



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
3232 Elder Street
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Boise, Idaho 83720-0009
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E-mail: fsb@dhw.idaho.gov

December 17, 2015

7000 0520 0023 1950 8589

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

RE: Teton Home Health, Provider #137061

Dear Mr. Bailey:

On December 3, 2015, an on-site follow-up revisit was conducted to verify that Teton Home Health was in compliance with all Conditions of Participation. The agency's allegation of compliance indicated your agency was in substantial compliance as of November 15, 2015. However, based on our on-site revisit, your agency remains out of compliance with the following Condition of Participation:

- **ACCEPTANCE OF PATIENTS, PLAN OF CARE, MEDICAL SUPERVISION (42 CFR 484.18)**

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

The deficiencies, which caused the condition to be unmet, substantially limit the capacity of Teton Home Health to furnish services of sufficient level and 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. Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing corrected deficiencies, is also enclosed.

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

Jason Bailey, Administrator
December 17, 2015
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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 **December 30, 2015**. It is strongly recommended that the agency's Credible Allegation /Plan of Correction for the Condition of Participation and related standard level deficiencies show compliance no later than **January 17, 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 were recommended to the Centers for Medicare/Medicaid (CMS) Region X Office, following the (date of original survey), recertification survey of your agency:

- Termination [42 CFR 488.865]

You were notified of these recommendation in our [date of letter], letter, sent following the [date of original survey], recertification survey.

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

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compliance, CMS may choose to revise sanctions imposed.

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/pt

Enclosures

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Linda Harris, CMS Region X Office



December 28, 2015

SYLVIA CRESWELL, Co-Supervisor
Non-Long Term Care Section
Bureau of Facility Standards
P.O. Box 83720
3232 Elder Street
Boise, ID 83720-0009

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DEC 28 2015
FACILITY STANDARDS

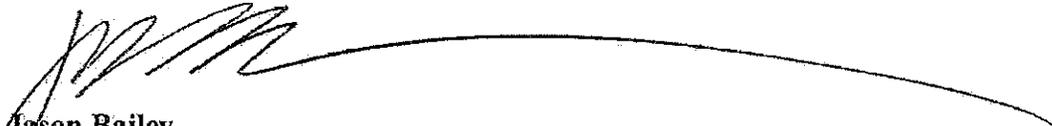
Re: Plan of Correction – Teton Home Health
Provider No. 137061

Dear Sylvia Creswell:

Enclosed is our Plan of Correction in response to the Survey conducted on November 30, 2015. We have listed the G-Tag cited at survey along with an explanation of corrective measures we plan to use and/or implement towards alleviating all deficiencies identified. We have chosen our date of proposed compliance as December 27, 2015.

Please do not hesitate to contact myself, or any member of our administrative team with any questions.

Kind regards,


Jason Bailey
Administrator

Teton Home Health
2470 Jafer Court
Idaho Falls, ID 83404
208.529.3636 - Office
208.529.1715 - Fax

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

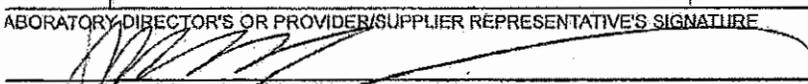
PRINTED: 12/17/2015
FORM APPROVED
OMB NO. 0938-0391

