



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0099  
PHONE 208-334-6626  
FAX 208-364-1688

**CERTIFIED MAIL: 7007 0710 0002 7979 0901**

January 12, 2011

Christopher Weston, Administrator  
Teton Home Health  
3101 Valencia Drive  
Idaho Falls, ID 83404

**RECEIVED**

JAN 25 2011

**FACILITY STANDARDS**

RE: Teton Home Health, Provider #137061

Dear Mr. Weston:

Based on the survey completed at Teton Home Health, on January 5, 2011, by our staff, we have determined Teton Home Health is out of compliance with the Medicare Home Health Agency (HHA) **Conditions of Participation on Acceptance of Patients, Plan of Care, and Medical Supervision (42 CFR 484.18)** and **Comprehensive Assessment of Patients (42 CFR 484.55)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;

Christopher Weston, Administrator  
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- 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 each form.

**Such corrections must be achieved and compliance verified by this office, before February 19, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than February 11, 2011.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **January 25, 2011.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

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.

Sincerely,



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

TH/srm  
Enclosures  
cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief  
Kate Mitchell, CMS Region X Office



January 24, 2011

SYLVIA CRESWELL, Co-Supervisor  
Non-Long Term Care Section  
Bureau of Facility Standards  
P.O. Box 83720  
3232 Elder Street  
Boise, ID 83720-0036

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 January 5, 2011. You will find the letter split in two sections with Appendix: I & II explaining our corrective measures.

Please don't hesitate to contact us with any questions.

Kind regards,

**Chris Weston**  
Administrator  
**Teton Home Health**  
3101 Valencia Dr.  
Idaho Falls, ID 83404  
208.529.3636 - Office  
208.528.6562 - Fax

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JAN 25 2011  
**FACILITY STANDARDS**

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

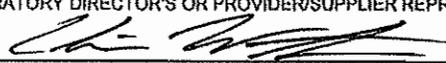
PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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  01/05/2011
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NAME OF PROVIDER OR SUPPLIER  TETON HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 3101 VALENCIA DRIVE 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
G 000	INITIAL COMMENTS  The following deficiencies were cited during the recertification survey of your home health agency.  The surveyors conducting the survey were:  Teresa Hamblin, RN, MS, HFS Team Leader Susan Costa, RN, HFS  Acronyms used in this report include:  BG - Blood Glucose BSW - Baccalaureate Social Work CHF- Congestive Heart Failure COPD- Chronic Obstructive Pulmonary Disease C-PAP- Continuous Positive Airway Pressure DME- Durable Medical Equipment DON- Director of Nurses HHA - Home Health Agency IV- Intravenous LMSW - Licensed Master's Social Worker LPN - Licensed Practical Nurse LSW- Licensed Social Worker MD- Medical Doctor MS- Multiple Sclerosis MSW- Master's Social Worker PA- Physician Assistant POC - Plan of Care PRN - As Needed PT- Physical Therapy RN - Registered Nurse SOC- Start of Care SN- Skilled Nurse	G 000	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  (See Attached) <b>APPENDIX - I:</b>	
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 156		

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JAN 25 2011  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1/24/2011
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 156	Continued From page 1 This CONDITION is not met as evidenced by: Based on record review, staff interview, and a patient interview, it was determined the agency failed to ensure plans of care covered all appropriate items, failed to alert physicians to falls, and failed to ensure all written plans of care were authorized by a physician. These failures had the potential to interfere with quality, completeness, coordination, and safety of patient care. Findings include:  1. Refer to G158 as it relates to the agency's failure to ensure a physician established and reviewed the written plan of care.  2. Refer to G159 as it relates to the agency's failure to ensure the plan of care covered all appropriate items.  3. Refer to G164 as it relates to the agency's failure to alert the physician to patients' falls.  The cumulative effects of these negative practices seriously impeded the ability of the agency to provide services of adequate quality.	G 156	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - I:</b>		
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 review of clinical records and interviews with HHA staff, it was determined that the agency failed to ensure a physician established and reviewed the written plan of care for 1 of 12 patients (#6) whose records were reviewed. This	G 158			

