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
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April 17, 2014

Jana Stowell, Administrator
St Alphonsus HHA & Hospice, An Amedisys Partner
9199 West Black Eagle Drive
Boise, ID 83709-1572

RE: St Alphonsus HHA & Hospice, An Amedisys Partner, Provider #137006

Dear Ms. Stowell:

On April 10, 2014, a follow-up visit of your facility, St Alphonsus HHA & Hospice, An Amedisys Partner, was conducted to verify corrections of deficiencies noted during the survey of 02/24/2014.

We were able to determine that the **Conditions of Participation of Organization, Services & Administration (42 CFR 484.14) and Acceptance of Patients, POC, Med Surper (42 CFR 484.18)** are now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Also 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 **April 30, 2014**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626.

Sincerely,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures
ec: Kate Mitchell, CMS Region X Office

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

PRINTED: 04/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137006	A. BUILDING _____ B. WING _____	R 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER	9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709

(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 of your home health agency on 4/09/14 through 4/10/14. Surveyors conducting the follow up were: Susan Costa, RN, HFS - Team Leader Nancy Bax, RN, BSN, HFS Acronyms used in this report include: DME - Durable Medical Equipment DOO - Director of Operations HHA - Home Health Aide MSW - Medical Social Worker OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy RN - Registered Nurse SLP - Speech Language Pathologist SN - Skilled Nursing SOC - Start of Care TED hose - Thrombo Embolic Deterrent (compression stockings)	{G 000}		
{G 158}	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to	{G 158}	G158 The agency will follow a written plan established by the physician of care for each patient as outlined in AA-003 Patient Assessment/Reassessment and TX-001 Physician Orders. The DOO or designee will be responsible for correcting this deficiency and ensuring ongoing compliance to the regulation. The findings of this survey will be presented to the clinicians at the staff meetings scheduled for 4/30/14 by the DOO or Regional Director of Operations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sara Stovall RN Director of Operations 4.29.14

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 participatien.

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{G 158}	Continued From page 1 ensure care followed a written POC for 2 of 8 patients (#1, #4) whose records were reviewed. This resulted in delayed implementation of therapy services, missed visits and care provided without physicians' orders. Findings include: 1. Patient #4 was an 83 year old female admitted to the agency on 3/29/14, following a right total hip replacement. Additional diagnoses included HTN and chronic venous embolism (blood clots in the veins). Patient #4's orders for home health included SN, PT, OT and HHA services. The agency's policy AA-003, titled "Patient Assessment/Reassessment", stated "When rehabilitation therapy (PT, OT, and SLP) is ordered, in addition to nursing, the licensed therapist will perform the initial evaluation/assessment within 72 hours of the date of the order, unless otherwise directed by the physician or upon special request of the patient/family, or per state regulations." Patient #4's record for the certification period of 3/29/14 to 5/27/14 was reviewed. The SOC assessment was completed by an RN on Saturday, 3/29/14. The PT evaluation was completed on Thursday, 4/03/14, 5 days after the SOC. Patient #4's record did not include documentation the physician or the patient requested a delay in the implementation of PT services. Additionally, there was no documentation showing the physician was informed of the delay. During an interview on 4/10/14 at 4:55 PM, the DOO reviewed Patient #4's record. She confirmed the PT evaluation was late and did not comply with the agency's policy. The DOO	{G 158}	The process for scheduling all new evaluations in the appropriate time frame will be reviewed with all clinicians and schedulers week of 4/28/14. A process has been developed to ensure the clinicians report any additional services for therapy to the clinical manager no later than the morning following the admission and receipt for additional disciplines to include HHA. This will be completed on a calendar that will be submitted to the schedulers immediately for processing. The Clinical managers and the schedulers will meet daily to discuss all admissions, pending and completed evaluations to ensure the appropriate timeline is met. There will be further review with the office staff the week of 4/28/14 regarding the process of faxing all missed visits that do not document the MD has been notified. The fax confirmation sheet will be attached to the missed visit note and become part of the patient record. The paperwork is to be turned at a minimum of every other day to allow the notification to the MD to be timely.	

