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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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January 21, 2020

Randy Schellhous, Administrator
Encompass Health Home Health Of Idaho
6688 N. Central Expwy, Suite 1300
Dallas, TX 75206

RE: Encompass Health Home Health Of Idaho, Provider #137100

Dear Mr. Schellhous:

On January 8, 2020, a follow-up visit of your facility, Encompass Health Home Health Of Idaho, was conducted to verify corrections of deficiencies noted during the survey of November 18, 2019.

We were able to determine that the Condition of Participation of:
Care Planning, coordination, quality of car (42 CFR 484.60),
Skilled Professional Services (42 CFR 484.75, and
Organization and administration of services (42 CFR 484.105) are now met.

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

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

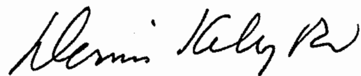
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;

- Monitoring and tracking procedures to ensure the PoC is effective in bringing the 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 **February 3, 2020**, and keep a copy for your records.

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

Sincerely,



DENNIS KELLY, Supervisor
Non-Long Term Care

DK/ac
Enclosures
ec: Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137100	A. BUILDING ______ B. WING ______	R 01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCOMPASS HEALTH HOME HEALTH OF IDAHO	16151 N BRINSON ST NAMPA, ID 83687

(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 follow-up survey conducted on 1/06/20 to 1/08/20. Surveyors conducting the follow-up survey were: Teresa Hamblin, RN, MS, HFS Trish O'Hara, RN, HFS Acronyms used in this report include: DM - Diabetes Mellitus DME - Durable Medical Equipment MRSA - Methicillin-Resistant Staphylococcus Aureus SOC - Start of Care SN - Skilled Nursing MD - Medical Doctor MSW - Medical Social Worker OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy PTA - Physical Therapy Assistant RN - Registered Nurse SN - Skilled Nursing ST - Speech Therapy	{G 000}	RECEIVED FEB - 3 2020 FACILITY STANDARDS	
G 578	Conformance with physician orders CFR(s): 484.60(b) Standard: Conformance with physician orders. This STANDARD is not met as evidenced by: Based on patient medical record review and staff interview, it was determined the agency failed to ensure services were provided as ordered by the physician for 2 of 8 patients (Patients #3 and #4) whose records were reviewed. This failure had the potential for inappropriate patient care, lack of needed patient care, and negative patient outcomes. Findings include:	G 578	Please see the attached Plan of Correction	2/13/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Regional Administrator	1/31/2020

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 578	Continued From page 1 1. Patient #3 was a 69 year old female with an admitting diagnosis of mild cognitive impairment. Her record, including the POC, for the certification period 12/27/19 - 2/24/20 was reviewed. A physician referral, dated 12/23/19, signed by a physician, ordered "Home Health: Nursing Eval [evaluation], Home Care Assistance." Patient #3's record showed an initial visit and assessment had been performed by an ST on 12/27/19. There was no documented nursing evaluation as ordered. A verbal order was obtained from the physician's office on 12/26/19 stating "ST/OT to eval [evaluate] and treat." The order did not include the exclusion of the ordered nursing evaluation. In an interview on 1/08/20, starting at 8:00 AM, the Interim Branch Director said the discipline change was made by another branch director after a review of additional M.D. office visit documentation included with Patient #3's referral. She also stated the 12/26/19 verbal order should have included the exclusion of the ordered nursing evaluation. The agency failed to ensure services were rendered as ordered by the physician. 2. Patient #4 was a 74 year old female admitted to the agency on 12/19/19 with a primary diagnosis of sepsis due to MRSA. Additional diagnoses included a history of myocardial infarction, urinary tract infection, and DM Type 2. She received SN, PT, OT, and MSW services. Her record, including the POC, for the certification	G 578		

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G 578	Continued From page 2 period 12/19/19 to 2/16/20, was reviewed. A physician's signed referral order, dated 12/17/19, included an order for a bath aide. There was no documentation in Patient #4's record aide services were provided or offered and refused. The Interim Branch Director was interviewed on 1/08/20 at 9:30 AM. She reviewed Patient #4's record and confirmed there was no documentation indicating bath aide services were provided or offered. She stated OT services were provided to assist Patient #4 with bathing instruction. She stated she would have expected to see documentation a bath aide was offered and refused and the physician was notified. An order for bath aide services for Patient #4 was not provided in accordance with a physician's referral order.	G 578		
{G 606}	Integrate all services CFR(s): 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is not met as evidenced by: Based on medical record review, agency policy review, observation, and staff interview, it was determined the agency failed to ensure coordination of patient care between MSW and SN services for 1 of 8 patients (Patient #5) whose records were reviewed. This had the potential for unmet patient needs. Findings include:	{G 606}	Please see the attached Plan of Correction	2/13/2020

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{G 606}	Continued From page 3	{G 606}		

An agency policy "CARE COORDINATION," undated, stated, "It will be the responsibility of the Case Manager to facilitate communication about changes in the patient status among assigned personnel...Timely and ongoing communication is the responsibility of each team member, will be appropriate to the needs and abilities of the patient, and will be relevant to the care provided. The clinicians will be responsible for facilitating communications in the patient's status among the assigned personnel...Written evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patient's clinical record." This policy was not followed. Findings include:

Patient #5 was a 58 year old male with admitting diagnoses, on 12/20/19, of hypertension and DM type 2.