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G 158	Continued From page 2 resulted in the agency providing services without appropriate physician oversight. It had the potential to negatively impact quality and safety of patient care. Findings include:  Patient #6 was an 87 year old female with a SOC of 9/10/10. Her primary diagnosis was uncontrolled type 2 diabetes, macular degeneration, and chronic kidney disease. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/09/10 to 1/07/11, was signed by a physician's assistant, and not a physician.  In an interview on 12/16/10 at 9:30 AM, the DON confirmed the plan of care had been signed by a PA and should have been signed by a physician. She stated the previous "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 9/10/10 to 11/08/10 had been signed by a physician.  The facility failed to ensure the POC was signed by a physician.	G 158	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - I:</b>		
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:	G 159			

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G 159	<p>Continued From page 3</p> <p>Based on patient interview, medical record review, and staff interview it was determined the agency failed to ensure the plan of care covered all appropriate items for 11 of 12 patients, (#1, #2, #3, #4, #5, #6, #7, #8, #9, #11, and #12) whose records were reviewed. This failure had the potential to impede or delay the ability of the patient to attain his or her highest practicable functional capacity as well as the ability to evaluate patient outcome. Findings include:</p> <p>1. Patient #8 was a 92 year old male with a SOC of 8/31/10. His primary diagnosis was Vitamin B deficiency, with additional diagnoses of atrial fibrillation, testicular hypofunction, and depression. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/30/10 to 12/28/10, directed the SN to assess Patient #8 for pain with each visit, and instruct the patient in proper use of pain medication for safety. Patient #8's plan of care did not include a diagnosis related to pain, and the medications listed did not include pain medications.</p> <p>The plan of care also included instructions for the SN to observe and assess the patient for chest pain, and noted the use of nitroglycerin. The nitroglycerin was not included in the medications listed on the plan of care.</p> <p>The plan of care did not reflect an update or revision of goals, as the date of goals was the same as on the initial certification period of 10/29/10, and were identical in wording. The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #8 was not receiving IV therapy.</p>	G 159	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>

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G 159	<p>Continued From page 4</p> <p>In an interview on 12/17/10 at 10:00 AM, the DON reviewed the record of Patient #8 and stated the DME and supplies listed were a result of a software program issue that was prepopulated with the items listed. She stated the case manager was able to list additional supplies, but the needle, solution, syringe, and tape was listed for all patients. The DON was unable to explain why the nitroglycerin was not listed in the medication area of the plan of care. She provided a list from the pharmacy of medications that Patient #8 was reported to be taking. The medication list provided by the pharmacy was different from the plan of care medication list, and included nitroglycerin, as well as, multiple pain medications.</p> <p>The POC did not include all medications and included supplies not needed by Patient #8.</p> <p>2. Patient #2 was an 87 year old female with a SOC of 11/04/10. Her primary diagnosis was type 2 diabetes, malaise and fatigue, COPD, and arthropathy. Patient #2 was receiving nursing visits, home health aide services to assist with bathing, and physical therapy services to assist with mobility. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/04/10 to 1/02/11, indicated Patient #2 was to take medications as ordered for pain, although there was no pain medication listed on the POC. The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #2 was not receiving IV therapy.</p> <p>In an interview on 12/16/10 at 10:20 AM, the DON confirmed Patient #2 had no orders for pain medications, and confirmed there was no</p>	G 159	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	

