IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN– Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

June 4, 2019

Amy Mansfield, Administrator
Encompass Health Home Health Of Eastern Idaho
6688 N Central Expressway Suite 1300
Dallas, TX 75206

RE: Encompass Health Home Health Of Eastern Idaho, Provider #137105

Dear Ms. Mansfield:

On May 29, 2019, a follow-up visit of your facility, Encompass Health Home Health Of Eastern Idaho, was conducted to verify corrections of deficiencies noted during the survey of March 8, 2019.

We were able to determine that the Condition of Participation of **Condition of Participation of Care planning, coordination of services, and quality of care. (CFR 484.60)** is now met.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Home Health Agency into compliance, and that the Home Health Agency remains in compliance

with the regulatory requirements;

- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **June 17, 2019**, and keep a copy for your records.

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

Sincerely,

Dennis Kelly RN

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

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

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Sincerely,

Dennis Kelly RN

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137105	A. BUILDING _____ B. WING _____	R 05/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCOMPASS HEALTH HOME HEALTH OF EASTERN IDAHO	3686 WASHINGTON PARKWAY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS The following deficiencies were cited during the Medicare follow-up survey of your agency conducted on 5/28/19 to 5/29/19. Surveyors conducting the follow-up survey were: Nancy Bax, RN, BSN, HFS, Team Lead Brian Osborn, RN, HFS Acronyms used in this report include: ADL - Activities of Daily Living BID - Twice Daily CHF - Congestive Heart Failure CKD - Chronic Kidney Disease COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus HFS - Health Facility Surveyor HTN - Hypertension IADL - Instrumental Activities of Daily Living LMP - Liters per Minute LPN - Licensed Practical Nurse mg - Milligram MSW - Medical Social Worker OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy RN - Registered Nurse RNCM - Registered Nurse Case Manager SOC - Start of Care SN - Skilled Nursing ST - Speech Therapy VP - Vice President	{G 000}		
{G 572}	Plan of care CFR(s): 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan	{G 572}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] RN	Regional Administrator	6/12/19

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 572}	Continued From page 1 of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. 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 modifications to the original plan. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patients received PT services in accordance with an individualized plan of care for 1 of 4 patients (Patient #6) who received PT services and whose records were reviewed. This had the potential to interfere with the quality of patient care. Findings include: Patient #6 was an 84 year old female admitted to the agency on 5/08/19, with a primary diagnosis of CHF. Additional diagnoses included muscle weakness, insulin dependent DM, and dementia. She received SN, PT, and OT services. Her record, including the POC, for the certification period 5/08/19 to 7/06/19, was reviewed. Patient #6's record included a PT evaluation, dated 5/09/19, signed by the Physical Therapist. Her record included a PT POC with interventions, goals, and frequency of PT visits, dated 5/09/19, signed by the Physical Therapist. The POC included PT visits 1 time a week for 1 week, then 2 times a week for 6 weeks, effective 5/08/19. Patient #6's record did not include documentation of communication with her physician to obtain approval of her PT POC.	{G 572}		

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{G 572}	Continued From page 2 Patient #6's record did not include PT visits between 5/09/19 and 5/21/19. The first PT visit completed after the PT evaluation was on 5/21/19. Patient #6 did not receive 2 PT visits during the week of 5/12/19 to 5/18/19, as ordered on her POC. Patient #6's PT POC stated it was "APPROVED/PROCESSED" by a Clinical Operations RN on 5/17/19, 8 days after it was signed by the Physical Therapist. It was signed by her physician on 5/21/19. The Regional Administrator, Branch Director, and VP of Regulatory Affairs were interviewed together on 5/29/19 at 8:40 AM. They reviewed Patient #6's record, and confirmed there was no communication with her physician to obtain verbal approval of her PT POC. They stated the order for the PT POC could not be sent to her physician for signature until it was approved by the Clinical Operations RN. The Regional Administrator, Branch Director, and VP of Regulatory Affairs were unable to determine the reason for the 8 day delay in approving the PT POC order, that resulted in the delay in implementing Patient #6's PT POC. The agency failed to obtain physician approval of Patient #6's PT POC, resulting in a delay in implementation of PT visits.	{G 572}		
{G 574}	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and	{G 574}		

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{G 574}	Continued From page 3 cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This ELEMENT is not met as evidenced by: Based on observation, medical record review, and patient caregiver and staff interview, it was determined the agency failed to ensure POCs were individualized and inclusive of required content for 4 of 6 patients (#1, #2, #3, and #4) whose records were reviewed. This resulted in inaccurate and/or incomplete POCs that did not address all of the individualized needs of patients. Findings include: 1. Patient #1 was a 72 year old female admitted to the agency on 5/10/19, with a primary diagnosis of left breast infection. Additional	{G 574}		

