



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
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P.O. Box 83720
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CERTIFIED MAIL: 7000 1670 0011 3315 1484

September 3, 2015

Jason Bailey, Administrator
Teton Home Health
2470 Jafer Court
Idaho Falls, ID 83404-7575

RE: Teton Home Health, Provider #137061

Dear Mr. Bailey:

Based on the survey completed at Teton Home Health, on August 20, 2015, by our staff, we have determined the agency is out of compliance with the Medicare Home Health Agency (HHA)

Conditions of Participation:

- **Patients Rights (42 CFR 484.10)**
- **Acceptance of Patients, POC, Med Super (42 CFR 484.18)**
- **Skilled Nursing Services (42 CFR 484.30).**

To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Teton Home Health, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction 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 **both the state and federal 2567 forms.**

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **September 17, 2015**. It is recommended the Credible Allegation of Compliance for each Condition of Participation and related standard level deficiencies show compliance no later than **October 4, 2015**, 45 days from survey exit. We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies compliance.

Please note, all references to regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Consistent with the provisions of 42 CFR 488, Alternative Sanctions for Home Health Agencies, the following remedies will be recommended to the Centers for Medicare/Medicaid (CMS) Region X Office:

- If compliance with all Conditions of Participation is not achieved, termination effective February 20, 2016, 6 months from the survey exit date [42 CFR 488.865]
- Civil Monetary Penalty [42 CFR 488.820(b)]

Please be aware, this notice does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal written notice of that determination.

If the revisit survey of the agency finds one or more of same Conditions of Participation out of compliance, CMS may choose to revise sanctions imposed.

Jason Bailey, Administrator
September 3, 2015
Page 3 of 3

In accordance with 42 CFR 488.745, you have one opportunity to question the deficiencies that resulted in the Conditions of Participation being found out of compliance through an informal dispute resolution (IDR) process. To be given such an opportunity, you are required to send your written request and all required information as directed in the attached document. This request must be received by **September 17, 2015**. If your request for IDR is received after **September 17, 2015**, the request will not be granted. An incomplete IDR process will not delay the effective date of any enforcement action. If the agency wants the IDR panel to consider additional evidence, the evidence and six (6) copies of the evidence must be received 15 calendar days before the IDR meeting (Refer to page 6 of the attached IDR Guidelines).

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt

Enclosures

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Fe Yamada, CMS Region X Office

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

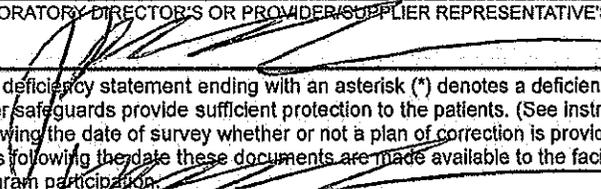
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FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137061 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/20/2015 |
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|---|--|
| NAME OF PROVIDER OR SUPPLIER TETON HOME HEALTH | STREET ADDRESS, CITY, STATE, ZIP CODE 2470 JAFER COURT IDAHO FALLS, ID 83404 |
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| G 000 | <p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your home health agency on 8/17/15 through 8/20/15. The surveyors conducting the recertification were:</p> <p>Nancy Bax RN, HFS, Team Lead Laura Thompson RN, HFS</p> <p>Acronyms used in this report include:</p> <p>AC - Anticubital ADL - Activities of Daily Living ALF - Assisted Living Facility BG - Blood Glucose BP - Blood Pressure bpm - beats per minute CABG - Coronary Artery Bypass Graft CHF - Congestive Heart Failure CKD - Chronic Kidney Disease COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure DM - Diabetes Mellitus DON - Director of Nursing EMR - Electronic Medical Record H & P - History and Physical HHA - Home Health Aide HTN - Hypertension IADL - Instrumental Activities of Daily Living IV - Intravenous LPN - Licensed Practical Nurse mg - milligram ml - milliliter MRSA - Methicillin Resistant Staphylococcus Aureus MSW - Medical Social Worker NGT - Nasogastric Tube NOMNC - Notice of Medicare Non-Coverage</p> | G 000 | <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> <p style="text-align: center; margin-top: 20px;">RECEIVED SEP 17 2015 FACILITY STANDARDS</p> | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 9-17-15 |
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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 000 | Continued From page 1 OT - Occupational Therapy POC - Plan of Care prn - as needed pt - patient PT - Physical Therapy PTA - Physical Therapy Assistant QIO - Quality Improvement Organization RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care ST - Speech Therapy Wound VAC - Wound Vacuum Assisted Closure device | G 000 | <div style="border: 1px solid black; padding: 5px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
| G 100 | 484.10 PATIENT RIGHTS This CONDITION is not met as evidenced by: Based on observation, review of patient records, complaint documentation, and agency contracts, and staff and patient interview, it was determined the agency failed to ensure patients were informed of potential financial liability for services, and of their right to appeal their discharge. Additionally, the agency failed to ensure confidentiality of patient information and failed to thoroughly document patient complaints. These resulted in violations of patients' rights. Findings include: 1. Refer to G101 as it relates to the failure of the agency to ensure patients were fully informed of their right to appeal a discharge from home health services. 2. Refer to G107 as it relates to the failure of the agency to sufficiently document the investigation and resolution of patient complaints. | G 100 | | |

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| G 100 | Continued From page 2 3. Refer to G111 as it relates to the failure of the agency to ensure the patients' right to confidentiality of the clinical information maintained by the agency. 4. Refer to G113 as it relates to the failure of the agency to ensure patients were informed of the extent to which payment could be expected from their health insurance and the charges the individual might have to pay. The cumulative effect of these systemic failures impeded the ability of the agency to protect the rights of patients. | G 100 | <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | | |
| G 101 | 484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. This STANDARD is not met as evidenced by: Based on review of patient medical records and staff interview, it was determined the agency failed to ensure patients were fully informed of their right to appeal a discharge from home health services for 1 of 2 discharged patients (#12) who were Medicare beneficiaries and whose records were reviewed. This also affected all patients who were Medicare beneficiaries. This had the potential for services to be terminated without the patients' understanding of their ability to appeal the discharge. Findings include: The CMS Manual System, Pub 100-04 provides direction to home health providers regarding the "Notice Of Medicare Non-Coverage" (NOMNC) form. The direction includes the following: | G 101 | | | |

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| G 101 | <p>Continued From page 3</p> <ul style="list-style-type: none"> - "The beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of the notice delivery." - "The information provided should include the following: "The beneficiary's last day of covered services...The telephone number of the QIO to request the appeal." - "The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end..." - "... the delivery of the notice should be closely tied to the impending end of coverage so a beneficiary will more likely understand and retain the information regarding the right to an expedited determination. The notice may not be routinely given at the time services begin." <p>Patient #12 was an 85 year old male admitted to the agency on 7/08/15, for care following a CABG. Additional diagnoses included DM, CHF and asthma. He received SN and PT services. His record, including the POC for the certification period 7/08/15 to 9/05/15, was reviewed. Patient #12 was discharged from the agency on 8/12/15.</p> <p>Patient #12's record included a NOMNC form. The form included the signature of Patient #12's wife. The signature was dated 8/06/15.</p> <p>The form lacked the required information, as follows:</p> <ul style="list-style-type: none"> - The section of the form which stated "The Effective Date Coverage of Your Current Home | G 101 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| G 101 | <p>Continued From page 4</p> <p>Health Services Will End:____," was completed with "September 5, 2015 (at the latest)." The form did not specify Patient #12's last day of covered services.</p> <p>- The section of the form titled "How to Ask for an Immediate Appeal" included "Call your QIO at: (insert name and number of QIO) to appeal, or if you have questions." The form did not include the name or telephone number of the QIO to request an appeal.</p> <p>During an interview on 8/20/15 at 11:30 AM, the RN Case Manager reviewed Patient #12's NOMNC form. He stated he was directed by the agency to have all patients sign the NOMNC form during the SOC visit, and to leave the date of the patient's signature blank. He stated the signed form was submitted to the office, and he did not see the form again. The RN Case Manager stated the patient was not given a copy of the form. Additionally, he stated he did not know how the date of the patient's signature was completed but stated neither he or Patient #12's wife had entered the date next to the signature.</p> <p>During an interview on 8/20/15 at 2:20 PM, the Administrator stated the NOMNC form was included in the packet of forms completed during patients' SOC visits. He stated the RN completing the SOC visit had the form signed by the patient, leaving the date services would end, and the date next to the patient's signature, blank. He stated the form was submitted to the office immediately after the SOC visit, and the dates were inserted by office staff at the time of discharge. He confirmed patients were not given a copy of the form. The Administrator reviewed the form and confirmed it did not include the</p> | G 101 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |

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| G 101 | Continued From page 5 required information, including the date services would end and contact information for the QIO. | G 101 | | |
| G 107 | <p>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of complaint documentation over the last 12 months, it was determined the agency failed to thoroughly document the investigation and resolution of complaints for 6 of 6 agency patients' complaint records reviewed (#13 - #18). Failure to document resolution of complaints and the investigation process led to a lack of clarity as to whether complaints were addressed and resolved. Findings include:</p> <p>Six complaints were documented between 4/09/15 and 8/07/15. Six of the complaints did not thoroughly document the investigation and/or resolution. Examples include:</p> <p>a. A complaint report dated 6/08/15, documented Patient #16 was informed by his RN Case</p> | G 107 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |

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| G 107 | <p>Continued From page 6</p> <p>Manager to call the on-call nurse if he had any issues with his wound VAC. Patient #16 called the on-call nurse stating he needed to be seen right away because his wound VAC was leaking and his leg was swollen. Patient #16 was informed he needed to ask a church member for a ride to the local hospital or to an out of state hospital, because he had no vehicle and was homebound.</p> <p>The report stated Patient #16 was interviewed by the DON in his home. However, there was no documentation of the interview. Additionally, there was no documentation of an interview with the on-call nurse to determine whether agency policy was followed. The resolution stated the Assistant Administrator would follow up with the DON. There was no documentation of a follow up or resolution of the complaint.</p> <p>b. A complaint report dated 4/20/15, documented Patient #15 had called for a nurse to come to her house and assess her. The nurse made an appointment for the following day, then arrived 2 hours late. The report stated Patient #15 and the nurse were interviewed. However, there was no documentation about the interviews or further details related to the investigation. Additionally, the resolution was the nurse would not visit Patient #15 again but did not adequately address the original complaint.</p> <p>c. A complaint report dated 4/09/15, documented Patient #13 wanted his Physical Therapist changed because he felt the clinician was not spending enough time with him. The report stated, following the complaint, the Physical Therapist was changed. However, an investigation related to the specific complaint was</p> | G 107 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | | |

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| G 107 | <p>Continued From page 7 not documented.</p> <p>d. A complaint report dated 4/20/15, documented Patient #14 had called for a nurse to come to his home and no one came. The report stated the nurse was questioned about the call. However, there was no documentation about the conversation with the nurse or further details related to the investigation.</p> <p>e. A complaint report dated 7/23/15, documented Patient #17 had requested her RN Case Manager refill her prescriptions and deliver them to her home. She also wanted to have daily nursing visits. The report stated Patient #17's RN Case Manager was to be switched to an LPN. However, there was no documentation of an investigation related to the complaint or how the complaint was resolved.</p> <p>f. A complaint report dated 8/07/15, documented Patient #18 stated an LPN raised her voice to him during a home visit and it upset him. The report stated Patient #18 lived in an ALF and the ALF Administrator was called. However, there was no other documentation regarding the conversation with the ALF Administrator or whether the LPN was interviewed. Additionally, the report documented the resolution was the agency Administrator "Spoke with patient."</p> <p>During an interview on 8/20/15 at 2:30 PM, the Administrator reviewed the complaint log and the identified complaints. He stated he is responsible for investigating complaints. The Administrator confirmed the lack of documentation.</p> <p>Agency complaint investigations did not include all necessary information.</p> | G 107 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| G 111 | <p>484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS</p> <p>The patient has the right to confidentiality of the clinical records maintained by the HHA.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, review of contracts, and observation, it was determined the agency failed to ensure the patients' right to confidentiality of clinical information maintained by the agency. This had the potential to result in unauthorized release of patient information. Findings include:</p> <p>1. On 8/20/15 at 9:35 AM, an agency Physical Therapist was interviewed regarding Patient #6. When asked how an order was obtained for Patient #6's PT evaluation, he stated someone in the office was responsible for obtaining the physician order. He stated the office notified him to complete the evaluation by sending a text message to his personal cellular phone.</p> <p>The Physical Therapist displayed the text message on his cellular phone. The message was a screen shot of Patient #6's "PATIENT PROFILE" and included her name, address, telephone number and date of birth.</p> <p>The agency failed to maintain confidentiality of patient records.</p> <p>2. During the survey entrance conference on 8/17/15 at 12:00 PM, the Administrator stated the agency contracted with a certified coder to complete the ICD-9 coding on all home health patients.</p> <p>The contract with the coder, dated 6/20/14, and</p> | G 111 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| NAME OF PROVIDER OR SUPPLIER TETON HOME HEALTH | STREET ADDRESS, CITY, STATE, ZIP CODE 2470 JAFER COURT IDAHO FALLS, ID 83404 |
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| G 111 | Continued From page 9 signed by the Administrator and the contracted coder, was reviewed. The contract stated patient information would be sent to the coder via fax, mail, email, or through the EMR system. The contract did not state how the confidentiality of patient information would be protected. During an interview on 8/20/15 at 4:10 PM, the DON confirmed the agency's contract with the certified coder did not state how the confidentiality of patient information would be protected. | G 111 | Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) APPENDIX - I | |
| G 113 | 484.10(e)(1) PATIENT LIABILITY FOR PAYMENT The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. This STANDARD is not met as evidenced by: Based on review of medical records and patient/caregiver and staff interview, it was determined the agency failed to ensure patients were informed in writing of the extent to which payment could be expected from their health insurance, and the charges the individual might have to pay, for 1 of 1 patient (#6) whose record documented patient financial liability. This had the potential to interfere with patients'/caregivers' ability to make reasonable, informed decisions about financial matters related to the agency's care and treatment. Findings include: | G 113 | | |

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| G 113 | <p>Continued From page 10</p> <p>Patient #6 was a 53 year old female admitted to the agency on 8/11/15, for services related to liver damage. Additional diagnoses included hepatic encephalopathy and thrombocytopenia. She received SN, PT and OT services. Her record, including the POC, for the certification period 8/11/15 to 10/09/15, was reviewed.</p> <p>Patient #6's record included an "INSURANCE VERIFICATION" form stating her insurance would cover 90% of the home health charges and she would be responsible for the remaining 10%. Her record did not include documentation stating she was informed of her financial responsibility.</p> <p>A visit was made to Patient #6's home on 8/18/15 at 1:00 PM, to observe an OT evaluation visit. Following the visit, Patient #6 and her husband were interviewed. They stated they did not know to what extent home health charges were covered by their insurance. They stated they had not been informed by the agency of the amount they would have to pay for services.</p> <p>During an interview on 8/19/15 at 2:45 PM, the RN Case Manager stated when a patient had an out of pocket expense, she would be informed by the office, and she would then inform the patient. She stated she was not aware of an out of pocket expense for Patient #6.</p> | G 113 | <div style="border: 1px solid black; padding: 10px; margin: 10px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
| G 118 | <p>484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS</p> <p>The HHA and its staff must operate and furnish services in compliance with all applicable Federal,</p> | G 118 | | |

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| G 118 | <p>Continued From page 11</p> <p>State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.</p> <p>This STANDARD is not met as evidenced by: Based on review of personnel files, review of state licensing rules, and staff interview it was determined the agency failed to ensure social services were provided by a qualified social worker in accordance with state licensing rules. Failure to adhere to state licensing rules had the potential to result in inadequate provision of care to patients. Findings include:</p> <p>1. The Social Work Licensing Act found at Idaho Code 54-3214, states "License required -- Representation to public. (1) No person may engage in the practice of social work unless he is licensed under this chapter, or is a student under the supervision of a person who is licensed under this chapter."</p> <p>State licensing rules for Home Health Agencies, found at IDAPA 16.03.07.026.01, states "If the agency furnishes medical social services, those services are given by a qualified social worker, licensed in Idaho..."</p> <p>During an interview on 8/20/15 at 11:40 AM, the Assistant Administrator stated the agency employed 1 MSW, and she was not licensed in the state of Idaho.</p> <p>During an interview on 8/20/15 at 5:10 PM, the MSW stated she started working for the agency on 6/15/15. She confirmed she was not licensed</p> | G 118 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | | |

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| G 118 | Continued From page 12 as a social worker in the state of Idaho. Additionally, she confirmed she provided MSW visits to agency patients without oversight of a licensed Social Worker. | G 118 | <div style="border: 1px solid black; padding: 10px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> </div> | | |
| G 143 | <p>Social Services were not provided in accordance with Idaho statutes and licensing rules. 484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>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 care coordination between disciplines for 1 of 9 patients (#5) who received services from more than 1 discipline and whose records were reviewed. This had the potential to interfere with quality, safety and continuity of patient care. Findings include:</p> <p>Patient #5 was an 88 year old female admitted to the agency on 5/21/15, for services related to generalized muscle weakness. Additional diagnoses included dementia. She received SN, PT and MSW services. Her record, including the POC, for the certification period 7/21/15 to 9/18/15, was reviewed.</p> <p>The National Institutes of Health website, accessed 8/24/15, stated the normal resting heart rate for adults is 60 to 100 bpm. It stated bradycardia, a heart rate lower than 60 bpm, may</p> | G 143 | | | |

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| G 143 | <p>Continued From page 13 result in weakness, dizziness or fainting.</p> <p>The agency's policy #6.011.1, titled "Emergencies in the Home/Reporting Patient Problems," stated "All staff members report identified clinical problems to appropriate person(s), document their finding and any actions taken." The policy's definition of moderate emergency included bradycardia.</p> <p>Patient #5's record included a PT visit note dated 8/05/15, and signed by the Physical Therapist. The note stated Patient #5's heart rate was 57 bpm. Her record did not include documentation stating her RN Case Manager was notified of her low heart rate.</p> <p>Patient #5's record included a PT visit note dated 8/11/15, and signed by the Physical Therapist. The note stated Patient #5's heart rate was 59 bpm. Her record did not include documentation stating her RN Case Manager was notified of her low heart rate.</p> <p>During an interview on 8/20/15 at 9:30 AM, the Physical Therapist reviewed the record and confirmed he did not contact the RN Case Manager regarding Patient #5's low heart rate.</p> | G 143 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
| G 144 | <p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>The Physical Therapist did not notify the RN Case Manager of Patient #5's low heart rate.</p> <p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> | G 144 | | |

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| G 144 | <p>Continued From page 14</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records, it was determined the agency failed to ensure care coordination between disciplines was documented for 1 of 9 patients (Patient #11) who received services from more than one discipline and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. Findings include:</p> <p>Patient #11 was a 52 year old female admitted to the agency on 7/31/15, for SN and PT services related to general muscle weakness. Additional diagnoses included abnormal gait, peripheral neuropathy, asthma, DM, HTN, anemia, borderline personality disorder, depression, history of falls, and knee replacement. Her record, including the POC, for the certification period 7/31/15 to 9/28/15, was reviewed.</p> <p>Patient #11 was admitted to the agency after undergoing surgery for a right total knee replacement on 7/27/15.</p> <p>A SN visit dated 8/06/15, documented "SN noted that patient has an extremely shiny right leg below the surgical site. Patient stated that she has a follow-up appointment with the MD on the 10th. SN educated patient on possible reasons for shiny leg and patient stated that she will let her MD now [sic] during the visit." The note did not include documentation Patient #1's physician was informed by the SN of changes to her surgical extremity.</p> <p>During an interview on 8/19/15 at 4:00 PM, the</p> | G 144 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> </div> | |
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| G 144 | Continued From page 15 RN Case Manager reviewed the record and confirmed Patient #1's right lower leg was shiny in appearance. She stated she did speak with Patient #1's physician about the changes to her leg, but the physician stated it was alright for Patient #1 to wait for her follow up appointment for the leg to be evaluated. The RN Case Manager confirmed the conversation with the physician was not documented in the record. | G 144 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | | |
| G 156 | <p>Patient #11's record did not include documentation her physician was updated about changes in her status.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>This CONDITION is not met as evidenced by: Based on medical record review, policy review, observations during home visits and staff interview, it was determined the agency failed to ensure patient needs were met, care was provided in accordance with patients' POCs, the POCs included all pertinent information, physicians were consulted to approve POCs, the physician was notified of changes in patients' conditions, and treatments were administered as ordered by the physician. This resulted in unmet patient needs, and care provided without physician authorization. Findings include:</p> <p>1. Refer to G157 as it relates to the agency's failure to ensure patients were accepted for treatment on the basis of a reasonable expectation that the patients' needs could be met.</p> | G 156 | | | |