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G 159	<p>Continued From page 5</p> <p>direction for the staff that provided care to Patient #2 to monitor her vital signs and oxygen saturations. The DON stated the DME and supplies listed were a result of a software program issue that was prepopulated with the items listed. She stated the case manager was able to adapt the list for additional supplies, but the needle, solution, syringe, and tape was initially listed for all patients.</p> <p>Patient #2's plan of care included supplies she did not need, instructed her to take pain medications when none was ordered for her, and did not include when and by whom her oxygen levels were to be monitored.</p> <p>3. Patient #6 was an 87 year old female with a SOC of 9/10/10. Her primary diagnoses was uncontrolled type 2 diabetes, macular degeneration, and chronic kidney disease. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/09/10 to 1/07/11 listed included IV supplies, needle and solution, syringe, and tape, although Patient #6 was not receiving IV therapy.</p> <p>In an interview on 12/16/10 at 9:30 AM, the DON stated the DME and supplies listed were a result of a software program issue that was prepopulated with the items listed. She stated the case manager was able to adapt the list for additional supplies, but the needle, solution, syringe, and tape was initially listed for all patients.</p> <p>The POC listed supplies not needed by Patient #6.</p> <p>4. Patient #7 was a 52 year old female with a</p>	G 159	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX -I:</b></p>		

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G 159	<p>Continued From page 6</p> <p>SOC of 12/07/10. Her primary diagnosis was open wound, with additional diagnoses of chronic depression, type 2 diabetes, morbid obesity, and CHF. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 12/07/10 to 2/04/11, directed the SN to instruct Patient #7 how to take her pulse and about alterations in rate and rhythm to report to MD. There was no indication on the plan of care that Patient #7 had a history of abnormal heart rate. The plan of care medication list included pain medications Methadone and Oxycodone, however, there was no nursing intervention included to address pain management. Patient #7 was on multiple antidepressant medications, however, the POC did not include nursing interventions that included assisting the patient with management of depression. The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #7 was not receiving IV therapy. Nursing interventions also included that Patient #7 demonstrate use of oxygen, although oxygen was not listed on the DME or the medication list.</p> <p>In an interview on 12/16/10 at 12:00 PM, the DON reviewed the medical record of Patient #7, and confirmed the plan of care did not address the depression, pain management, and cardiac rhythm assessment. The DON stated the nurse had designed the plan of care to address the open wound for which the primary diagnosis listed. The DON stated the DME and supplies listed was a software program issue that was prepopulated with the items listed. She stated the case manager would be able to list additional supplies, but the needle, solution, syringe, and tape was initially listed for all patients.</p>	G 159	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>

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G 159	<p>Continued From page 7</p> <p>The facility failed to ensure the plan of care was inclusive of all pertinent diagnosis and interventions.</p> <p>5. Patient #1 was a 90 year old male with a SOC of 9/01/10. His primary diagnosis was dehydration, with additional diagnoses listed as prostate cancer, Alzheimer's disease, hypertension, and generalized muscle weakness.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/31/10 to 12/29/10, indicated Patient #1 was to be observed and assessed every nursing visit for signs and symptoms of depression and mood. Patient #1's medications included Seroquel SR, which is a medication used for schizophrenia or bipolar disorders. The diagnoses of depression, schizophrenia, or bipolar disorder were not included on the POC.</p> <p>In an interview on 12/17/10 at 10:00 AM, the DON confirmed Patient #1's record did not include a diagnosis which reflected his mental status and included his need for antipsychotic medication.</p> <p>6. Patient #9 was a 67 year old female with a SOC of 11/08/10. Her primary diagnosis was renal failure, hypotension, type 2 diabetes, muscle weakness, and hyperpotassemia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/08/10 to 1/06/11, directed the SN to notify the physician for oxygen saturations of 86% or less while on oxygen, although the plan of care did not indicate Patient #9 was on oxygen in the medications or the DME and supplies listed.</p> <p>Reviewing the medications listed on the plan of</p>	G 159	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	
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G 159	<p>Continued From page 8</p> <p>care, it was discovered Patient #9 was on medications for glaucoma, as well as, on medications for multiple sclerosis, although those diagnoses were not listed on the plan of care. The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #9 was not receiving IV therapy.</p> <p>In an interview on 12/17/10 at 10:45 AM, the DON reviewed the medical record of Patient #9 and stated the DME and supplies listed was a software program issue that was prepopulated with the items listed. She stated the case manager was able to list additional supplies, but the needle, solution, syringe, and tape was listed for all patients. The DON confirmed the medications listed on the plan of care indicated Patient #9 had MS, as well as, glaucoma, and was unable to explain why the case manager did not include those diagnosis on the plan of care.</p> <p>The facility failed to ensure the plan of care incorporated the comprehensive assessment and medication review.</p> <p>7. Patient #12 was a 21 year old female with a SOC of 10/22/10. Her primary diagnosis was general muscle weakness, neuromyelitis optica, paralysis, and gastroparesis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/22/10 to 12/20/10 instructed the SN to "cleanse site with NS (normal saline)/ gauze....cover with duoderm until healed."</p> <p>The plan of care did not include a diagnosis of a wound. The plan of care listed methadone, but there was no diagnosis or interventions for pain management.</p>	G 159	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>