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{G 158}	Continued From page 2 confirmed Patient #4's physician was not informed of the delayed PT evaluation, and stated she was unable to determine why the evaluation was delayed. Patient #4 did not receive her initial PT evaluation within 72 hours of her SOC, as required by the agency's policy. Her physician was not informed of the delay in implementation of PT services. 2. Patient #1 was a 75 year old female admitted to the agency on 3/03/14 following a hospitalization for pneumonia. Additional diagnoses included chronic kidney disease, muscle weakness and congestive heart failure. Patient #1 received SN, PT, OT and HHA services from the agency. Her record for the certification period of 3/03/14 to 5/01/14 was reviewed. Patient #1's POC was updated on 3/19/14 following a hospitalization. The updated orders included HHA visits once a week for one week, and twice a week for 3 weeks, beginning 3/19/14. The week of 3/31/14 was the third week, therefore 2 HHA visits were ordered. An HHA visit was documented on Monday 3/31/14. No other HHA visits were documented that week. A "MISSED VISIT NOTE" was dated 4/03/14, and signed by the HHA. There was no documentation in the record to indicate Patient #1's physician was informed of the missed visit. During an interview on 4/10/14 at 4:45 PM, the DOO reviewed Patient #1's record and confirmed her physician was not notified of the missed HHA visit. Patient #1's HHA visits did not follow her POC.	{G 158}	Monitoring process: Frequencies will be monitored daily by the schedulers at the time of "call off". If a visit is not made, the clinician will be asked for a missed visit note and the information will be given to the clinical manager for the appropriate follow up. The admissions and evaluations will be discussed at the scheduling meeting that occurs on a daily basis and is attended by the Director of Operations (DOO), Business Office Manager (BOM), the schedulers and the clinical managers (CM). It will be determined that all evaluations are scheduled appropriately and have occurred as scheduled. If compliance is determined not to have occurred there will be an immediate in-service with appropriate personnel. The DOO or clinical designee will audit 20% of active and discharge charts emphasizing conformance with MD orders as well as timely evaluations, utilizing the Saint Alphonsus Home Health Survey Audit Tool. Once significant compliance is realized, the agency will resume clinical records review of 10% of patient census. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly.	

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{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 patient records and staff interview, it was determined the agency failed to ensure POCs included all pertinent information, including diagnosis and appropriate nursing interventions, equipment, wound status and care instructions and treatments for 2 of 8 patients (#3 and #4) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include: 1. Patient #4 was an 83 year old female admitted to the agency on 3/29/14, following a right total hip replacement. Additional diagnoses included HTN and chronic venous embolism (blood clots in the veins). Patient #4 received SN, PT, OT and HHA services from the agency. Patient #4's POC for the certification period 3/31/14 to 5/27/14 was reviewed. The POC was missing pertinent information as follows: a. The SOC assessment completed by the RN on 3/29/14, indicated Patient #4 had a dressing in place to a surgical wound on her right hip.	{G 159}	The findings will also be discussed on the weekly AVP call as indicated. Completion date: 5/1/14 G 159 The plan of care developed with the agency staff and MD will cover pertinent diagnosis, nursing interventions, equipment, wound care instructions and all pertinent treatments at a minimum as outlined in TX-001 Physician Orders. The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance. The findings of this survey will be presented to the clinicians at the staff meeting scheduled on 4/30/14 by the DOO or Regional Director of Operations. It will be reviewed with all clinicians regarding the importance of documenting the wound appearance, measurements, wound care and application of dressings and any education regarding surgical wounds. The specific clinician related to this deficiency will be in-serviced in addition to the general meeting the same week. It will be reviewed will all clinicians the importance of including all aspects pertaining to an anticoagulant such as	