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{G 574}	Continued From page 4 diagnoses included HTN. She received SN services. Her record, including the POC, for the certification period 5/10/19 to 7/08/19, was reviewed. Patient #1's record included an SOC comprehensive assessment, dated 5/10/19, signed by the RNCM. The assessment stated Patient #1 complained of left breast pain that ranged from 6 to 8 on a scale of 0 to 10, with 10 being the worst pain. She stated the pain was present all of the time, and increased with any movement. Patient #1's POC did not include interventions to assess or treat her pain. The Regional Administrator, Branch Director, and VP of Regulatory Affairs were interviewed together on 5/29/19 at 8:22 AM. They reviewed Patient #1's POC and confirmed it did not include interventions to assess or treat her pain. Patient #1's POC did not include interventions to address or treat her pain. 2. Patient #4 was a 65 year old female admitted to the agency on 5/11/19, with a primary diagnosis of infected abdominal wound. Additional diagnoses included pulmonary emboli, malignant melanoma, and HTN. She received SN, PT, and OT services. Her record, including the POC, for the certification period 5/11/19 to 7/09/19, was reviewed Patient #4's POC included an order for Hydrochlorthiazide 25 mg to be taken daily if she gained 3 pounds in 24 hours. Her POC did not include an order for daily weights, to determine a weight gain of 3 pounds in 24 hours. It did not include an order to educate Patient #4 to weigh	{G 574}		

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{G 574}	Continued From page 5	{G 574}		

herself daily. Patient #4's record did not include documentation of her weight after her SOC assessment.

The Regional Administrator, Branch Director, and VP of Regulatory Affairs were interviewed together on 6/29/19 at 8:15 AM. They reviewed Patient #4's record and confirmed her POC did not include orders for daily weights or patient education regarding daily weights.

Patient #4's POC did not include interventions to address her need for daily weights.

3. Patient # 2 was an 80 year old female admitted to the agency on 5/11/19, with a primary diagnosis of hemiplegia following a CVA. Additional diagnoses included epilepsy, aphasia, depression, and CKD. She received SN, PT, and ST services. Her record, including the POC, for the certification period 5/11/19 to 7/09/19, was reviewed.

a. A PT visit was observed in Patient #2's home on 5/28/19, from 2:54 PM to 3:42 PM. During the visit, the Physical Therapist performed a medication reconciliation and identified the following discrepancy regarding Patient #2's Eliquis (a blood thinning medication). Patient #2's agency medication profile and POC stated she was taking Eliquis 1/2 tab BID. However, Patient #2's prescription instructions (dated 5/10/19) for Eliquis, located on the medication bottle, stated to take 1 tab BID.

Patient #2's daughter, who was present for the visit, stated she did not want her mother to take 1 tab of Eliquis BID because "she would bleed out."

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{G 574}	Continued From page 6 When asked if the RNCM reconciled Patient #2's medications on the SN SOC comprehensive assessment visit on 5/11/19, Patient #2's daughter stated "I believe so." The RN who performed Patient #2's SN SOC comprehensive assessment on 5/11/19, was interviewed on 5/28/19, beginning at 4:23 PM. When asked if she performed a medication reconciliation for Patient #2, the RN stated "yes." When asked if she compared Patient #2's medication bottles against her agency medication profile, the RN stated she believed so, but "couldn't remember for sure." The RN stated it was difficult to "get medications right" because patients disclosed new medications every visit. The Regional Administrator and VP of Regulatory Affairs were interviewed together on 5/28/19, beginning at 4:50 PM, and Patient #2's medical record was reviewed in their presence. The Regional Administrator confirmed Patient #2's Eliquis prescription did not match her agency medication profile or POC. Patient #2's medications were not accurate on her POC. b. Patient #2's medical record included a "Discharge Instructions/Order [hospital name]" form from a local acute care hospital, dated 5/10/19, signed by her hospital physician, which stated: "Oxygen Therapy...I have met face-to-face with the patient and assessed patient requirement for supplemental oxygen. Oxygen Use Diagnosis...hypoventilation	{G 574}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	R 05/29/2019

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{G 574}	Continued From page 7	{G 574}		

Oxygen Requirement: 2 LPM"

Patient #2's agency medication profile and POC did not include oxygen.

A PT visit was observed in Patient #2's home on 5/28/19, from 2:54 PM to 3:42 PM. During the visit, it was noted Patient #2 did not have portable oxygen tanks or an oxygen concentrator.

