. She stated she awaited information from the patient's insurance company then would call the patient or caregiver and verbally inform them of their financial obligations.</p> <p>Patient #10 was not informed in writing of potential financial liability before services were provided.</p> <p>2. Patient #1 was an 83 year old male admitted to the agency on 11/12/14, for SN and PT services related to wound care for a surgical incision. The Admission Service Agreement, signed and dated 11/12/14, had a checkmark next to private insurance, under the section labeled Liability for Payment. The area for projected percentage of charges to be covered after the deductible was left blank. There was no information regarding Patient #10's financial liability.</p> <p>During an interview on 11/19/14 at 3:05 PM, the</p>	G 113		

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G 113	<p>Continued From page 3</p> <p>Office Manager confirmed the Admission Service Agreement was left blank where the percentage of charges and specific financial obligations should have been written. She stated there was a note regarding Patient #1's insurance benefits in his chart. She presented a copy of the clinical note dated 11/12/14, as the payment information she had received from his insurance company. The Office Manager stated this information was given to Patient #1 over the phone but not in writing.</p> <p>Patient #1 was not informed in writing of potential financial liability before services were provided.</p> <p>3. Patient #6 was a 78 year old female admitted to the agency on 7/25/14 for SN services related to diabetes. The Admission Service Agreement, signed and dated 7/25/14, had a checkmark next to Medicaid, under the section Liability for Payment. There was no information regarding Patient #6's financial liability.</p> <p>During an interview on 11/19/14 at 3:30 PM, the Clinical Manager confirmed Patient #6's Admission Service Agreement was signed by herself as the admitting clinician. She confirmed the form was marked next to Medicaid, to indicate Patient #6's insurance provider. The Clinical Manager stated it was marked incorrectly and it should have indicated Patient #6 was covered under Medicare. The Clinical Manager confirmed there was no information regarding Patient #6's financial liability.</p> <p>Patient #6 was not informed in writing of potential financial liability before services were provided.</p>	G 113		

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G 113	Continued From page 4 4. Patient #4 was a 72 year old female admitted to the agency on 11/09/14, for SN, OT, and PT services related to a blood clot in her leg. The Admission Service Agreement, signed and dated 11/09/14, had a checkmark next to private "insurance," under the section labeled Liability for Pavment. The form stated "Project 20% of charges to be covered after deductible met. Specify amounts." A line was on the form for the amount of Patient #4's portion of the charges was left blank. There was no specific information regarding Patient #4's financial liability. An interview was conducted with the Clinical Manager on 11/19/14 at 2:55 PM. She was the nurse who filled out the Admission Service Agreement. She confirmed the amount of Patient #4's financial liability was not documented. Patient #4 was not informed in writing of her potential financial liability before services were provided.	G 113		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER EDEN HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1480 MIDWAY AVENUE, UNIT 7 AMMON, ID 83406
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NU00	<p>03.03.07 INITIAL COMMENTS</p> <p>The following deficiency was cited during the Idaho state licensure survey of your home health agency conducted from 11/17/14 - 11/19/14. The surveyors conducting the licensure review were:</p> <p>Gary Guiles, RN, HFS - Team Leader Laura Thompson, RN, BSN, HFS</p>	N 000	<p>Administrator in-serviced staff with regard to patient rights (see attachment #3, #5/5a). Signatures to be obtained by Clinical Manager/PT upon admission, administrator to monitor for the next 90 days.</p>	
N041	<p>03.07020. ADMIN. GOV. BODY</p> <p>N041 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following:</p> <p>d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following:</p> <p>c) The charges that the patient may have to pay; and</p> <p>This Rule is not met as evidenced by: Refer to G0113.</p>	N 041	<p>RECEIVED JAN 20 2015 FACILITY STANDARDS</p>	

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

Bureau of Facility Standards

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JAN 26 2015
DIV OF LIC & CERT

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