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{G 159}	Continued From page 4 However, the POC did not include information regarding Patient #4's surgical wound, including wound appearance, measurements, wound care, application of dressings or patient education regarding care of her surgical wound. b. The SOC assessment completed by the RN indicated Patient #4 had an additional skin lesion that was to receive care by the agency clinicians. However, the POC did not include information pertaining to a skin lesion, including location, assessment, measurements, wound care or patient education regarding care of the lesion. c. Patient #4's medication list included Lovenox, a medication that thins the blood to prevent blood clots following a surgery or period of inactivity. Lovenox is injected into the subcutaneous tissue. The Lovenox was marked as a new medication for Patient #4. Her POC did not include orders to educate the patient or caregiver regarding the proper administration of the injectable medication, or precautions related to medications that thin the blood. d. The OT evaluation completed on 4/01/14 stated Patient #4 had a shower chair and a raised toilet seat in her bathroom. The SN visit note on 4/09/14 stated the patient had a cane and was wearing TED hose. However, the POC did not include the shower chair, raised toilet seat, cane or TED hose. During an interview on 4/10/14 at 4:55 PM, the DOO reviewed Patient #4's chart and confirmed the POC did not include interventions related to her surgical wound, skin lesion or injectable medication. Additionally, she confirmed the POC did not include all the equipment present in the	{G 159}	Lovenox as part of the plan of care as well as documentation regarding education of the medication, administration of the medication and precautions related to the medication. The specific clinician involved in this deficiency will be in-serviced individually in addition to the general staff review. All clinicians will be re-instructed on how to write a plan of care the week of 4/28/14. They will be given course study 5090017 "Writing an Effect Plan of Care" to be completed by 5/30/14. (Appendix A) All clinicians will be re- educated that all DME and supplies were to be included on POC at staff meeting on 4/30/14. They will be re- instructed on where to document the supplies and DME to have them pull over on the plan of care. Monitoring Process: The DOO or designee will review 100% of the 485s, utilizing the Saint Alphonsus Survey Audit tool for 485/ Evaluation; before they are sent to the physician for signature. The review will include all supplies and DME as well as ensuring the interventions are supported by the diagnosis. If compliance is not met, an	

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{G 159}	Continued From page 5 patient's home. Patient #4's POC did not include all pertinent equipment, interventions and treatments required for her care. 2. Patient #3 was a 75 year old female admitted to the agency on 3/26/14 for SN, PT, and OT services following a hospitalization related to anxiety and dementia in which her medications had been adjusted. Patient #3's POC for the certification period 3/26/14 to 5/24/14 was reviewed. The POC included nursing orders, goals, and interventions that were not appropriate to her diagnoses as follows: -"SN to check for edema location and degree." Patient #3's record did not include a diagnosis that required an assessment of edema. Her SOC assessment, dated 3/26/14 noted her pulmonary and cardiovascular systems were normal. -"SN to observe/instruct s/s (signs and symptoms) UTI." The SOC assessment did not include documentation Patient #3 had a recent UTI or was at risk for a potential UTI. During an interview on 3/09/14 beginning at 4:40 PM, the DOO reviewed Patient #3's record and confirmed the nursing interventions were not supported by her diagnoses. Patient #3's POC was not developed to meet her individualized needs.	{G 159}	immediate in-service with the clinician will be conducted by the DOO or designee. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated. Completion date: 5/1/14	
{G 160}	484.18(a) PLAN OF CARE	{G 160}		

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{G 160}	Continued From page 6 If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on medical record review, policy review and staff interview, it was determined the agency failed to ensure the physician was consulted to authorize additional orders after the initial assessment was completed for 1 of 8 patients (#7) whose records were reviewed. This resulted in the provision of care without physician approval. Findings include: Agency Policy AA-002, Titled "INITIAL REFERRAL/ADMISSION PROCESS," stated "Upon the patient's acceptance for admission to home care, the physician will be notified. Findings of the initial assessment will be reported, additional orders will be obtained, and the Plan of Care developed." Patient #7 was a 64 year old male admitted to the agency on 4/01/14 after hospitalization for a stroke which resulted in left upper extremity weakness. He had an additional diagnosis of atrial fibrillation. Patient #7 received SN, PT and OT services from the agency. His record for the certification period of 4/01/14 to 5/29/14 was reviewed. The OT evaluation was completed on 4/03/14. The medical record did not include documentation the occupational therapist received orders from Patient #7's physician for OT services following the evaluation visit. A form	{G 160}	G 160 The agency will ensure a physician is consulted to approve the plan of care for all patients. The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance. TX-001 Physician Orders and Medical Supervision of the Plan of Care Policy will reviewed with clinicians at staff meeting scheduled on 4/30/14. It will be reviewed that all clinicians must contact the MD after the initial comprehensive assessment and evaluation visits to approve the pan of care. Documentation of this contact will include the communication that took place and the physician's name. The process be reviewed with the office staff the same week to ensure the copy of a fax confirmation will be placed in the patient record. The OT cited in this deficiency has been terminated by the agency. Monitoring Process: 100% of the initial assessments will be audited using the Saint Alphonsus Home Health Survey Audit Tool for 485/EVAL by the Clinical Managers to ensure the documentation of the physician contact to approve the	

