IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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April 26, 2017

John Williams, Administrator
Oneida County Hospital Home Care
150 North 200 West
Malad, ID 83252

RE: Oneida County Hospital Home Care, Provider #137077

Dear Mr. Williams:

This is to advise you of the findings of the Medicare/Licensure survey at Oneida County Hospital Home Care, which was concluded on April 20, 2017.

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

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

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

After you have completed your Plan of Correction, return the original to this office by **May 8, 2017**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, comments or concerns, please contact Dennis Kelly, R.N. or Nicole Wisenor, Co-Supervisors, Non- Long Term Care at (208) 334-6626, option 4.

Sincerely,

Dennis Kelly RN

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosures

NELL J REDFIELD
MEMORIAL HOSPITAL
"An Oneida County Facility"

Oneida County Hospital Home Care
150 N 200 W
Malad City, ID 83252
Phone 208-766-5805
Fax 208-766-4819
www.oneidahospital.com

May 4, 2017

Dennis Kelly, RN Supervisor
Non-Long Term Care
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
PO Bo 83720
Boise, ID 83720-0009

Nancy Bax, RN, BSN, HFS, Team Leader
Kristin Inglis, RN, HFS

RE: Oneida County Hospital Home Care, Provider #137077

Mr. Dennis Kelly,

This letter and attached documents are in response to the Medicare/Licensure survey conducted at Oneida County Hospital Home Care 4/17/2017 – 4/20/2017 and the Statement of Deficiencies/Plan of Correction , Form CMS-2567 and a copy of the original Statement of Deficiencies/Plan of Correction.

If any question or concerns regarding this Corrective Action Plan please feel free to contact Melanie Bowcutt at (208) 766-5805 or 208 221-9107.

Sincerely,

Melanie Bowcutt, RN, BSN
Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	150 NORTH 200 WEST MALAD, ID 83252

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency conducted on 4/17/17 to 4/20/17. Surveyors conducting the survey were: Nancy Bax, RN, BSN, HFS, Team Leader Kristin Inglis, RN, HFS Acronyms used in this report include: BPH - Benign Prostatic Hyperplasia CHF - Congestive Heart Failure DM - Diabetes Mellitus HTN - Hypertension MAHC - Missouri Alliance for Home Care mg - milligram POC - Plan of Care PT - Physical Therapy PTA - Physical Therapy Assistant RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care UTI - Urinary Tract Infection	G 000	RECEIVED MAY 09 2017 FACILITY STANDARDS	
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 medical record review and staff interview it was determined the agency failed to ensure coordination of care between disciplines occurred for 2 of 4 patients (#5 and #7) who	G 143		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Wmd. | TITLE: CEO | (X6) DATE: 5/4/17

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

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G 143	Continued From page 1 received therapy services and whose records were reviewed. This interfered with quality, safety, and continuity of patient care. Findings include: 1. Patient #5 was a 97 year old female admitted to the agency on 8/30/16. Her record, including the POC, for the certification period 2/26/17 to 4/26/17, was reviewed. For the certification period, Patient #5's primary diagnosis was a non-pressure ulcer on her left heel. Additional diagnoses included polyneuropathy and CHF. She received SN services. Patient #5's record included SN visit notes dated 2/27/17, 3/02/17, 3/06/17, 3/09/17, 3/13/17, 3/16/17, 3/20/17, and 3/23/17, signed by her RN Case Manager. The 8 SN visit notes stated Patient #5's respiratory status was normal, with no shortness of breath or other problems noted. She was afebrile with temperature of 98.6 degrees or less, and her oxygen saturation levels ranged from 92% to 96% while on oxygen. Patient #5's record included an SN visit note dated 3/27/17, signed by an RN who was not the Case Manager. The visit note documented a low grade fever of 99.1 degrees, and oxygen saturation level of 88 to 91%. The note stated Patient #5 was short of breath on exertion. There was no documentation stating her RN Case Manager was notified of the change in her condition. During an interview on 4/19/17 at 11:05 AM, the Director reviewed Patient #5's record and confirmed her RN Case Manager was not notified of the change in her condition. She stated the RN who completed the visit on 3/27/17, should	G 143		