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 R 12/03/2015
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{G 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare follow up survey of your agency from 11/30/15 to 12/3/15. The surveyors conducting the follow up survey were:</p> <p>Nancy Bax, RN, BSN, HFS Dennis Kelly, RN-BC, CHPN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ADL - Activity of Daily Living DON - Director of Nurses HH - Home Health HHA - Home Health Agency HIPAA - Health Insurance Portability and Accountability Act mg - Milligrams NOMNC - Notice of Medicare Non-Coverage OASIS - Outcome and Assessment Information Set OT - Occupational Therapy OTC - Over the Counter PHI - Protected Health Information POC - Plan of Care prn - As Needed PT - Physical Therapy RN - Registered Nurse ROM - Range of Motion SN - Skilled Nursing SOC - Start of Care</p>	{G 000}	<p>RECEIVED DEC 28 2015 FACILITY STANDARDS</p> <p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	
{G 101}	<p>484.10 PATIENT RIGHTS</p> <p>The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights.</p>	{G 101}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/27/15
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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 their 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 101}	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on review of patient medical records and staffing training documents 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. This impacted 2 of 3 discharged patients (#3 and #4) who were Medicare beneficiaries and whose records were reviewed and had the potential to affect all patients who were Medicare beneficiaries. This resulted in the potential for services to be terminated without the patients' ability to appeal the discharge. Findings include:</p> <p>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:</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." <p>A review of agency education provided on 12/01/15, documented agency employees received an in-service on 9/03/15, titled "Notice of Medicare Non-Coverage." The attendee sign in sheet documented the Administrator presented the education.</p> <p>During an interview on 12/01/15 at 7:00 PM, the Administrator stated he was unaware a copy of the NOMNC form needed to be left with the</p>	{G 101}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	
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{G 101}	<p>Continued From page 2</p> <p>patient after a signature was obtained. The Administrator confirmed agency employees did not receive instructions to leave a signed and dated copy of the NOMNC with the patient or with the patient's authorized representative. The Administrator confirmed patients or their authorized representatives did not have the necessary information available to them on how to appeal their discharge from home health services.</p> <p>Examples include:</p> <p>1. Patient #3 was an 80 year old female admitted to the agency on 10/05/15, for SN and PT services related to recent joint replacement surgery. She was discharged from the agency on 11/30/15. Her agency discharge information was reviewed.</p> <p>Patient #3's record included a discharge assessment and discharge summary completed by the RN Case Manager, dated 11/30/15. The discharge summary stated: "PT [Physical Therapist] stated to SN that patient was already discharged as of 11/19/15...PT had patient sign notice of medicare non-coverage."</p> <p>Patient #3's record included a NOMNC form. The form included Patient #3's signature, dated 11/17/15. The form stated home health services would end on 11/30/15. It was unclear how the PT knew the RN Case Manager would complete the discharge assessment on 11/30/15, 9 days after the final PT visit.</p> <p>During an interview on 12/01/15 at 6:05 PM, the RN Case Manager stated after contacting the Physical Therapist, she attempted to contact</p>	{G 101}	<p>Teton Home Health</p> <p>Plan of Correction</p> <p>Provider # 137061</p> <p>Ref: 12/3/2015</p> <p>(See Attached)</p> <p>APPENDIX - I</p>	
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{G-101}	<p>Continued From page 3</p> <p>Patient #3 to schedule a discharge assessment visit. She stated she left a telephone message but did not receive a return call. On 11/30/15, she completed the discharge assessment based on information from the Physical Therapist. She stated she did not complete a discharge visit to Patient #3. She was unable to explain how the Physical Therapist knew she would complete the discharge paperwork on 11/30/15.</p> <p>During an interview on 12/01/15 at 5:20 PM, the Physical Therapist reviewed the NOMNC form and confirmed he delivered the notice to Patient #3 on 11/17/15, 2 days prior to his final visit. He stated he did not complete the date home health services would end on the form, and the 11/30/15 date was added to the form after it was submitted to the office. Additionally, he stated he did not leave a copy of the NOMNC form in Patient #3's home. The Physical Therapist confirmed the patient was not notified of the date her home health services would end, and was not given a copy of the NOMNC form with instructions on how to appeal her discharge.</p> <p>The agency failed to inform Patient #3 of the date her home health services would end, or give her necessary information to appeal her discharge from home health services.</p> <p>2. Patient #4 was a 70 year old female admitted to the agency on 10/13/15, for SN and PT services related to generalized muscle weakness. She was discharged from the agency on 11/23/15. Her record, including the POC for the certification period 10/13/15 to 12/11/15, was reviewed.</p> <p>Patient #4's record included a NOMNC form</p>	{G 101}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	

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{G 101} Continued From page 4
stating her home health services would end on 11/23/15. It included her signature dated 11/20/15.

During an interview on 12/01/15 at 5:20 PM, the Physical Therapist stated he obtained Patient #4's signature on the NOMNC form on 11/20/15, and submitted the form to the office. He stated he did not leave a copy of the form with Patient #4.

{G 111} Patient #4 was not given a paper copy of the NOMNC form.
484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS

The patient has the right to confidentiality of the clinical records maintained by the HHA.

This STANDARD is not met as evidenced by:
Based on observation, staff interview, and review of medical records, agency policies, and Governing Body Meeting Minutes, it was determined the agency failed to ensure confidentiality of patients' clinical information was maintained by the agency. This impacted 1 of 12 patients (#5) whose records were reviewed, and had the potential to affect all patients. This failure had the potential to result in unauthorized release of patients' confidential health information.
Findings include:

1. The agency Governing Board Meeting Minutes dated 9/24/15, and signed by the Owner/HHA Administrator/PharmD, CEO, Office Manager, Director of Nursing and Co-Administrator, was reviewed. The minutes stated "We have drafted

{G 101}

{G 111} Teton Home Health
Plan of Correction
Provider # 137061
Ref: 12/3/2015
(See Attached)
APPENDIX - I

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{G 111}	<p>Continued From page 5</p> <p>an updated HIPAA policy which all employees have read and signed. A copy of the signed draft will be placed in each employees file. The updated policy can be found in the policies and procedures manual under patient information, policy number 4.001.1."</p> <p>HHA policy 4.001.1 titled "Patient Information" was reviewed on 12/01/15. The policy stated "Patient information may not be shared using personal mobile devices."</p> <p>This policy was not followed. Examples include:</p> <p>a. Staff interviewed indicated they used personal mobile devices to share patient information.</p> <p>* During an interview on 12/01/15 at 5:55 PM, PT A confirmed he received the updated policy. He also stated he used his personal cell phone to email patient information and coordinate care with team members and he had not been issued a cell phone from the agency.</p> <p>* During an interview on 12/01/15 at 6:05 PM, RN A confirmed she received the updated policy. She also stated she used her personal cell phone to email and text patient information and coordinate care with team members.</p> <p>* During an interview on 12/02/15 at 9:30 AM, PT B confirmed he received the updated policy. He also stated he used his personal cell phone to communicate patient information and coordinate care with team members.</p> <p>* During an interview on 12/02/15 at 10:00 AM, RN B confirmed she received the updated policy. She also stated she used her personal cell phone</p>	{G 111}	<p>Teton Home Health</p> <p>Plan of Correction</p> <p>Provider # 137061</p> <p>Ref: 12/3/2015</p> <p>{See Attached}</p> <p>APPENDIX - I</p>	