On 1/03/20 the agency received a physician's order from a wound care clinic in a nearby town, ordering an agency MSW evaluation for Patient #5. The order was specifically for evaluation of Patient #5's transportation needs for wound care clinic appointments. The order was directed to the agency MSW.

There was no evidence the RN Case Manager was made aware of the order.

In an interview on 1/07/20 starting at 8:00 AM, the Interim Branch Director said she had spoken with the MSW. The MSW said she had not completed a Client Coordination Note Report or communicated the wound clinic care clinic information to other team disciplines.

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{G 606}	Continued From page 4 In an interview on 01/08/20 at 3:45 PM, the Interim Branch Director said she had spoken with the RN Case Manager. The Case Manager said she was not aware Patient #5 was being seen by the wound care clinic. The agency failed to ensure integration of outside services, and failed to ensure coordination of care between disciplines occurred for Patient #5. 2. Patient #1 was an 83 year old female admitted to the agency on 12/24/19 for pneumonia due to MRSA. Additional diagnoses included dysphagia, multiple sclerosis, pressure ulcer of the sacral region, and dependence on supplemental oxygen. She received SN, PT, OT, and ST services. Her record, including the POC, for certification period 12/24/19 to 2/21/20, was reviewed. a. A "Medical Record Coordination Notes Report," documented an entry by a Speech Therapist. It stated "[name redacted] FROM [name redacted] DOCTOR [name redacted] OFFICE WANTED TO KNOW IF NURSING WAS ABLE TO CHANGE PATIENT [Patient #1's] CATHETER YESTERDAY. SLP [Speech Language Pathologist] TOLD HER THAT WE WOULD CONTACT THE PATIENT HOME HEALTH NURSE TO RESPOND TO THIS INQUIRY. EMAIL SENT TO [name redacted] RN." There was no documentation to indicate the information was clarified with nursing staff and Patient #1's physician office was informed as to whether nursing staff was able to change Patient #1's catheter the prior day.	{G 606}		

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{G 606}	Continued From page 5 The Interim Branch Director was interviewed on 1/08/20 at 8:30 AM. She reviewed Patient #1's medical record and confirmed there was no documentation of coordination with the RN or again with Patient #1's physician office. b. A home visit was conducted on 1/07/20 from 12:55 PM until 2:45 PM to observe the services of a PTA. i. During the home visit, the PTA stated "Oh, oxygen is not on her medication list." Patient #1 was observed to be on 2 liters of oxygen via nasal cannula. There was no documentation the PTA reported to an RN or PT the omission of oxygen on Patient #1's medication list. ii. During the medication review with the PTA, the daughter stated Patient #1 took Gabapentin 800 mg 1/2 tab 2 times per day rather than one time per day, as stated on her medication list. The daughter clarified Patient #1 also took 1 full 800 mg tab of Gabapentin in addition to the the 2 half tabs. There was no documentation to indicate the medication discrepancy was reported to the RN or PT. iii. During the home visit, the PTA discovered acetaminophen, a medication not on Patient #1's medication list. Patient #1's daughter explained to the PTA that her mother (Patient #1) had never used it, would never use it because she preferred to take Excedrin. The PTA visit note, dated 1/07/19, documented reporting "IDENTIFUED [sic] ACETEMINOPHEN [sic] 325 MG AS NEW MED [medication] FOUND." The note did not communicate the daughter's additional relevant comments about the medication.	{G 606}		

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{G 606}	Continued From page 6 The Interim Branch Director was interviewed on 1/08/20 at 8:30 AM. She reviewed Patient #1's record and confirmed PTA documentation did not document reporting of the oxygen omission from the medication list, the discrepancy in the Gabapentin dosage, and the additional comments related to the acetaminophen. Documentation did not indicate coordination of care for Patient #1 did not occur effectively between a PTA and RN or PT staff.	{G 606}		
{G 716}	Preparing clinical notes CFR(s): 484.75(b)(6) Preparing clinical notes; This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined, the agency failed to ensure clinical notes were complete and accurate for 1 of 8 patients (Patient #1) whose records were reviewed. This had the potential to interfere with coordination of patient care. Findings include: Patient #1 was an 83 year old female admitted to the agency on 12/24/19 for pneumonia due to MRSA. Additional diagnoses included dysphagia, multiple sclerosis, pressure ulcer of the sacral region, and dependence on supplemental oxygen. She received SN, PT, OT, and ST services. Her record, including the POC, for certification period 12/24/19 to 2/21/20, was reviewed. Clinical record documentation was incomplete or inaccurate. Examples include: a. A SOC assessment, dated 12/24/19, signed	{G 716}	Please see the attached Plan of Correction	2/13/2020