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G 143	Continued From page 2 have communicated Patient #5's symptoms to her RN Case Manager. Patient #5's change in condition was not communicated to her RN Case Manager. 2. Patient #7 was a 74 year old male admitted to the agency on 4/02/17, for care following a surgical fusion of his cervical spine. Additional diagnoses included low back pain, HTN, and asthma. He received SN and PT services. His record, including the POC, for the certification period 4/02/17 to 5/31/17, was reviewed. Patient #7's record included a PT visit note dated 4/14/17, signed by the Physical Therapist. The note stated Patient #7 achieved his therapy goals and was discharged from PT services. There was no documentation of communication with his RN Case Manager regarding his discharge from PT services. During an interview on 4/19/17 at 11:02 AM, the Director stated the agency's therapy services were provided under contract with a therapy group. She stated the home health agency received a call from the therapy group office stating Patient #7 was discharged from PT services. She stated she was surprised by the discharge, as the Physical Therapist had not informed the office or the RN Case Manager of his plan to discharge Patient #7. The agency failed to ensure coordination of care between disciplines for Patient #7.	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES	G 144		

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G 144	Continued From page 3 The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure care coordination between disciplines was documented for 2 of 4 patients (#3 and #7) who received therapy services and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. Findings include: 1. Patient #7 was a 74 year old male admitted to the agency on 4/02/17, for care following a surgical fusion of his cervical spine. Additional diagnoses included low back pain, HTN, and asthma. He received SN and PT services. His record, including the POC, for the certification period 4/02/17 to 5/31/17, was reviewed. The Mayo Clinic website, accessed on 4/24/17, stated "Normal pulse oximeter readings usually range from 95 to 100 percent. Values under 90 percent are considered low." Patient #7's record included a PT visit note dated 4/10/17, signed by the PTA. The note stated his oxygen saturation level was 78% when the PTA arrived at his home. The level rose to 91% with deep breathing, but dropped to 81% after performing exercises. The note stated the PTA contacted the home health office to report Patient #7's condition. The note did not state Patient #7's Physical Therapist was notified.	G 144		

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G 144	Continued From page 4 Patient #7's record included a PT visit note dated 4/12/17, signed by the PTA. The note stated his oxygen saturation dropped to 82% with seated exercise, and dropped to 72% with standing exercises. The note stated the PTA contacted the home health office to report Patient #7's condition. The note did not state Patient #7's Physical Therapist was notified. Patient #7's record included a PT note dated 4/14/17, signed by the Physical Therapist. The note did not document his oxygen saturation level, or an assessment of his respiratory status. The note stated Patient #7 achieved his therapy goals and was discharged from PT services. It could not be determined if the Physical Therapist was aware of Patient #7's low oxygen saturation levels on the previous PT visits. During a phone interview on 4/19/17 at 5:00 PM, the Physical Therapist stated he was aware of Patient #7's low oxygen saturation levels during the 2 PTA visits. He confirmed there was no documentation of communication between the Physical Therapist and the PTA regarding Patient #7's oxygenation status. The agency failed to ensure communication regarding Patient #7's status was documented in his record. 2. Patient #3 was a 76 year old female admitted to the agency on 3/10/17, with a primary diagnosis of tibia fracture. Additional diagnoses included generalized muscle weakness, unsteady gait, and asthma. She received SN, PT, and aide services. Her record, including the POC, for the certification period 3/10/17 to 5/08/17, was	G 144		

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G 144	Continued From page 5 reviewed. A PT note, dated 3/13/17, documented Patient #3 fell on 3/10/17. Patient #3 stated she was unable to get up and required the help of 3 neighbors. The note, signed by the PTA, stated Patient #3 had some pain in her buttocks which resolved. There was no documentation Patient #3's RN Case Manager or physician was informed of her fall. During an interview at 10:26 AM on 4/19/17, the Director reviewed the record and confirmed there was no documentation Patient #3's RN Case Manager or physician were informed of her fall. She confirmed the coordination should have been documented in the record. The PTA failed to document coordination with the RN and the physician regarding Patient #3's fall.	G 144		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the agency failed to ensure POCs included all accurate and pertinent	G 159		

