

C.L. "BUTCH" OTTER - Governor RUSSELL S. BARRON- Director TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. - Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 31, 2017

Joe Frasure, Administrator Aspen Home Care 2867 E Copperpoint Dr Meridian, ID 83642

RE: Aspen Home Care, Provider #137091

Dear Mr. Frasure:

This is to advise you of the findings of the Medicare/Licensure survey at Aspen Home Care, which was concluded on August 28, 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.

Joe Frasure, Administrator August 31, 2017 Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **September 11, 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,

Mennis Kelly RN, Supervisor

Non-Long Term Care

DK/pmt Enclosures

PRINTED: 08/31/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		137091	B, WING		Minimum	08/	28/2017
	ROVIDER OR SUPPLIER	·		28	REET ADDRESS, CITY, STATE, ZIP CODE 367 E COPPERPOINT DR JERIDIAN, ID 83642		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
G 000	INITIAL COMMEN	TS	G	000			
	Medicare recertific	ciencies were cited during the ation survey of your agency /17 to 8/28/17. Surveyors vey were:					
	Gary Guiles, RN, F Brian Osborn, RN,						
	Acronyms used in	this report include:					
	transferring, toileting CHF - Congestive CKD - Chronic Kid COPD - Chronic CDM - Diabetes MeDME - Durable MeDON - Director of HTN - Hypertensic	Heart Failure Iney Disease Obstructive Pulmonary Disease Ilitus edical Equipment Nursing			PRECEIVED SER 1 1 2017 PACILITY STANDAR	DO.	
	such as laundry, h preparation LBS - Pounds MD - Doctor of Me OASIS - Outcome Set	edicine and Assessment Information					
	OT - Occupationa POC - Plan of Car PRN - As Needed PT - Physical The ROC - Resumptio SN - Skilled Nursi SOC - Start of Ca WT - Weight	re rapy n of Care ng					
G 159	484.18(a) PLAN (OF CARE	G	159			
	The plan of care of	developed in consultation with					
LABORATOR	Y DIDECTOR'S OR BROY	IDENSIPPLIER REPRESENTATIVES SIG	ZNATURE		/ TALE / /		(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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:SGDZ11