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G 159	<p>Continued From page 9</p> <p>The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #12 was not receiving IV therapy.</p> <p>In an interview on 12/17/10 at 1:30 PM, the DON stated Patient #12 was referred for wound care only, and confirmed the plan of care did not provide a comprehensive needs plan for Patient #12. The DON reviewed the record of Patient #12 and stated the DME and supplies listed was a software program issue that was prepopulated with the items listed. She stated the case manager was able to list additional supplies, but the needle, solution, syringe, and tape was listed for all patients.</p> <p>The facility failed to include medications and treatments, equipment required, pertinent diagnosis, and the interventions required to ensure a measurable goal for each patient.</p> <p>8. Patient #3 was a 51 year old female admitted to the agency on 9/15/10 primarily for wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/14/10 to 1/12/11, lacked internal consistency and completeness. While the POC stated SN orders were for 3 x per week for 9 weeks, the POC also stated SN would assess and change the dressing to the right hip on a daily basis (a discrepancy of 4 x per week). While a goal was listed for Patient #3 to gain or maintain her weight of 90 lbs, there was no intervention listed to assess Patient #3's weight. While a goal was listed to control Patient #3's pain at a level of 4 or less, there was no intervention listed to assess Patient #3's rating of pain. During an interview on</p>	G 159	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/05/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TETON HOME HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3101 VALENCIA DRIVE IDAHO FALLS, ID 83404</b>
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G 159	<p>Continued From page 10</p> <p>12/15/10 at 4:25 PM, the DON reviewed the record and confirmed the findings.</p> <p>During a home visit on 12/15/10 beginning at 11:00 AM, the visiting RN was observed to change a dressing and gripper at a port-a-cath site (a site where a port is installed beneath the skin to allow venous access) on Patient #3's upper left chest area. The procedure was not included on Patient #3's POC. The visiting RN was interviewed immediately following the visit. She stated she had been doing the procedure since the SOC (9/15/10) and considered it a standard of practice and did not realize it was necessary to put it on the POC.</p> <p>The POC was incomplete and inconsistent.</p> <p>9. Patient #4 was a 72 year old male admitted to the agency on 11/29/10 for post-stroke care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/29/10 to 01/27/10 was incomplete. "Hypertension" was listed as a pertinent diagnosis. However, there was no corresponding intervention, such as monitoring blood pressure, to address the diagnosis. There were orders for an Aide 3 x per week for 8 weeks. However, the plan did not indicate type of aide services to be performed, such as bathing assistance. "IV Supplies" were listed under "DME and Supplies." However, there was no indication Patient #4 was on IV therapy. During an interview on 12/15/10 at 4:00 PM, the DON reviewed the record and confirmed the findings.</p> <p>The POC was incomplete.</p> <p>10. Patient #5 was a 49 year old diabetic male</p>	G 159	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	
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G 159	<p>Continued From page 11</p> <p>admitted to the agency on 6/27/10 primarily for wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 10/25/10 to 12/23/10, was incomplete. Orders for physical therapy did not include the frequency of treatment. The POC did not include reporting parameters for blood glucose. A goal for the client to be compliant with performing 4 x per day accuchecks (blood glucose monitoring) did not include corresponding SN interventions to assess Patient #5 for compliance with blood sugar monitoring. The POC did not include patient use of C-PAP (a device for treating sleep apnea) although nursing documentation on 12/06/10 at 11:45 AM indicated Patient #5 used C-PAP at night. A section, "DME and Supplies," included "IV Supplies" although Patient #5 was not on IV medications. During an interview on 12/16/10 at 11:15 AM, the DON reviewed the POC. She stated the PT frequency was listed separately on PT documentation. She confirmed no specific BG parameters were listed on the POC and there was no policy for standardized reporting of BGs. She acknowledged the discrepancy between goals and interventions.</p> <p>11. Patient #11 was a 90 year old male admitted to the agency on 7/21/10 for care related to muscle weakness. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/18/10 to 1/16/10, was incomplete. It did not include Patient #11's diagnosis of diabetes or the diabetic medication metformin Patient #11 was taking. A section, "DME and Supplies," included "IV Supplies," although no IV medications were listed on the POC. During an interview on 12/17/10 at 11:30 AM, the DON reviewed the record and confirmed</p>	G 159	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	