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G 159	Continued From page 6 diagnoses, interventions, and equipment for 4 of 11 patients (#4, #6, #7, and #11) whose records were reviewed. This had the potential to result in unmet patient needs and adverse patient outcomes. Findings include: 1. Patient #7 was a 74 year old male admitted to the agency on 4/02/17, for care following a surgical fusion of his cervical spine. Additional diagnoses included low back pain, HTN, and asthma. He received SN and PT services. His record, including the POC, for the certification period 4/02/17 to 5/31/17, was reviewed. Patient #7's record included an SOC comprehensive assessment completed on 4/02/17, signed by the RN Case Manager. The note stated he complained of pain in his neck and lower back that he rated as 5 to 6 on a scale of 0 to 10, with 10 being the worst pain. Patient #7's POC did not include interventions to monitor his pain, or non-pharmacologic methods to address and decrease his pain. During an interview on 4/19/17 at 11:02 AM, the Director reviewed Patient #7's record and stated his POC did not include interventions related to his pain. Patient #7's POC did not include interventions to monitor and mitigate his pain. 2. Patient #4 was an 88 year old female admitted to the agency on 3/12/15. Her record, including the POC, for the certification period 3/01/17 to 4/29/17, was reviewed. For the certification period, Patient #4's primary diagnosis was uterine prolapse. Additional diagnoses included urinary incontinence, muscle weakness, and HTN. She	G 159		

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G 159	Continued From page 7 received SN services. Patient #4's POC included a diagnosis of long term (current) use of aspirin. The current medications listed on her POC did not include aspirin. Patient #4's record included a 60 day summary dated 2/28/17. The summary stated she had been taking aspirin 81 mg daily, and stated it was discontinued on 2/01/17. During an interview on 4/19/17 at 11:00 AM, the Director reviewed Patient #4's record. She confirmed her aspirin was discontinued. The Director stated the diagnosis was carried over from Patient #4's previous certification period, and should not have been included on her current POC. Patient #4's POC included a diagnosis that was not accurate or pertinent to her current status. 3. Patient #11 was an 81 year old female admitted to the agency on 4/18/14. Her record, including the POC, for the certification period 4/02/17 to 5/31/17, was reviewed. For the certification period, Patient #11's diagnosis was vitamin B12 deficiency. Additional diagnoses included insulin dependent DM, CHF, and atrial fibrillation. She received SN services. Patient #11's POC included a diagnosis of dependence on supplemental oxygen. Her POC included an oxygen concentrator. However, her POC did not include an order for oxygen to determine how many liters per minute she should receive, or whether she was to receive oxygen continuously or as needed. During an interview on 4/19/17 at 11:25 AM, the	G 159		

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G 159	Continued From page 8 Director reviewed Patient #11's record. She confirmed her oxygen dosage and frequency was not included on her POC and stated it was an oversight. Patient #11's POC did not include her oxygen dosage or frequency of use. 4. Patient #6 was a 97 year old female admitted to the agency on 1/18/17, with a primary diagnosis of pneumonia. Additional diagnoses included HTN and abnormal gait. Her record, including the POC, for the certification period 1/18/17 to 3/18/17, was reviewed. She received SN, PT, and aide services. An SOC comprehensive assessment, dated 1/18/17, signed by the RN Case Manager, stated Patient #6 was at risk for falls. Patient #6's assessment included the MAHC-10 Fall Risk Assessment, a validated tool to assess risk of falling in community dwelling elders, on which a score of 4 or more is considered at risk for falling. The RN Case Manager documented Patient #6 scored a 5 and was at risk for falling. The POC included keeping walkways clear and safe as part of safety measures. However, the POC did not include any other interventions for fall prevention for Patient #6. During an interview at 10:30 AM on 4/19/17, the Director reviewed Patient #6's record and confirmed her POC did not include individualized interventions for preventing falls. Patient #6's POC did not include interventions to prevent falls.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF	G 164		

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G 164	Continued From page 9 CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure agency professional staff promptly alerted the physician to changes in patient conditions for 2 of 11 patients (#1 and #3) whose records were reviewed. This had the potential to interfere with physician updates to plans of care and to negatively impact safety and quality of patient care. Findings include: 1. Patient #1 was an 87 year old female admitted to the agency on 10/31/16. Her record, including the POCs, for the certification periods 12/30/16 to 2/27/17, and 2/28/17 to 4/28/17, was reviewed. For the certification periods, Patient #1's primary diagnosis was lymphedema. Additional diagnoses included Parkinson's Disease, CHF, and low back pain. She received SN and aide services. a. Patient #1's POC included an order for SN to assess for signs of exacerbation of her CHF, a weakness of the heart that leads to a buildup of fluid in the lungs and other body tissues. The American College of Cardiology website, accessed on 4/24/17, included patient education entitled "Heart Failure: Checking Your Weight Daily." It stated "When you have heart failure, you need to watch for changes in your weight. A sudden weight gain can mean more fluid is building up in your body and your heart failure is	G 164		