Fadility ID; OAS001270

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		137091	B, WING			08/2	28/2017
ASPEN I	PROVIDER OR SUPPLIER	DESCRIPTION DE DEFINISHED		28	TREET ADDRESS, CITY, STATE, ZIP CODE 867 E COPPERPOINT DR BERIDIAN, ID 83642		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
G 159	the agency staff co including mental st equipment required prognosis, rehabilit limitations, activities requirements, med safety measures to instructions for time any other appropriate. This STANDARD Based on medical interview, it was deensure POCs including treatments, interve 10 patients (#5 and reviewed. This has unmet patient need outcomes. Finding 1. Patient #5 was to the agency on 8 spinal surgery after included HTN, degreceived SN, PT, a including the POC 8/04/17 to 10/02/11 a. Patient #5's medevaluation visit no Occupational The Therapist docume brace. This DME #5's POC. b. Patient #5's medevaluation visit no evaluation visit no	vers all pertinent diagnoses, atus, types of services and differency of visits, ation potential, functional spermitted, nutritional ications and treatments, any protect against injury, ely discharge or referral, and ate items. is not met as evidenced by: record review and staff elermined the agency failed to ided all accurate and pertinent entions, and equipment for 2 of difference and adverse patient in include: a 70 year old female admitted diod/17, for services related to orcare. Additional diagnoses pression, and pain. She and OT services. Her record, for the certification period		159	Clinical Director will in-service disciplines providing skilled car 09/08/2017 on the need to incall accurate and pertinent treatments, interventions, and equipment to the plan of care of services and equipment requedication and treatment or Clinical Director or audit design will audit 100% of 485/plans of for 5 weeks to ensure all documentation include all accurant pertinent treatments, interventions, and equipment. Target Threshold is 95%. Once threshold is met, will continue audit 10% of 485s/plans of car quarterly.	re by clude (types uired, ers). nee f care urate	9/8/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		137091	B. WING			08/2	8/2017
	PROVIDER OR SUPPLIER HOME CARE			28	REET ADDRESS, CITY, STATE, ZIP CODE 367 E COPPERPOINT DR ERIDIAN, ID 83642	in Estimate	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BÉ	(X5) COMPLETION DATE
G 159	documented Patier This DME was not The DON was interest 2:04 PM, and Pereviewed in her preserviewed in her preserviewed in her preserviewed in her preserviewed all require 2. Patient #8 was to the agency on 7 right femur fracture included DM Type She received SN, record, including the period 7/17/17 to 9 Patient #8's medic orders from her SI her physician. The "NOTIFY MD IF WILBS IN 5 DAYS." Patient #8's medic dated 7/17/17, signification of the physician of the preserviewed in her previewed i	nt #5 used a lumbar brace. included on Patient #5's POC. rviewed on 8/28/17, beginning atient #5's medical record was esence. She confirmed Patient should have been included on to ensure Patient #5's POC d equipment. a 79 year old female admitted /17/17, for services related to a e. Additional diagnoses 2, HTN, CHF, and depression. PT, and OT services. Her he POC, for the certification 0/14/17, was reviewed. all record included discharge NF, dated 7/16/17, signed by the discharge orders included /T > 3 LBS OVERNIGHT OR 5 and record also included a POC, ned by her physician. The POC a previous discharge order to physician regarding her weight		159			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		137091	B. WING		0	08/2	28/2017
	PROVIDER OR SUPPLIER HOME CARE			28	REET ADDRESS, CITY, STATE, ZIP CODE 867 E COPPERPOINT DR IERIDIAN, ID 83642	17.11	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING (NFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) 38 ((X5) COMPLETION DATE
G 159	The agency failed covered all treatmed 484.32 THERAPY The qualified there progress notes. This STANDARD Based on medical interview, it was deen user therapists progress notes for who received the records were revisinterfere with qualifindings include: Patient #8 was and the agency on 7/1 right femur fractur included DM Type She received SN, record, including the period 7/17/17 to Patient #8's medical diagnosis of CHF also included a pito "NOTIFY MD II to LBS IN 5 DAYS Patient #8's CHF	to ensure Patient #8's POC ents. SERVICES apist prepares clinical and is not met as evidenced by: I record review and staff etermined the agency failed to prepared complete clinical and 1 of 10 patients (Patient #8) apy services and whose ewed. This had the potential to ity and safety of patient care. 79 year old female admitted to 7/17, for services related to a e. Additional diagnoses 2, HTN, CHF, and depression. PT, and OT services. Her the POC, for the certification 9/14/17, was reviewed. cal record included a POC, pned by her physician. The POC ent #8 had a secondary . Patient #8's medical record hysician order [related to CHF] F WT > 3 LBS OVERNIGHT OR the certification of the certification order and weight were not ddressed by therapy services.	G	159	G187 Clinical Director will in-service disciplines providing skilled car 09/08/2017 on the need to en all clinicians, specifically theral prepared complete clinical and progress notes (to include CHF weight documentation). Clinical Director or audit design will audit 50% of all therapy of for 5 weeks to ensure clinical documentation and progress are complete. Target Threshold 95%. Once threshold is met work continue to audit 10% of paties records quarterly.	re by sure pists, d and nee otes notes id is	9/8/17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		137091	B, WING			08/28/2017	
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 867 E COPPERPOINT DR TERIDIAN, ID 83642		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
G 187	documented or add Therapist on 4 of 4 OT evaluation vis by the Occupational Or visit note, dal Occupational Thera OT visit note, dal Occupational Thera OT discharge vis by the Occupational 2. Patient #8's CH documented or add Therapist on 9 of 9 PT evaluation vis by the Physical Th PT visit note, da Physical Therapist PT visit note, da Physical Therapis The visit note, da Physical Therapis The DON was interapis The DON was interapis The DON was interapis The DON was interapis	IF and weight were not dressed by the Occupational visits: sit note, dated 7/19/17, signed at Therapist ted 7/21/17, signed by the apist ted 7/25/17, signed by the apist sit note, dated 7/28/17, signed at Therapist IF and weight were not dressed by the Physical ovisits: sit note, dated 7/20/17, signed erapist ted 7/24/17, signed by the ted 7/26/17, signed by the ted 8/05/17, signed by the ted 8/08/17, signed by the ted 8/09/17, signed by the ted 8/09/17, signed by the ted 8/14/17, signed by the ted 8/14/17, signed by the ted 8/15/17, signed by the 4/15/15/15/15/15/15/15/15/15/15/15/15/15/	G	187			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	İ	137091	B. WING		08/2	8/2017
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G 187	Physical and Occu	nge 5 pational Therapists did not ss Patient #8's CHF and	G 187			
G 189	clinical notes for Pa 484.32 THERAPY		G 189	G189 Clinical Director will in-service disciplines on need to participal in-service programs by 09/08/	ate in	9/8/17
	Based on personr interview, it was de ensure participatio of 1 PRN therapy s were reviewed. The	is not met as evidenced by: nel record review and staff etermined the agency failed to n in in-service programs for 1 staff whose personnel records nis had the potential to result in care from under-qualified lings include;		Clinical Director and/or Administrator will audit all personnel files to ensure all standard participated with the insprogram. Target Threshold is 1 Once threshold is met, will cor	ervice 100%.	
	at 9:40 AM, and the personnel file was in-service program Physical Therapis The DON stated F	erviewed on 8/23/17, beginning the PRN Physical Therapist's reviewed in her presence. In verification for the PRN it was not found in his record. PRN staff did not participate in She stated she would ensure ated in the future.		to audit personnel files quarte	1	
G 322	Therapist participa	to ensure the PRN Physical ated in in-service programs, RACY OF ENCODED OASIS	G 322			
		SIS data must accurately reflect s at the time of assessment.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	137091	B. WING	·		08/2	8/2017
NAME OF PROVIDER OR SUPPLIER ASPEN HOME CARE			28	TREET ADDRESS, CITY, STATE, ZIP CODE 867 E COPPERPOINT DR IERIDIAN, ID 83642		
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE !	(X5) COMPLETION DATE
Based on medical interview, it was de ensure encoded Otime of the assessi #5, and #8) whose resulted in the repodata. Findings incl. 1. Patient #5 was to the agency on 8 spinal surgery afte included HTN, depreceived SN, PT, a including the POC 8/04/17 to 10/02/1 Patient #5's medic SOC visit note, da Case Manager. Tincluded "M1340 E Surgical Wound?" Manager documer did have a manager's a M1340 answer was 17 me agency failed OASIS data was a 2. Patient #2 was to the agency on right hip fracture.	is not met as evidenced by: record review and staff stermined the agency failed to ASIS data was accurate at the ment for 3 of 10 patients (#2, records were reviewed. This bring of inaccurate OASIS lude: a 70 year old female admitted //04/17, for services related to reare. Additional diagnoses bression, and pain. She and OT services. Her record, for the certification period for the certification period for was reviewed. al record included an OASIS ted 8/04/17, signed by her RN the OASIS SOC visit note boos this patient have a to which the RN Case to which the RN Case to which the RN Case anted "No." However, Patient #5 ented spinal surgical wound dission. erviewed on 8/28/17, beginning attent #5's medical record was esence. She confirmed the RN answer to the OASIS SOC as not accurate. to ensure Patient #5's encoded		322	G322 Clinical Director will in-service staff on need to ensure enco OASIS data is accurate at time assessment by 09/08/2017. Clinical Director or audit desi will audit 100% of OASIS assessments to ensure encodo OASIS data is accurate at time assessment. Target Threshold 95%. Once threshold is met we continue to audit 10% of OASIS assessments quarterly.	ded e of ded e of d is	9/8/17