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G 159	Continued From page 12 the findings.  During an interview on 12/16/10 at 11:00 AM, the Managing Coordinator stated the nurses had trouble with the computer documentation program, and as a result did not always appropriately update the POCs. For example, she explained the DME and Supplies came pre-populated on the program and nursing staff had to know how to de-select the supplies and add relevant ones. They also had trouble updating the medications to indicate the medications were new or changed.	G 159	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  (See Attached) APPENDIX - I:		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE  Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to alert the physician to the falls of 3 of 4 sample patients (#5, #10, and #11) who had documented falls. This interfered with the ability of physicians to evaluate patient needs and potentially alter the plan of care. Findings include:  1. Patient #5 was a 49 year old diabetic male admitted to the agency on 6/27/10 primarily for wound care. An LPN visit note, dated 12/10/10 at 2:31 PM, stated Patient #5 reported falling three times in the previous week, once in the bathroom	G 164			

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G 164	<p>Continued From page 13</p> <p>and twice in his living room. There was no documentation to indicate the falls had been reported to the physician.</p> <p>During an interview on 12/16/10 at 11:00 AM, the DON reviewed the record and confirmed there was no evidence the physician had been alerted.</p> <p>2. Patient #10 was an 85 year old female admitted to the agency on 11/12/10 with vertigo and history of falls. A Case Conference note, dated 12/07/10, stated Patient #10 reported a recent fall in her bathroom while preparing for a shower. There was no documentation to indicate the fall had been reported to the physician.</p> <p>During an initial interview on 12/17/10 at 10:45 AM the DON and Managing Coordinator did not know if the physician had been contacted. A fax, dated 12/17/10, was presented to surveyors on 12/20/10 indicating the physician was notified after the request for evidence of physician notification.</p> <p>3. Patient #11 was a 90 year old male admitted to the agency on 7/21/10 for care related to muscle weakness and abnormality of gait. A therapy visit note, dated 11/22/10 at 3:15 PM, documented "reports fell 2 days ago in bedroom." There was no documentation to indicate the fall had been reported to the physician.</p> <p>During an interview on 12/17/10 at 10:30 AM, the DON reviewed the record and stated she was not sure if the physician had been reported and would check and let us know. A fax, dated 12/17/10, was presented to surveyors on 12/20/10 indicating the physician was notified after the request for evidence of physician notification.</p>	G 164	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	