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| G 156 | <p>Continued From page 16</p> <p>2. Refer to G158 as it relates to the agency's failure to ensure care was provided in accordance with POCs.</p> <p>3. Refer to G159 as it relates to the agency's failure to ensure the POC included all pertinent diagnoses, types of services and equipment required.</p> <p>4. Refer to G160 as it relates to the agency's failure to consult physicians to approve POCs following evaluation visits.</p> <p>5. Refer to G164 as it relates to the agency's failure to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter their POCs.</p> <p>6. Refer to G165 as it relates to the agency's failure to ensure drugs and treatments were administered only as ordered by the physician.</p> <p>The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs.</p> | G 156 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
| G 157 | <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.</p> <p>This STANDARD is not met as evidenced by: Based on record review, review of agency</p> | G 157 | | |

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| G 157 | <p>Continued From page 17</p> <p>policies, and staff interview, it was determined the agency failed to ensure patients were accepted for treatment on the basis of a reasonable expectation that the patients' needs could be met and services provided in a timely manner, for 2 of 9 sampled patients (#2 and #5) whose records were reviewed for SOC. This resulted in delay of necessary services and unmet patient needs, and had the potential to result in negative outcomes for agency patients. Findings include:</p> <p>During the survey entrance interview on 8/17/15 at 12:00 PM, the Administrator stated it was the agency's policy for the SOC comprehensive assessment to be completed by an RN. He stated the agency required additional disciplines ordered, such as therapies, to complete their initial evaluations within 5 days. Additionally he stated, if a discipline was ordered by the physician, but the agency was unable to provide the service, the referral would be passed to another agency that had the ability to provide all services offered. This process was not followed. Examples include:</p> <p>1. Patient #2 was a 78 year old female admitted to the agency on 12/19/14, for services related to generalized muscle weakness. Additional diagnoses included HTN, backache, and history of falls. She received SN, PT and HHA services. Her record, including the POC, for the certification period 12/19/14 to 2/16/15, was reviewed.</p> <p>Patient #2's record included an order for home health services, dated 12/19/15, and signed by a physician. The order included PT services.</p> <p>Patient #2's record included an SN SOC comprehensive assessment completed on</p> | G 157 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 157 | <p>Continued From page 18 12/19/14, and signed by the RN Case Manager. The assessment stated "Patient reports she is unable to walk even with the walker ...Patient will require PT for strength and stability..."</p> <p>Patient #2's SN SOC comprehensive assessment included a fall risk assessment completed by the RN Case Manager. The assessment rated her risk of falling on a scale of 1 to 10, with 10 indicating the highest risk of falls. Patient #2's fall risk score was 9 out of 10.</p> <p>Patient #2's record included a PT evaluation, dated 12/29/14, 10 days after her SOC. Her record did not include documentation of a PT visit prior to 12/29/14. Additionally, it did not include documentation of the reason the PT evaluation was delayed. The PT evaluation stated "Pt [patient] is considered a high fall risk and lives independently."</p> <p>Patient #2's record included a transfer summary dated 1/15/15. The summary stated Patient #2 was transferred to the hospital due to a fall in her home.</p> <p>During an interview on 8/19/15 at 3:20 PM, the RN Case Manager reviewed Patient #2's record and stated her PT evaluation was probably delayed due to the holidays and staff vacations.</p> <p>During an interview on 8/20/15 at 10:15 AM, the Physical Therapist reviewed Patient #2's record and stated he did not know why her PT evaluation was delayed for 10 days.</p> <p>The agency failed to ensure Patient #2 received PT services as ordered by the physician at the SOC.</p> | G 157 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| NAME OF PROVIDER OR SUPPLIER TETON HOME HEALTH | STREET ADDRESS, CITY, STATE, ZIP CODE 2470 JAFER COURT IDAHO FALLS, ID 83404 |
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| G 157 | <p>Continued From page 19</p> <p>2. Patient #5 was an 88 year old female admitted to the agency on 5/21/15, for services related to generalized muscle weakness. Additional diagnoses included dementia. She received SN, PT and MSW services. Her record, including the POC, for the certification period 7/21/15 to 9/18/15, was reviewed.</p> <p>Patient #5's record included a PT evaluation dated 7/23/15, and signed by the Physical Therapist. The evaluation stated PT visits would be provided 1 time a week for 3 weeks, then 2 times per week for 6 weeks.</p> <p>During an interview on 8/20/15 at 9:30 AM, the Physical Therapist was asked why visits were provided only 1 time a week for the first 3 weeks. The Physical Therapist stated he was working part time and his schedule did not allow for more than one visit weekly at that time.</p> | G 157 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
| G 158 | <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on observation, medical record review, patient/caregiver interview and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 11 of 12 patients (#1, #2, #3, #4, #5, #6, #7, #9, #10,</p> | G 158 | | |

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| G 158 | <p>Continued From page 20 #11, and #12) whose records were reviewed. This resulted in omissions of care and unmet patient needs. Findings include:</p> <p>1. Patient #1 was a 59 year old female admitted to the agency on 11/03/14, for SN and PT services related to general muscle weakness. Additional diagnoses included hemiplegia, abnormal gait, chronic pain, pressure ulcers to ankle and lower back, chronic airway obstruction, schizophrenia, depression, lupus, and convulsions. Her record, including the POC, for the certification period 11/03/14 to 1/01/15, was reviewed.</p> <p>a. Patient #1's POC included SN orders for assessment, intervention, and education related to her diagnoses that were not followed. Examples include:</p> <p>i. Patient #1's POC included orders for the SN to instruct and educate Patient #1 and her caregiver on interventions for depression.</p> <p>The SN orders included interventions for instruction on medications, possible referral for treatment, or a monitoring plan for current treatment. Patient #1's record included 28 SN visit notes for the certification period 11/03/14 to 1/01/15. The 28 SN visit notes did not document Patient #1's depression was assessed or interventions were performed.</p> <p>ii. Patient #1's POC included orders for the SN to assess and instruct Patient #1 and her caregiver on the signs and symptoms of COPD.</p> <p>SN visits documented on 12/01/14, 12/03/14, 12/06/14, 12/10/14, 12/11/14, 12/15/14, 12/17/14,</p> | G 158 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | |
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| G 158 | <p>Continued From page 21 12/22/14, 12/24/14 and 12/26/14 did not include documentation of patient instruction related to signs and symptoms of COPD.</p> <p>During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed the orders on the POC for instruction and education. The RN Case Manager stated she did education about Patient #1's respiratory condition. She confirmed she did not consistently document the education or teaching she did with Patient #1 during the visits.</p> <p>Patient #1's orders were not followed for instruction and education related to her disease processes.</p> <p>b. Patient #1's POC included orders for SN visits 2 times a week for 2 weeks, 1 time a week for 1 week, and 4 PRN visits for falls and changes in condition.</p> <p>A physician order request dated 11/03/14, documented a request for the SN to provide wound care 2 times a week. However, the SN provided wound care 3 times a week during weeks 2, 3, 4, and 5 of Patient #1's certification period. Additionally, the order was not signed by the physician until 12/12/14.</p> <p>During an interview on 8/20/15 at 3:45 PM, the DON reviewed the record and confirmed physician orders were not followed for visit frequencies.</p> <p>SN visit frequencies were not followed according to physician orders.</p> <p>2. Patient #3 was a 2 month old female admitted</p> | G 158 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| G 158 | <p>Continued From page 22</p> <p>to the agency on 7/24/15, for SN services related to congenital esophageal fistula. Additional diagnoses included coarctation of aorta, fetal growth retardation, and 37 weeks gestation with complications. Her record, including the POC, for the certification period 7/24/15 to 9/21/15, was reviewed.</p> <p>a. Patient #3's record included a referral order from the hospital, dated 7/20/15, for home health services. The referral included SN services 1-2 times per week for 2 weeks, and an OT evaluation. However, the referral order was signed by a Nurse Practitioner. Additionally, Patient #3's POC was not signed by her physician until 8/13/15 and SN visits were completed on 7/24/15 and 7/28/15.</p> <p>During an interview on 8/20/15 at 3:40, the DON reviewed the record and confirmed the referral order was signed by a Nurse Practitioner.</p> <p>The agency failed to ensure Patient #3's orders were signed by a physician.</p> <p>b. Patient #3's POC included orders to assess and instruct her parents on NGT measurement, placement, and return, signs and symptoms of cardiopulmonary dysfunction, developmental delays, and signs or symptoms of hyperglycemia and hypoglycemia.</p> <p>SN visits were completed on 7/24/15, 7/28/15, 8/13/15, and 8/18/15. There was no documentation in the visit notes Patient #3's parents were instructed or educated about her feeding equipment or possible signs and symptoms related to her disease processes.</p> | G 158 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 158 | <p>Continued From page 23</p> <p>A home visit was conducted on 8/18/15 beginning at 11:00 AM, for observation of a SN visit. The RN Case Manager did not instruct or educate Patient #3's parents on her feedings, feeding equipment, or signs and symptoms related to her disease processes.</p> <p>During an interview on 8/20/15 at 11:20 AM, the RN Case Manager reviewed the record and confirmed there was no documentation of teaching or education. He stated because Patient #3's mother was a nurse he did not believe she needed the education or instruction.</p> <p>Patient #3's orders were not followed for instructing and educating her parents related to her disease processes or feeding equipment.</p> <p>3. Patient #4 was an 88 year old male admitted to the agency on 3/17/15, for SN, PT, and HHA services related to general muscle weakness. Additional diagnoses included syncope, abnormal gait, hypertensive heart, CKD, prostate cancer, and renal dialysis. His record, including the POC, for the certification period 7/15/15 to 9/12/15, was reviewed.</p> <p>Patient #4's POC ordered SN visits 1 time a week for 3 weeks and 2 PRN visits for falls, injury, or education. There was no documentation of a SN visit during the first week of the certification period.</p> <p>During an interview on 8/19/15 at 1:45 PM, the RN Case Manager reviewed the record and confirmed she did not complete a visit during the first week. She stated she made a visit on 7/14/15, for the recertification evaluation, and believed that was considered a visit for the first</p> | G 158 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |

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| G 158 | <p>Continued From page 24</p> <p>week of the new certification period. The RN Case Manager stated she was unaware the first week started with the beginning date of the certification period.</p> <p>SN visit frequencies were not followed according to physician orders.</p> <p>4. Patient #9 was an 80 year old male admitted to the agency on 4/07/15, for SN, PT, and HHA services related to secondary Parkinsonism. Additional diagnoses included general muscle weakness, abnormal gait, atrial fibrillation, DM, long-term use of anticoagulants, and history of falls. His record, including the POC, for the certification period 8/05/15 to 10/03/15, was reviewed.</p> <p>a. Patient #9's POC included orders for SN to assess and instruct on diabetic care which included diet, activity, stress, foot care, and skin care. Patient #9 did not receive education and instruction regarding diabetic care as stated on his POC. Examples include:</p> <ul style="list-style-type: none"> - A SN visit note, dated 8/10/15, did not include documentation of diabetic teaching or education. - A SN visit note, dated 8/17/15, did not include documentation of diabetic teaching or education. <p>During a home observation, on 8/19/15 beginning at 10:30 AM, Patient #9's spouse was asked how often he checked his blood sugars. The spouse stated she checked them daily and his blood sugar readings averaged 150 to 170. When asked if they had received any diabetic education or instruction during the SN visits, Patient #9's wife was unable to recall any discussions related</p> | G 158 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 158 | <p>Continued From page 25 to DM.</p> <p>During an interview on 8/19/15 at 12:50 PM, the LPN reviewed the record and confirmed she had not instructed or educated Patient #9 or his spouse regarding diabetic care as ordered on the POC.</p> <p>During an interview on 8/19/15 at 1:30 PM, the RN Case Manager reviewed the record and confirmed she was not teaching or educating Patient #9 or his spouse as ordered on the POC.</p> <p>Patient #9's POC was not followed for instruction and education related to diabetic care.</p> <p>b. Patient #9's POC ordered SN visits 1 time a week for 9 weeks and 4 PRN visits for additional blood draws, changes in condition, and falls. There was no documentation of a SN visit during the first week of the certification period.</p> <p>During an interview on 8/19/15 at 1:30 PM, the RN Case Manager reviewed the record and confirmed she did not complete a visit during the first week. She stated she made a visit on 8/03/15, for the recertification evaluation and believed that was considered a visit for the first week of the new certification period. The RN Case Manager stated she was unaware the first week started with the beginning date of the certification period.</p> <p>Patient #9's SN visit frequencies were not followed according to his POC.</p> <p>5. Patient #11 was a 52 year old female admitted to the agency on 7/31/15, for SN and PT services related to general muscle weakness. Additional</p> | G 158 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | |
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| G 158 | <p>Continued From page 26</p> <p>diagnoses included abnormal gait, peripheral neuropathy, asthma, DM, HTN, anemia, borderline personality disorder, depression, history of falls, and knee replacement. Her record, including the POC, for the certification period 7/31/15 to 9/28/15, was reviewed.</p> <p>Patient #11's POC included orders for the SN to assess and instruct on diabetic care which included diet, activity, stress, foot care, and skin care. Patient #11 did not receive education and instruction regarding diabetic care as stated on her POC. Examples include:</p> <p>Patient #11's SN visit notes, dated 8/06/15, 8/11/15, and 8/13/15, did not document an assessment related to her DM. Additionally, there was no documentation of diabetic teaching or education.</p> <p>During an interview on 8/19/15 at 4:00 PM, the RN Case Manager reviewed the record and confirmed Patient #11 did have diabetes. She confirmed she did not follow the POC for diabetic care and education.</p> <p>Patient #11's POC was not followed for assessment, instruction and education related to diabetic care.</p> <p>6. Patient #2 was a 78 year old female admitted to the agency on 12/19/14, for services related to generalized muscle weakness. Additional diagnoses included HTN, backache, and history of falls. She received SN, PT and HHA services. Her record, including the POC, for the certification period 12/19/14 to 2/16/15, was reviewed.</p> <p>Patient #2's record included a referral order dated</p> | G 158 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 158 | <p>Continued From page 27</p> <p>12/19/14, and signed by a physician. The order for home health included SN, PT, OT, ST and MSW services. Patient #2's record included documentation of SN and PT visits. Her record did not include documentation of OT, ST or MSW visits, or the reason the visits were not provided.</p> <p>During an interview on 8/19/15 at 3:20 PM, the RN Case Manager reviewed Patient #2's record and confirmed the disciplines were not provided as ordered by her physician. She was unable to explain why OT, ST and MSW visits were not provided.</p> <p>Patient #2 did not receive OT, ST and MSW services as ordered by the physician.</p> <p>7. Patient #5 was an 88 year old female admitted to the agency on 5/21/15, for services related to generalized muscle weakness. Additional diagnoses included dementia. She received SN, PT and MSW services. Her record, including the POC, for the certification period 7/21/15 to 9/18/15, was reviewed.</p> <p>a. Patient #5's POC included SN visits 2 times a week for 2 weeks, then 1 time a week for 1 week. Her record included an SN SOC comprehensive assessment dated 7/21/15, signed by the RN Case Manager. However, her record did not include a second SN visit during week 1 of her certification period.</p> <p>b. Patient #5's record included a physician telephone order dated 8/14/15, and signed by the Administrator, who was a pharmacist, for 4 PRN SN visits through the end of the certification period. However, the order did not state the medical signs and symptoms that would indicate</p> | G 158 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 158 | <p>Continued From page 28 the need for a PRN SN visit.</p> <p>During an interview on 8/19/15 at 2:10 PM, the RN Case Manager reviewed Patient #5's record and confirmed 2 SN visits were ordered and only 1 SN visit was completed during the first week of the certification period. Additionally, she confirmed the order for SN PRN visits did not include the reason the visits would be provided.</p> <p>Patient #5 did not receive SN visits as ordered on her POC. Additionally, her record did not include the reason SN PRN visits would be provided.</p> <p>8. Patient #6 was a 53 year old female admitted to the agency on 8/11/15, for services related to liver damage. Additional diagnoses included hepatic encephalopathy and thrombocytopenia. She received SN, PT and OT services. Her record, including the POC, for the certification period 8/11/15 to 10/09/15, was reviewed.</p> <p>Patient #6's POC included an order for 3 PRN SN visits. However, the order did not state the medical signs and symptoms for which a PRN SN visit would be made.</p> <p>During an interview on 8/19/15 at 2:45 PM, the RN Case Manager reviewed Patient #6's record and confirmed the order for SN PRN visits did not include the reason the visits would be provided.</p> <p>Patient #6's POC did not state the reason SN PRN visits would be provided.</p> <p>9. Patient #7 was a 60 year old female admitted to the agency on 4/21/15, for services related to a localized skin infection. Additional diagnoses included depression and oxygen dependency.</p> | G 158 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 158 | <p>Continued From page 29</p> <p>She received SN and PT services. Her record, including the POC, for the certification period 6/20/15 to 8/18/15, was reviewed.</p> <p>a. Patient #7's POC included orders for SN visits 3 times a week for 8 weeks. However, her record included 1 SN visit note for week 1 of her certification period, dated 6/20/15. Her record included 2 SN visit notes for week 2 of her certification period, dated 6/22/15 and 6/26/15.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed Patient #7's record and confirmed SN visits were not completed as ordered for weeks 1 and 2 of the certification period.</p> <p>Patient #7 did not receive SN visits as ordered in her POC.</p> <p>b. Patient #7's record included a physician telephone order dated 7/06/15, and signed by the Administrator, who was a pharmacist, for 3 PRN SN visits through the end of the certification period. However, the order did not state the medical signs and symptoms for which PRN SN visits would be made.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed Patient #7's record and confirmed the order for SN PRN visits did not include the reason the visits would be provided.</p> <p>Patient #7's record did not include the reason SN PRN visits would be provided.</p> <p>10. Patient #10 was a 6 year old female admitted to the agency on 7/11/15, for services related to an MRSA infection. Additional diagnoses</p> | G 158 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> </div> | |
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| G 158 | <p>Continued From page 30</p> <p>included cellulitis of the buttock. She received SN services. Her record, including the POC, for the certification period 7/11/15 to 9/09/15, was reviewed.</p> <p>Patient #10's record included an SN SOC assessment dated 7/11/15, and signed by the RN Case Manager. Her record also included SN visit notes dated 7/12/15 and 7/13/15, signed by the RN Case Manager. However, Patient #10's POC did not include orders for SN visits.</p> <p>During an interview on 8/19/15 at 2:25 PM, the RN Case Manager reviewed Patient #10's record and confirmed there was no order for SN visits.</p> <p>SN visits were provided to Patient #10 without a physician's order.</p> <p>11. Patient #12 was an 85 year old male admitted to the agency on 7/08/15, for care following a CABG. Additional diagnoses included DM, CHF and asthma. He received SN and PT services. His record, including the POC, for the certification period 7/08/15 to 9/05/15, was reviewed.</p> <p>a. Patient #12's record included a referral order dated 7/08/15, and signed by a physician. The order for home health included SN, PT, and OT services. Patient #12's record included documentation of SN and PT visits. Her record did not include documentation of OT visits, or the reason the visits were not provided.</p> <p>During an interview on 8/20/15 at 11:30 AM, the RN Case Manager reviewed Patient #12's record and confirmed OT services were ordered but were not provided.</p> | G 158 | <div style="border: 1px solid black; padding: 10px; margin: 10px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |

