IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

May 30, 2013

Deanna Baird, Administrator
Integricare Of Eastern Idaho
P.O. Box 3881
Idaho Falls, ID 83403

RE: Integricare Of Eastern Idaho, Provider #137048

Dear Ms. Baird:

This is to advise you of the findings of the Medicare/Licensure survey at Integricare Of Eastern Idaho, which was concluded on May 23, 2013.

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 **June 11, 2013**, and keep a copy for your records.

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

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pt
Enclosures

The Aspen Group, Inc.
IntegriCare of Eastern Idaho
3470 Washington Parkway
Idaho Falls, ID 83404

Via US Postal Service

June 11, 2013

Sylvia Creswell, Co-Supervisor
Non-Long Term Care
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83705

Re: Plan of Correction – IntegriCare of Eastern Idaho
Medicare Provider No.13-7048

Dear Sylvia:

Enclosed you will find our Credible Allegations in response to the survey conducted May 24th, 2013.

Please extend our thanks to Mr. Giles and his colleagues who were helpful and professional throughout the survey..

If there is any other information I can provide just let me know.

Best Regards:

Robert Collette

/s
enclosure (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137048	A. BUILDING _____ B. WING _____	05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRICARE OF EASTERN IDAHO	3470 WASHINGTON PKWY IDAHO FALLS, ID 83404

(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 home health agency. The surveyors conducting the recertification were: Gary Guiles, RN, HFS - team leader Libby Doane, BSN, RN, HFS Don Sylvester, RN, HFS Acronyms used in this report include: AFOS - Orthopedic Splints DME - Durable Medical Equipment ER - Emergency Room HHA - Home Health Aide OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy pt - patient RN - Registered Nurse SN - Skilled Nursing ST - Speech Therapy	G 000	Please refer to the attached **Appendix I** for all plans of correction.	
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 staff interview and review of clinical records, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 2 of 12 patients (#2 and #10) whose records were	G 164	RECEIVED JUN 12 2013 FACILITY STANDARDS	

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

[signature] | PRESIDENT | 6/10/2013

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137048	A. BUILDING _____ B. WING _____	05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRICARE OF EASTERN IDAHO	3470 WASHINGTON PKWY IDAHO FALLS, ID 83404

(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 1 reviewed. This resulted in missed opportunity for physicians to alter the plan of care to meet patient needs. Findings include: 1. Patient #2 was a 50 year old female admitted to the agency on 3/24/12. Her POC for the certification period of 3/19/13 to 5/17/13 was reviewed and contained the diagnoses of pressure ulcers, diabetes, end stage renal disease, and a below the knee amputation of her left leg. Her POC included orders for SN and HHA. An RN "Visit Note Report" from 3/21/13 at 7:33 AM documented that Patient #2 was "very weak, and lethargic...urine looks (dark) and cloudy, pt is swollen from her knees up even to her face...." The RN also documented that the wound to Patient #2's right heel had gotten worse. The RN documented that she encouraged Patient #2's family to take her to the ER, as the last time Patient #2 had symptoms like these she "was very sick and wounds went bad fast." There was no documentation to indicate the RN notified Patient #2's physician. An RN "Visit Note Report" from 3/22/13 at 8:28 AM documented that Patient #2 had gone to the ER after the RN visit and was admitted to the hospital. The Clinical Director reviewed the record and was interviewed on 5/22/13 at 11:20 AM. She confirmed the RN had not notified the physician of Patient #2's changes in condition that required hospitalization. Patient #2's physician was not notified of changes in her condition.	G 164	Please refer to the attached **Appendix I** for all plans of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137048	A. BUILDING _____ B. WING _____	05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRICARE OF EASTERN IDAHO	3470 WASHINGTON PKWY IDAHO FALLS, ID 83404

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G 164	Continued From page 2 2. Patient #10 was a 3 year old female admitted to the agency on 4/16/13 for treatment related to a diagnosis of metabolic encephalopathy and delayed milestones. Her medical record for the certification period of 4/16/13 to 6/14/13 was reviewed. A "REFERRAL" form, signed by the physician on 4/01/13, contained orders for PT, OT and ST. The POC, signed by the physician on 5/06/13, untimed, contained orders for only PT. There were no orders for ST or OT. A "Client Coordination Note Report" from 5/02/13, untimed, documented that ST had tried to contact Patient #10's family several times to schedule an appointment and that Patient #10's family would call when they were available for an appointment. There was no further documentation in the medical record to explain why ST or OT services had not been initiated. The Clinical Director reviewed the record and was interviewed on 5/22/13 at 11:25 AM. She stated that Patient #10's mother had refused ST services. She confirmed there was no documentation to indicate this in the record, nor was there documentation to indicate Patient #10's physician had been notified of the refusal of ST services. In addition, the Clinical Director stated Patient #10's mother had not refused OT, she was just not ready for Patient #10 to begin OT services yet. The Clinical Director confirmed that there was no documentation of this in the medical record. She also confirmed there was no documentation to indicate Patient #10's physician had been notified of the delay in OT services.	G 164	Please refer to the attached **Appendix I** for all plans of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137048	A. BUILDING _____ B. WING _____	05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRICARE OF EASTERN IDAHO	3470 WASHINGTON PKWY IDAHO FALLS, ID 83404

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G 164	Continued From page 3 Patient #10's physician was not notified of changes to the initially ordered treatments.	G 164	Please refer to the attached **Appendix I** for all plans of correction.	

IntegriCare of Eastern Idaho
Medicare Provider # 13-7048
State License Number HH-117
May 23, 2013 Survey
HCFA-Identified Deficiencies Credible Allegation

Appendix I

IntegriCare of Eastern Idaho
Medicare Provider # 13-7048
State License Number HH-117
May 23, 2013 Survey

HCFA-Identified Deficiencies Credible Allegation

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
G164	This area of concern was covered in inservices held with all nurses during the first two weeks of May 2013. Additional inservices will be held during June with all clinical staff to re-emphasize the importance of documenting all communications with physicians and other caregivers. These communications will be documented in clinical and/or coordination notes in all instances. Compliance will be reviewed through ongoing chart audits by the clinical director and staff.	Deanna Baird RN Natalie Beck FNP	Ongoing	06/19/2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001305	A. BUILDING: _____ B. WING _____	05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRICARE OF EASTERN IDAHO	3470 WASHINGTON PKWY IDAHO FALLS, ID 83404

(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) COMPLETE DATE
N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Idaho State licensure survey of your home health agency. The surveyors conducting the review were: Gary Guiles, RN, HFS - team leader Libby Doane, BSN, RN, HFS Don Sylvester, RN, HFS	N 000	Please refer to the attached **Appendix II** for all plans of correction.	
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		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT — (X6) DATE: 6/10/2013

IntegriCare of Eastern Idaho
Medicare Provider # 13-7048
State License Number HH-117
May 23, 2013 Survey
State-Identified Deficiencies Credible Allegation

Appendix II

IntegriCare of Eastern Idaho
Medicare Provider # 13-7048
State License Number HH-117
May 23, 2013 Survey
State-Identified Deficiencies Credible Allegation

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
N172	Please see response to Federal ID G164	N/A	N/A	N/A