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{G 111}	<p>Continued From page 6</p> <p>to email and text patient information and coordinate care with team members and with physicians. She stated this was a common practice.</p> <p>* During an interview on 12/02/15 at 3:00 PM, the Administrator stated he presented the policy in an in-service to agency employees on 9/01/15. He confirmed the policy included instructions "patient information may not be shared using personal devices." He also stated he was unaware staff continued to use personal devices for communicating patient information.</p> <p>The agency failed to protect the privacy of patient personal health information.</p> <p>b. The Surveyors met with the agency's DON on 11/30/15 at 12:10 PM. During the meeting the DON stated she was exchanging text messages with a patient regarding pain medication. The DON placed her phone on the table and a picture of a patient's medication bottle was observed on her phone. The picture included the patient's name and information regarding her medication.</p> <p>During an interview on 12/02/15 at 4:15 PM, the DON confirmed she communicated with a patient by text message and received a picture of the patient's medication label. She confirmed the text message and picture were still on her phone, and showed the picture to the surveyor.</p> <p>The agency's DON received and stored a patient's PHI on her cell phone.</p> <p>c. Patient #5 was a 91 year old female admitted to the agency on 11/20/15, for SN and PT services related to generalized muscle weakness</p>	{G 111}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	

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{G 111}	<p>Continued From page 7</p> <p>and unsteadiness of gait. She was a current patient of the agency as of 12/03/15. Her record, including the POC, for the certification period 11/20/15 to 1/18/16, was reviewed.</p> <p>Patient #5's record included a SOC comprehensive assessment dated 11/20/15, and signed by the RN Case Manager. The assessment stated problems were found during a drug regimen review. Additionally, it stated "SN texted MD with the one moderate interaction."</p> <p>During an interview on 12/02/15 at 10:05 AM, the RN Case Manager reviewed the record and confirmed she used her personal cell phone to send a text message to Patient #5's physician regarding the medication interaction. She stated she identified Patient #5 in the text message by using the first 3 letters of her last name and the first 2 letters of her first name. She stated this was a common practice.</p> <p>Patient #5's personal information was included in a text message on a personal cell phone.</p>	{G 111}		
{G 156}	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>This CONDITION is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure care was provided in accordance with patients' POCs, the POCs included all pertinent information, physicians were consulted to approve POCs, and physicians were notified of changes in patients' conditions. This resulted in</p>	{G 156}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	

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{G 156}	Continued From page 8 unmet patient needs, and care provided without physician authorization. Findings include: 1. Refer to G158 as it relates to the agency's failure to ensure care was provided in accordance with patients' POCs. 2. Refer to G159 as it relates to the agency's failure to ensure patients' POCs included all pertinent diagnoses, types of services, and supplies and equipment required. 3. Refer to G160 as it relates to the agency's failure to consult physicians to approve patients' POCs following evaluation visits. 4. 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.	{G 156}	Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I	
{G 158}	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 5 of 12 patients (#1, #4, #5, #8, and #11)	{G 158}		