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| G 158 | Continued From page 31 Patient #12 did not received OT visits as ordered by the physician. b. Patient #12's POC, signed by his physician on 7/27/15, included an order for SN visits 1 time a week for one week, and 2 times a week for 7 weeks. Patient #12's record included an SN visit note dated 7/20/15, and signed by the RN Case Manager. The note stated the frequency of SN visits would be decreased to 1 time per week. However, Patient #12's record did not include a physician's order to decrease his SN visit frequency to 1 time per week. During an interview on 8/20/15 at 11:30 AM, the RN Case Manager confirmed SN visit frequency was decreased to 1 time per week beginning 7/20/15. He stated he did not contact Patient #12's physician to obtain an order to decrease the SN visit frequency. | G 158 | Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) APPENDIX - I | | |
| G 159 | Patient #12's SN visit frequency did not follow the POC signed by his physician. 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. | G 159 | | | |

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| G 159 | <p>Continued From page 32</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation, patient/caregiver interview, and staff interview, it was determined the agency failed to ensure POCs covered all pertinent information for 8 of 12 patients (#1, #2, #3, #5, #7, #9, #10 and #12) whose records were reviewed. This had the potential to result in unmet patient needs and adverse patient outcomes. Findings include:</p> <p>1. Patient #12 was an 85 year old male admitted to the agency on 7/09/15, for care following a CABG. Additional diagnoses included DM, CHF and asthma. He received SN and PT services. His record, including the POC, for the certification period 7/08/15 to 9/05/15, was reviewed.</p> <p>The POC did not include all pertinent information. Examples include:</p> <p>a. The POC did not include diagnoses.</p> <p>b. Patient #12's record included a "CLINICAL SUMMARY" dated 7/09/15 and signed by the RN Case Manager. The summary stated "Patient currently requires oxygen delivery through nasal cannula..." However, Patient #12's POC did not include oxygen or equipment used to deliver his oxygen.</p> <p>c. Patient #12's record included an SN SOC comprehensive assessment dated 7/09/15, and signed by the RN Case Manager. The assessment stated Patient #12 used a CPAP and a nebulizer. However, the CPAP and nebulizer were not included on his POC.</p> <p>d. Patient #12's SN SOC comprehensive assessment documented he was at risk of</p> | G 159 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | | |

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| G 159 | <p>Continued From page 33</p> <p>developing pressure ulcers. However, interventions to monitor his skin for breakdown, and to prevent pressure ulcers were not included on his POC.</p> <p>e. Patient #12's SN SOC comprehensive assessment documented he was diabetic and required diabetic foot care and patient/caregiver education on foot care. However, intervention and education related to diabetic foot care were not included on his POC.</p> <p>During an interview on 8/20/15 at 11:30 AM, the RN Case Manager reviewed Patient #12's record and confirmed the POC signed by the physician did not include diagnoses, oxygen, oxygen supplies, CPAP, or nebulizer. Additionally, he confirmed Patient #12's POC did not include interventions or education related to pressure ulcer prevention or diabetic foot care.</p> <p>Patient #12's POC was not comprehensive to include pertinent diagnoses, equipment and interventions required for his care.</p> <p>2. Patient #10 was a 6 year old female admitted to the agency on 7/11/15, for services related to an MRSA infection. Additional diagnoses included cellulitis of the buttock. She received SN services. Her record, including the POC, for the certification period 7/11/15 to 9/09/15, was reviewed.</p> <p>The POC did not include all pertinent information. Examples include:</p> <p>a. Patient #10's record included a "CLINICAL SUMMARY" dated 7/11/15, and signed by the RN Case Manager. The summary stated Patient #10</p> | G 159 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 159 | <p>Continued From page 34</p> <p>was admitted to home health for infusion of IV antibiotics. However, her POC did not include orders to insert and maintain IV access, or supplies used to insert and maintain her IV access.</p> <p>b. Patient #10's POC included orders for wound care to her right buttock. However, her POC did not include supplies necessary to perform the wound care.</p> <p>c. Patient #10's POC included Clindamycin Phosphate (an antibiotic) 300 mg/50 ml IV. However, the POC did not state how often the antibiotic was to be infused.</p> <p>d. Patient #10's record included an H&P written by a physician during her hospitalization immediately prior to her home health admission. The H&P stated Patient #10 was allergic to Penicillin. However, her POC did not include her allergy to Penicillin.</p> <p>e. Patient #10's record included an order for home health services signed by her physician on 7/11/15. The order stated sitz baths three times a day for 2 to 3 days were recommended. However, her POC did not include sitz baths or education related to sitz baths.</p> <p>f. Patient #10's POC did not include nutritional requirements, mental status, activities permitted, or safety measures.</p> <p>During an interview on 8/19/15 at 2:25 PM, the RN Case Manager reviewed Patient #10's record and confirmed the POC did not include IV orders or supplies, wound care supplies, frequency of antibiotic administration, accurate allergy</p> | G 159 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| G 159 | <p>Continued From page 35</p> <p>information, education related to sitz baths, nutritional requirements, mental status, activities permitted, or safety measures.</p> <p>Patient #10's POC was not comprehensive to include all orders, supplies, and other pertinent information.</p> <p>3. Patient #2 was a 78 year old female admitted to the agency on 12/19/14, for services related to generalized muscle weakness. Additional diagnoses included HTN, backache, and history of falls. She received SN, PT and HHA services. Her record, including the POC, for the certification period 12/19/14 to 2/16/15, was reviewed.</p> <p>Patient #2's POC included oxygen to be used at night. However, her POC did not include the equipment used to deliver her oxygen, such as a concentrator or tanks.</p> <p>During an interview on 8/19/15 at 3:20 PM, the RN Case Manager reviewed Patient #2's record and confirmed the equipment used to deliver her oxygen was not included on her POC.</p> <p>Patient #2's POC did not include all equipment required for her care.</p> <p>4. Patient #5 was an 88 year old female admitted to the agency on 5/21/15, for services related to general muscle weakness. Additional diagnoses included dementia. She received SN, PT and MSW services. Her record, including the POC, for the certification period 7/21/15 to 9/18/15, was reviewed.</p> <p>a. Patient #5's record included a PT evaluation dated 7/23/15, and PT visit notes dated 7/29/15,</p> | G 159 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 159 | <p>Continued From page 36</p> <p>8/05/15, 8/11/15, and 8/13/15, signed by the Physical Therapist. However, her POC did not include an order for PT visits, PT interventions or PT goals.</p> <p>During an interview on 8/20/15 at 9:30 AM, the Physical Therapist reviewed Patient #5's record and confirmed PT orders, interventions and goals were not included in her POC. He stated he did not use the appropriate evaluation in the EMR, therefore the information did not automatically flow to the POC.</p> <p>b. Patient #5's record included an SN SOC comprehensive assessment dated 5/21/15, and signed by the RN Case Manager. The assessment stated Patient #5 experienced pain daily, but not constantly and stated interventions to monitor and mitigate pain were to be included in her care. However, her POC did not include interventions related to pain.</p> <p>During an interview on 8/19/15 at 2:10 PM, the RN Case Manager reviewed Patient #5's record and confirmed the POC did not include interventions to monitor and mitigate her pain.</p> <p>Patient #5's POC was not comprehensive to include all services and interventions required for her care.</p> <p>5. Patient #7 was a 60 year old female admitted to the agency on 4/21/15, for services related to a localized skin infection. Additional diagnoses included depression and oxygen dependency. She received SN and PT services. Her record, including the POC, for the certification period 6/20/15 to 8/18/15, was reviewed.</p> | G 159 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| G 159 | <p>Continued From page 37</p> <p>a. Patient #7's record included a "CLINICAL SUMMARY" dated 6/20/15, and signed by the RN Case Manager. The summary stated Patient #7 was admitted to home health for wound care to an abdominal wound. However, her POC did not include supplies to be used for her wound care.</p> <p>b. Patient #7's POC included oxygen to be used at night. However, her POC did not include the equipment used to deliver her oxygen, such as a concentrator or tanks.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed Patient #7's record and confirmed the POC did not include supplies used to provide her wound care or equipment used to deliver her oxygen.</p> <p>Patient #7's POC was not comprehensive to include all supplies and equipment required for her care.</p> <p>6. Patient #1 was a 59 year old female admitted to the agency on 11/03/14, for SN and PT services related to general muscle weakness. Additional diagnoses included hemiplegia, abnormal gait, chronic pain, pressure ulcers to ankle and lower back, chronic airway obstruction, schizophrenia, depression, lupus, and convulsions. Her record, including the POC, for the certification period 11/03/14 to 1/01/15, was reviewed.</p> <p>a. Patient #1's record included an SN SOC comprehensive assessment dated 11/03/14, and signed by the RN Case Manager. The assessment documented 2 wounds, one on the coccyx and the other on the right ankle. The SN documented Patient #1 would require SN</p> | G 159 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | | |

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| G 159 | <p>Continued From page 38</p> <p>services for wound care. However, the POC did not include orders for wound care or wound care supplies.</p> <p>b. Patient #1's POC included oxygen to be used to keep her oxygen level greater than 90%. However, her POC did not include the equipment used to deliver her oxygen, such as a concentrator or tanks.</p> <p>During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed Patient #1 was using oxygen at night but it was not listed on her POC. She confirmed the POC did not include wound care orders or supplies.</p> <p>Patient #1's POC was not comprehensive to include all supplies and equipment or physician orders required for her care.</p> <p>7. Patient #3 was a 2 month old female admitted to the agency on 7/24/15, for SN services related to congenital esophageal fistula. Additional diagnoses included coarctation of aorta, fetal growth retardation, and 37 weeks gestation with complications. Her record, including the POC, for the certification period 7/24/15 to 9/21/15, was reviewed.</p> <p>Patient #3's referral order, dated 7/20/15, from the acute care facility included a cardiac/apnea monitor. However, a cardiac/apnea monitor was not listed on her POC. Additionally, there was no order for interventions related to instructing, using, or monitoring a cardiac/apnea monitor.</p> <p>During an observation on 8/18/15, beginning at 11:00 AM, Patient #3's parents were asked about</p> | G 159 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> </div> | | |

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| G 159 | <p>Continued From page 39</p> <p>the cardiac/apnea monitor. The mother confirmed she was using a cardiac/apnea monitor for Patient #3 when she was sleeping.</p> <p>During an interview on 8/20/15 at 11:20 AM, the RN Case Manager confirmed the POC did not include a cardiac/apnea monitor. He stated he was unaware Patient #3 was using the monitor.</p> <p>Patient #3's POC was not comprehensive to include all interventions and equipment related to her care.</p> <p>8. Patient #9 was an 80 year old male admitted to the agency on 4/07/15, for SN, PT, and HHA services related to secondary Parkinsonism. Additional diagnoses included general muscle weakness, abnormal gait, atrial fibrillation, DM, long-term use of anticoagulants, and history of falls. His record, including the POC, for the certification period 8/05/15 to 10/03/15, was reviewed.</p> <p>a. Patient #9's record included a PT evaluation dated 8/05/15, and PT visit notes dated 8/05/15, 8/10/15, 8/13/15, 8/17/15, and 8/19/15. However, his POC did not include an order for PT visits, PT interventions, or PT goals.</p> <p>During an interview on 8/20/15 at 9:25 AM, the Physical Therapist reviewed the record and confirmed the POC did not include PT orders. He stated after his evaluation visit the office staff would either contact the physician or fax the page from his evaluation note which documented visit frequencies, interventions, and goals. The Physical Therapist stated he did not call the physician after his evaluation of Patient #9 to obtain orders for additional PT visits.</p> | G 159 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| G 159 | Continued From page 40 b. The PT evaluation dated 8/05/15, and signed by the Physical Therapist documented Patient #9 had a wheelchair, walker, and grab bars in the home. However, his POC did not list a wheelchair or grab bars. During an interview on 8/19/15 at 1:30 PM, the RN Case Manager reviewed the record and confirmed all of the equipment used by Patient #9 in his home was not included on his POC. Patient #9's POC was not comprehensive to include all interventions and equipment related to his care. | G 159 | Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) APPENDIX – I | | |
| G 160 | 484.18(a) PLAN OF CARE 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 review of patient records and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the plan of care for 11 of 12 patients (#1, #2, #3, #4, #5, #6, #7, #9, #10, #11, and #12) whose records were reviewed. This resulted in POCs that were developed and initiated without appropriate physician approval. Findings include: 1. Patient #2 was a 78 year old female admitted to the agency on 12/19/14, for services related to generalized muscle weakness. Additional diagnoses included HTN, backache, and history of falls. She received SN, PT and HHA services. | G 160 | | | |

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| G 160 | <p>Continued From page 41</p> <p>Her record, including the POC, for the certification period 12/19/14 to 2/16/15, was reviewed.</p> <p>Patient #2's record included a PT evaluation dated 12/29/14, signed by the Physical Therapist. Her record did not include documentation of physician contact after the evaluation to approve the PT POC. Patient #2's POC was signed by her physician on 1/19/15. However, PT visits were completed on 12/30/14, 1/07/15, 1/09/15, and 1/12/15, prior to physician approval of her POC.</p> <p>During an interview on 8/20/15 at 10:15 AM, the Physical Therapist reviewed the record and stated he did not call Patient #2's physician to approve her PT POC.</p> <p>Patient #2's physician was not consulted to approve her PT POC and additional visits following the PT evaluation.</p> <p>2. Patient #5 was an 88 year old female admitted to the agency on 5/21/15, for services related to generalized muscle weakness. Additional diagnoses included dementia. She received SN, PT and MSW services. Her record, including the POC, for the certification period 7/21/15 to 9/18/15, was reviewed.</p> <p>a. Patient #5's record included an SN SOC comprehensive assessment completed 5/21/15, and signed by the RN Case Manager. Her record did not include documentation of physician contact after the assessment to approve the SN POC. Patient #5's POC was signed by her physician on 8/17/15. However, SN visits were provided on 7/27/15, 7/29/15, 7/31/15, 8/04/15, and 8/10/15, prior to physician approval of her</p> | G 160 | <div style="border: 1px solid black; padding: 10px; margin: 10px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |

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| G 160 | <p>Continued From page 42 POC.</p> <p>During an interview on 8/19/15 at 2:10 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #5's physician to approve her SN POC.</p> <p>b. Patient #5's record include a PT evaluation dated 7/23/15, and signed by the Physical Therapist. Her record did not include documentation of physician contact after the evaluation to approve the PT POC. Patient #5's POC did not include orders for PT visits, PT interventions or goals. PT visits were provided on 7/29/15, 8/05/15, 8/11/15, and 8/13/15, without physician approval.</p> <p>During an interview on 8/20/15 at 9:30 AM, the Physical Therapist reviewed the record and confirmed he did not contact Patient #5's physician to obtain orders for her PT POC.</p> <p>Patient #2's physician was not contacted to approve her SN or PT POCs, or additional visits after the initial assessments.</p> <p>3. Patient #6 was a 53 year old female admitted to the agency on 8/11/15, for services related to liver damage. Additional diagnoses included hepatic encephalopathy and thrombocytopenia. She received SN, PT and OT services. Her record, including the POC, for the certification period 8/11/15 to 10/09/15, was reviewed.</p> <p>a. Patient #6's record included an SN SOC comprehensive assessment dated 8/11/15, and signed by the RN Case Manager. Her record did not include documentation of physician contact after the assessment to approve the SN POC.</p> | G 160 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 160 | <p>Continued From page 43</p> <p>Patient #6's POC was unsigned by her physician as of 8/20/15. However, SN visits were provided on 8/14/15, and 8/17/15, prior to physician approval of her POC.</p> <p>During an interview on 8/19/15 at 2:45 PM, the RN Case Manager reviewed the record and stated Patient #6 did not have a primary care physician. She stated the home health referral orders were written by the hospitalist at the time of her hospital discharge. The RN Case Manager confirmed she did not contact the hospitalist to approve Patient #6's SN-POC.</p> <p>b. Patient #6's record included a PT evaluation dated 8/18/15, and signed by the Physical Therapist. Her record did not include documentation of physician contact after the evaluation to approve the PT POC. Patient #6's POC was unsigned by her physician as of 8/20/15. However, a PT visit was provided on 8/19/15, prior to physician approval of her POC.</p> <p>During an interview on 8/20/15 at 9:35 AM, the Physical Therapist reviewed Patient #6's record and stated he did not call the physician to approve her PT POC.</p> <p>Patient #6's physician was not contacted to approve her SN or PT POCs, or additional visits after the initial assessments.</p> <p>4. Patient #7 was a 60 year old female admitted to the agency on 4/21/15, for services related to a localized skin infection. Additional diagnoses included depression and oxygen dependency. She received SN and PT services. Her record, including the POC, for the certification period 6/20/15 to 8/18/15, was reviewed.</p> | G 160 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 160 | <p>Continued From page 44</p> <p>Patient #7's record included an SN Recertification comprehensive assessment for the certification period 6/20/15 to 8/18/15, completed 6/18/15, and signed by the RN Case Manager. Her record did not include documentation of physician contact after the assessment to approve the SN POC for the new certification period, including wound care to be provided. Patient #5's POC was signed by her physician on 7/7/15. However, SN visits were provided on 6/22/15, 6/26/15, 6/29/15, 7/01/15, 7/03/15, and 7/06/15, prior to physician approval of her POC.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #7's physician to approve the POC for the new certification period.</p> <p>Patient #7's physician was not contacted to approve her SN POC, or additional visits after the recertification assessment.</p> <p>5. Patient #10 was a 6 year old female admitted to the agency on 7/11/15, for services related to a MRSA infection. Additional diagnoses included cellulitis of the buttock. She received SN services. Her record, including the POC, for the certification period 7/11/15 to 9/09/15, was reviewed.</p> <p>Patient #10's record included an SN SOC comprehensive assessment completed 7/11/15, and signed by the RN Case Manager. Her record did not include documentation of physician contact after the assessment to approve the SN POC. Patient #5's POC was signed by her physician on 7/22/15. However, SN visits were</p> | G 160 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | |
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| G 160 | <p>Continued From page 45 provided on 7/12/15, 7/13/15, and 7/14/15, prior to physician approval of her POC.</p> <p>During an interview on 8/19/15 at 2:25 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #10's physician to approve her POC.</p> <p>Patient #10's physician was not contacted to approve her SN POC, or additional visits after the initial assessment.</p> <p>6. Patient #12 was an 85 year old male admitted to the agency on 7/08/15, for care following a CABG. Additional diagnoses included DM, CHF and asthma. He received SN and PT services. His record, including the POC for the certification period 7/08/15 to 9/05/15, was reviewed.</p> <p>a. Patient #12's record included an SN SOC comprehensive assessment completed 7/08/15, and signed by the RN Case Manager. His record did not include documentation of physician contact after the assessment to approve the SN POC. Patient #12's POC was signed by his physician on 7/27/15. However, SN visits were provided on 7/13/15, 7/16/15, and 7/20/15, prior to physician approval of his POC.</p> <p>During an interview on 8/20/15 at 11:30 AM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #12's physician following his SOC assessment to approve his SN POC.</p> <p>b. Patient #12's record include a PT evaluation dated 7/13/15, and signed by the Physical Therapist. His record did not include documentation of physician contact after the</p> | G 160 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 160 | <p>Continued From page 46</p> <p>evaluation to approve the PT POC. PT visits were provided on 7/15/15, 7/21/15, and 7/23/15, prior to physician approval of his POC.</p> <p>During an interview on 8/20/15 at 10:00 AM, the Physical Therapist reviewed the record and confirmed he did not contact Patient #12's physician to approve his PT POC.</p> <p>Patient #12's physician was not contacted to approve his SN or PT POCs, or additional visits after the initial assessments.</p> <p>7. Patient #1 was a 59 year old female admitted to the agency on 11/03/14, for SN and PT services related to general muscle weakness. Additional diagnoses included hemiplegia, abnormal gait, chronic pain, pressure ulcers to ankle and lower back, schizophrenia, depression, lupus, and convulsions. Her record, including the POC, for the certification period 11/03/14 to 1/01/15, was reviewed.</p> <p>a. Patient #1's record included an SN SOC comprehensive assessment completed 11/03/14, and signed by the RN Case Manager. Her record did not include documentation of physician contact after the assessment to approve the SN POC. Patient #1's POC was unsigned as of 8/20/15. Twenty eight SN visits were completed during the certification period.</p> <p>During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #1's physician to approve her SN POC.</p> <p>b. Patient #1's record included a PT evaluation dated 11/10/14, and signed by the Physical</p> | G 160 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 160 | <p>Continued From page 47</p> <p>Therapist. Her record did not include documentation of physician contact after the evaluation to approve the PT POC. PT visits were provided 3 times a week for 2 weeks, and 2 times a week for 6 weeks, without physician approval.</p> <p>During an interview on 8/20/15 at 3:45 PM, the DON reviewed the record and confirmed there was no documentation of physician contact for approval of the PT POC.</p> <p>Patient #1's physician was not contacted to approve her SN or PT POCs, or additional visits after the initial assessments.</p> <p>8. Patient #3 was a 2 month old female admitted to the agency on 7/24/15, for SN services related to congenital esophageal fistula. Additional diagnoses included coarctation of aorta, fetal growth retardation, and 37 weeks gestation with complications. Her record, including the POC, for the certification period 7/24/15 to 9/21/15, was reviewed.</p> <p>Patient #3's record included an SN SOC comprehensive assessment completed 7/24/15, and signed by the RN Case Manager. Her record did not include documentation of physician contact after the assessment to approve the SN POC. Patient #3's POC was signed by her physician on 8/13/15. However, an SN visit was provided on 7/28/15, prior to physician approval of her POC.</p> <p>During an interview on 8/20/15 at 11:20 AM, the RN Case Manager reviewed the record and confirmed he did not contact Patient #3's physician for approval of the SN POC.</p> | G 160 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |