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{G 716}	Continued From page 7 by an RN, included documentation Patient #1's height and weight were assessed. Her height and weight were both documented as zero. This documentation was not accurate. b. A PTA visit note, dated 1/07/20, documented Patient #1's oxygen saturation level was 96 percent on room air. A surveyor was present at the home visit. Patient #1 was observed to be on oxygen at 2 liters during the visit, including the time oxygen saturation levels were assessed. The documentation was not accurate. The Interim Branch Director was interviewed on 1/08/20 at 8:30 AM. She reviewed Patient #1's record and confirmed the height and weight documented at SOC were not accurate. She also confirmed the PTA visit note, dated 1/07/20, stated oxygen saturation level was documented as taken on room air rather than while on oxygen. Patient #1's medical record documentation was incomplete or inaccurate.	{G 716}		

G578 Conformance with physician orders
CFR(s):484.60(b)

January 9, 2020

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Policy Review

RECEIVED
FEB -3 2020
FACILITY STANDARDS

2/13/2020
A review of policy/ies and documents:

- Service Delivery 5.0: Coordination of Care
- Service Delivery 6.0: Physician's Role

were completed to confirm compliance to federal and state regulations.
(See Attachment S05, S06)

The policies were found to support all federal and state requirements in relationship to provide services as ordered by the physician. No changes were made to the policies at this time. All policies are available for staff review to assure they are appropriately followed. The requirement to adhere to all company policies will be reinforced with all staff on an ongoing basis.

Implementation of Plan:
The Clinical Manager will ensure staff will be inserviced, at the weekly mandatory case conference to include all clinical staff, related to the federal and state requirements and Encompass policies to ensure services are provided as ordered by the physician.

Planned In Service-
All planned in service/training will occur on or before February 13, 2020.

Follow up:
All in services/training will occur on or before February 13, 2020. Ongoing chart audits of at least 10% will be completed weekly by the local branch leaders and quarterly by the clinical operations auditor. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar.

Compliance:

Compliance will be met on or before February 13, 2020.
If ongoing 100 % compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits will occur to ensure ongoing compliance.

G606 Integrate All Services
CFR(s): 484.60(d)(3)

January 9, 2020

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Policy Review

2/13/2020
A review of policy/ies and documents:

- Service Delivery 1.0: Scope of Services
- Service Delivery 5.0: Coordination of Care

were completed to confirm compliance to federal and state regulations.
(See Attachment S01, S05)

The policies were found to support all federal and state requirements in relationship to having coordination of patient care with the interdisciplinary team and outside services. No changes were made to the policies at this time. All policies are available for staff review to assure they are appropriately followed. The requirement to adhere to all company policies will be reinforced with all staff on an ongoing basis.

Implementation of Plan:
The Clinical Manager will ensure staff will be inserviced, at the weekly mandatory case conference to include all clinical staff, related to the federal and state requirements and Encompass policies to ensure coordination of care with the interdisciplinary team and outside services occurs.

Planned In Service-
All planned in service/training will occur on or before February 13, 2020.

Follow up:
All in services/training will occur on or before February 13, 2020. Ongoing chart audits of at least 10% will be completed weekly by the local branch leaders and quarterly by the clinical operations auditor. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar.

Compliance:

Compliance will be met on or before February 13, 2020

If ongoing 100 % compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits will occur to ensure ongoing compliance.

G716 Preparing Clinical Notes
CFR(s): 484.75(b)(6)

January 9, 2020

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Policy Review

2/13/2020
A review of policy/ies and documents:

- Service Delivery 14.0: Clinical Records Home Health

(See Attachment S14)

The policies were found to support all federal and state requirements in relationship to having clinical notes that were prepared, complete, and accurate. No changes were made to the policies at this time. All policies are available for staff review to assure they are appropriately followed. The requirement to adhere to all company policies will be reinforced with all staff on an ongoing basis.

Implementation of Plan:
The Clinical Manager will ensure staff will be inserviced, at the weekly mandatory case conference to include all clinical staff, related to the federal and state requirements and Encompass policies to ensure clinical notes are prepared, complete, and accurate.

Planned In Service-
All planned in service/training will occur on or before February 13, 2020

Follow up:
All in services/training will occur on or before February 13, 2020. Ongoing chart audits of at least 10% will be completed weekly by the local branch leaders and quarterly by the clinical operations auditor. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar.

Compliance:

Compliance will be met on or before February 13, 2020

If ongoing 100 % compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits will occur to ensure ongoing compliance.