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G 164	Continued From page 14	G 164			
G 173	<p>Agency professional staff did not promptly alert the physician to patient falls.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse initiates the plan of care and necessary revisions.</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure patient plans of care were revised by the RN for 6 of 6 patients (#1, #3, #5, #6, # 8 and #11), who had been on services for more than one certification period. A failure to revise patients' POCs as needed has the potential to negatively impact coordination and quality of patient care. Findings include:</p> <p>1. Patient #1 was a 90 year old male with a SOC of 9/01/10. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/31/10 to 12/29/10, included goals that were dated 10/30/10, the same date as the prior certification period of 9/01/10 to 10/30/10 and contained the same wording. The POC had not been revised to reflect the new goals and discharge plans for Patient #1.</p> <p>In an interview on 12/17/16/10 at 10:15 AM, the DON reviewed the records and verified the findings. She stated the when recertification paperwork had been completed, the RN was supposed to update the goals and dates. She stated when an RN printed the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," that RN was also responsible to review it for errors</p>	G 173	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>		

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G 173	<p>Continued From page 15 before sending it to the physician.</p> <p>2. Patient #6 was an 87 year old female with a SOC of 9/10/10. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 11/09/10 to 1/07/11, included goals to be completed by 11/08/10, the same date as the prior certification period of 9/10/10 to 11/08/10 and contained the same wording. The POC had not been revised to reflect the new goals and discharge plans for Patient #6.</p> <p>In an interview on 12/17/16/10 at 10:15 AM, the DON reviewed the records and verified the findings. She stated the when recertification paperwork had been completed, the RN was supposed to update the goals and dates. She stated when an RN printed the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," that RN was also responsible to review it for errors before sending it to the physician.</p> <p>3. Patient #8 was a 92 year old male with a SOC of 8/31/10. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/30/10 to 12/28/10, included goals to be completed by 10/29/10, the same date as the prior certification period of 8/31/10 to 10/29/10 and contained the same wording. The POC had not been revised to reflect the new goals and discharge plans for Patient #8.</p> <p>In an interview on 12/17/16/10 at 10:15 AM, the DON reviewed the records and verified the findings. She stated the when recertification paperwork had been completed, the RN was supposed to update the goals and dates. She stated when an RN printed the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," that</p>	G 173	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>		

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G 173	<p>Continued From page 16</p> <p>RN was also responsible to review it for errors before sending it to the physician.</p> <p>The facility failed to revise and update the goals on the POCs.</p> <p>4. Patient #3 was a 51 year old female admitted to the agency on 9/15/10 primarily for wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/14/10 to 1/12/11, included orders for continuous oxygen at 2 liters. During a home visit on 12/15/10 (approximately 11:00 AM to 12:30 PM), Patient #3 stated her doctor had allowed her to use oxygen as needed for the previous 6 months. The POC had not been revised to reflect this change in oxygen use. The RN who was present during the home visit confirmed she was aware of the PRN use of oxygen and the need to update the POC to accurately reflect use.</p> <p>5. Patient #5 was a 49 year old diabetic male admitted to the agency on 6/27/10 primarily for wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 10/25/10 to 12/23/10, had not been revised to reflect current goal dates. The goals included completion dates of 10/24/10, which reflected goals for the previous certification period.</p> <p>In an interview on 12/17/16/10 at 10:15 AM, the DON reviewed the records and verified the findings. She stated the when recertification paperwork had been completed, the RN was supposed to update the goals and dates. She stated when an RN printed the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," that RN was also responsible to review it for errors</p>	G 173	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	

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G 173	Continued From page 17 before sending it to the physican.  During an interview on 12/16/10 at 11:00 AM, the Managing Coordinator stated nurses had trouble with the computer documentation program and knowing how to change the dates to update goals.  6. Patient #11 was a 90 year old male admitted to the agency on 7/21/10 for care related to muscle weakness. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/18/10 to 1/16/10 was not revised to indicate current goal dates. The goals included complellon dates of 11/17/10, which reflected goals for the previous certification period.  In an interview on 12/17/16/10 at 10:15 AM, the DON reviewed the records and verified the findings. She stated the when recertification paperwork had been completed, the RN was supposed to update the goals and dates. She stated when an RN printed the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," that RN was also responsible to review it for errors before sending it to the physican.  During an interview on 12/16/10 at 11:00 AM, the Managing Coordinator stated nurses had trouble with the computer documentation program and knowing how to change the dates to update goals.	G 173	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - I:</b>		
G 195	484.34 MEDICAL SOCIAL SERVICES  If the agency furnishes medical social services, those services are given by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker,	G 195			