The RN who performed Patient #2's SN SOC comprehensive assessment on 5/11/19, was interviewed on 5/28/19, beginning at 4:23 PM. When asked if she performed a medication reconciliation for Patient #2, the RN stated "yes." When asked why Patient #2 did not have her physician ordered oxygen, the RN stated there was confusion as to whether she qualified for oxygen. When asked if she contacted Patient #2's home health physician to clarify the oxygen order from the acute care hospital physician, the RN stated "no."

The Regional Administrator and VP of Regulatory Affairs were interviewed together on 5/28/19, beginning at 4:50 PM, and Patient #2's medical record was reviewed in their presence. The Regional Administrator confirmed Patient #2's prescribed oxygen should have been clarified with her home health physician and that her agency medication profile and POC were incorrect.

Patient #2's medications were not accurate on her POC.

4. Patient #3 was a 91 year old female admitted to the agency on 5/10/19, with a primary diagnosis of left toe cellulitis. Additional

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{G 574}	Continued From page 8 diagnoses included COPD and CKD. She received SN and MSW services. Her record, including the POC, for the certification period 5/10/19 to 7/08/19, was reviewed. Patient #3's medical record included an SN SOC comprehensive assessment, dated 5/10/19, signed by her RNCM, which stated: "TOTAL NUTRITION ASSESSMENT SCORE: 3 BASED ON THE SCORE, THE NUTRITIONAL RISK LEVEL IS: PATIENT IS AT MODERATE NUTRITIONAL RISK" Patient #3's medical record included a POC, dated 5/16/19, signed by her physician. Her POC did not include interventions or goals for her moderate nutritional risk. The Regional Administrator, Branch Director, and VP of Regulatory Affairs were interviewed together on 5/29/19, beginning at 8:52 AM, and Patient #3's medical record was reviewed in their presence. The Regional Administrator confirmed Patient #3's POC did not include interventions or goals regarding her moderate nutritional risk. Patient #3's POC was not complete.	{G 574}		
{G 584}	Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a	{G 584}		

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(G 584)	Continued From page 9	(G 584)		

physician's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician in accordance with applicable state laws and regulations, as well as the HHA's internal policies.
This ELEMENT is not met as evidenced by:
Based on medical record review and staff interview, it was determined the agency failed to ensure verbal orders were documented in the patient's record for 1 of 6 patients (Patient #1) whose records were reviewed. This failure had the potential to negatively impact coordination and clarity of patient care. Findings include:

Patient #1 was a 72 year old female admitted to the agency on 5/10/19, with a primary diagnosis of left breast infection. Additional diagnoses included HTN. She received SN services. Her record, including the POC, for the certification period 5/10/19 to 7/08/19, was reviewed.

a. Patient #1's record included an SN visit note, dated 5/11/19, signed by the RNCM. The note stated Bacitracin (antibiotic ointment) was applied to her left breast wound per doctor's order. Patient #1's record included a physician's verbal order for wound care that included Bacitracin to her wound. The order was dated 5/14/19, 3 days after the RNCM first used Bacitracin for her wound care.

The Regional Administrator, Branch Director, and VP of Regulatory Affairs were interviewed

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{G 584}	Continued From page 10	{G 584}		

together on 5/29/19 at 8:22 AM. They confirmed the order for Bacitracin was dated 5/14/19, 3 days after it was implemented by the RNCM. The Regional Administrator stated the RNCM received the verbal order from Patient #1's physician on 5/11/19, but failed to enter it into her record until 5/14/19. She confirmed the verbal order did not include the date it was received from Patient #1's physician.

Patient #1's RNCM failed to accurately document a physician's verbal order.

b. Patient #1's record included an SOC comprehensive assessment, dated 5/10/19, signed by the RNCM. The assessment documented 1 wound to Patient #1's left breast. Her record included an SN visit note, dated 5/19/19, signed by a different RN. The note documented a second wound to Patient #1's left breast, and stated wound care was completed to both wounds. Patient #1's record did not include a physician's order for care of her second breast wound.

The Regional Administrator, Branch Director, and VP of Regulatory Affairs were interviewed together on 5/29/19 at 8:22 AM. The VP of Regulatory Affairs reviewed Patient #1's record and stated there was a communication note that stated her physician was contacted and a verbal order was received to treat the second breast wound with the same protocol as the original breast wound. The VP of Regulatory Affairs confirmed the physician's order was not documented in Patient #1's record, to be sent to her physician for signature.