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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 R 12/03/2015
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{G 158}	<p>Continued From page 9</p> <p>whose records were reviewed. This resulted in services provided without physician orders, omissions of care, and unmet patient needs. Findings include:</p> <p>1. Patient #4 was a 70 year old female admitted to the agency on 10/13/15, for SN and PT services related to generalized muscle weakness. She was discharged from the agency on 11/23/15. Her record, including the POC, for the certification period 10/13/15 to 12/11/15, was reviewed.</p> <p>Patient #4's POC included an order for PT visits twice a week for 4 weeks. The fourth week of her certification period ended on 11/07/15. However, Patient #4's record included PT visit notes dated 11/18/15 and 11/20/15. Her record did not include physician orders for PT visits after 11/07/15.</p> <p>During an interview on 12/01/15 at 5:20 PM, the Physical Therapist reviewed Patient #4's record and confirmed there was no physician order for the PT visits completed on 11/18/15 and 11/20/15.</p> <p>Patient #4's PT visits were completed without a physician's order.</p> <p>2. Patient #5 was a 91 year old female admitted to the agency on 11/20/15, for SN and PT services related to generalized muscle weakness and unsteadiness of gait. She was a current patient of the agency as of 12/03/15. Her record, including the POC, for the certification period 11/20/15 to 1/18/16, was reviewed.</p> <p>Patient #5's record included a home health</p>	{G 158}	<p>Teton Home Health</p> <p>Plan of Correction</p> <p>Provider # 137061</p> <p>Ref: 12/3/2015</p> <p>(See Attached)</p> <p>APPENDIX – I</p>	
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{G 158}	<p>Continued From page 10</p> <p>referral order dated 11/20/15, and signed by her physician. The order did not include PT services. Patient #5's record included a PT evaluation dated 11/23/15. However, her record did not include a physician's order for the PT evaluation.</p> <p>During an interview on 12/02/15 at 10:05 AM, the RN Case Manager stated after she completed the SOC comprehensive assessment on 11/20/15, she called the agency's office and reported Patient #5 would benefit from PT services. She confirmed she did not obtain a physician order for a PT evaluation.</p> <p>During an interview on 12/02/15 at 4:00 PM, the DON reviewed Patient #5's record and confirmed there was no physician order for the PT evaluation.</p> <p>Patient #5's PT evaluation was completed without a physician's order.</p> <p>3. Patient #8 was an 86 year old female admitted to the agency on 7/29/15, for SN and PT services related to generalized muscle weakness. She was discharged from the agency on 11/25/15. Her record for the certification period 9/27/15 to 11/25/15 was reviewed.</p> <p>Patient #8's record included a physician's order for PT and OT services, dated 10/30/15. However, her record did not include documentation of an OT evaluation or OT visits prior to her discharge date of 11/25/15.</p> <p>During an interview on 12/02/15 at 4:10 PM, the DON reviewed Patient #8's record and confirmed she did not receive OT services as ordered by her physician.</p>	{G 158}	<p>Teton Home Health</p> <p>Plan of Correction</p> <p>Provider # 137061</p> <p>Ref: 12/3/2015</p> <p>(See Attached)</p> <p>APPENDIX - I</p>	
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{G 158}	<p>Continued From page 11</p> <p>Patient #8 did not receive OT services as ordered by her physician.</p> <p>4. Patient #11 was a 51 year old female admitted to the agency on 11/27/15, for SN and PT services related to recent joint replacement surgery. She was a current patient of the agency as of 12/03/15. Her record, including the POC, for the certification period 11/27/15 to 1/25/16, was reviewed.</p> <p>Patient #11's record included an order dated 11/30/15, for a change in her Coumadin dosage. The order was obtained by the DON from a Physician's Assistant.</p> <p>During an interview on 12/02/15 at 4:30 PM, the DON reviewed Patient #11's record and confirmed the order for Coumadin dosage was obtained from a Physician's Assistant.</p> <p>The agency failed to ensure Patient #11's orders were obtained from a physician.</p> <p>5. Patient #1 was a 59 year old female admitted to the agency on 11/19/15, for SN, PT and OT services related to hypokalemia, muscle weakness and unspecified abnormalities of gait and mobility. Her record, including the POC, for the certification period 11/19/15 to 1/17/16, was reviewed.</p> <p>Patient #1's POC included a clinical summary, completed by the RN Case Manager. The summary stated "Patient will require a PT/OT eval for strength/stability/ROM/ADL safety."</p> <p>An OT evaluation was not found in Patient #1's</p>	{G 158}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	
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{G 158}	Continued From page 12 medical record. During an interview on 12/02/15 at 10:00 AM, the RN Case Manager reviewed Patient #1's record and confirmed there was a need for an OT evaluation documented on her POC. The RN Case Manager confirmed an OT evaluation had not been completed.	{G 158}	Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I	
{G 159}	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure POCs covered all pertinent information for 5 of 9 patients (#1, #5, #6, #7, and #9) whose POCs were reviewed. This had the potential to result in unmet patient needs and adverse patient outcomes. Findings include: 1. Patient #5 was a 91 year old female admitted to the agency on 11/20/15, for SN and PT services related to generalized muscle weakness and unsteadiness of gait. She was a current	{G 159}		

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{G 159}	<p>Continued From page 13</p> <p>patient of the agency as of 12/03/15. Her record, including the POC, for the certification period 11/20/15 to 1/18/16, was reviewed.</p> <p>Patient #5's POC did not include all pertinent information, as follows:</p> <p>a. Patient #5's POC included a principal diagnosis of "Other specified disorders of the skin and subcutaneous tissue." However, her SOC comprehensive assessment, completed on 11/20/15-stated she had no wounds or skin lesions. Patient #5's POC was marked "completed" in the electronic medical record.</p> <p>During an interview on 12/02/15 at 10:05 AM, the RN Case Manager reviewed the record. She confirmed Patient #5 did not have a wound or skin lesion. She stated the diagnoses are added to the POC by a medical coder who is contracted by the agency. She stated she was unaware of the diagnoses codes on Patient #5's POC.</p> <p>During an interview on 12/02/15 at 2:20 PM, the Assistant Administrator stated a document status of "completed" in the electronic medical record meant the document was reviewed by the office, completed and ready to send to the physician for signature.</p> <p>During an interview on 12/02/15 at 4:00 PM, the DON reviewed Patient #5's record. She confirmed the principal diagnoses on the POC was incorrect. Additionally, she confirmed the POC was completed and ready to be sent to the physician for signature.</p> <p>Patient #5's POC did not include an accurate primary diagnosis.</p>	{G 159}	<p>Teton Home Health</p> <p>Plan of Correction</p> <p>Provider # 137061</p> <p>Ref: 12/3/2015</p> <p>(See Attached)</p> <p>APPENDIX - I</p>	
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{G 159}	<p>Continued From page 14</p> <p>b. Patient #5's POC included dressing supplies. However, Patient #5 did not have a wound or skin lesion requiring dressing supplies. Additionally, her POC did not include an order for care requiring dressing supplies.</p> <p>During an interview on 12/02/15 at 10:05 AM, the RN Case Manager reviewed Patient #5's record. She confirmed her POC did not include care requiring dressing supplies. She stated she included dressing supplies on the POC because Patient #5 had an increased risk of falls and there was a potential for an injury requiring dressing supplies.</p> <p>Patient #5's POC included supplies that were not pertinent to her care.</p> <p>c. Patient #5's record included a SOC comprehensive assessment dated 11/20/15, and signed by the RN Case Manager. The pain profile included in the assessment stated she had low back pain daily but not constantly, that was relieved by pain medication. However, Patient #5's POC did not include medications to relieve pain.</p> <p>During an interview on 12/02/15 at 10:05 AM, the RN Case Manager reviewed Patient #5's record. She stated Patient #5 took over the counter medication to relieve her pain. She confirmed her POC did not include her over the counter pain medications.</p> <p>Patient #5's POC did not include her pain medication.</p> <p>2. Patient #6 was a 51 year old female admitted</p>	{G 159}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	