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{G 160}	Continued From page 7 titled "OT Orders and Goals" included the statement, "Order approved by fax." However, the record did not include a copy of the fax, or other indication of the contents of the fax. Patient #7's record included documentation of a second OT visit on 4/09/14. However, his POC was not finalized or sent to his physician at the time of the survey exit on 4/10/14. During an interview on 4/10/14 at 4:20 PM, the DOO reviewed Patient #7's record and confirmed his record did not contain evidence of verbal orders for OT services after the evaluation visit. She confirmed the OT services on 4/09/14 were provided without physician orders. Patient #7's physician was not consulted to approve his POC.	{G 160}	plan of care is present. If non-compliance is found, an immediate in-service will be held. Once significant compliance is realized, the agency will resume clinical records review of 10% of active and discharged patients. Completion Date: 5/1/14	
{G 164}	484.18(b) PERIODIC REVIEW OF PLAN OF 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 review of clinical records and staff interview, it was determined the agency failed to ensure the physician was notified of changes in patient condition that resulted in a change to the POC for 1 of 8 patients (#8) whose records were reviewed. This limited the physician's ability to effectively manage the patient's changing needs. Findings include: Patient #8 was an 87 year old male admitted to	{G 164}	G 164 Agency staff will promptly alert the physician to any changes that suggest a need to alter the plan of care. The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance. Clinicians will be notified of all deficiencies in the report from the State the week of 4/28/14 Clinicians will be re-educated regarding the importance of notification of the MD and documentation of such communication. Education to the staff will include the necessity of including in the communication between disciplines the determination of who will notify the MD of a change in the plan to include the discharge. Additionally, all of the communications must be documented. They must include what was communicated to whom as part of	

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{G 164}	Continued From page 8 the agency on 3/19/14, after a surgical repair of a diaphragmatic hernia. Additional diagnoses included abnormality of gait, muscle weakness, non-insulin dependent DM and HTN. Patient #8 received SN and PT services from the agency. His record for the certification period of 3/19/14 to 5/17/14 was reviewed. Patient #8's POC included orders for SN visits 1 time a week for 1 week, 2 times a week for 2 weeks and 1 time a week for 6 weeks for a total of 11 visits. However, the patient was discharged on 4/01/14, after 4 nursing visits, when it was determined during an LPN visit that he was no longer homebound. Patient #8's record did not include an SN discharge summary or any indication the physician was notified he was discharged prior to receiving all visits ordered on the POC. During an interview on 4/10/14 at 4:30 PM, the DOO reviewed Patient #8's record and confirmed his physician was not notified of the discharge, or notified of the availability of a discharge summary. She stated the RN Case Manager was on medical leave at the time of Patient #8's SN discharge and therefore did not complete the nursing discharge and summary. Patient #8's physician was not notified of his discharge from home health services.	{G 164}	the coordination of care. It is the process in the office to notify the CM or DOO upon determining a patient is ready for discharge. The CM or DOO will be responsible for asking the clinician during such report if the physician has been notified and if it was documented. Monitoring Process: The DOO or clinical designee, utilizing the Saint Alphonsus Home Health Survey Audit Tool, will audit 20% of active and discharge charts with emphasis on notification of the physician of changes in the patient's condition in the audit tool. Once significant compliance is demonstrated, the agency will resume clinical record review of 10% of the patient census. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated. DOO will review 100% of occurrence reports to ensure all areas are complete and clinicians notified the MD and or altered the plan of care as appropriate. Once significant compliance is realized, the agency will resume clinical records review of 10% of patient census. Completion date: 5/1/14	

PRINTED: 04/17/2014
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001175	A. BUILDING: _____ B. WING _____	R 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{N 000}	16.03.07 INITIAL COMMENTS A state licensing follow up survey was completed at your agency 4/09/14 and 4/10/14. Surveyors completing the survey were: Susan Costa, RN, HFS, Team Leader Nancy Bax, RN, HFS	{N 000}	Completion date: 5/1/14	
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 155 Refer to G 159	
N 161	03.07030.PLAN OF CARE N161 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: i. Medication and treatment orders; This Rule is not met as evidenced by: Refer to G159	N 161	N 161 Refer to G 159	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 170	03.07030.04.PLAN OF CARE N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or podiatric medicine. This Rule is not met as evidenced by: Refer to G160	N 170	N 170 Refer to G 160	
N 185	03.07031.CLINICAL REC. N185 02. Contents. Clinical records must include: k. A discharge summary. This Rule is not met as evidenced by: Refer to G164	N 185	N 185 Refer to G 164	