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G 195	<p>Continued From page 18</p> <p>and in accordance with the plan of care. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems.</p> <p>This STANDARD is not met as evidenced by: Based on personnel record review, patient record review, and staff interview, it was determined the agency failed to ensure social services were provided by a qualified social worker in accordance with the plan of care for 1 of 1 sample patient (#12) who received social work services. This failure had the potential to negatively impact the ability of the agency to meet patient needs. Findings include:</p> <p>1. Patient #12 was a 21 year old female with a SOC of 10/22/10. Her diagnoses included paralysis and muscle weakness.</p> <p>On 11/23/10 the case manager for Patient #12 obtained a verbal order for MSW services. The "CONFIRMATION OF PHYSICIAN'S ORDERS" request that was written and faxed to the physician for his signature, stated: "Can we please get an order for MSW services for the pt? She cont (continues) to have difficulty with her depression." The physician response, dated 11/24/10, contained the notation "OK as above." with the date and signature of the physician. There was no direction provided as to number or frequency of visits.</p> <p>An undated form, titled "LMSW SOCIAL WORK VISIT," stated the purpose of the visit was for "Complete social work assessment and plan." The "Social Work Note" stated "Met with (Patient</p>	G 195	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>		

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G 195	<p>Continued From page 19</p> <p>#12) in her home and completed social work visit. Discussed her circumstances and needs. We attempted to explore options and opportunities to increase socialization and interaction. LSW will link (Patient #12) to information and resources as needed to address her depression and emotional needs. LSW will follow up as needed. LSW will follow up with 4 more visits to address issue." The visit note was signed by the LSW (a BSW) and co-signed by an LMSW. The note was then faxed to the physician, who signed it on 12/02/10.</p> <p>The "Social Work Note" did not document that a mental, environmental or social assessment had been performed or a depression screening to assess severity of depression. The plan for four visits lacked information regarding the frequency or goal of the visits.</p> <p>In an interview on 12/17/10 at 1:20 PM, the LSW stated he would have documented better if the agency had used a better template. He stated the form he had used was new, and not one that he was familiar with. The LSW confirmed he had not performed a depression or mental health screening. The LSW indicated a LMSW had reviewed and signed his visit note, showing evidence of oversight. The LSW stated the visit had been made on 12/01/10, and he had not returned for any additional visits. The LSW was unable to explain the delay of eight days from the order for MSW services and the initial social work visit.</p> <p>2. The agency had a contract signed on 7/26/10, with a corporation for social work services. The agency's personnel records were reviewed. A personnel record was present for the LSW, who owned the corporation. The personnel record</p>	G 195	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	

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NAME OF PROVIDER OR SUPPLIER  TETON HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 VALENCIA DRIVE 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)
G 195	<p>Continued From page 20</p> <p>included a copy of a social work license, indicating a bachelor's degree preparation for licensure.</p> <p>In an interview on 12/17/10 at 1:20 PM, the LSW stated the agency contracted with his corporation to provide social work services to agency patients. He stated his corporation employed an MSW who provided the required oversight. He described the process of MSW oversight. Upon an initial social work visit, the LSW would complete the patient assessment and plan, anticipate the number of visits needed and request physician orders to provide the services. The MSW (employed by his corporation) would then review and sign the paperwork, indicating oversight. The LSW stated the contract he had signed with the agency was for the corporation to provide social work services which also included the MSW oversight.</p> <p>The contract, titled "HOME THERAPY AGREEMENT," dated 7/26/10, was a four page agreement between the agency and the corporation to provide social work services, specifically listing BSW services (Bachelor of Social Work services). The contract did not specify MSW services or detail how the BSW (LSW) would be supervised by an MSW. The incomplete contract failed to clarify that medical social services would be provided by a qualified social worker (licensed MSW) or by a qualified social work assistant (such as a BSW) under the supervision of a qualified social worker to ensure the social work needs of patients would be met.</p> <p>The social work assessment and the contract for social work services were incomplete, leading to unmet patient needs.</p>	G 195	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>