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{G 159}	<p>Continued From page 15</p> <p>to the agency on 11/20/15, for SN and PT services related to recent joint replacement surgery. She was a current patient of the agency as of 12/03/15. Her record, including the POC for the certification period 11/20/15 to 1/18/16, was reviewed.</p> <p>Patient #6's POC did not include all pertinent information, as follows:</p> <p>a. Patient #6's POC included wound care to her surgical site. However, her POC did not include wound care supplies</p> <p>During an interview on 12/01/15 at 6:25 PM, the RN Case Manager reviewed Patient #6's record and confirmed wound care supplies were missing from her POC.</p> <p>Patient #6's POC did not include her wound care supplies.</p> <p>b. Patient #6's record included a SOC comprehensive assessment dated 11/20/15, and signed by the RN Case Manager. The pain profile included in the assessment stated she had right knee pain daily but not constantly. Her pain at the time of the assessment was rated as 8 on a scale of 1 to 10.</p> <p>Patient #6's POC included Oxycodone-Acetaminophen 7.5-325 mg tablets to be taken once daily. "Drugs.com" (an internationally recognized database and public access website established as a resource for nurses and clinical staff,) accessed on 12/04/15, stated the usual adult dose of Oxycodone-Acetaminophen is 1 to 2 tablets every 6 hours, as needed to relieve pain.</p>	{G 159}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	

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{G 159}	<p>Continued From page 16</p> <p>During an interview on 12/01/15 at 6:25 PM, the RN Case Manager reviewed Patient #6's record and confirmed she was taking Oxycodone-Acetaminophen several times daily for pain relief. She stated the frequency on the POC was not correct.</p> <p>Patient #6's POC did not include the correct frequency of her pain medication.</p> <p>3. Patient #1 was a 59 year old female admitted to the agency on 11/19/15, for SN, PT and OT services related to hypokalemia, muscle weakness and unspecified abnormalities of gait and mobility. Her record, including the POC, for the certification period 11/19/15 to 01/17/16, was reviewed.</p> <p>Patient #1's POC included "ace wrap" and "dressing supplies" however, the record did not include documentation of a wound or use of an ace wrap.</p> <p>During an interview on 12/02/15 at 10:00 AM, the RN Case Manager reviewed Patient #1's record and confirmed her POC included "ace wrap" and "dressing supplies" however she did not have a wound or a need for an ace wrap. She stated she "included any DME and supply needs past, present and future" on Patient #1's POC.</p> <p>During an interview on 12/02/15 at 3:45 PM, the DON reviewed Patient #1's record and confirmed it documented ace wrap and dressing supplies. She confirmed there was no documentation of a wound or need for an ace wrap. She stated Patient #1's POC included supplies that were not</p>	{G 159}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	
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{G 159}	<p>Continued From page 17 pertinent to her care.</p> <p>Patient #1's POC included supplies that were not used in her care.</p> <p>4. Patient #7 was an 84 year old female admitted to the agency on 11/18/15, for SN, PT and home-health aide services related to muscle weakness and unspecified abnormalities of gait and mobility. Her record, including the POC, for the certification period 11/18/15 to 01/16/16, was reviewed.</p> <p>a. Patient #7's POC included an insertion kit and a syringe, however, her record did not include documentation of a need for either supply.</p> <p>During an interview on 12/01/15 at 6:05 PM, the RN Case Manager reviewed Patient #7's record and confirmed her POC included an "insertion kit" and "syringe" however she did not have a need for an insertion kit or a syringe. She stated she could not explain why she included an insertion kit or syringe on Patient #7's POC.</p> <p>During an interview on 12/02/15 at 3:45 PM, the DON reviewed Patient #7's record and confirmed it documented an insertion kit and syringe, however, there was no documentation of a need for the supplies.</p> <p>Patient #7's POC included supplies that were not pertinent to her care.</p> <p>b. Patient #7's record included a SN note dated 11/23/15 and signed by the RN Case Manager. It included a pain assessment that documented Patient #7's self reported pain rating of 4 on a 0-10 scale. The RN Case Manager documented</p>	{G 159}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	
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{G, 159}	<p>Continued From page 18</p> <p>"patient states that the OTC medication is assisting with the pain."</p> <p>Patient #7's POC did not include any pain medications.</p> <p>During an interview on 12/01/15 at 8:05 PM, the RN Case Manager reviewed Patient #7's record and confirmed her visit note dated 11/23/15, documented Patient #7 rated her pain as 4 on a 0-10 scale and included her statement her "OTC medication is assisting with the pain." The RN Case Manager confirmed she did not document the OTC medications in Patient #7's record.</p> <p>During an interview on 12/02/15 at 3:46 PM, the DON reviewed Patient #7's record and confirmed it did not include pain medications on her POC or on an update to her POC.</p> <p>5. Patient #9 was a 74 year old male admitted to the agency on 09/29/14, for SN, PT, OT and home health aide services related to muscle weakness. His record, including the POC, for the certification period 11/23/15 to 01/21/16, was reviewed.</p> <p>Patient #9's medical record included an OT functional reassessment dated 11/18/15. The assessment stated Patient #9 would benefit from continued OT services.</p> <p>Patient #9's POC, completed by the RN Case Manager, stated "Occupational Therapy Visit Frequency". However, the frequency of OT visits to be completed were not included on the POC.</p> <p>The Occupational Therapist was unavailable for interview. However, during an interview on</p>	{G, 159}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	