The RN failed to document a wound care order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137105	A. BUILDING _____ B. WING _____	R 05/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCOMPASS HEALTH HOME HEALTH OF EASTERN IDAHO	3686 WASHINGTON PARKWAY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 584}	Continued From page 11 received from Patient #1's physician.	{G 584}		
{G 606}	Integrate all services CFR(s): 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure coordination of patient care for 1 of 6 patients (Patient #3) whose records were reviewed. This had the potential for missed opportunities to adjust the POC. Findings include: Patient #3 was a 91 year old female who was admitted on 5/10/19, with a primary diagnosis of left toe cellulitis. Additional diagnoses included COPD and CKD. She received SN and MSW services. Her record, including the POC, for the certification period of 5/10/19 to 7/08/19, was reviewed. Patient #3's medical record included SN visit notes, dated 5/18/19 and 5/19/19, signed by a weekend RN, which stated: "INDICATE BEHAVIORAL ASSESSMENT FINDINGS: 0 - MEMORY DEFICIT: FAILURE TO RECOGNIZE FAMILIAR PERSONS/PLACES, INABILITY TO RECALL EVENTS OF PAST 24 HOURS, SIGNIFICANT MEMORY LOSS SO THAT SUPERVISION IS REQUIRED	{G 606}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137105	A. BUILDING _____ B. WING _____	R 05/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCOMPASS HEALTH HOME HEALTH OF EASTERN IDAHO	3686 WASHINGTON PARKWAY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 606}	Continued From page 12 1 - IMPAIRED-DECISION MAKING: FAILURE TO PERFORM USUAL ADLS OR IADLS, INABILITY TO APPROPRIATELY STOP ACTIVITIES, JEOPARDIZES SAFETY THROUGH ACTIONS" The weekend RN did not document if she contacted Patient #3's RNCM regarding her assessment findings. Prior to these 2 SN visits, Patient #3 had SN visits on 5/10/19, 5/11/19, 5/12/19, 5/13/19, 5/15/19, 5/16/19, and 5/17/19. These 7 SN visit notes described Patient #3's mental status as: "ALERT ORIENTED TO PERSON ORIENTED TO TIME ORIENTED TO PLACE" The Regional Administrator, Branch Director, and VP of Regulatory Affairs were interviewed together on 5/29/19, beginning at 8:52 AM, and Patient #3's medical record was reviewed in their presence. The Regional Administrator confirmed the weekend RN did not document if she contacted Patient #3's RNCM regarding her assessment findings. The weekend RN failed to coordinate care with Patient #3's RNCM.	{G 606}		

G572 Plan of Care
CFR(s): 484.60(a)(1)

29 May 2019

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

Implementation of Plan:

The current process for reviewing the Plan of Care was evaluated by the management team. After evaluation it was determined to move to the a more efficient, effective back office support system. The current PRQI plan of care reviewing process will be eliminated and replaced with the CTL (clinical team lead) position. This will bring all plan of care review into each individual office. The new CTL position objective is as follows:
The clinical team lead ensures the overall coordination of home health services provided to all clients is delivered according to acceptable standards of practice. The CTL is responsible for the electronic review and approval of all patient information submitted by the licensed professional (LP) during Start of Care, Recertification, Resumption of Care, or Evaluation visit. The CTL assists with Case Conference, reviews and approves orders, in addition to providing oversite of patient care. The CTL is responsible for assisting the Branch Director with day-to-day office and staff management related to patient care and assists the Branch Director to provide ongoing education and training to all branch clinicians to ensure understanding of documentation requirements to meet regulatory standards. The CTL contributes to the overall company success of providing A Better Way to Care by effectively facilitating the relationship between physicians, referral sources, patients, caregivers, and employees. The CTL follows all procedures as outlines in the Standard Operating Procedure.

Planned In Service:

Training of current/new CTL staff began 5/28/2019. This consisted of Specific OASIS guidance training, ICD-10 coding review training, and packet review training. Training is being completed using Webinars, training videos, and one on one plan of care training. Training will be completed and implemented by 6/30/2019 and the CTL model will be fully implemented.

Follow up:

Implementation will occur by June 30, 2019. All training and in services will be completed by that date.

Compliance:

Compliance will be met on or before June 30, 2019. The new structure will be evaluated with the assistance of the Regional Administrator or designee, with ongoing Plan of care Audits of at least 20%. Continuing training and evaluation of Positions. If 90% compliance is not met re-education will be completed with disciplinary action as appropriate.