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G 164	Continued From page 10 getting worse." Patient #1's record included a recertification assessment completed on 12/26/16, signed by the RN. The assessment stated her current weight was 135 pounds. No weights were documented between 12/26/16 and 2/26/17. Patient #1's record included a recertification assessment completed on 2/27/17, signed by the RN. The assessment stated her current weight was 144 pounds. Patient #1's record did not include documentation stating her physician was notified of her 9 pound weight gain. During an interview on 4/19/17 at 10:45 AM, the Director reviewed Patient #1's record. She confirmed Patient #1's physician was not notified of her weight gain. Patient #1's physician was not notified of a change in her condition. b. Patient #1's POC for the certification period 2/28/17 to 4/28/17, included an order for SN to assess her pain level and her need for further interventions to address her pain. Her POC included a goal of a pain level of 3 or less during the certification period. SN visits during the certification period documented her pain on a scale of 1 to 10 with 10 being the worst pain. Her pain was documented as follows: 2/27/17 - 4 3/06/17 - 6 3/13/17 - 6 3/21/17 - 3 3/27/17 - 8 4/03/17 - 6 4/10/17 - 8	G 164		

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G 164	Continued From page 11 4/17/17 - 6 Patient #1's record did not include documentation of physician notification of her increased levels of pain. During an interview on 4/19/17 at 10:45 AM, the Director reviewed Patient #1's record. She confirmed Patient #1's physician was not notified of her pain. She stated pain levels higher than the patients' stated goal should be addressed and communicated to the physician. Patient #1's physician was not notified of her increased pain. 2. Patient #3 was a 76 year old female admitted to the agency on 3/10/17, with a primary diagnosis of tibia fracture. Additional diagnoses included generalized muscle weakness, unsteady gait, and asthma. She received SN, PT, and aide services. Her record, including the POC, for the certification period 3/10/17 to 5/08/17, was reviewed. a. A PT note, dated 3/13/17, documented Patient #3 fell on 3/10/17. Patient #3 stated she was unable to get up and required the help of 3 neighbors. The note stated Patient #3 had some pain in her buttocks which resolved. There was no documentation Patient #3's physician was informed of her fall. b. An SN visit note, dated 3/10/17, documented Patient #3's weight was 205 pounds. Her next documented weight was 227 pounds on 4/07/17, a gain of 22 pounds in 28 days. During that time SN visit notes documented Patient #3 had 1+ pitting edema on 3/20/17, 3/23/17, 3/27/17,	G 164		

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	137077	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	150 NORTH 200 WEST MALAD, ID 83252

(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 12 4/03/17, and 4/13/17. On 4/07/17 and 4/17/17, SN visit notes documented Patient #3 had non-pitting edema. The National Institutes for Health website, accessed 4/24/17, included a patient education guide for congestive heart failure. It stated heart failure is a condition where the heart is not able to pump blood at a normal rate, resulting in buildup of fluid in the feet, ankles, and legs (called edema). It stated one of the first signs of heart failure is sudden weight gain due to the accumulation of fluid. There was no documentation Patient #3's physician was informed of her weight gain. During an interview at 10:26 AM on 4/19/17, the Director reviewed the record and confirmed there was no documentation Patient #3's physician was informed of her fall or her weight gain. She confirmed Patient #3's physician should have been notified of both. Patient #3's physician was not notified by her RN Case Manager when she fell or gained a significant amount of weight.	G 164		
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs. This STANDARD is not met as evidenced by: Based on medical record review and staff interview it was determined the agency failed to ensure the RN provided necessary instruction to	G 177		

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G 177	Continued From page 13 patients or caregivers for 2 of 11 patients (#7 and #8) whose records were reviewed. This created the potential for patients to experience adverse outcomes. Findings include: 1. Patient #7 was a 74 year old male admitted to the agency on 4/02/17, for care following a surgical fusion of his cervical spine. Additional diagnoses included low back pain, HTN, and asthma. He received SN and PT services. His record, including the POC, for the certification period 4/02/17 to 5/31/17, was reviewed. Patient #7's POC included an order for a soft or liquid diet for 2 weeks, following surgery to his cervical spine. His record did not include documentation of patient education related to his dietary restrictions or the reason for the restrictions. SN visits completed on 4/02/17, 4/07/17, 4/11/17, and 4/14/17, signed by an RN, documented his diet as regular, not soft or liquid. During an interview on 4/19/17 at 11:02 AM, the director reviewed Patient #7's record. She stated he should have received education regarding his dietary restrictions. She confirmed there was no documentation of dietary education. The RN failed to educate Patient #7 regarding his temporary dietary restrictions. 2. Patient #8 was a 74 year old male admitted to the agency on 11/20/13. His record, including the POC, for the certification period 3/04/17 to 5/02/17, was reviewed. For the certification period, Patient #8's primary diagnosis was fitting an adjustment of a urinary device. Additional diagnoses included neuromuscular dysfunction, history of UTI, BPH, venous HTN, emphysema,	G 177		