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{G 159}	Continued From page 19 12/01/15 at 6:05 PM, the RN Case Manager reviewed Patient #9's record and confirmed there was a need for OT documented on her POC, however, the POC did not include the frequency of visits. During an interview on 12/02/15 at 3:45 PM, the DON reviewed Patient #9's record and confirmed there was a need for OT documented on the OT functional reassessment dated 11/18/15. The DON further confirmed the frequency of OT visits was not included on the POC for the certification period of 11/23/15 to 1/21/16. The agency failed to ensure Patient #9's POC included all pertinent information.	{G 159}	Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached)	
{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 2 of 8 patients (#6 and #11) whose SOC records were reviewed. This resulted in POCs that were developed and initiated without appropriate physician approval. Findings include: 1. Patient #6 was a 51 year old female admitted to the agency on 11/20/15, for SN and PT services related to recent joint replacement surgery. She was a current patient of the agency	{G 160}	APPENDIX - I	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 160}	<p>Continued From page 20 as of 12/03/15. Her record, including the POC, for the certification period 11/20/15 to 1/18/16, was reviewed.</p> <p>Patient #6's record included a PT evaluation dated 11/21/15, and signed by the Physical Therapist. Her record included a physician order form dated 11/21/15, stating "PT eval [evaluation] done week #1 and then HH PT 2x/wk for 8 weeks, or until goals are met. Per Nurses Voicemail on 11/21/15." It was followed by the initials of the administrator. The form did not include PT treatment or interventions. Additionally, it did not state a return phone call was received from the physician's office to approve the PT visits. Patient #6's POC was unsigned by the physician as of 12/03/15. However, PT visits were completed on 11/23/15, and 11/25/15, prior to physician approval of her POC.</p> <p>During an interview on 12/02/15 at 3:00 PM, the Administrator reviewed the record and stated he did not receive a call from Patient #6's physician to approve her PT POC.</p> <p>Patient #6's physician was not consulted to approve her PT POC and additional visits following the PT evaluation.</p> <p>2. Patient #11 was a 51 year old female admitted to the agency on 11/27/15, for SN and PT services related to recent joint replacement surgery. She was a current patient of the agency as of 12/03/15. Her record, including the POC, for the certification period 11/27/15 to 1/25/16, was reviewed.</p> <p>Patient #11's record included a PT evaluation</p>	{G 160}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	

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

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FORM APPROVED
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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 R 12/03/2015
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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 160}	<p>Continued From page 21</p> <p>dated 11/30/15, and signed by the Physical Therapist. Her record included a physician order form dated 11/30/15, stating "HH PT 4x/wk for 2 weeks, then reducing to 2x/wk for 2 more wks. Per voicemail at Dr. [name] office on 11/30/15:" It was followed by the initials of the administrator. The form did not include PT treatment or interventions. Additionally, it did not state a return phone call was received from the physician's office to approve the PT visits. Patient #11's POC was unsigned by the physician as of 12/03/15. However, PT visits were completed on 12/01/15, and 12/02/15, prior to physician approval of her POC.</p> <p>During an interview on 12/02/15 at 3:00 PM, the Administrator reviewed the record and stated he did not receive a call from Patient #11's physician to approve her PT POC.</p> <p>Patient #11's physician was not consulted to approve her PT POC and additional visits following the PT evaluation.</p>	{G 160}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	
{G 164}	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>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 RNs promptly alerted the physician to patients' status at the SOC that suggested a need to alter the plan of care for 1 of 8 patients (#6) whose SOC assessments were reviewed. This</p>	{G 164}		