G574 Plan of care must include the following:
CFR(s): 484.60(a)(2)(i-xvi)

29 May 2019

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

Implementation of Plan:

The current process for reviewing the Plan of Care was evaluated by the management team. After evaluation it was determined to move to the a more efficient, effective back office support system. The current PRQI plan of care reviewing process will be eliminated and replaced with the CTL (clinical team lead) position. This will bring all plan of care review into each individual office. The new CTL position objective is as follows:
The CTL position will allow for the same support RN to follow the patient through the process from referral through discharge. The CTL will be responsible for reviewing the referral information, reviewing with the Branch Director to ensure the agency's ability to care for the patient, review of all orders, plan of care, coordination notes and all subsequent orders. This will ensure all pertinent patient information is reviewed and added to the Plan of care for adequate follow up and care of the patient.

Planned In Service:

Training of current/new CTL staff began 5/28/2019. This consisted of Specific OASIS guidance training, ICD-10 coding review training, and packet review training. Training is being completed using Webinars, training videos, and one on one plan of care training. CTL training will also include current CFSS process including but not limited to, coordination of care, case conference preparation, physician order review, physician and staff communication. Training will be completed and implemented by 6/30/2019 and the CTL model will be fully implemented.

Follow up:

Implementation will occur by June 30, 2019. All training and in services will be completed by that date.

Compliance:

Compliance will be met on or before June 30, 2019. The new structure will be evaluated with the assistance of the Regional Administrator or designee, with ongoing Plan of care Audits of at least 20%. Continuing training and evaluation of Positions. If 90% compliance is not met re-education will be completed with disciplinary action as appropriate.

G584 Verbal Orders
CFR(s): 484.60(b)(3)(4)

29 May 2019

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

Implementation of Plan:

The current process for CFSS (Clinical Field Staff Supervisor) back office support was evaluated by the management team. After evaluation it was determined to move to the a more efficient, effective back office support system. The current PRQI/CFSS back office support position will be eliminated and replaced with the CTL (clinical team lead) position. This will bring all back-office support tasks to the local office to be completed for each patient by the same RN from the time of referral to the time of discharge from the agency. This will ensure continuity and improvement of patient care. The new CTL position objective is as follows:
The CTL position will allow for the same support RN to follow the patient through the process from referral through discharge. The CTL will be responsible for reviewing the referral information, reviewing with the Branch Director to ensure the agency's ability to care for the patient, review of all orders, plan of care, coordination notes and all subsequent orders. The CTL will be responsible for reviewing each coordination note, and physician verbal orders to ensure that verbal orders are documented and implemented effectively.

Planned In Service:

Training of current/new CTL staff began 5/28/2019. This consisted of Specific OASIS guidance training, ICD-10 coding review training, and packet review training. Training is being completed using Webinars, training videos, and one on one plan of care training. CTL training will also include current CFSS process including but not limited to, coordination of care, case conference preparation, physician order review, physician and staff communication. Training will be completed and implemented by 6/30/2019 and the CTL model will be fully implemented.

Follow up:

Implementation will occur by June 30, 2019. All training and in services will be completed by that date.

Compliance:

Compliance will be met on or before June 30, 2019. The new structure will be evaluated with the assistance of the Regional Administrator or designee, with ongoing Plan of care Audits of at least 20%. Continuing training and evaluation of Positions. If 90% compliance is not met re-education will be completed with disciplinary action as appropriate.

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

29 May 2019

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

Implementation of Plan:

The current process for ensuring continuity of care between clinicians. After evaluation it was determined to move to the a more efficient, effective back office support system. The current CFSS process will be eliminated and replaced with the CTL (clinical team lead) position. The new CTL position objective is as follows:
The CTL position will allow for the same support RN to follow the patient through the process from referral through discharge. The CTL will be responsible for reviewing the referral information, reviewing with the Branch Director to ensure the agency's ability to care for the patient, review of all orders, plan of care, coordination notes and all subsequent orders. This will ensure all pertinent patient information is reviewed and added to the Plan of care for adequate follow up and care of the patient.
The Coordination notes from each weekend and evening will be reviewed by the CTL. All on-call coordination notes will be reviewed each morning to ensure Case Manager and clinical team is aware of any changes, needs to be followed up on. Education of coordination of services will be on-going through Case Conference, Case manger meetings, and staff meetings.

Planned In Service:

Training of Coordination of services will be completed on or before 6/30/2019. Training will to include, implementation of CTL process, Coordination of Services training for all staff through individual clinical meetings.

Follow up:

Implementation will occur by June 30, 2019. All training and in services will be completed by that date.

Compliance:

Compliance will be met on or before June 30, 2019. On-going audits of coordination of services to be completed by the Branch Director and Regional Administrator or designee until 100% compliance is achieved. If 100% compliance is not achieved re-education will occur with disciplinary action taken as appropriate.