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| G 160 | <p>Continued From page 48</p> <p>Patient #3's physician was not contacted to approve her SN POC, or additional visits after the initial assessment.</p> <p>9. Patient #4 was an 88 year old male admitted to the agency on 3/17/15, for SN, PT, and HHA services related to general muscle weakness. Additional diagnoses included syncope, abnormal gait, hypertensive heart, CKD, prostate cancer, and renal dialysis. His record, including the POC, for the certification period 7/15/15 to 9/12/15, was reviewed.</p> <p>a. Patient #4's record included an SN recertification assessment completed on 7/14/15, and signed by the RN Case Manager. His record did not include documentation of physician contact after the assessment to approve the SN POC. Patient #4's POC was signed by his physician on 8/01/15. However, SN visits were provided on 7/21/15 and 7/28/15, prior to physician approval of his POC.</p> <p>During an interview on 8/19/15 at 1:45 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #4's physician for approval of the SN POC.</p> <p>b. Patient #4's record included a PT evaluation dated 7/14/15, and signed by the Physical Therapist. His record did not include documentation of physician contact after the evaluation to approve the PT POC. PT visits were provided on 7/20/15, 7/25/15, 7/28/15, and 7/30/15, prior to physician approval of his POC.</p> <p>During an interview on 8/20/15 at 9:25 AM, the Physical Therapist reviewed the record and</p> | G 160 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 160 | <p>Continued From page 49</p> <p>confirmed he did not contact Patient #4's physician for approval of the PT POC.</p> <p>Patient #4's physician was not contacted to approve her SN or PT POCs, or additional visits after the initial assessments.</p> <p>10. Patient #9 was an 80 year old male admitted to the agency on 4/07/15, for SN, PT, and HHA services related to secondary Parkinsonism. Additional diagnoses included general muscle weakness, abnormal gait, atrial fibrillation, DM, long-term use of anticoagulants, and history of falls. His record, including the POC, for the certification period 8/05/15 to 10/03/15, was reviewed.</p> <p>a. Patient #9's record included an SN recertification assessment completed on 8/03/15, and signed by the RN Case Manager. His record did not include documentation of physician contact after the assessment to approve the SN POC. Patient #9's POC was signed by his physician on 8/14/15. However, an SN visit was provided on 8/10/15, prior to physician approval of his POC.</p> <p>During an interview on 8/19/15 at 1:30 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #9's physician for approval of the SN POC.</p> <p>b. Patient #9's record included a PT evaluation dated 8/05/15, and signed by the Physical Therapist. His record did not include documentation of physician contact after the evaluation to approve the PT POC. PT visits were provided on 8/05/15, 8/10/15, and 8/13/15, prior to physician approval of his POC.</p> | G 160 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 160 | <p>Continued From page 50</p> <p>During an interview on 8/20/15 at 9:25 AM, the Physical Therapist reviewed the record and confirmed he did not contact Patient #9's physician for approval of the PT POC.</p> <p>Patient #9's physician was not contacted to approve her SN or PT POCs, or additional visits after the initial assessments.</p> <p>11. Patient #11 was a 52 year old female admitted to the agency on 7/31/15, for SN and PT services related to general muscle weakness. Additional diagnoses included abnormal gait, peripheral neuropathy, asthma, DM, HTN, anemia, borderline personality disorder, depression, history of falls, and knee replacement. Her record, including the POC, for the certification period 7/31/15 to 9/28/15, was reviewed.</p> <p>a. Patient #11's record included an SN SOC comprehensive assessment completed on 7/31/15, and signed by the RN Case Manager. Her record did not include documentation of physician contact after the assessment to approve the SN POC. Patient #11's POC was signed by her physician on 8/10/15. However, an SN visit was provided on 8/06/15, prior to physician approval of her POC.</p> <p>During an interview on 8/19/15 at 4:00 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #11's physician for approval of the SN POC.</p> <p>b. Patient #11's record included a PT evaluation dated 8/04/15, and signed by the Physical Therapist. His record did not include</p> | G 160 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 160 | Continued From page 51 documentation of physician contact after the evaluation to approve the PT POC. A PT visit was provided on 8/06/15, prior to physician approval of her POC. During an interview on 8/20/15 at 10:15 AM, the Physical Therapist reviewed the record and confirmed he did not contact Patient #11's physician for approval of the PT POC. Patient #11's physician was not contacted to approve her SN or PT POCs, or additional visits after the initial assessments. | G 160 | Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) APPENDIX - I | | |
| 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 professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 4 of 12 patients (#1, #2, #7, and #12) whose records were reviewed. This resulted in missed opportunities for the physician to alter patients' POCs to meet their needs. Findings include: 1. Patient #2 was a 78 year old female admitted to the agency on 12/19/14, for services related to generalized muscle weakness. Additional diagnoses included HTN, backache, and history of falls. She received SN, PT and HHA services. Her record, including the POC, for the certification | G 164 | | | |

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| G 164 | <p>Continued From page 52 period 12/19/14 to 2/16/15, was reviewed.</p> <p>Patient #2's record included a PT evaluation dated 12/29/15, and signed by the Physical Therapist. The evaluation documented Patient #2 reported a pain level of 9 on a scale of 1 to 10, with 10 being the worst pain. The evaluation stated Patient #2 reported she experienced the pain daily but not constantly. Patient #2's record did not include documentation of physician notification of her severe pain.</p> <p>During an interview on 8/20/15 at 10:15 AM, the Physical Therapist reviewed the record and confirmed he did not notify the physician of Patient #2's pain.</p> <p>Agency staff failed to notify Patient #2's physician of her severe level of pain.</p> <p>2. Patient #7 was a 60 year old female admitted to the agency on 4/21/15, for services related to a localized skin infection. Additional diagnoses included depression and oxygen dependency. She received SN and PT services. Her record, including the POC, for the certification period 6/20/15 to 8/18/15, was reviewed.</p> <p>Patient #7's POC included an order to notify her physician when her BP was outside of the following parameters:</p> <ul style="list-style-type: none"> -Systolic greater than 140 and less than 100 -Diastolic greater than 90 and less than 60 <p>Patient #7's SN visit notes included BP readings outside of the established parameters, as follows:</p> <p>6/22/15 - 155/89</p> | G 164 | <div style="border: 1px solid black; padding: 5px; margin: 10px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |

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| G 164 | <p>Continued From page 53</p> <p>7/03/15 - 142/63 7/06/15 - 141/55 7/08/15 - 125/55 7/13/15 - 155/64 7/16/15 - 120/58 7/17/15 - 116/54 7/22/15 - 149/83 7/24/15 - 145/76 7/31/15 - 118/55 8/05/15 - 124/56 8/07/15 - 122/57 8/10/15 - 117/54 8/14/15 - 110/95</p> <p>Patient #7's record did not include documentation her physician was notified of the BP readings outside of the established parameters.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #7's physician to report BP readings outside of the parameters ordered on her POC.</p> <p>Agency staff did not notify Patient #7's physician of BP readings outside of established parameters.</p> <p>3. Patient #12 was an 85 year old male admitted to the agency on 7/08/15, for care following a CABG. Additional diagnoses included DM, CHF and asthma. He received SN and PT services. His record, including the POC, for the certification period 7/08/15 to 9/05/15, was reviewed.</p> <p>Patient #12's POC included orders to notify his physician for vital signs outside of parameters, including temperature less than 96 degrees, and heart rate less than 60 bpm.</p> | G 164 | <div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: fit-content;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| G 164 | <p>Continued From page 54</p> <p>Patient #12's record included a discharge assessment completed on 8/10/15, and signed by the RN Case Manager. The assessment documented a temperature of 90 degrees and heart rate of 58 bpm. Patient #12's record did not include documentation stating his physician was notified of his vital signs outside of parameters.</p> <p>During an interview on 8/20/15 at 11:30 AM, the RN Case Manager reviewed the record and confirmed he did not notify Patient #12's physician of his low temperature and heart rate.</p> <p>Agency staff did not notify Patient #12's physician of vital signs outside of established parameters.</p> <p>4. Patient #1 was a 59 year old female admitted to the agency on 11/03/14, for SN and PT services related to general muscle weakness. Additional diagnoses included hemiplegia, abnormal gait, chronic pain, pressure ulcers to ankle and lower back, chronic airway obstruction, schizophrenia, depression, lupus, and convulsions. Her record, including the POC, for the certification period 11/03/14 to 1/01/15, was reviewed.</p> <p>Patient #1's medication list included oxygen to keep her oxygen levels above 90%.</p> <p>- An SN visit note dated 11/17/14, signed by the RN Case Manager, documented Patient #1's oxygen level was 86% on room air. There was no documentation Patient #1's physician was notified of the low oxygen level.</p> <p>- An SN visit note dated 11/24/14, signed by the RN Case Manager, documented Patient #1's</p> | G 164 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 164 | <p>Continued From page 55</p> <p>oxygen level was 88 to 90%. Additionally, the SN documented Patient #1 stated she did not use her oxygen most of the time. However, there was no documentation Patient #1's physician was notified of the low oxygen level or that Patient #1 did not use her oxygen supplement as ordered.</p> <p>During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed she did not contact or notify Patient #1's physician of her low oxygen saturation levels or that she was not using her oxygen supplement.</p> | G 164 | | |
| G 165 | <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</p> <p>Drugs and treatments are administered by agency staff only as ordered by the physician.</p> <p>This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview it was determined the agency failed to ensure physician orders were obtained/clarified prior to the provision of wound care and infusion therapy for 5 of 12 patients (#1, #7, #9, #10 and #11) whose records were reviewed. This resulted in unauthorized medication administration and wound care, and had the potential to negatively impact patient safety. Findings include:</p> <p>An Agency policy, 6.004.1 "Wound Care Management," undated, stated staff will obtain specific physician orders to perform wound care for patients. "Orders at a minimum contain the</p> | G 165 | <div style="border: 1px solid black; padding: 5px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |

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| G 165 | <p>Continued From page 56</p> <p>specific protocol, technique to be observed, supplies, frequency, duration and any adverse events to report to the physician." This policy was not followed. Examples include:</p> <p>1. Patient #7 was a 60 year old female admitted to the agency on 4/21/15, for services related to a localized skin infection. Additional diagnoses included depression and oxygen dependency. She received SN and PT services. Her record, including the POC, for the certification period 6/20/15 to 8/18/15, was reviewed.</p> <p>a. Patient #7's POC included an order to pack her abdominal wound with sterile packing gauze.</p> <p>-SN visit notes dated 6/20/15, 6/22/15, 6/24/15, 6/26/15, 6/29/15, 7/01/15, 7/03/15, 7/06/15, 7/08/15, 7/10/15, 7/13/15, 7/15/15, 7/16/15, 7/17/15, 7/20/15, 7/22/15, 7/24/15, 7/27/15, 7/29/15, 7/31/15, and 8/03/15, documented Patient #7's abdominal wound was irrigated with normal saline, packed with sterile gauze, and secured with skin prep, hydrophilic foam dressing and Tegaderm. However, her POC did not include orders to irrigate her wound, or specify what products to use to secure her dressing.</p> <p>-SN visit notes dated 8/05/15, 8/07/15, 8/10/15, 8/12/15, and 8/14/15, documented Patient #7's wound was packed with iodine impregnated sterile gauze. However, her record did not include a physician's order to use iodine impregnated sterile gauze.</p> <p>b. An SN visit note dated 7/06/15, stated a stage II pressure ulcer was identified on Patient #7's left ear.</p> | G 165 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |

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| G 165 | <p>Continued From page 57</p> <p>-SN visit notes dated 7/06/15, 7/08/15, 7/10/15, 7/13/15, 7/15/15, 7/17/15, 7/20/15, 7/22/15, and 7/24/15, stated the ulcer was cleansed with normal saline, and covered with foam dressing and tape. However, Patient #7's record did not include physician orders for wound care to her left ear.</p> <p>-An SN visit note dated 7/29/15, stated the RN applied Bacitracin ointment to Patient #7's left ear wound. However, Patient #7's record did not include a physician order for Bacitracin ointment.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed Patient #6's record and confirmed she did not obtain a physician's order to irrigate the abdominal wound, or to specify products to secure the wound dressing. She stated she started using iodine impregnated gauze without contacting the physician or obtaining an order. Additionally, she stated she did not obtain a physician's order to provide wound care, or to apply Bacitracin, to Patient #7's left ear.</p> <p>The agency failed to ensure Patient #7's wound care was provided as ordered by her physician.</p> <p>2. Patient #10 was a 6 year old female admitted to the agency on 7/11/15, for services related to an MRSA infection. Additional diagnoses included cellulitis of the buttock. She received SN services. Her record, including the POC, for the certification period 7/11/15 to 9/09/15, was reviewed.</p> <p>Patient #10's record included a "CLINICAL SUMMARY" dated 7/11/15, and signed by the RN Case Manager. The summary stated Patient #10</p> | G 165 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 165 | <p>Continued From page 58</p> <p>was admitted to home health for infusion of IV antibiotics. Physician orders for drugs and treatments were not obtained, as follows:</p> <p>a. Patient #10's POC included Clindamycin Phosphate (an antibiotic) 300 mg/50 ml IV. However, the POC did not state how often the antibiotic was to be infused.</p> <p>b. Patient #10's record did not include physician orders to insert an IV, including the type and size of IV access to be inserted.</p> <p>c. Patient #10's record did not include physician orders to maintain her IV access, including method and frequency of flushing the IV catheter.</p> <p>During an interview on 8/19/15 at 2:25 PM, the RN Case Manager reviewed Patient #10's record and confirmed her POC did not include the frequency of Clindamycin administration. Additionally, she confirmed there were no physician orders for IV insertion or maintenance.</p> <p>The agency failed to ensure Patient #10's medication and IV care were administered as ordered by a physician.</p> <p>3. Patient #1 was a 59 year old female admitted to the agency on 11/03/14, for SN and PT services related to general muscle weakness. Additional diagnoses included hemiplegia, abnormal gait, chronic pain, pressure ulcers to ankle and lower back, chronic airway obstruction, schizophrenia, depression, lupus, and convulsions. Her record, including the POC, for the certification period 11/03/14 to 1/01/15, was reviewed.</p> | G 165 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137061 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 08/20/2015 |
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| NAME OF PROVIDER OR SUPPLIER TETON HOME HEALTH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2470 JAFER COURT IDAHO FALLS, ID 83404 | | |
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| G 165 | <p>Continued From page 59</p> <p>Patient #1's record included an SN SOC comprehensive assessment dated 11/03/14, signed by the RN Case Manager. Two stage I pressure ulcers were identified during the comprehensive assessment, 1 on her coccyx and 1 on her right ankle. However, the next SN visit note, dated 11/07/14, documented Patient #1 had open wounds. According to the Johns Hopkins Medicine website, accessed 8/28/15, a stage I pressure ulcer is intact skin with non-blanchable redness.</p> <p>SN visit notes documented Patient #1's wound treatment changed 8 times during the certification period. Examples include but are not limited to the following:</p> <p>SN visit notes dated 11/07/14, 11/12/14, 11/14/14, and 11/17/14, documented Patient #1's right ankle wound was cleansed with normal saline, covered with a non-latex sponge dressing, and the ankle was wrapped with gauze.</p> <p>An SN visit note dated 11/19/14, documented Patient #1's right ankle was cleansed with normal saline, lotion was applied to the surrounding skin, covered with a non-latex AG sponge (a dressing with silver alginate in the sponge), and the ankle was wrapped in gauze.</p> <p>SN visit notes dated 11/21/14, 11/24/14, and 11/26/14, documented Patient #1's right ankle was cleansed with normal saline, medicated cream was applied to the surrounding skin, covered with a non-latex sponge, and wrapped in gauze.</p> <p>An SN visit note dated 11/28/14, documented Patient #1's right ankle was cleansed with normal</p> | G 165 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 165 | <p>Continued From page 60</p> <p>saline, lotion was applied to the surrounding skin, covered with an Adaptic dressing (a clear non-adhering dressing which has petrolatum), and the ankle was wrapped in gauze.</p> <p>SN visit notes dated 12/01/14 and 12/03/14, documented Patient #1's coccyx was cleansed with normal saline and covered with a polymem foam dressing (a foam which absorbs moisture and pads the tissue to protect). The right ankle wound was cleansed with normal saline, lotion was applied to the surrounding skin, a hydrophilic foam dressing (a highly absorbent foam dressing for draining wounds) was applied, and the ankle was wrapped in gauze.</p> <p>Two physician order requests, dated 11/03/14 and 12/10/14, included requests for the SN to provide wound care for Patient #1. Both orders were signed by Patient #1's physician on 12/12/14. However, the orders did not specify how the wounds were to be cleansed or what types of dressings were to be used for treatment of the identified pressure ulcers.</p> <p>During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed the changes in wound treatment for Patient #1. She stated Patient #1 would only allow staff to use her own wound supplies. The RN Case Manager confirmed there were no physician orders for wound treatment.</p> <p>The agency failed to ensure wound treatments were ordered and followed for Patient #1.</p> <p>4. Patient #11 was a 52 year old female admitted to the agency on 7/31/15, for SN and PT services related to general muscle weakness. Additional</p> | G 165 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 165 | <p>Continued From page 61</p> <p>diagnoses included abnormal gait, peripheral neuropathy, asthma, DM, HTN, anemia, borderline personality disorder, depression, history of falls, and knee replacement. Her record, including the POC, for the certification period 7/31/15 to 9/28/15, was reviewed.</p> <p>Patient #11's record included an SN SOC comprehensive assessment dated 7/31/15, signed by the RN Case Manager. A surgical wound was identified during the comprehensive assessment. SN visit notes documented the SN performed wound treatment on the surgical wound. Examples include:</p> <ul style="list-style-type: none"> - An SN visit note dated 8/06/15, documented Patient #11's surgical incision was cleansed with normal saline, bacitracin was applied to the incision, and covered with a telfa dressing (a non-adherent dressing). - SN visit notes dated 8/11/15 and 8/13/15, documented Patient #11's surgical incision was covered with a hydrophilic foam dressing. <p>A physician order request dated 8/02/15, documented a request for the SN to provide wound care for Patient #11's surgical incision. The order request was signed by Patient #11's physician on 8/13/15. However, the order did not specify how the surgical incision was to be cleansed or what type of dressing was to be used for treatment of the wound.</p> <p>During an interview on 8/19/15 at 4:00 PM, the RN Case Manager reviewed the record and confirmed she had performed treatments on the surgical incision during her visits. She confirmed there was not an order from Patient #11's</p> | G 165 | <p style="text-align: center;">Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p style="text-align: center;">(See Attached) APPENDIX - I</p> | |
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| G 165 | <p>Continued From page 62</p> <p>physician on how treatments were to be performed for the surgical incision.</p> <p>The agency failed to ensure wound treatments were ordered and followed for Patient #11.</p> <p>5. Patient #9 was an 80 year old male admitted to the agency on 4/07/15, for SN, PT, and HHA services related to secondary Parkinsonism. Additional diagnoses included general muscle weakness, abnormal gait, atrial fibrillation, DM, long-term use of anticoagulants, and history of falls. His record, including the POC, for the certification period 8/05/15 to 10/03/15, was reviewed.</p> <p>Patient #9 was taking an anticoagulant medication, Warfarin. According to the Drugs.com website, a national medication reference accessed 8/28/15, Warfarin may increase bleeding which could be dangerous or life threatening. The website further stated bleeding times must be monitored with frequent blood tests. "Blood tests which monitor bleeding times are called a PT/INR (prothrombin time and international normalized ratio). The doctor will use the INR to adjust a person's drug dosage to get the PT into the desired range that is right for the person and their condition."</p> <p>Patient #9's record included a Protime Flow Sheet which documented the PT/INR weekly results from 1/12/15 to 7/20/15. Each week the flow sheet was faxed to Patient #9's physician to inform him of that week's test results. The Protime Flow Sheet included an area for the physician to document orders to the agency, regarding changes in Warfarin dosage, and when to perform the next PT/INR test.</p> | G 165 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 165 | Continued From page 63 | G 165 | | | |
| G 168 | <p>Orders received by the agency on 1/26/15, 3/02/15, and 6/15/15 were signed by a Physician Assistant.</p> <p>During an interview on 8/20/15 at 3:40, the DON reviewed the record and confirmed the referral order was signed by a Physician Assistant.</p> <p>The agency failed to ensure Patient #9's treatments were ordered by a physician. 484.30 SKILLED NURSING SERVICES</p> <p>This CONDITION is not met as evidenced by: Based on record review, policy review, observation, patient/caregiver interview and staff interview, it was determined the agency failed to ensure skilled nursing services were furnished in accordance with the plan of care and consistent with patients' needs, and failed to ensure patients received comprehensive assessments. This negatively impacted quality, coordination, and safety of patient care. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to G170 as it relates to a failure of the agency to ensure skilled nursing services were furnished in accordance with the POC. 2. Refer to G173 as it relates to the failure of the agency to ensure nursing staff developed and updated POCs to meet patients' medical and nursing needs. 3. Refer to G175 as it relates to the failure of the agency to ensure a registered nurse initiated appropriate preventive and rehabilitative nursing | G 168 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |