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G 177	Continued From page 14 hyperlipidemia, DM Type II, and dermatitis. He received SN and aide services. Patient #8's POC listed oxygen as one of his medications and emphysema (a long term, progressive disease of the lungs) as one of his secondary diagnoses. The medication list documented he used 2.5 liters of oxygen continuously at night. A recertification comprehensive assessment, dated 3/02/17, signed by the RN Case Manager, documented Patient #8 smoked10 cigarettes a day and required oxygen. However, there was no documentation related to the safe use of oxygen in the home, especially near open flames and smoking. SN visit notes, dated 3/06/17, 3/20/17, 3/21/17, 3/27/17, 4/03/17, and 4/17/17, did not include documentation of patient education related to Patient #8's use of oxygen in the home. During an interview at 10:32 AM on 4/19/17, the Director reviewed Patient #8's record and confirmed there were no interventions for oxygen use on his POC and no documentation in the SN notes of patient education related to use of oxygen in the home. She was unable to provide documentation of education for Patient #8 by the RN Case Manager. The RN Case Manager failed to provide Patient #8 with education related to the use and safety of oxygen in the home.	G 177		
G 186	484.32 THERAPY SERVICES The qualified therapist assists the physician in	G 186		

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G 186	Continued From page 15 evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure the Physical Therapist assisted the physician in evaluating the patient's level of function for 1 of 4 patients (Patient #7) who received PT services and whose records were reviewed. This had the potential to result in unmet needs. Findings include: Patient #7 was a 74 year old male admitted to the agency on 4/02/17, for care following a surgical fusion of his cervical spine. Additional diagnoses included low back pain, HTN, and asthma. He received SN and PT services. His record, including the POC, for the certification period 4/02/17 to 5/31/17, was reviewed. The Mayo Clinic website, accessed on 4/24/17, stated "Normal pulse oximeter readings usually range from 95 to 100 percent. Values under 90 percent are considered low." Patient #7's record included a PT visit note dated 4/10/17, signed by the PTA. The note stated his oxygen saturation level was 78% when the PTA arrived at his home. The level rose to 91% with deep breathing, but dropped to 81% after performing exercises. Patient #7's record included a PT visit note dated 4/12/17, signed by the PTA. The note stated his oxygen saturation dropped to 82% with seated exercise, and dropped to 72% with standing	G 186		

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G 186	Continued From page 16 exercises. Patient #7's record included a PT note dated 4/14/17, signed by the Physical Therapist. The note did not document his oxygen saturation level, or an assessment of his respiratory status. The note did not state how Patient #7 tolerated activity during the therapy visit. The note stated Patient #7 achieved his therapy goals and was discharged from PT services. During a phone interview on 4/19/17 at 5:00 PM, the Physical Therapist stated that monitoring Patient #7's oxygen saturation level was not part of his PT POC. He stated Patient #7 was monitoring his oxygen saturation levels. He confirmed he did not evaluate Patient #7's oxygen saturation level during his discharge visit on 4/19/17. The Physical Therapist failed to evaluate Patient #7's respiratory status during his PT discharge visit.	G 186		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001420	A. BUILDING: _____ B. WING _____	04/20/2017

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ONEIDA COUNTY HOSPITAL HOME CARE	150 NORTH 200 WEST MALAD, ID 83252

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N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G143 and G144	N 062	RECEIVED MAY 09 2017 FACILITY STANDARDS	
N 099	03.07024.SK. NSG. SERV. N099 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: g. Counsels the patient and family in meeting nursing and related needs; This Rule is not met as evidenced by: Refer to G177	N 099		
N 124	03.07025.01.THERAPY SERV. N124 01. Qualified Therapist. A qualified therapist duties include the following: a. Assists in developing the	N 124		

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N 124	Continued From page 1 plan of care and revising it when necessary; This Rule is not met as evidenced by: Refer to G186	N 124		
N 153	03.07030.PLAN OF CARE N153 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: a. All pertinent diagnoses; This Rule is not met as evidenced by: Refer to G159	N 153		
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 165	03.07030.PLAN OF CARE	N 165		

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N 165	Continued From page 2 N165 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: m. The patient and his family's teaching needs; This Rule is not met as evidenced by: Refer to G159	N 165		
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G164	N 172		

COORDINATION OF PATIENT SERVICES

G143

OCH Home Care will continue to ensure that all personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.