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{G 164}	<p>Continued From page 22.</p> <p>resulted in missed opportunities for the physician to alter patients' POCs to meet their needs. Findings include:</p> <p>1. Patient #6 was a 51 year old female admitted to the agency on 11/20/15, for SN and PT services related to recent joint replacement surgery. She was a current patient of the agency as of 12/03/15. Her record, including the POC, for the certification period 11/20/15 to 1/18/16, was reviewed.</p> <p>Patient #6's record included a SOC comprehensive assessment completed on 11/20/15, and signed by the RN Case Manager. The assessment stated "Patient was delirious at the time of admit and stated that it was a side effect of the pain medication...SN noted that patient has uncontrolled pain and is sleepy." Additionally, the assessment stated Patient #6's pain was intractable (severe, constant pain that is unrelieved by current treatment.) The assessment rated her current pain as an 8 on a scale of 1 to 10.</p> <p>Patient #6's record did not include documentation of contact with her physician regarding her mental status and pain that was not relieved with her current pain medication regimen.</p> <p>During an interview on 12/01/15 at 6:25 PM, the RN Case Manager confirmed she did not contact Patient #6's physician to report her mental status or unrelieved pain.</p> <p>Patient #6's physician was not contacted regarding her altered mental status and unrelieved pain.</p>	{G 164}	<p>Teton Home Health</p> <p>Plan of Correction</p> <p>Provider # 137061</p> <p>Ref: 12/3/2015</p> <p>(See Attached)</p> <p>APPENDIX - I</p>	

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{G 176} {G 176}	<p>Continued From page 23</p> <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 1 of 9 patients (#6) who received SN services and whose nurses' visit notes 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>Patient #6 was a 51 year old female admitted to the agency on 11/20/15, for SN and PT services related to recent joint replacement surgery. She was a current patient of the agency as of 12/03/15. Her record, including the POC for the certification period, 11/20/15 to 1/18/16, was reviewed.</p> <p>Patient #6's record included a SOC comprehensive assessment completed on 11/20/15, and signed by the RN Case Manager. The assessment stated "Patient was delirious at the time of admit and stated that it was a side effect of the pain medication...SN noted that patient has uncontrolled pain and is sleepy." Additionally, the assessment stated Patient #6's pain was intractable (severe, constant pain that is</p>	{G 176} {G 176}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX - I</p>	

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{G 176} Continued From page 24
unrelieved by current treatment.) The assessment rated her current pain as an 8 on a scale of 1 to 10.

Patient #6's record did not include documentation of contact with her physician regarding her mental status and pain that was not relieved with her current pain medication regimen.

During an interview on 12/01/15 at 6:25 PM, the RN Case Manager stated Patient #6 described her mental status as delirious. She confirmed she did not document her assessment of Patient #6's mental status. Additionally, she confirmed she did not contact Patient #6's physician to report her mental status or unrelieved pain.

Patient #6's SOC assessment was not accurate to describe her mental status. Additionally, the RN failed to contact Patient #6's physician regarding her altered mental status and unrelieved pain.

{G 177} 484.30(a) DUTIES OF THE REGISTERED NURSE

The registered nurse counsels the patient and family in meeting nursing and related needs.

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 for 1 of 9 patients (#6) who received SN services and whose nurses' visit notes were reviewed. This created the potential for patients to experience adverse outcomes. Findings include:

{G 176}

Teton Home Health
Plan of Correction
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{G 177}

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{G 177}	<p>Continued From page 25</p> <p>Patient #6 was a 51 year old female admitted to the agency on 11/20/15, for SN and PT services related to recent joint replacement surgery. She was a current patient of the agency as of 12/03/15. Her record, including the POC, for the certification period 11/20/15 to 1/18/16, was reviewed.</p> <p>Patient #6's POC included the medication Eliquis, a blood thinner used to prevent blood clots after joint replacement surgery. The 2016 Nursing Drug Handbook stated Eliquis can cause serious, potentially fatal bleeding and patients should be instructed to report unusual bleeding, and take precautions to prevent bleeding and bruising.</p> <p>Patient #6's SN assessment and visit note dated 11/20/15, did not include documentation of patient education related to Eliquis and risk of bleeding. Her POC stated her next SN visit would be in 2 weeks. Therefore she did not receive important education related to risk of serious bleeding in the first 2 weeks of her home health services.</p> <p>During an interview on 12/01/15 at 6:25 PM, the RN Case Manager reviewed Patient #6's record and confirmed she did not provide education related to Eliquis and risk of bleeding during her initial visit. She stated she had not performed a second visit as of 12/01/15.</p> <p>The agency failed to ensure Patient #6 was educated regarding risks related to her medication.</p>	{G 177}	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: 12/3/2015 (See Attached) APPENDIX – I</p>	

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{N 000}	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Medicare follow up survey of your agency from 11/30/15 to 12/3/15. The surveyors conducting the follow up survey were: Nancy Bax, RN, BSN, HFS Dennis Kelly, RN, BSN, HFS	{N 000}	<p style="text-align: center;"><i>RECEIVED</i></p> <p style="text-align: center;"><i>DEC 28 2015</i></p> <p style="text-align: center;"><i>FACILITY STANDARDS</i></p> <p>Teton Home Health</p> <p>Plan of Correction</p> <p>Provider #137061</p> <p>Ref: 12/3/2015</p> <p>(See Attached)</p> <p>APPENDIX – II</p>	
{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}		
{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.	{N 022}		