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| G 168 | Continued From page 64 procedures. 4. Refer to G176 as it relates to the failure of the agency to ensure staff informed the physician and other members of the health care team of changes in patients' conditions. 5. Refer to G177 as it relates to the failure of the agency to ensure a registered nurse counseled the patient and family in meeting nursing and related needs. 6. Refer to G331 as it relates to the failure of the agency to ensure an RN completed a comprehensive assessment of the patient within 48 hours of referral. 6. Refer to G337 as it relates to the failure of the agency to ensure the comprehensive assessment completed by the RN included a medication review to obtain a current list of patient medications, evaluation of drug interactions, identification of possible significant side effects or noncompliance, and reconciliation of the medications with the physician. The cumulative effects of these negative practices seriously impeded the ability of the agency to provide services of adequate quality. | G 168 | Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) <u>APPENDIX - I</u> | | |
| G 170 | 484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on review of medical records, observation, patient/caregiver interview, and staff | G 170 | | | |

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| G 170 | <p>Continued From page 65</p> <p>interview, it was determined the agency failed to ensure SN services were provided in accordance with POCs for 3 of 12 patients (#1, #3, and #9) who received SN services and whose records were reviewed. This resulted in patients not receiving education and/or assessment related to depression, COPD, pressure ulcer prevention, infection, diabetes, and NGT equipment and use. Findings include:</p> <p>1. Patient #1 was a 59 year old female admitted to the agency on 11/03/14, for SN and PT services related to general muscle weakness. Additional diagnoses included hemiplegia, abnormal gait, chronic pain, pressure ulcers to ankle and lower back, chronic airway obstruction, schizophrenia, depression, lupus, and convulsions. Her record, including the POC, for the certification period 11/03/14 to 1/01/15, was reviewed.</p> <p>Patient #1's POC included SN orders for assessment, intervention, and education related to her diagnoses that were not followed. Examples include:</p> <p>a. Patient #1's POC included orders for the SN to instruct and educate Patient #1 and her caregiver on interventions for depression.</p> <p>The SN orders included interventions for instruction on medications, possible referral for treatment, or a monitoring plan for current treatment. Patient #1's record included 28 SN visit notes for the certification period 11/03/14 to 1/01/15. The 28 SN visit notes did not document Patient #1's depression was assessed or interventions were performed.</p> | G 170 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| G 170 | <p>Continued From page 66</p> <p>b. Patient #1's POC included orders for the SN to assess and instruct Patient #1 and her caregiver on the signs and symptoms of COPD.</p> <p>SN visits documented on 12/01/14, 12/03/14, 12/06/14, 12/10/14, 12/11/14, 12/15/14, 12/17/14, 12/22/14, 12/24/14 and 12/26/14 included instruction by the SN to Patient #1 on deep breathing and coughing to assist with opening her airway and lung expansion. However, the SN visit notes did not include documentation of signs or symptoms for COPD, or other measures to manage her disease process.</p> <p>c. Patient #1's POC included orders for the SN to assess and instruct Patient #1 and her caregiver on interventions related to prevention of pressure ulcers and the signs and symptoms of infection.</p> <p>Patient #1's record included 28 SN visit notes. SN visits on 11/07/14, 11/10/14, 11/12/14, 11/17/14, 11/19/14, 11/21/14, 11/26/14, and 11/28/14, did not include documentation of teaching or educating Patient #1 or her caregiver about preventing pressure ulcers or the signs and symptoms of infection.</p> <p>During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed the POC included orders for instruction and education related to pressure ulcers and infection. She stated she discussed the signs and symptoms of infection and how to prevent further skin breakdown with Patient #1 and her spouse. The RN Case Manager also stated she provided education about Patient #1's respiratory condition. She confirmed she did not consistently document the teaching she did with Patient #1 during the visits.</p> | G 170 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 170 | <p>Continued From page 67</p> <p>Patient #1's POC was not followed for instruction and education related to her diagnoses.</p> <p>2. Patient #3 was a 2 month old female admitted to the agency on 7/24/15, for SN services related to congenital esophageal fistula. Additional diagnoses included coarctation of aorta, fetal growth retardation, and 37 weeks gestation with complications. Her record, including the POC, for the certification period 7/24/15 to 9/21/15, was reviewed.</p> <p>Patient #3's POC included orders to assess and instruct her parents on NGT measurement, placement, and return, signs and symptoms of cardiopulmonary dysfunction, developmental delays, and signs or symptoms of hyperglycemia and hypoglycemia.</p> <p>SN visits were completed on 7/24/15, 7/28/15, 8/13/15, and 8/18/15. There was no documentation in the visit notes Patient #3's parents were instructed or educated about her feeding equipment or possible signs and symptoms related to her disease processes.</p> <p>During an interview on 8/20/15 at 11:20 AM, the RN Case Manager reviewed the record and confirmed there was no documentation of teaching or education. He stated because Patient #3's mother was a nurse he did not believe she needed the education or instruction.</p> <p>Patient #3's POC was not followed for instructing and educating her parents related to her disease processes or feeding equipment.</p> <p>3. Patient #9 was an 80 year old male admitted</p> | G 170 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | | |

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| G 170 | <p>Continued From page 68</p> <p>to the agency on 4/07/15, for SN, PT, and HHA services related to secondary Parkinsonism. Additional diagnoses included general muscle weakness, abnormal gait, atrial fibrillation, DM, long-term use of anticoagulants, and history of falls. His record, including the POC, for the certification period 8/05/15 to 10/03/15, was reviewed.</p> <p>Patient #9's POC included orders for SN to assess and instruct in diabetic care which included diet, activity, stress, foot care, and skin care. Patient #9 did not receive education and instruction regarding diabetic care as ordered on his POC. Examples include:</p> <p>Patient #9's record included 2 SN visit notes, dated 8/10/15 and 8/17/15. The 2 notes did not include documentation of diabetic teaching or education.</p> <p>During a home observation, on 8/19/15 beginning at 10:30 AM, Patient #9's spouse was asked how often he checked his blood sugars. The spouse stated she checked them daily and his blood sugar readings averaged 150 to 170. When asked if they had received any diabetic education or instruction during the SN visits, Patient #9's wife was unable to recall any discussions regarding DM.</p> <p>During an interview on 8/19/15 at 12:50 PM, the LPN reviewed the record and confirmed she had not provided instruction related to DM to Patient #9 or his spouse.</p> <p>During an interview on 8/19/15 at 1:30 PM, the RN Case Manager reviewed the record and confirmed she did not educate Patient #9 or his</p> | G 170 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |

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| NAME OF PROVIDER OR SUPPLIER TETON HOME HEALTH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2470 JAFER COURT IDAHO FALLS, ID 83404 | | |
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| G 170 | Continued From page 69 spouse about DM as ordered on the POC. | G 170 | | | |
| G 173 | <p>Patient #9's POC was not followed for instruction and education related to diabetic care.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse initiates the plan of care and necessary revisions.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patients' POCs were initiated and revised to ensure their medical and nursing needs were met, for 5 of 12 patients (#1, #2, #7, #11, and #12), whose records were reviewed. This resulted in incomplete POCs and a lack of assessment and patient/caregiver education relevant to patient needs, and had the potential to result in negative patient outcomes. Findings include:</p> <p>1. Patient #12 was an 85 year old male admitted to the agency on 7/09/15, for care following a CABG. Additional diagnoses included DM, CHF and asthma. He received SN and PT services. His record, including the POC, for the certification period 7/08/15 to 9/05/15, was reviewed.</p> <p>Patient #12's record included an SN SOC comprehensive assessment dated 7/08/15, and signed by the RN Case Manager. The assessment included a list of diagnoses related to his home health services. The diagnoses included DM Type II, and stated his DM symptoms were controlled with difficulty, affected</p> | G 173 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |

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| G 173 | <p>Continued From page 70</p> <p>his daily functioning, and required ongoing monitoring. The assessment also identified 5 wounds related to his recent CABG.</p> <p>The National Institutes of Health website, accessed on 8/26/15, stated "Diabetic patients are at an increased risk for adverse outcomes of surgery...Hyperglycemia is associated with likely risks for poorer wound healing, increased susceptibility to infection..."</p> <p>Patient #12's POC did not include interventions related to his co-morbidity of DM. Examples include:</p> <p>a. Patient #12's POC did not include monitoring of his BG level to assess for hyperglycemia.</p> <p>b. Patient #12's POC did not include patient/caregiver education related to the effect of BG levels on wound healing, and the importance of monitoring BG levels.</p> <p>c. Nutritional requirements on Patient #12's POC stated he was on a low sodium diet. The POC did not include nutritional requirements related to diabetes, such as limited intake of sugars and carbohydrates for BG control.</p> <p>During an interview on 8/20/15 at 11:30 AM, the RN Case Manager reviewed Patient #12's record and confirmed interventions related to diabetes were not included on his POC.</p> <p>Patient #12's POC was not comprehensive to include management of DM.</p> <p>2. Patient #7 was a 60 year old female admitted to the agency on 4/21/15, for services related to a</p> | G 173 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> |

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| G 173 | <p>Continued From page 71</p> <p>localized skin infection. Additional diagnoses included depression and oxygen dependency. She received SN and PT services. Her record, including the POC, for the certification period 6/20/15 to 8/18/15, was reviewed.</p> <p>Patient #7's record included an SN recertification assessment completed on 6/18/15, and signed by the RN Case Manager. The assessment stated Patient #7 weighed 370 pounds, was incontinent of urine and was occasionally incontinent of stool. Additionally, the assessment stated "Pt [patient] spends the majority of her time in bed but does, occasionally, ambulate to the main LR [living room] of home to sit in a recliner."</p> <p>Patient #7's obesity, incontinence and immobility placed her at risk for skin breakdown. However, her POC did not include interventions to assess her skin condition or to educate her on prevention of skin breakdown.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed Patient #7's record and confirmed her POC did not include interventions related to her increased risk of skin breakdown.</p> <p>Patient #7's POC was not comprehensive to include interventions related to increased risk of skin breakdown.</p> <p>3. Patient #2 was a 78 year old female admitted to the agency on 12/19/14, for services related to generalized muscle weakness. Additional diagnoses included HTN, backache, and history of falls. She received SN, PT and HHA services. Her record, including the POC, for the certification period 12/19/14 to 2/16/15, was reviewed.</p> | G 173 | <p>Teton Home Health, Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 173 | <p>Continued From page 72</p> <p>Patient #2's record included an SN SOC assessment completed on 12/19/15, and signed by the RN Case Manager. The assessment documented Patient #2 required assistance with ADL's, IADL's, safety, and ability to participate in appropriate medical care. However, Patient #2's POC did not include interventions to address those needs.</p> <p>During an interview on 8/19/15 at 3:20 PM, the RN Case Manager reviewed Patient #2's record and confirmed interventions were not initiated to address her needs related to ADL's, IADL's, safety, and ability to participate in appropriate medical care.</p> <p>Patient #2's POC was not comprehensive to address her needs.</p> <p>4. Patient #1 was a 59 year old female admitted to the agency on 11/03/14, for SN and PT services related to general muscle weakness. Additional diagnoses included hemiplegia, abnormal gait, chronic pain, pressure ulcers to ankle and lower back, chronic airway obstruction, schizophrenia, depression, lupus, and convulsions. Her record, including the POC, for the certification period 11/03/14 to 1/01/15, was reviewed.</p> <p>Patient #1's record included an SOC comprehensive assessment dated 11/03/14, and signed by the RN Case Manager. The assessment documented she had 2 wounds upon admission to the agency. Wound #1 was a right ankle stage I pressure ulcer. Wound #2 was a stage I pressure ulcer to the coccyx. Patient #1's POC did not include orders for the care and</p> | G 173 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 173 | Continued From page 73 treatment of the wounds. During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed there were no physician orders for wound treatment on the POC. Patient #1's POC was not comprehensive to include management of her wounds. 5. Patient #11 was a 52 year old female admitted to the agency on 7/31/15, for SN and PT services related to general muscle weakness. Additional diagnoses included abnormal gait, peripheral neuropathy, asthma, DM, HTN, anemia, borderline personality disorder, depression, history of falls, and knee replacement. Her record, including the POC, for the certification period 7/31/15 to 9/28/15, was reviewed. Patient #11's record included an SOC comprehensive assessment dated 7/31/15, signed by the RN Case Manager. The assessment identified a surgical wound related to her recent knee surgery. Patient #11's POC did not include orders for treatment and care of the surgical wound. During an interview on 8/19/15 at 4:00 PM, the RN Case Manager reviewed the record and confirmed there were no orders for wound treatment on the POC. Patient #11's POC was not comprehensive to include management of her surgical wound. | G 173 | Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) APPENDIX – I | |
| G 175 | 484.30(a) DUTIES OF THE REGISTERED NURSE | G 175 | | |

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| G 175 | <p>Continued From page 74</p> <p>The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, and staff interview, it was determined the agency failed to ensure the RN evaluated patients to determine needed preventative or rehabilitative nursing measures for 4 of 12 patients (#7, #9, #11, and #12) whose records were reviewed. This resulted in a lack of preventative actions for patients with DM, infusion therapy and increased risk of skin breakdown, and significantly increased the potential for negative patient outcomes. Findings include:</p> <p>1. Patient #12 was an 85 year old male admitted to the agency on 7/09/15, for care following a CABG. Additional diagnoses included DM, CHF and asthma. He received SN and PT services. His record, including the POC, for the certification period 7/08/15 to 9/05/15, was reviewed.</p> <p>a. Patient #12's record included an SN SOC comprehensive assessment dated 7/08/15, and signed by the RN Case Manager. The assessment included a list of diagnoses related to his home health services. The diagnoses included DM Type II, and stated his DM symptoms were controlled with difficulty, affected his daily functioning, and required ongoing monitoring. The assessment also identified 5 wounds related to his recent CABG.</p> <p>The National Institutes of Health website, accessed on 8/26/15, stated "Diabetic patients are at an increased risk for adverse outcomes of</p> | G 175 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |

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| G 175 | <p>Continued From page 75</p> <p>surgery...Hyperglycemia is associated with likely risks for poorer wound healing, increased susceptibility to infection..."</p> <p>Patient #12's SN SOC comprehensive assessment did not include his BG level. His record included 5 additional SN visit notes. The 5 notes did not document his BG level. Additionally, Patient #12's SN visit notes did not indicate whether Patient #12 was monitoring his BG levels.</p> <p>Patient #12's SN visit notes did not document patient education related to diabetes, including BG monitoring, nutritional requirements or increased risk of wound infection.</p> <p>b. Patient #12's SN SOC comprehensive assessment documented 5 wounds. However, the assessment did not include a description of the wounds, including size, appearance, or drainage. Lack of wound descriptions interfered with the ability to determine improvement or deterioration of the wounds on subsequent visits.</p> <p>The second SN visit note, dated 7/13/15, and signed by the RN Case Manager, documented the size and appearance of 2 wounds. There was no documentation of the 3 additional wounds identified on the SOC visit.</p> <p>During an interview on 8/20/15 at 11:30 AM, the RN Case Manager reviewed the record and confirmed Patient #12's SN visits did not include assessment or education related to DM. Additionally, he confirmed Patient #12's SOC assessment did not include descriptions of the 5 identified wounds, and only 2 wounds were assessed on the second SN visit.</p> | G 175 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 175 | <p>Continued From page 76</p> <p>Patient #12's SN visits did not include assessment or education related to his DM. Additionally, his wounds were not fully assessed and monitored.</p> <p>2. Patient #7 was a 60 year old female admitted to the agency on 4/21/15, for services related to a localized skin infection. Additional diagnoses included depression and oxygen dependency. She received SN and PT services. Her record, including the POC, for the certification period 6/20/15 to 8/18/15, was reviewed.</p> <p>Patient #7's record included an SN recertification assessment completed on 6/18/15, and signed by the RN Case Manager. The assessment stated Patient #7 weighed 370 pounds, was incontinent of urine and occasionally incontinent of stool. Additionally, the assessment stated "Pt [patient] spends the majority of her time in bed but does, occasionally, ambulate to the main LR [living room] of home to sit in a recliner."</p> <p>Patient #7's obesity, incontinence and immobility placed her at risk for skin breakdown. Her record included 20 SN visit notes completed by an RN during the time period of 6/20/15 to 8/14/15. The RN visit notes did not document assessment of her skin for redness or symptoms of breakdown. Additionally, they did not document patient education related to prevention of skin breakdown.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed the record and stated Patient #7 had an increased risk of skin breakdown. However, she stated she had not assessed Patient #7 for symptoms of skin</p> | G 175 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX -- I</p> | |
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| G 175 | <p>Continued From page 77 breakdown, or educated her regarding prevention of skin breakdown.</p> <p>Patient #7 did not receive preventative services related to skin breakdown.</p> <p>3. Patient #9 was an 80 year old male admitted to the agency on 4/07/15, for SN, PT, and HHA services related to secondary Parkinsonism. Additional diagnoses included general muscle weakness, abnormal gait, atrial fibrillation, DM, long-term use of anticoagulants, and history of falls. His record, including the POC, for the certification period 8/05/15 to 10/03/15, was reviewed.</p> <p>Patient #9's record included an SN recertification assessment dated 8/03/15, and signed by the RN Case Manager. The assessment included a list of diagnoses related to his home health services. The diagnoses included DM, and stated his DM symptoms were controlled with difficulty, affected his daily functioning, and required ongoing monitoring.</p> <p>Patient #9's recertification assessment did not include his BG level. His record included 2 additional SN visit notes. The notes did not document his BG level. Additionally, Patient #9's SN visit notes did not document an assessment related to his DM.</p> <p>During an interview on 8/19/15 at 12:50 PM, the LPN reviewed the record and confirmed she did not check Patient #9's BG levels. She stated she mistakenly marked he had no problems with his endocrine system on the nursing notes. The LPN confirmed the notes did not include documentation of patient education related to</p> | G 175 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | |

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| G 175 | <p>Continued From page 78</p> <p>DM.</p> <p>Patient #9's SN visit notes did not document patient assessment or education related to DM, including BG monitoring.</p> <p>4. Patient #11 was a 52 year old female admitted to the agency on 7/31/15, for SN and PT services related to general muscle weakness. Additional diagnoses included abnormal gait, peripheral neuropathy, asthma, DM, HTN, anemia, borderline personality disorder, depression, history of falls, and knee replacement. Her record, including the POC, for the certification period 7/31/15 to 9/28/15, was reviewed.</p> <p>Patient #11's record included an SN SOC comprehensive assessment dated 7/31/15, and signed by the RN Case Manager. The assessment included a list of diagnoses related to her home health services. The diagnoses included DM, and stated her DM symptoms were controlled with difficulty, affected her daily functioning, and required ongoing monitoring.</p> <p>Patient #11's SOC assessment did not include her BG level. Her record included 3 additional SN visit notes. The notes did not document her BG level. Additionally, Patient #11's SN visit notes did not document an assessment related to her DM.</p> <p>During an interview on 8/19/15 at 4:00 PM, the RN Case Manager reviewed the record and confirmed she did not document or monitor Patient #11's BG levels. She stated she marked no problems with her endocrine system because Patient #11 had been managing her DM for several years.</p> | G 175 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 175 | Continued From page 79 | G 175 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |
| G 176 | <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the RN prepared clinical notes that accurately described the patient's condition, and informed the physician of changes in the patient's condition and needs for 4 of 12 patients (#1, #7, #10, and #12) who received SN services and whose records were reviewed. This had the potential to result in unmet patient needs and negatively impact continuity and quality of patient care. Findings include:</p> <p>1. Patient #10 was a 6 year old female admitted to the agency on 7/11/15, for services related to an MRSA infection. Additional diagnoses included cellulitis of the buttock. She received SN services. Her record, including the POC, for the certification period 7/11/15 to 9/09/15, was reviewed.</p> <p>Patient #10's record included a "CLINICAL SUMMARY" dated 7/11/15, and signed by the RN Case Manager. The summary stated Patient #10 was to have 3 days of IV antibiotics. Additionally,</p> | G 176 | | | |

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| G 176 | <p>Continued From page 80</p> <p>it stated her mother would be trained to deliver the medications.</p> <p>a. Patient #10's record included a pediatric assessment completed on 7/11/15, and signed by the RN Case Manager. The note stated "Patient has an IV access in her right AC." However, the note did not include the type of IV access, when it was inserted, or a description of the insertion site. The note did not document infusion of the IV antibiotic, or care of the IV, including flushing of the port following infusion. It was unclear if the infusion occurred during the visit.</p> <p>During an interview on 8/19/15 at 2:25 PM, the RN Case Manager reviewed Patient #10's record and stated she inserted the IV on her first SN visit and infused the antibiotic. She confirmed the IV insertion and infusion was not documented in her visit note. Additionally, she confirmed the visit note did not document an assessment of the IV insertion site.</p> <p>b. Patient #10's record included an SN visit note dated 7/13/15, and signed by the RN Case Manager. The note stated Patient #10's IV access would be removed and she would be discharged from home health on the following visit. However, there was no documentation of a subsequent visit, or of removal of Patient #10's IV access.</p> <p>Patient #10's record included a discharge summary dated 7/15/15, and signed by the RN Case Manager. It stated she was discharged from home health due to completion of her IV therapy. However, the discharge summary did not include documentation of an SN visit or removal of Patient #10's IV access.</p> | G 176 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 176 | Continued From page 81 During an interview on 8/19/15 at 2:25 PM, the RN Case Manager stated she provided an SN visit to Patient #10 on 7/14/15, removed her IV access and discharged her from home health. She stated she did not complete an SN visit note, and did not document removal of her IV access. Patient #10's SN visit notes did not accurately reflect her status or the RN services she received. 2. Patient #7 was a 60 year old female admitted to the agency on 4/21/15, for services related to a localized skin infection. Additional diagnoses included depression and oxygen dependency. She received SN and PT services. Her record, including the POC, for the certification period 6/20/15 to 8/18/15, was reviewed. a. Patient #7's record included an SN visit note dated 7/15/15, and signed by the RN Case Manager. The note documented wound care was provided, and an assessment was completed. However, the visit note did not document Patient #7's status at the time of the visit. The following sections of the note were blank: vital signs, cardiovascular status, respiratory status, neurological status, genitourinary status, digestive/nutrition status and musculoskeletal status. Patient #7's record included an SN visit note dated 7/16/15, and signed by the RN Case Manager. The note documented wound care was provided, and an assessment was completed. However, the visit note did not document Patient #7's status at the time of the visit. The following sections of the note were blank: cardiovascular | G 176 | <hr/> Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) APPENDIX - I <hr/> | | |

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| G 176 | <p>Continued From page 82 status, skin, digestive/nutrition status, musculoskeletal status and pain.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed Patient #7's record and confirmed the visit notes dated 7/15/15 and 7/16/15, were incomplete and did not adequately document her status at the time of the visits.</p> <p>Patient #7's SN visit notes did not document her current status.</p> <p>b. Patient #7's POC included an order to notify her physician when her BP was outside of the following parameters:</p> <p>-Systolic greater than 140 and less than 100 -Diastolic greater than 90 and less than 60</p> <p>Patient #7's SN visit notes included BP readings outside of the established parameters, as follows:</p> <p>6/22/15 - 155/89 7/03/15 - 142/63 7/06/15 - 141/55 7/08/15 - 125/55 7/13/15- 155/64 7/16/15 - 120/58 7/17/15 - 116/54 7/22/15 - 149/83 7/24/15 - 145/76 7/31/15 - 118/55 8/05/15 - 124/56 8/07/15 - 122/57 8/10/15 - 117/54 8/14/15 - 110/95</p> <p>Patient #7's record did not include documentation her physician was notified of the BP readings</p> | G 176 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |

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| G 176 | <p>Continued From page 83 outside of the established parameters.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #7's physician to report BP readings outside of the parameters ordered on the POC.</p> <p>The RN did not notify Patient #7's physician of BP readings outside of established parameters.</p> <p>3. Patient #12 was an 85 year old male admitted to the agency on 7/08/15, for care following a CABG. Additional diagnoses included DM, CHF and asthma. He received SN and PT services. His record, including the POC, for the certification period 7/08/15 to 9/05/15, was reviewed.</p> <p>Patient #12's POC Included orders to notify his physician for vital signs outside of parameters, including temperature less than 96 degrees, and heart rate less than 60 bpm.</p> <p>Patient #12's record included a discharge assessment completed on 8/10/15, and signed by the RN Case Manager. The assessment documented a temperature of 90 degrees and heart rate of 58 bpm. Patient #12's record did not include documentation stating his physician was notified of his vital signs outside of parameters.</p> <p>During an interview on 8/20/15 at 11:30 AM, the RN Case Manager reviewed the record and confirmed he did not notify Patient #12's physician of his low temperature and heart rate.</p> <p>The RN did not notify Patient #12's physician of vital signs outside of established parameters.</p> | G 176 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |

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| G 176 | <p>Continued From page 84</p> <p>4. Patient #1 was a 59 year old female admitted to the agency on 11/03/14, for SN and PT services related to general muscle weakness. Additional diagnoses included hemiplegia, abnormal gait, chronic pain, pressure ulcers to ankle and lower back, chronic airway obstruction, schizophrenia, depression, lupus, and convulsions. Her record, including the POC, for the certification period 11/03/14 to 1/01/15, was reviewed.</p> <p>a. An SN visit note dated 11/26/14, documented Patient #1 had a pain pump for management of her pain. However, there was no documentation on the medication list or POC of an implanted pain pump, or pain medication to be used in a pain pump.</p> <p>During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed she documented Patient #1 had a pain medication pump. She stated Patient #1 was not using a pain medication pump and had written that in the visit note by mistake.</p> <p>The SN did not accurately document her findings in Patient #1's record.</p> <p>b. Patient #1's medication list included oxygen to keep her oxygen levels above 90%.</p> <p>- An SN visit note dated 11/17/14, signed by the RN Case Manager, documented Patient #1's oxygen level was 86% on room air. There was no documentation Patient #1's physician was notified of the low oxygen level.</p> <p>- An SN visit note dated 11/24/14, signed by the RN Case Manager, documented Patient #1's</p> | G 176 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| G 176 | <p>Continued From page 85</p> <p>oxygen level was 88 to 90%. Additionally, the SN documented Patient #1 stated she did not use her oxygen most of the time. However, there was no documentation Patient #1's physician was notified of the low oxygen level or that Patient #1 did not use her oxygen supplement most of the time.</p> <p>During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed she did not contact or notify Patient #1's physician of her low oxygen saturation levels or that she was not using her oxygen supplement.</p> <p>The SN did not notify Patient #1's physician of oxygen level readings outside of ordered parameters.</p> | G 176 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> </div> | |
| G 177 | <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse counsels the patient and family in meeting nursing and related needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview it was determined the agency failed to ensure the RN provided necessary instruction to patients or caregivers for 2 of 12 patients (#3 and #10) who received SN services and whose records were reviewed. This created the potential for patients to experience adverse outcomes. Findings include:</p> <p>1. Patient #10 was a 6 year old female admitted to the agency on 7/11/15, for services related to an MRSA infection. Additional diagnoses included cellulitis of the buttock. She received SN services. Her record, including the POC, for</p> | G 177 | | |

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| G 177 | <p>Continued From page 86</p> <p>the certification period 7/11/15 to 9/09/15, was reviewed. Patient #10 was discharged from home health services on 7/14/15.</p> <p>a. Patient #10's POC included orders for wound care to her right buttock and stated her mother would provide the wound care. The POC included an order to instruct the patient/caregiver in wound care. However, the 4 SN visit notes documented between 7/11/15 and 7/14/15, did not include documentation Patient #10's caregiver was provided instruction on wound care or how to monitor for symptoms of wound infection.</p> <p>b. Patient #10's record included an order for home health services signed by her physician on 7/11/15. The order stated sitz baths three times a day for 2 to 3 days were recommended. However, the 4 SN visit notes documented between 7/11/15 and 7/14/15, did not document patient/caregiver education related to sitz baths.</p> <p>During an interview on 8/19/15 at 2:25 PM, the RN Case Manager reviewed Patient #10's record and confirmed it did not include documentation of patient/caregiver education related to wound care, assessment of wound or sitz baths.</p> <p>The RN failed to provide appropriate patient/caregiver education.</p> <p>2. Patient #3 was a 2 month old female admitted to the agency on 7/24/15, for SN services related to congenital esophageal fistula. Additional diagnoses included coarctation of aorta, fetal growth retardation, and 37 weeks gestation with complications. Her record, including the POC, for the certification period 7/24/15 to 9/21/15, was reviewed.</p> | G 177 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| G 177 | Continued From page 87 Patient #3's POC included orders to assess and instruct her parents on NGT measurement, placement, and return, signs and symptoms of cardiopulmonary dysfunction, developmental delays, and signs or symptoms of hyperglycemia and hypoglycemia. SN visits were completed on 7/24/15, 7/28/15, 8/13/15, and 8/18/15. There was no documentation in the visit notes Patient #3's parents were instructed or educated about her feeding equipment or possible signs and symptoms related to her disease processes. A home visit was conducted on 8/18/15 beginning at 11:00 AM, for observation of an SN visit. The RN Case Manager did not instruct or educate Patient #3's parents on her feedings, feeding equipment, or signs and symptoms related to her disease processes. During an interview on 8/20/15 at 11:20 AM, the RN Case Manager reviewed the record and confirmed there was no documentation of teaching or education. He stated because Patient #3's mother was a nurse he did not believe she needed the education or instruction. The agency failed to ensure Patient #3's parents were instructed and taught how to care for her needs. | G 177 | Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) APPENDIX - I | | |
| G 250 | 484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether | G 250 | | | |

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| G 250 | Continued From page 88 established policies are followed in furnishing services directly or under arrangement. This STANDARD is not met as evidenced by: Based on staff interview and review of chart audit results, it was determined the agency failed to ensure health professionals representing the scope of the program participated in quarterly record review. This resulted in an incomplete review and lack of interdisciplinary input. Findings include: During the entrance conference on 8/17/15 beginning at 12:00 PM, the Administrator stated the agency provided SN, PT, OT, ST, and MSW services. The Administrator, who was a pharmacist, was interviewed on 8/20/15 at 3:45 PM. He stated he completed quarterly record reviews of active and closed records. He stated the agency's Physical Therapists completed peer review of therapy records. However, he stated RNs had not participated in quarterly record reviews in 2015. | G 250 | <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | | |
| G 331 | 484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. | G 331 | | | |

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| G 331 | <p>Continued From page 89</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the initial SOC comprehensive assessment included a thorough examination including status of wounds, respiratory status and treatments, nutrition, pain, and risk of fall, for 4 of 9 patients, (#1, #2, #6, and #12) whose admission assessments and records were reviewed. This failure placed patients at risk of negative outcomes. Findings include:</p> <p>1. Patient #2 was a 78 year old female admitted to the agency on 12/19/14, for services related to generalized muscle weakness. Additional diagnoses included HTN, backache, and history of falls. She received SN, PT and HHA services. Her record, including the POC, for the certification period 12/19/14 to 2/16/15, was reviewed.</p> <p>Patient #2's record included an SN SOC assessment completed on 12/19/15, and signed by the RN Case Manager. The assessment was not comprehensive, as follows:</p> <p>a. The assessment stated Patient #2 experienced pain daily but not constantly, and rated her pain as a 5 on a scale of 1-10 with 10 being the worst pain. However, the location of her pain was not documented.</p> <p>b. The pain assessment stated the pain site was edematous. However, the section of the assessment used to document edema was blank.</p> <p>c. The assessment stated Patient #2 was short of breath with moderate exertion and dependent on oxygen. However, an oxygen saturation level</p> | G 331 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 331 | <p>Continued From page 90 was not documented.</p> <p>During an interview on 8/19/15 at 3:20 PM, the RN Case Manager reviewed the record and confirmed Patient #2's SOC assessment did not document the location of her pain, edema or her oxygen saturation level.</p> <p>Patient #2's initial assessment was not comprehensive to determine all her needs.</p> <p>2. Patient #6 was a 53 year old female admitted to the agency on 8/11/15, for services related to liver damage. Additional diagnoses included hepatic encephalopathy and thrombocytopenia. She received SN, PT and OT services. Her record, including the POC, for the certification period 8/11/15 to 10/09/15, was reviewed.</p> <p>Patient #6's record included an SN SOC assessment completed on 8/12/15, and signed by the RN Case Manager. The assessment was not comprehensive, as follows:</p> <p>a. The assessment stated Patient #6 experienced pain daily but not constantly, and rated her pain as a 4 on a scale of 1-10 with 10 being the worst pain. However, the location of her pain was not documented.</p> <p>b. The assessment stated "Patient was wearing baggy clothes that appeared unkempt, her spouse reports that she has been losing [sic] a lot of weight." Patient #6's record included a form titled "BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK IN HOME CARE." The scale included an assessment of the patient's nutrition. Patient #6's current nutrition status was scored "Very Poor." However, Patient #6's</p> | G 331 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> </div> | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137061 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 08/20/2015 |
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| NAME OF PROVIDER OR SUPPLIER TETON HOME HEALTH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2470 JAFER COURT IDAHO FALLS, ID 83404 | | |
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| G 331 | <p>Continued From page 91</p> <p>current weight was not obtained, to allow for monitoring of additional weight loss. Additionally, the Nutrition/Hydration section of Patient #6's SOC assessment was blank.</p> <p>During an interview on 8/19/15 at 2:45 PM, the RN Case Manager reviewed Patient #6's record and confirmed the site of her pain was not documented. Additionally, she confirmed Patient #6's nutritional status was not fully assessed.</p> <p>Patient #6's Initial assessment was not comprehensive to determine all her needs.</p> <p>3. Patient #12 was an 85 year old male admitted to the agency on 7/08/15, for care following a CABG. Additional diagnoses included DM, CHF and asthma. He received SN and PT services. His record, including the POC, for the certification period 7/08/15 to 9/05/15, was reviewed.</p> <p>Patient #12's record included an SN SOC assessment completed on 7/09/15, and signed by the RN Case Manager. The assessment documented he had 5 wounds. However, the assessment did not include a description of the wounds, including size, appearance, or drainage. Additionally, it did not indicate how the wounds were to be treated.</p> <p>During an interview on 8/20/15 at 11:30 AM, the RN Case Manager reviewed the record and confirmed Patient #12's SN SOC assessment did not include descriptions of the 5 identified wounds, or state whether wound care was needed.</p> <p>Patient #12's initial assessment was not comprehensive to determine all his needs.</p> | G 331 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | | |

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| G 331 | Continued From page 92 4. Patient #1 was a 59 year old female admitted to the agency on 11/03/14, for SN and PT services related to general muscle weakness. Additional diagnoses included hemiplegia, abnormal gait, chronic pain, pressure ulcers to ankle and lower back, chronic airway obstruction, schizophrenia, depression, lupus, and convulsions. Her record, including the POC, for the certification period 11/03/14 to 1/01/15, was reviewed. Patient #1's record included an SOC assessment completed on 11/03/14, and signed by the RN Case Manager. The assessment was not comprehensive as follows: a. The assessment documented Patient #1 had 2 stage I pressure ulcers, 1 on her coccyx and 1 on her right ankle. However, the next SN visit note dated 11/07/14, documented Patient #1 had open wounds to her coccyx and right ankle. b. The assessment documented Patient #1 did not use respiratory treatments in her home. However, her medication list included supplemental oxygen to keep her oxygen levels above 90%. Additionally, an SN visit note dated 11/24/14, documented Patient #1 had sleep apnea and used oxygen at night. During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed oxygen was listed as a medication on the POC for Patient #1. She stated the SOC assessment related to respiratory treatments in the home was marked inaccurately. The RN Case Manager confirmed Patient #1 had open wounds at the SOC assessment visit and she had | G 331 | <div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | | |

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| G 331 | Continued From page 93 staged them incorrectly. | G 331 | | |
| G 337 | <p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records, observation, staff interview and patient/caregiver interview it was determined the agency failed to ensure a comprehensive drug regimen review was completed for 7 of 12 patients, (#1, #2, #5, #6, #7, #10, and #12) whose records were reviewed. This resulted in the increased potential for patients to experience adverse events related to medications. Findings include:</p> <p>1. Patient #12 was an 85 year old male admitted to the agency on 7/08/15, for care following a CABG. Additional diagnoses included DM, CHF and asthma. He received SN and PT services. His record, including the POC, for the certification period 7/08/15 to 9/05/15, was reviewed.</p> <p>a. Patient #12's record included an SN SOC comprehensive assessment completed on 7/08/15, and signed by the RN Case Manager. The assessment stated a complete drug regimen review indicated potential clinically significant medication issues were identified. However, the</p> | G 337 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |

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| G 337 | <p>Continued From page 94</p> <p>problems identified were not documented. The assessment stated a physician was contacted within one day to resolve the medication issues. However, contact with Patient #12's physician was not documented.</p> <p>b. Patient #12's POC included Hydrocodone-Acetaminophen 7.5/325 mg, to be taken every 4 hours as needed, and Hydrocodone-Acetaminophen 7.5/325 mg, 1/2 tablet, to be taken as needed. It was unclear whether he should take 1/2 or 1 tab, and how often he should take it. Patient #12's record did not include documentation of physician contact to clarify the medication order.</p> <p>c. Patient #12's POC included Amiodarone 200 mg, to be taken 2 times a day. An SN visit note dated 7/27/15, and signed by the RN Case Manager documented a medication change. It stated "cut in 1/2 Amiodarone. See updated medlist [medication list]." It was unclear if Patient #12 should take Amiodarone 100 mg, 2 times a day, or take Amiodarone 200 mg, 1 time a day. Patient #12's updated medication list was reviewed. It stated Amiodarone 200 mg, to be taken 2 times a day, was discontinued on 7/27/15, and Amiodarone 100 mg, to be taken 1 time a day was added. Therefore, his total daily dose changed from 400 mg to 100 mg.</p> <p>During an interview on 8/20/15 at 11:30 AM, the RN Case Manager reviewed Patient #12's record and confirmed medication issues identified at the SOC assessment were not documented. He confirmed the orders for Hydrocodone-Acetaminophen were unclear. He stated he did not contact Patient #12's physician following the SOC assessment to resolve</p> | G 337 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 337 | <p>Continued From page 95</p> <p>medication issues, but stated the office faxed a list of medication interactions to the physician following all admissions. He stated he did not know if the physician responded. Additionally, he stated the updated Amiodarone order was incorrect. He stated Patient #12 told him his physician decreased his Amiodarone by half. He stated he did not see the physician's order, and did not contact the physician to clarify the order.</p> <p>The agency failed to ensure Patient #12's physician was contacted to resolve medication issues.</p> <p>2. Patient #5 was an 88 year old female admitted to the agency on 5/21/15, for services related to generalized muscle weakness. Additional diagnoses included dementia. She received SN, PT and MSW services. Patient #5 resided in an ALF. Her record, including the POC for the certification period 7/21/15 to 9/18/15, was reviewed.</p> <p>a. Patient #5's record included an SN SOC comprehensive assessment dated 7/21/15, and signed by the RN Case Manager. The assessment stated a complete drug regimen review indicated potential clinically significant medication issues were identified. However, the problems identified were not documented. The assessment stated a physician was contacted within one day to resolve the medication issues. However, contact with Patient #5's physician was not documented.</p> <p>b. Patient #5's LPN visit was observed on 8/18/15 at 2:30 AM. Following the visit, Patient #5's ALF medication profile was obtained from the ALF staff. The ALF medication profile</p> | G 337 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – I</p> | | |

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| G 337 | <p>Continued From page 96</p> <p>included Benazepril/HCT 10/12.5 mg to be taken daily, beginning 4/29/15. Patient #5's home health POC and medication profile did not include Benazepril/HCT.</p> <p>During an interview on 8/19/15 at 2:10 PM, the RN Case Manager reviewed Patient #5's record and confirmed there was no documentation to determine what medication issues were identified. She confirmed there was no documentation of physician contact to resolve medication issues. Additionally, she confirmed Patient #5's medication profile did not include all medications she was taking.</p> <p>Patient #5's physician was not contacted to resolve her medication issues and her medication profile was not accurate to reflect her current medications.</p> <p>3. Patient #6 was a 53 year old female admitted to the agency on 8/11/15, for services related to liver damage. Additional diagnoses included hepatic encephalopathy and thrombocytopenia. She received SN, PT and OT services. Her record, including the POC, for the certification period 8/11/15 to 10/09/15, was reviewed.</p> <p>A visit was made to Patient #6's home on 8/18/15 at 1:00 PM, to observe an OT evaluation visit. Her medications were reviewed and discrepancies were identified, as follows:</p> <p>a. Patient #6 stated she took Lactulose 30 ml, twice a day. However, Lactulose was not included on her POC or medication profile.</p> <p>b. Patient #6's POC and medication profile included Zofran 4 mg, to be taken as needed.</p> | G 337 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |

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| G 337 | <p>Continued From page 97</p> <p>However, Patient #6 and her husband stated she did not have Zofran in her home.</p> <p>c. Patient #6's husband stated her hospital discharge instructions included Rifaximin, but they had not been able to obtain the medication because their insurance would not pay for it. There was no documentation Patient #6's physician was informed of her inability to obtain her medication.</p> <p>Patient #6's record did not include documentation of the medication discrepancies or of physician contact to resolve her medication issues.</p> <p>During an interview on 8/20/15 at 4:00 PM, the DON reviewed Patient #6's record and confirmed her medication profile was inaccurate. Additionally, she confirmed Patient #6's inability to obtain her medication should have been documented and communicated to her physician.</p> <p>Patient #6's physician was not contacted to resolve her medication issues and her medication profile was not accurate to reflect her current medications.</p> <p>4. Patient #2 was a 78 year old female admitted to the agency on 12/19/14, for services related to generalized muscle weakness. Additional diagnoses included HTN, backache, and history of falls. She received SN, PT and HHA services. Her record, including the POC, for the certification period 12/19/14 to 2/16/15, was reviewed.</p> <p>Patient #2's record included an SN SOC comprehensive assessment dated 12/19/15, and signed by the RN Case Manager. The assessment stated a complete drug regimen</p> | G 337 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 337 | <p>Continued From page 98</p> <p>review indicated potential clinically significant medication issues were identified. However, the problems identified were not documented. The assessment stated a physician was contacted within one day to resolve the medication issues. However, contact with Patient #2's physician was not documented.</p> <p>During an interview on 8/19/15 at 3:20 PM, the RN Case Manager reviewed Patient #2's record and confirmed there was no documentation to determine what medication issues were identified. Additionally, she confirmed she did not contact Patient #2's physician to reconcile medication issues.</p> <p>The agency failed to ensure Patient #2's physician was contacted to resolve medication issues.</p> <p>5. Patient #7 was a 60 year old female admitted to the agency on 4/21/15, for services related to a localized skin infection. Additional diagnoses included depression and oxygen dependency. She received SN and PT services. Her record, including the POC, for the certification period 6/20/15 to 8/18/15, was reviewed.</p> <p>Patient #7's record included a Medication Profile. The profile included Amoxicillin 875 mg, to be taken 2 times a day. The start date for Amoxicillin was 5/07/15, and there was no end date, indicating it was taken continuously since 5/07/15.</p> <p>A visit was made to Patient #7's home on 8/19/15 at 9:30 AM, to observe an SN visit. During the visit, Patient #7 stated her physician ordered Amoxicillin for her and she had just completed a</p> | G 337 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | |
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| G 337 | <p>Continued From page 99</p> <p>10 day course of the antibiotic. She stated her physician ordered antibiotics intermittently, when her abdominal wound showed signs of infection.</p> <p>During an interview on 8/19/15 at 4:10 PM, the RN Case Manager reviewed Patient #7's record and confirmed she had not been taking Amoxicillin continuously since 5/07/15, and her medication profile should have been updated with the end date, and new start date.</p> <p>Patient #7's medication profile was not accurate to reflect her current medications.</p> <p>6. Patient #10 was a 6 year-old female admitted to the agency on 7/11/15, for services related to an MRSA infection. Additional diagnoses included cellulitis of the buttock. She received SN services. Her record, including the POC, for the certification period 7/11/15 to 9/09/15, was reviewed.</p> <p>Patient #10's POC included Clindamycin Phosphate (an antibiotic) 300 mg/50 ml IV. However, the POC did not state how often the antibiotic was to be infused.</p> <p>During an interview on 8/19/15 at 2:25 PM, the RN Case Manager reviewed Patient #10's record and confirmed the POC did not include the frequency of her Clindamycin infusions.</p> <p>Patient #10's POC did not include the frequency of her antibiotic infusions.</p> <p>7. Patient #1 was a 59 year old female admitted to the agency on 11/03/14, for SN and PT services related to general muscle weakness. Additional diagnoses included hemiplegia,</p> | G 337 | <div style="border: 1px solid black; padding: 10px; margin: 10px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> </div> | |
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| G 337 | <p>Continued From page 100</p> <p>abnormal gait, chronic pain, pressure ulcers to ankle and lower back, chronic airway obstruction, schizophrenia, depression, lupus, and convulsions. Her record, including the POC, for the certification period 11/03/14 to 1/01/15, was reviewed.</p> <p>An SOC comprehensive assessment dated 11/03/14, signed by the RN Case Manager, documented problems were found during the medication review for Patient #1. The RN Case Manager documented Patient #1's physician was informed of the medication problems within 1 calendar day. However, there was no documentation in the record how the physician was contacted or what problems were identified with Patient #1's medications.</p> <p>During an interview on 8/19/15 at 2:00 PM, the RN Case Manager reviewed the record and confirmed she documented problems were found during the medication review. She believed the problems identified were medication interactions. The RN Case Manager stated the medication list, which identified interactions, was faxed to the physician. She stated she did not speak to the physician to discuss any medication problems identified.</p> <p>The agency failed to ensure Patient #1's physician was contacted to resolve potentially significant medication issues.</p> | G 337 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - I</p> | | |

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| N 000 | <p>16.03.07 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state licensure survey of your home health agency on 8/17/15 through 8/20/15. The surveyors conducting the survey were:</p> <p>Nancy Bax RN, HFS, Team Lead Laura Thompson RN, HFS</p> <p>Acronyms used in this report include:</p> <p>AC - Anticubital ADL - Activities of Daily Living ALF - Assisted Living Facility BG - Blood Glucose BP - Blood Pressure bpm - beats per minute CABG - Coronary Artery Bypass Graft CHF - Congestive Heart Failure CKD - Chronic Kidney Disease COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure DM - Diabetes Mellitus DON - Director of Nursing EMR - Electronic Medical Record H & P - History and Physical HHA - Home Health Aide HTN - Hypertension IADL - Instrumental Activities of Daily Living IV - Intravenous LPN - Licensed Practical Nurse mg - milligram ml - milliliter MRSA - Methicillin Resistant Staphylococcus Aureus MSW - Medical Social Worker NGT - Nasogastric Tube NOMNC - Notice of Medicare Non-Coverage OT - Occupational Therapy POC - Plan of Care</p> | N 000 | <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - II</p> </div> <p style="text-align: center; margin-top: 20px;"> RECEIVED SEP 17 2015 FACILITY STANDARDS </p> | |

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

L5X211

If continuation sheet 1 of 13

[Handwritten Signature] Administrator 9-17-15

Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001600 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/20/2015 |
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| NAME OF PROVIDER OR SUPPLIER TETON HOME HEALTH | STREET ADDRESS, CITY, STATE, ZIP CODE 2470 JAFER COURT IDAHO FALLS, ID 83404 |
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| N 000 | Continued From page 1 prn - as needed pt - patient PT - Physical Therapy PTA - Physical Therapy Assistant QIO - Quality Improvement Organization RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care ST - Speech Therapy Wound VAC - Wound Vacuum Assisted Closure device | N 000 | | |
| N 013 | 03.07020.ADMIN.GOV.BODY. N013 03. Responsibilities. The governing body shall assume responsibility for: j. Assuring that services will be provided directly or under arrangement with another person, agency or organization. Overall administrative and supervisory responsibility for services provided under arrangement rests with HHA. The HHA assures that legal physician's orders are carried out regardless of whether the service is provided directly or under arrangement. The home health agency and it's staff, including staff services under arrangement, must operate and furnish services in accordance with all applicable federal, state, and local laws. This Rule is not met as evidenced by: | N 013 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) APPENDIX – II</p> </div> | |

Bureau of Facility Standards

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| N 013 | Continued From page 2 Refer to G118 | N 013 | | | |
| N 015 | 03.07020. ADMIN. GOV. BODY N015 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: a. Home health providers have an obligation to protect and promote the exercise of these rights. The governing body of the agency must insure patients' rights are recognized. This Rule is not met as evidenced by: Refer to G101 | N 015 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX - II</p> </div> | | |
| N 022 | 03.07020. ADM. GOV. BODY N022 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.iv. A patient has the right to confidentiality with regard to information about his health, social and financial circumstances and about what takes place in his home. This Rule is not met as evidenced by: Refer to G111 | N 022 | | | |
| N 026 | 03.07020. ADMIN. GOV. BODY N026 04. Patients' Rights. Insure | N 026 | | | |

Bureau of Facility Standards

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| N 026 | Continued From page 3 that patients' rights are recognized and include as a minimum the following: d.viii. The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA and must document both the existence of the complaint and the resolution of the complaint. This Rule is not met as evidenced by: Refer to G107 | N 026 | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – II</p> </div> | |
| N 039 | 03.07020. ADMIN.GOV. BODY N039 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: a) The extent to which payment may be expected from third party payors.; and This Rule is not met as evidenced by: Refer to G113 | N 039 | | |
| N 062 | 03.07021. ADMINISTRATOR | N 062 | | |

Bureau of Facility Standards

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| N 062 | Continued From page 4 N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G143 and G144 | N 062 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) APPENDIX – II</p> </div> | |
| N 091 | 03.07024. SK.NSG.SERV. N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G170 | N 091 | | |
| N 093 | 03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: | N 093 | | |

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| N 093 | Continued From page 5 Refer to G331 | N 093 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – II</p> </div> | |
| N 094 | 03.07024. SK. NSG. SERV. N094 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: b. Initiates the plan of care and makes necessary revisions; This Rule is not met as evidenced by: Refer to G173 | N 094 | | |
| N 096 | 03.07024. SK. NSG. SERV. N096 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: d. Initiates appropriate preventive and rehabilitative nursing procedures; This Rule is not met as evidenced by: Refer to G175 | N 096 | | |
| N 097 | 03.07024. SK. NSG. SERV. N097 01. Registered Nurse. A | N 097 | | |

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| N 097 | Continued From page 6 registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: e. Prepares clinical and progress notes, and summaries of care; This Rule is not met as evidenced by: Refer to G176 | N 097 | <div style="border: 1px solid black; padding: 10px; transform: rotate(-2deg);"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015 (See Attached) APPENDIX - II</p> </div> | |
| N 098 | 03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G176 | N 098 | | |
| N 099 | 03.07024.SK. NSG. SERV. N099 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: | N 099 | | |

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| N 099 | Continued From page 7 g. Counsels the patient and family in meeting nursing and related needs; This Rule is not met as evidenced by: Refer to G177 | N 099 | | |
| N 151 | 03.07030.PLAN OF CARE N151 030. PLAN OF CARE. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's plan of care. This Rule is not met as evidenced by: Refer to G157 | N 151 | <div style="border: 1px solid black; padding: 5px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – II</p> </div> | |
| N 152 | 03.07030.01.PLAN OF CARE N152 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: This Rule is not met as evidenced by: Refer to G158 | N 152 | | |
| N 153 | 03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each | N 153 | | |

Bureau of Facility Standards

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| N 153 | Continued From page 8 patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: a. All pertinent diagnoses; This Rule is not met as evidenced by: Refer to G159 | N 153 | <div style="border: 1px solid black; padding: 10px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – II</p> </div> | |
| N 154 | 03.07030.PLAN OF CARE N154 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: b. The patient's mental status; This Rule is not met as evidenced by: Refer to G159 | N 154 | | |
| 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: | N 155 | | |

Bureau of Facility Standards

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| N 155 | Continued From page 9 Refer to G159 | N 155 | <div style="border: 1px solid black; padding: 10px; margin: 10px;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – II</p> </div> | |
| N 156 | 03.07030.PLAN OF CARE. N156 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: d. Frequency of visits; This Rule is not met as evidenced by: Refer to G159 | N 156 | | |
| N 157 | 03.07030.PLAN OF CARE N157 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: e. Functional limitations; This Rule is not met as evidenced by: Refer to G159 | N 157 | | |
| N 159 | 03.07030.PLAN OF CARE N159 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing | N 159 | | |

Bureau of Facility Standards

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|--------------------|---|---------------|---|--------------------|
| N 159 | Continued From page 10 services for that patient. Care follows the written plan of care and includes: g. Activities permitted; This Rule is not met as evidenced by: Refer to G159 | N 159 | <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – II</p> | |
| 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 162 | 03.07030.PLAN OF CARE N162 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: j. Any safety measures to protect against injury; This Rule is not met as evidenced by: | N 162 | | |

Bureau of Facility Standards

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| N 162 | Continued From page 11 Refer to G159 | N 162 | | |
| N 168 | 03.07030.02. PLAN OF CARE N168 02. Goals of Patient Care. The goals of patient care must be expressed in behavioral terms that provide measurable indices for performance. This Rule is not met as evidenced by: Refer to G159 | N 168 | <div style="border: 1px solid black; padding: 10px; width: fit-content;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – II</p> </div> | |
| 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 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 | | |
| N 173 | 03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by | N 173 | | |

Bureau of Facility Standards

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| N 173 | Continued From page 12 agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G165 and G337 | N 173 | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 8/20/2015</p> <p>(See Attached) APPENDIX – II</p> </div> | |
| N 197 | 03.07050. CINICAL REC. REVIEW N197 050. CLINICAL RECORD REVIEW. The agency shall have a subcommittee to perform an audit of clinical records on at least a quarterly basis to determine the adequacy of services provided in meeting patient's needs. The committee members will represent the scope of the program consisting of health professionals. The review shall consist of at least ten per cent (10%) sampling of both active and closed clinical records representing all services being offered. A written summary of findings and recommendations of the committee shall be utilized in the overall review and self-evaluation of the agency. This Rule is not met as evidenced by: Refer to G250 | N 197 | | |

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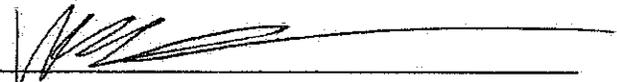
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FACILITY STANDARDS

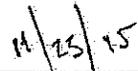
Nancy,

Please attach this signature letter to the Plan of Corrections submitted previously this week. Have a Happy Thanksgiving Day.