Childir	O LON MILDIOMINE	O MEDICALO SERVICEO				1112 110.	7000-000 1
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUC A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		137091	B. WING			08/2	8/2017
	PROVIDER OR SUPPLIER			28	REET ADDRESS, CITY, STATE, ZIP CODE 167 E COPPERPOINT DR ERIDIAN, ID 83642		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
G 322	services. Her reco- certification period reviewed. Patient #2's medicing Soc visit note, dat Don. The OASIS "M1018 Conditions Regimen Change of Days" to which the Incontinence." Hourinary incontinence. Hourinary incontinence. The Don was interested in her prooper of the agency on 7 right femur fractur included DM Type She received SN, record, including the period 7/17/17 to 9 Patient #8's medical Roc visit note, da Don. The OASIS "M1000 From white Facilities was the past 14 days?" to "Skilled Nursing Fire and the past 14 days?" to "Skilled Nursing Fire in the past 14 days?" to "Ski	rd, including the POC, for the 7/19/17 to 9/16/17, was all record included an OASIS and 7/19/17, signed by the SOC visit note included a Prior to Medical or Treatment or Inpatient Stay Within Past 14 DON documented "Uninary wever, Patient #2 did not have		322	DEFICIENCY		
	at 1:16 PM, and F	erviewed on 8/28/17, beginning Patient #8's medical record was resence. She confirmed her					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		137091	B, WING		W.	08/2	8/2017
	PROVIDER OR SUPPLIER HOME CARE			28	REET ADDRESS, CITY, STATE, ZIP CODE 867 E COPPERPOINT DR ERIDIAN, ID 83642		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	PREF) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-RÉFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
G 322	answer to the OAS not accurate. The agency failed OASIS data was a 484.55(a)(1) INITIA A registered nurse assessment visit to and support needs Medicare patients, Medicare home he homebound status This STANDARD Based on staff intrecords, it was detensure an assess support needs of 2 whose records we This had the poter unmet care needs 1. Patient #6 was admitted for home She was currently diagnoses include to her lung. A phy 10:00 AM, stated coronary artery by medical record for 6/29/17 to 8/27/17 reviewed. Patient #6's SOC dated 6/29/17 but cancer and had u	to ensure Patient #8's encoded ccurate. AL ASSESSMENT VISIT must conduct an initial o determine the immediate care to fthe patient; and, for to determine eligibility for the patient, including			G331 Clinical Director will in-service a staff by 09/08/2017 on the nee ensure the assessment determithe care and support needs, including physical therapy, occupational therapy, social services, home health aide, nuretc. Clinical Director or audit design will audit 100% of initial assessments for 5 weeks to enthat the patient has all the care support needs they require on health services. Target thresholds is met, we continue to monitor 10% of initial assessments quarterly.	ed to ines rsing, nee sure e and home old is ill	9/8/17