For all current and/or future patients, agency professional staff has and will continue to ensure that all personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.

Staff will be in-serviced related to the federal and state requirements and OCH Home Care policies to assure the understanding of :

- The need for care coordination and follow up with other staff members and disciplines when the patient has a change in condition.

All inservices/training will occur on or before 6/1/2017.

Compliance to the requirement will be monitored by the Home Health Director, or designee with chart audits that are completed. Monitoring for documentation results will be included in the quarterly Performance Improvement report.

G144

OCH Home Care will continue to ensure that the clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.

For all current and/or future patients, agency professional staff has and will continue to ensure that the clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.

Staff will be in-serviced related to the federal and state requirements and OCH Home Care policies to assure the understanding of :

- The need to ensure care coordination between staff and disciplines when the patient has a change in condition.

All inservices/training will occur on or before 6/1/2017.

Compliance to the requirement will be monitored by the Home Health Director, or designee with chart audits that are completed. Monitoring for documentation results will be included in the quarterly Performance Improvement report.

PLAN OF CARE

G 159

OCH Home Care will continue to ensure the plan of care developed in consultation with the agency staff covers all pertinent diagnosis, 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.

For all current and/or future patients, the above items have and will continue to be included in the plan of care.

Staff will be in-serviced related to the federal and state requirements and OCH Home Care policies to assure the understanding of :

- Ensuring that the POC includes all pertinent information including diagnosis, medications interventions and equipment on the plan of care.

All inservices/training will occur on or before 6/1/2017.

Compliance to the requirement will be monitored by the Home Health Director, or designee with chart audits that are completed. Monitoring for documentation results will be included in the quarterly Performance Improvement report.

PERIODIC REVIEW OF PLAN OF CARE

G 164

OCH Home Care will continue to ensure that agency professional staffs promptly alert the physician to any changes that suggest a need to alter the plan of care.

For all current and/or future patients, agency professional staff has and will continue to promptly alert the physician to any changes that suggest a need to alter the plan of care.

Staff will be in-serviced related to the federal and state requirements and OCH Home Care policies to assure the understanding of :

- Ensuring that staff promptly alert the physician to any changes in the POC that suggest a need to alter the plan of care including weight changes, a change in pain or falls.

All inservices/training will occur on or before 6/1/2017.

Home Health Director and agency staff will review plans of care and notes to ensure that the staffs promptly alert the physician to any changes that suggest a need to alter the plan of care.

Compliance to the requirement will be monitored by the Home Health Director, or designee with chart audits that are completed. Monitoring for documentation results will be included in the quarterly Performance Improvement report.

DUTIES OF THE REGISTERED NURSE

G177

OCH Home Care will continue to ensure that the registered nurse counsels the patient and family in meeting nursing and related needs.

For all current and/or future patients, agency professional staff has and will continue to counsel the patient and family in meeting nursing and related needs.

Staff will be in-serviced related to the federal and state requirements and OCH Home Care policies to assure the understanding of:

- Education related to temporary/permanent diet requirements and the use and safety of oxygen in the home.

All inservices/training will occur on or before 6/1/2017.

Compliance to the requirement will be monitored by the Home Health Director, or designee with chart audits that are completed. Monitoring for documentation results will be included in the quarterly Performance Improvement report.

THERAPY SERVICES

G186

OCH Home Care will continue to ensure that the qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)

For all current and/or future patients, agency professional staff has and will continue to assist the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)

Staff will be in-serviced related to the federal and state requirements and OCH Home Care policies to assure the understanding of:

- The needs to assist the physician in evaluating the patient's level of function, and help develop the plan of care (revising it as necessary.)

All inservices/training will occur on or before 6/1/2017.

Compliance to the requirement will be monitored by the Home Health Director, or designee with chart audits that are completed. Monitoring for documentation results will be included in the quarterly Performance Improvement report.

N062 Administrator (See G 143 and 144)

N099 SK NSG. Serv (See G177)

N124 Therapy Serv (See G186)

N153 Plan of Care (See G159)

N165 Plan of Care (See G 159)

N 172 Plan of Care (See G 159)