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

TITLE

(X6) DATE

Administrator

12/27/15

Bureau of Facility Standards

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 R 12/03/2015
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{N 022}	Continued From page 1 This Rule is not met as evidenced by: Refer to G111	{N 022}	<p>Teton Home Health Plan of Correction Provider #137061 Ref: 12/3/2015 (See Attached) APPENDIX – II</p>	
N 023	03.07020. ADMIN. GOV. BODY N023 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.v. The HHA will only release information about a patient as required by law or authorized by a patient. This Rule is not met as evidenced by: Refer to G111	N 023		
{N 097}	03.07024. SK. NSG. SERV. N097 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: e. Prepares clinical and progress notes, and summaries of care; This Rule is not met as evidenced by: Refer to G176	{N 097}		
{N 099}	03.07024.SK. NSG. SERV. N099 01. Registered Nurse. A registered nurse assures that care is	{N 099}		

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{N 099}	Continued From page 2 coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: 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}	Teton Home Health Plan of Correction Provider #137061 Ref: 12/3/2015 (See Attached) APPENDIX – II	
{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 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:	{N 153}		

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{N 153}	Continued From page 3 Refer to G159	{N 153}		
{N 155}	03.07030. PLAN OF CARE N155- 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G159	{N 155}	Teton Home Health Plan of Correction Provider #137061 Ref: 12/3/2015 (See Attached)	
{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 G158	{N 161}	APPENDIX – II	
{N 170}	03.07030.04. PLAN OF CARE N170- 04. Initial Plan of Care. The initial plan of care and subsequent	{N 170}		

Bureau of Facility Standards

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{N 170}	Continued From page 4 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}	Teton Home Health	
{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}	Plan of Correction Provider #137061 Ref: 12/3/2015 (See Attached) APPENDIX – II	

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

G 101	<p><u>Action:</u> 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><u>Improved Process and Procedure:</u> 1. A mandatory in-service will be presented to inform the Clinical staff of the proper use and time frames of the NOMNC form, including the requirement to leave a copy of NOMNC with the patient. 2. HHA will obtain a new carbon-copy form of NOMNC, a copy of which will be left in the patient's home. 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><u>Completion Date:</u> In-service completed 12/21/2015. All necessary corrections and new procedures will be in place by 12/27/15.</p> <p><u>Monitoring and Tracking:</u> 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><u>Responsible Person:</u> Administrator and Director of Nursing will share the duty of final chart audits.</p>
G 111	<p><u>Action:</u> In-service staff on HHA PHI policy and procedure.</p> <p><u>Improved Process and Procedure:</u> In-Service for all employees completed. Specifically, all employees were reminded that HHA policy excludes the use of personal mobile devices for communicating PHI. Only agency approved mobile devices and methods, such as HHA owned and approved tablets and EMR containing the proper security mechanisms, are to be used for conducting patient care.</p> <p><u>Completion Date:</u> In-service and compliance was completed on 12/21/15. All necessary corrections and new procedures will be in place by 12/27/15.</p> <p><u>Monitoring and Tracking:</u> 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.</p> <p><u>Responsible Person:</u> Administrator</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 158. Refer to plan of correction G 159. Refer to plan of correction G 160 Refer to plan of correction G 164</p> <p>Responsible Person: DON</p>
G 158	<p>Action: HHA will review process to ensure that the plan of care for each patient is being followed correctly. In addition, HHA will purchase and implement a scheduling software to help manage the number of visits versus frequencies ordered.</p> <p>Improved Process and Procedure: In-service will be conducted and include training regarding the 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 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 completed by 12/28/15. All necessary corrections and new procedures will be in place by 12/27/15.</p> <p>Monitoring and Tracking: 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> <p>Completion Date: In-Services will be completed 12/28/15. All necessary corrections and new procedures will be in place by 12/27/15.</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>

G 159	<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 12/21/15. All necessary corrections and new procedures will be in place by 12/27/15.</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 due to changes in patients' status 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.</p> <p>Improved Process and Procedure: The 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 12/28/15. All necessary corrections and new procedures will be in place by 12/27/15.</p> <p>Monitoring and Tracking: Chart audits will assess for compliance any proposed changes to the Plan of Care will be reported to the physician in a timely manner. 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 176	<p>Action: The nurse case manager will review duties for timely contact of physician and other clinical 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 12/28/15. All necessary corrections and new procedures will be in place by 12/27/15.</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> <p>Completion Date: In-service will be completed 12/28/15. All necessary corrections and new procedures will be in place by 12/27/15.</p> <p>Monitoring and Tracking: 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>Responsible Person: Chart audits are the shared responsibility of the Administrator and the Director of Nursing.</p>

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TETON HOME HEALTH, PROVIDER #137061
PLAN OF CORRECTIONS
APPENDIX - II

N 015	Refer to plan of correction G 101
N 022	Refer to plan of correction G 111
N 023	Refer to plan of correction G 111
N 097	Refer to plan of correction G 176
N 099	Refer to plan of correction G 177
N 152	Refer to plan of correction G 158
N 153	Refer to plan of correction G 159
N 155	Refer to plan of correction G 159
N 161	Refer to plan of correction G 158
N 170	Refer to plan of correction G 160
N 172	Refer to plan of correction G 164