NAME OF PROVIDER OR SUPPLIER ASPEN HOME CARE STREET ADDRESS, CITY, STATE, ZIP CODE 2857 E COPPERPOINT OR 2857 E COPPERPOINT 2857 E COPPER 2857 E COPPERPOINT 2857 E COPPER 2857 E COPPERPOINT 2857 E COPPERPOINT 2857 E COPPERPOINT 2857 E		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 287 E COPPERPOINT DR MERIDIAN, ID 33642			137091	B. WING			08/2	8/2017
PRÉFIX TAG GACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLÉTION CONTINUED From page 9 ovaries. The assessment stated since the surgery, Patient #6"had increased weakness, decreased endurance, and unsteady gait, fall risk which make it difficult for her to accomplish ADLs and IADLs safely and independently." The assessment stated she lived at home with her daughter. Patient #6 was hospitalized on 7/25/17 for CHF. Her home health care was resumed on 7/31/17. An ROC assessment, dated 7/31/17 at 1:05 PM, stated she was "re-hospitalized recently due to a CHF exacerbation." The assessment again stated Patient #6 had difficulty with her ADLs and IADLs. Neither assessment documented the ability of Patient #6's daughter to care for her or whether Patient #6 could benefit from home health aide services. The DON reviewed Patient #6's medical record on 8/25/17 beginning at 1:40 PM. She stated there was no documentation of Patient #6's potential need for aide services. The agency did not assess Patient #6's care needs. 2. Patient #10 was an 94 year old female who was admitted for home health services on 8/23/17. Her diagnoses included fractured pelvis, bipolar disorder, and COPD. She was oxygen dependent. Patient #10's medical record for the					28	67 E COPPERPOINT DR		
ovaries. The assessment stated since the surgery, Patient #6"had increased weakness, decreased endurance, and unsteady gait, fall risk which make it difficult for her to accomplish ADLs and IADLs safely and independently." The assessment stated she lived at home with her daughter. Patient #6 was hospitalized on 7/25/17 for CHF. Her home health care was resumed on 7/31/17. An ROC assessment, dated 7/31/17 at 1:05 PM, stated she was "re-hospitalized recently due to a CHF exacerbation." The assessment again stated Patient #6 had difficulty with her ADLs and IADLs. Neither assessment documented the ability of Patient #6's daughter to care for her or whether Patient #6's daughter to care for her or whether Patient #6's could benefit from home health aide services. The DON reviewed Patient #6's medical record on 8/25/17 beginning at 1:40 PM. She stated there was no documentation of Patient #6's potential need for aide services. The agency did not assess Patient #6's care needs. 2. Patient #10 was an 94 year old female who was admitted for home health services on 8/4/17. Her diagnoses included fractured pelvis, bipplar disorder, and COPD. She was oxygen dependent. Patient #10's medical record for the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	JBE {	CONPLETION DATE
certification period 8/14/17 to 10/12/17 was reviewed. Patient #10's SOC comprehensive assessment	G 331	ovaries. The assesurgery, Patlent #6 decreased endural which make it difficand IADLs safely a assessment stated daughter. Patient #6 was hos Her home health of An ROC assessment stated she was " a CHF exacerbatic stated Patient #6 is IADLs. Neither assessme Patient #6 could be services. The DON reviewed on 8/25/17 beginn there was no doct potential need for The agency did not needs. 2. Patient #10 was was admitted for 8/14/17. She was 8/23/17. Her diag bipolar disorder, a dependent. Paties certification period reviewed.	issment stated since the "had increased weakness, nee, and unsteady gait, fall risk sult for her to accomplish ADLs and independently." The she lived at home with her spitalized on 7/25/17 for CHF, are was resumed on 7/31/17. Int, dated 7/31/17 at 1:05 PM, re-hospitalized recently due to on." The assessment again had difficulty with her ADLs and int documented the ability of after to care for her or whether enefit from home health aide of Patient #6's medical recording at 1:40 PM. She stated amentation of Patient #6's aide services. In assess Patient #6's care as an 94 year old female who home health services on gnoses included fractured pelvis, and COPD. She was oxygen at #10's medical record for the dis/14/17 to 10/12/17 was		331			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		137091	B. WING	Y-044		08/28/2017
	PROVIDER OR SUPPLIER HOME CARE			STREET ADDRESS, CITY, STATE, ZIP 2867 E COPPERPOINT DR MERIDIAN, ID 83642	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
G 331	was dated 8/14/17 stated she lived wil assessment stated weakness, decreas increased impaired increased short ter increased fall risk.' Patient #6 had diffi The assessment d Patient #10's daug Patient #10 could I services.	at 10:30 AM. The assessment th her daughter. The Patient #10"had increased sed endurance, unsteady gait, decision making due to m memory loss and is at an The assessment stated culty with her ADLs and IADLs, id not document the ability of their to care for her or whether benefit from home health aide assess Patient #10's care	GS	331		