Regards,



Jason Bailey, Administrator



Date

TETON HOME HEALTH, PROVIDER #137061
 PLAN OF CORRECTION
 APPENDIX - I

| | |
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| G 100 | <p>Action:</p> <p>G 100 – 148.10 Patient Rights</p> <p>Refer to plan of correction G 101 Refer to plan of correction G 107 Refer to plan of correction G 111 Refer to plan of correction G 113</p> <p>Responsible Person: Administrator and DON</p> |
| G 101 | <p>Action: HHA will assess and change as necessary the process and the presentation of the Notice of Non Medicare Coverage to satisfy CMS guidelines.</p> <p>Improved Process and Procedure: 1. The HHA will modify the NOMNC form to reflect the HHA correct information. 2. A mandatory in-service will be presented to inform the Clinical staff of the proper use and time frames of the NOMNC form. 3. During Case Conference all discharges will be reviewed. A clinician will be assigned to have the NOMNC form discussed and signed by the patient/POA within the CMS recommended timeframe.</p> <p>Completion Date: NOMNC form revised by August 31, 2015. In-service completed 9/3/2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: A line item on the technical audit which is completed on discharge will include verification that the form was signed and dated appropriately. Chart audits will be completed on 100% of new admissions for the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks</p> <p>Responsible Person: Administrator and Director of Nursing will share the duty of final chart audits.</p> |
| G 107 | <p>Action: HHA will assess, and modify as appropriate, the complaint, investigation, and resolution processes, including appropriate documentation procedures. An in-service will be presented to all staff covering the complaint process, including who fills out the complaint form, how to fill out the form properly, the process to follow-up on any complaints, complaint resolution, and the documentation required during each phase of the complaint, investigation, and resolution phases.</p> <p>Improved Process and Procedure: A workflow diagram of the complaint process was developed along with a checklist of important information to be gathered during the complaint, investigation, and resolution phases of the process. In addition to the current Complaint Form, a Complaint File will be developed for each patient complaint, maintained by the Administrator or designee. The file will contain the Complaint Form, investigation documentation, corrective action documentation, complaint response</p> |

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| | <p>documentation, all guided by the checklist of important documentation elements where applicable.</p> <p>Completion Date: In-Service was completed 9/8/2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: All complaints will be monitored for trends (for example, type of complaint, clinician involved, etc.) and opportunities for improvement. A compliant log will be maintained.</p> <p>Responsible Person: Administrator and Director on Nursing will share the responsibility of the tracking complaints depending on whether the complaint is administrative versus clinical.</p> |
| G 111 | <p>Action: Change HIPAA and electronic device policy to reflect CMS and State standards for protecting PHI. In-service staff on new policy and procedure. Current policy requires that any entities contracted with HHA will indicate they understand and will comply with PHI confidentiality, as stated in the Business Associates Agreement. HHA will ensure a BBA is in place with contracted entities prior to exchanging PHI. Annual audit of contracts will include proof of compliance.</p> <p>Improved Process and Procedure: Revised HIPAA and Electronic policies completed and presented to Governing Board for acceptance. In –Service for all employees completed. Employees signed new form indicating their understanding of the revised policies. Specifically, all employees were notified that new policy excludes the use of personal mobile devices for communicating PHI. Only agency approved mobile devices, such as HHA owned and approved tablets with the proper safety mechanisms, are to be used for conducting patient care. Employees demonstrated compliance to administrator. Contracts will be evaluated annually for compliance with HHA HIPAA policies.</p> <p>Completion Date: In-service and compliance was completed on September 1, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: Administrator will randomly ask employees to demonstrate continued compliance and will document results in compliance log. Any incidents of non-compliance will be addressed through the HHA’s human resources process. Administrator will perform annual contractor review.</p> <p>Responsible Person: Administrator</p> |
| G 113 | <p>Action: To ensure patients are advised of the extent of payments for HHA services and sign the Fee Disclosure Form.</p> <p>Improved Process and Procedure: New patient intake process reviewed with clinical staff. Clinicians in-serviced on patient’s right to know if there will be any charges for services provided. Intake process includes billing manager notifying admission nurse to any possible charges before patient elects services. Admission nurse to assess financial paperwork for correct and complete information and understanding of what charges may apply.</p> |

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| | <p><u>Completion Date:</u> In-Service completed September 1, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p><u>Monitoring and Tracking:</u> Technical Chart audit completed on 100% admissions paperwork in the first month will ensure Fee Disclosure Form has been completed and signed. 80% of new admissions thereafter will be assessed for compliance for complete fee disclosure forms until 90% compliance has been reached for 4 consecutive weeks.</p> <p><u>Responsible Person:</u> Administrator and Director of Nursing.</p> |
| G 118 | <p><u>Action:</u> All social work for the HHA will be provided by a licensed social worker professional who is licensed in the state of Idaho. HHA will contract with a licensed social worker in the community until a licensed social worker can be either hired in house, or current non licensed personnel obtains Idaho licensure.</p> <p><u>Improved Process and Procedure:</u> HHA will ensure, through the hiring process, that necessary licensure is in place before a job offer is extended. HHA patients will receive the high quality of care by a licensed individual in the State of Idaho and HHA will be in compliance with this requirement.</p> <p><u>Completion Date:</u> 10/12/15</p> <p><u>Monitoring and Tracking:</u> Contracted services will be obtained by Director of Business Development. Administrator will monitor progress on licensing exam completion.</p> <p><u>Responsible Person:</u> Administrator</p> |
| G 143 | <p><u>Action:</u> Assess and revise process of care coordination. Review with clinical staff the process of care coordination between disciplines.</p> <p><u>Improved Process and Procedure:</u> An in-service with all disciplines will review the role of the nurse case manager. Each discipline professional will receive the HHA vital sign parameters as well as understand who to call when any vital sign is outside of the parameters. Clinicians will understand where to chart documentation of communication with team members and/or physician.</p> <p><u>Completion Date:</u> In-service will be completed September 25, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p><u>Monitoring and Tracking:</u> Clinical audit will be completed on 100% of charts for 1 month and 80% thereafter until 90% compliance for 4 consecutive weeks is achieved for documentation of communication between disciplines related to vital signs being outside HHA parameters or those set by the physician. Then standard charts audits to monitor for vital signs outside of HHA or physician ordered parameters. If such vital signs are found, auditor will look for documentation of coordination of care.</p> <p><u>Responsible Person:</u> Director of Nursing and Administrator share duties of chart audits.</p> |

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| G 144 | <p>Action: Clinical team will be made aware of care coordination process. Review of Case Manager Role will improve communication.</p> <p>Improved Process and Procedure: Clinical staff will be in-serviced on the roles of the nurse case manager and the associated responsibilities of coordinating the care of the patient across all disciplines. The nurse case manager will contact the various disciplines for evaluations as indicated by physician order on referral intake. The involved disciplines will report back to the nurse case manager the results of the evaluation including suggested frequency of visits. The nurse case manager will then obtain the required orders from the physician to start care. Nurse Case Manager will then communicate with each discipline involved when the orders have been received.</p> <p>Completion Date: In-service will be completed by 9/25/2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: Chart audits will include verification of timely evaluations from various disciplines and the documentation received from ordering physician to indicate frequency orders to start care. 100% of the new admissions in the first month will be evaluated for compliance. 80% of new admissions after first month will be monitored until 90% compliance is achieved for 4 consecutive weeks. Standard audits will include these items.</p> <p>Responsible Person: Administrator and Director of Nursing share chart audit duties.</p> |
| G 156 | <p>Action:</p> <p>G 156 – 148.18 Acceptance of Patients, POC, MED Super</p> <p>Refer to plan of correction G 157 Refer to plan of correction G 158 Refer to plan of correction G 159 Refer to plan of correction G 160 Refer to plan of correction G 164 Refer to plan of correction G 165</p> <p>Responsible Person: DON</p> |
| G 157 | <p>Action: The intake process was reviewed by the DON, Administrator, and therapy providers. The adjusted process ensures that the HHA communicates with all disciplines to ensure the patient's needs can be met within HHA's policy timeframes. Nurse case manager's In-service performed on 9/15/15 reviewed the agency's acceptance of new patient's policy and addressed the acceptance of referral policy and addressed the need to make contact with therapist to confirm that the initial evaluation has been performed in a timely manner. PT service have been brought in-house to improve timeliness of care, communication, and coordination.</p> <p>Improved Process and Procedure: The initial intake review will ensure that the HHA has the needed services available in a timely manner. If needed services are not available, the referral source can be alerted in a timely manner to explore alternate placement. A</p> |

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| | <p>tracking report for new admissions will be developed to ensure the referral start of care was initiated timely or referred to another available agency.</p> <p>Completion Date: All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: A new tracking report has been developed. A new referral will be placed on the tracking report and progress of the new referral through the intake process will be assessed in the AM and the PM each day.</p> <p>Responsible Person: DON and Business Development</p> |
| G 158 | <p>Action: HHA will review process to ensure that the plan of care for each patient is being followed correctly.</p> <p>Improved Process and Procedure: Extensive in-servicing, as well as expert training on a consulting basis, will be presented on how the Plans of Care are developed from the information included on the Oasis and how the plan of care is developed for patients who do not have an oasis completed. In-service will also include a process of what items of an intake the admitting nurse needs to check to make sure all necessary orders are in place and signed by a physician. In-service will also address how the frequencies work from one plan of care to the next "recert" plan of care. The writing of correct PRN orders to include reasons for the PRN order will also be discussed. The chart audit process will include assessing the plan of care and comparing the visit notes to make sure all items have been addressed from the plan of care. The chart auditor will assess the number of visits versus frequencies ordered for the patient. Continued chart audits at policy standard number will continue to monitor these issues.</p> <p>Completion Date: In-services to be completed by September 25, 2015. Consultant training 11/13/15. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: To ensure that a physician is signing initial orders, and written verbal PRN orders are more specific, chart audits will be completed on 100% of new admissions for the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks.</p> <p>Responsible Person: Chart audits are the shared responsibility of the administrator and the Director of Nursing.</p> |
| G 159 | <p>Action: To ensure, upon initial assessment, that all elements required to be listed in the patient's chart are on the Plan of Care, including, but not limited to, DME/Supplies, diagnosis, interventions, therapies, and goals. Also to review writing complete orders including procedures to be used.</p> <p>Improved Process and Procedure: In-service will be presented to all the clinical staff, including therapies, about what information needs to be charted and where to chart the information. In-service will also be presented about the necessity of writing and communicating complete orders and what elements a complete order needs to contain.</p> |

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| | <p>Additional consultant training will be provided to educate staff on developing and following a comprehensive plan of care.</p> <p>Completion Date: In-Services will be completed by September 9, 2015. Additional training provided 11/13/15 by consultant. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: 100% of the charts will be audited for the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks. Subsequent chart audits per agency policy will include monitoring for these items.</p> <p>Responsible Person: Chart audits are the shared responsibility of the Administrator and the Director of Nursing.</p> |
| G 160 | <p>Action: Physician verbal order for care will be obtained after initial evaluations have been completed and before care actually starts. The new process will have all disciplines reporting to the case manager and the case manager will communicate with the physician about the plan of care including suggested frequencies and any additional orders the physician may have for the team. The in-service will also include how to document the communications between the physicians and the clinician for the plan of care or changes to the plan of care.</p> <p>Improved Process and Procedure: In-service for all clinical staff about the process of how the physician will learn about the plan of care or any subsequent changes to the plan of care. Duties of the case manager and the communication pathways for the clinical team will be reviewed.</p> <p>Completion Date: In-service will be completed by September 9, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: Clinical chart audits will assess chart for documentation related to the physician verbal order for care. Auditor will expect to see a name of the person the case manager talked with about the plan of care. Chart audits will be completed on 100% of new admissions for the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks. This item is included in the initial chart audit performed as the chart is being prepared for billing.</p> <p>Responsible Person: Chart audits are the shared responsibility of the Administrator and the Director of Nursing. The Billing Manager is part of the technical audit of the chart. The chart will be assessed for written verbal orders before billing will occur.</p> |
| G 164 | <p>Action: Any proposed changes to the plan of care will be promptly reported to the physician. If approved, the physician will provide to appropriate clinician a verbal order which will be written and sent to physician for signature. All clinical staff will review the agency parameters for vital signs. The policy of reporting parameters which are outside of the parameters will be reviewed and the communication pathway will be reiterated. Clinicians will be reminded to review orders for physician ordered parameters.</p> <p>Improved Process and Procedure: The clinicians will review the communication pathway for reporting vital signs which are outside the agency or physician stated parameters. The</p> |

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| | <p>communication with the physician will happen promptly and will be documented according to agency policy and procedure.</p> <p>Completion Date: In-service will be completed by September 25, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: Chart audits will assess for compliance to reporting vital sign parameters outside agency policy and/or physician orders. Clinicians will understand how to properly document who the vitals were reported to and any resulting changes to the plan of care. Chart audits will be completed on 100% of new admissions for the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks</p> <p>Responsible Person: Chart audits are the shared responsibility of the Administrator and the Director of Nursing.</p> |
| G 165 | <p>Action: HHA will workflow the current physician orders process and make necessary changes to prevent errors. HHA will change the process to better utilize the EMR provider order functionality in order workflow. Clinicians will not perform any treatments or administer any medications without the detailed order from the physician.</p> <p>Improved Process and Procedure: Through enhanced utilization of the EMR to enter and track orders, HHA will significantly reduce manual processes and paperwork. The EMR will also enable clinicians to verify orders while in the field as orders will be available electronically in the EMR. An in-service will be completed about the importance of having detailed/complete orders from the physician before performing any treatments or administering medications for patients. Clinicians will be reminded that orders cannot be signed by a Physician Assistant.</p> <p>Completion Date: In-service will be held before September 25, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: 100% of new charts will be audited for a month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks. Clinical notes will be monitored for any treatments or medications given to patient without complete and detailed orders.</p> <p>Responsible Person: Chart audits are the shared responsibility of the Administrator and the Director of Nursing.</p> |
| G 168 | <p>Action:</p> <p>G 168 – 148.30 Skilled Nursing Services</p> <p>Refer to plan of correction G 170 Refer to plan of correction G 173 Refer to plan of correction G 175 Refer to plan of correction G 176 Refer to plan of correction G 177 Refer to plan of correction G 331 Refer to plan of correction G 337</p> |

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| | <p>Responsible Person: DON</p> |
| G 170 | <p>Action: Skilled Nursing services will be provided according to the Plan of Care. Nurses will understand what the duties of the nurse case manager are versus a visit nurse. The Case managers will be reminded that the plan of care in its entirety needs to be addressed.</p> <p>Improved Process and Procedure: Nursing staff will attend an in-service on the importance of following the plan of care as outlined. The entire plan of care needs to be addressed with proper documentation to demonstrate all education and treatments were completed.</p> <p>Completion Date: In-service will be completed by September 25, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: Clinical chart audits will monitor visit notes compared to the plan of care to assess whether all parts of the plan of care have been addressed. 100% of charts will be monitored for the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks. Subsequent chart audits per agency policy will continue to monitor for documentation demonstrating complete plans of care.</p> <p>Responsible Person: Chart audits are the shared responsibility of the Administrator and the Director of Nursing.</p> |
| G 173 | <p>Action: Review of the duties of registered nurse in the assessment of services/ education to address all diagnosis of the patient. Reminding nurses that they can contact the physician about additional needed services if not listed on original home health order.</p> <p>Improved Process and Procedure: In-Service will be completed by nurses related to assessment of services related to all home health diagnosis. In-Service will include the process of contacting the physician for additional orders for additional services that may be appropriate for the patient and need to be added of the plan of care.</p> <p>Completion Date: In-Service to be held before September 25, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: 100% of new charts will be audited in the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks. During chart audits the auditor will monitor for documentation demonstrating that each listed diagnosis has been addressed and charted appropriately. The audit will also monitor if the physician was contacted for additional orders. A Patient Diagnosis Worksheet will be developed as a tracking mechanism. HHA will work with EMR vendor to make this worksheet available electronically in the patient record.</p> <p>Responsible Person: Chart audits are the shared responsibility of the Administrator and the Director of Nursing.</p> |
| G 175 | <p>Action: The registered nurse will initiate appropriate preventative and rehabilitative care.</p> |

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| | <p>Improved Process and Procedure: An in-service directed to the registered nurses, in particular the case managers will review and discuss appropriate preventative and rehabilitative care for home health patients and what the responsibility is of the nurse to assess the whole patient versus the one or two things the physician may have ordered.</p> <p>Completion Date: The in-service will be held before September 25, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: 100% of new charts will be audited in the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks, for appropriate services based on all of the patient's diagnosis. Charts will be also audited for additional physician orders if needed to increase care or to address other issues. A Patient Diagnosis Worksheet will be developed as a tracking mechanism. HHA will work with EMR vendor to make this worksheet available electronically in the patient record</p> <p>Responsible Person: Chart audits are the shared responsibility of the Administrator and the Director of Nursing.</p> |
| G 176 | <p>Action: The nurse case manager will review duties for timely contact of physician and other personnel of changes in patient's condition and subsequent changes to plan of care.</p> <p>Improved Process and Procedure: An in-service will be performed to remind the nurse case manager of the duties of the case manager related to communication of any and all changes in patient's condition. Communication includes documentation in the patient's chart, and case conference discussion.</p> <p>Completion Date: In-service will be completed by September 25, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p>Monitoring and Tracking: During chart audits the Case Conference documentation will be assessed to reveal if it reflects any changes noted in the patient during case conference discussions. Additional opportunities for documentation are available in the electronic medical record. The documentation requirements will be discussed and demonstrated. 100 % of new patient chart audits will be performed for the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks, to ensure case managers understand the concept. Continued compliance will be monitored through agency required monthly chart audits.</p> <p>Responsible Person: In-service will be conducted by the Director of Nursing. Chart audits are the shared responsibility of the Administrator and the Director of Nursing.</p> |
| G 177 | <p>Action: The nurse case manager will understand the importance of education for the patient and family and charting the education provided.</p> <p>Improved Process and Procedure: An in-service with clinical staff will be provided about appropriate documentation of education performed during visits. Clinical staff will also be reminded that the plan of care determines the education that needs to be performed. All items on the plan of care need to be completed.</p> |

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| | <p><u>Completion Date:</u> In-service will be completed by September 25, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p><u>Monitoring and Tracking:</u> During chart audits the auditor will monitor for documentation of education completed for each item on the plan of care. 100% of new charts will be audited in the first month for compliance, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks. Continued compliance will also be ensured during agency required monthly chart audits.</p> <p><u>Responsible Person:</u> Chart audits are the shared responsibility of the Administrator and the Director of Nursing.</p> |
| G 250 | <p><u>Action:</u> The DON will review the nurse's documentation on a quarterly basis.</p> <p><u>Improved Process and Procedure:</u> Feedback will be provided to each nurse indicating any identified deficiencies or opportunities for improvement. Also, the results of the chart audits will be reviewed as part of the QA review.</p> <p><u>Completion Date:</u> All necessary corrections and new procedures will be in place by 11/15/15.</p> <p><u>Monitoring and Tracking:</u> A report will be created on a monthly basis to identify which charts have been audited, by whom, and what the findings were. This report will be reviewed with the administrator and the QA team on a monthly basis. Chart audits will be completed on 100% of new admissions for the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks. For quality assurance, a minimum of 25% of all charts will be audited each quarter to ensure a 90% compliance can be obtained and sustained within the charts.</p> <p><u>Responsible Person:</u> DON and Administrator</p> |
| G 331 | <p><u>Action:</u> The DON and Administrator will ensure that the clinical staff is completing a comprehensive assessment of the patients during the initial visit and identifying the immediate care and support needs of the patient.</p> <p><u>Improved Process and Procedure:</u> The DON will begin conducting an audit of all paperwork completed during the initial visits to ensure that the staff has adequately and appropriately assessed the immediate care and support needs of the patient including status of wounds, respiratory status and treatments, nutrition, pain, and risk of falls. The findings of these audit results will be reviewed with each clinician that completed the initial assessment. In the event that the clinician has not adequately completed the initial visit assessment documentation then the DON will provide the clinician with additional training at that time to ensure that the clinician fully understands how to accurately conduct an initial visits and how to accurately complete the documentation. If necessary, DON will accompany nurses to the patient's home for observation of initial assessment.</p> |

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| | <p><u>Completion Date:</u> Training on initial assessment was conducted on September 1, 2015. All necessary corrections and new procedures will be in place by 11/15/15.</p> <p><u>Monitoring and Tracking:</u> The DON will prepare a report that will be reviewed with the administrator on a monthly basis. Chart audits will be completed on 100% of new admissions for the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks</p> <p><u>Responsible Person:</u> DON</p> |
| G 337 | <p><u>Action:</u> An In-service on Comprehensive Medication Review was conducted on 9/15/15. In-service focused on: 1) the need to visually inspect medication bottles in the home and comparing to the medication list, including looking around the home as needed for unlisted medications; 2) the need to notify the physician within 24hrs regarding significant drug interactions and in cases where discrepancies in the medication lists are found; 3) education of the patient on all types of medications including side effects, adverse effects, etc; The DON will begin conducting field and chart audits of medication reconciliation and medications profiles on SOC and upon recertification to verify that all medications listed on the patient's medication profile are accurate.</p> <p><u>Improved Process and Procedure:</u> The findings of these audits will be reviewed with each clinician who completed the med profile. In the event that the clinician has not adequately completed the medication profile documentation then the DON will provide the clinician with additional training at that time to ensure that the clinician fully understands how to accurately complete a medication profile.</p> <p><u>Completion Date:</u> All necessary corrections and new procedures will be in place by 11/15/15.</p> <p><u>Monitoring and Tracking:</u> The DON will prepare a report that contains the findings of these audits and the DON will review the findings with the administrator on a monthly basis. Chart audits will be completed on 100% of new admissions for the first month, 80% thereafter until 90% compliance is achieved for 4 consecutive weeks</p> <p><u>Responsible Person:</u> DON</p> |