STATEMEN	T FACILITY STANDARDS TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		OAS001270	B. WING		08/28	3/2017
	ROVIDER OR SUPPLIER	2867 E CC	PPERPOINT	STATE, ZIP CODE F DR		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MEMIDIAN TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID 83642	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICENCY)	DBE	(X5) COMPLETE DATE
N 126	The following defice Medicare recertification of the sundanted on 8/22 conducting the sundante of the sundante	iencies were cited during the ation survey of your agency 17 to 8/28/17. Surveyors vey were: IFS, Team Leader HFS PY SERV. Id Therapist. A duties include the inical and ad summaries of care, pet as evidenced by: PY SERV.	N 000 N 126 N 127	N126 Clinical Director will in-service disciplines providing skilled co 09/08/2017 on the need to e all clinicians, specifically there prepared complete clinical ar progress notes (to include CH weight documentation). Clinical Director or audit designated will audit 50% of all therapy of for 5 weeks to ensure clinical documentation and progress are complete. Target Threshold is met we continue to audit 10% of patimeter to audit 10% of patimeter to a continue	are by nsure apists, ad IF and gnee notes notes old is vill ent	9/8/17
N 158	following: d. Participates programs, This Rule is not n Refer to G-189. 03.07030. PLAN (N155 01. Writter written plan of car	in in-service net as evidenced by: OF CARE n Plan of Care. A	N 155	disciplines on need to particip in-service programs by 09/08, Clinical Director and/or Administrator will audit all personnel files to ensure all s have participated with the in- program. Target Threshold is Once threshold is met, will co to audit personnel files quart	taff service 100%.	

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

ATT FORM

Administrates

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If continuation sheet 1 of

Bureau of Facility Standards (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING OA\$001270 08/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2867 E COPPERPOINT DR ASPEN HOME CARE MERIDIAN, ID 83642 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX ID PREFIX (X6) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY N 155 Continued From page 1 N 155 N155 9/8/17 Clinical Director will in-service all patient by all disciplines providing services for that patient. Care disciplines providing skilled care by follows the written plan of care and 09/08/2017 on the need to include includes: all accurate and pertinent c. Types of services and treatments, interventions, and equipment required; equipment to the plan of care (types of services and equipment required, This Rule is not met as evidenced by: Refer to G-159. medication and treatment orders). N 161 N 161 03.07030.PLAN OF CARE Clinical Director or audit designee will audit 100% of 485/plans of care N161 01. Written Plan of Care, A written plan of care shall be for 5 weeks to ensure all developed and implemented for each documentation include all accurate patient by all disciplines providing and pertinent treatments. services for that patient. Care follows the written plan of care and interventions, and equipment. includes: Target Threshold is 95%. Once threshold is met, will continue to i. Medication and treatment orders; audit 10% of 485s/plans of care guarterly. This Rule is not met as evidenced by: N161 Refer to G-159. 9/8/17 Clinical Director will in-service all disciplines providing skilled care by 09/08/2017 on the need to include all accurate and pertinent treatments, interventions, and equipment to the plan of care (types) of services and equipment required, medication and treatment orders). Clinical Director or audit designee will audit 100% of 485/plans of care Bureau of Facility Standards illon sheet 2 of 2 STATE FORM sc for 5 weeks to ensure all documentation include all accurate and pertinent treatments. interventions, and equipment. Target Threshold is 95%. Once threshold is met, will continue to audit 10% of 485s/plans of care

quarterly.