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G 224	<p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE</p> <p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</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 provided written reporting parameters for the home health aide and supervision that assessed whether the aide was following the aide plan of care in 5 of 5 patients who received aide services (#1, #2, #4, #8, and #9) whose records were reviewed. This had the potential to negatively impact quality and safety of patient care. Findings include:</p> <p>1. Patient #4 was a 72 year old male who was admitted to the agency on 11/29/10. The "AIDE CARE PLAN," dated 12/07/10, included direction for the Aide to take Patient #4's pulse, respirations, and blood pressure, and provide foot care, nail care, and oral care. CNA visit notes, dated 12/08/10 at 3:20 AM, 12/10/10 at 1:45 AM, and 12/13/10 at 1:30 AM, indicated the following assigned tasks were not completed: taking Patient #4's pulse, respirations, and blood pressure, as well as providing foot care, nail care, or oral care. There was no RN documentation that the omissions had been addressed to provide direction to the Aide or to re-assess the need to update the POC. During an interview on 12/15/10 at 4:00 PM, the DON reviewed the record and confirmed the findings.</p>	G 224	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>		

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G 224	<p>Continued From page 22</p> <p>The POC did not include reporting guidelines for the vital signs. During an interview on 12/17/10 at 10:00 AM, an RN stated she did not provide reporting parameters for vital signs on the Aide POC. She also stated she was not aware of any standardized clinical guidelines.</p> <p>2. Patient #1 was a 90 year old male who was admitted to the agency on 9/01/10. Patient #1 was receiving Aide visits three times weekly for assistance with bathing and dressing. The "AIDE CARE PLAN," dated 10/29/10, included direction for the Aide to take Patient #1's temperature, pulse, respirations, and blood pressure (also known as "vital signs"), on a weekly basis in addition to when the caregiver requested. Patient #1 was to be weighed on a weekly basis as well. There was no documentation that the temperature, pulse, respirations, blood pressure or weights had been done by the Aide.</p> <p>In an interview on 12/16/10 at 1:50 PM, the Home Health Aide confirmed she had not taken the vital signs or weight for Patient #1. She stated she was unaware of the "AIDE CARE PLAN," instructions, and stated it must have been a miscommunication.</p> <p>3. Patient #2 was an 87 year old female who was admitted to the agency on 11/4/10. Patient #2 was receiving Aide visits three times weekly for assistance with bathing and dressing. The "AIDE CARE PLAN," dated 11/04/10, did not indicate vital signs were to be done. In a "Home Health Aide Supervisory Visit Report," dated 11/12/10, there was a comment "Patient would like (Aide) to start taking her vital signs at each visit." On 11/20/10, the "Home Health Aide Supervisory Visit Report" stated "(Aide) will start taking vital</p>	G 224	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>

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G 224	<p>Continued From page 23</p> <p>signs for client and report to RN." The "AIDE CARE PLAN" was not updated to include parameters or guidelines for when the Aide was expected to report to the case manager</p> <p>Aide visit notes, dated 11/22/10, 11/26/10, 12/01/10, 12/03/10, 12/07/10, 12/08/10, 12/10/10, and 12/13/10 did not include Patient #2's temperature.</p> <p>In an interview on 12/16/10 at 1:50 PM, the Home Health Aide confirmed temperatures had not been obtained with the vital signs. She stated Patient #2 did not have a thermometer, and the agency had not provided her with one.</p> <p>4. Patient #8 was a 92 year old male who was admitted to the agency on 8/31/10. Patient #8 was receiving aide visits three times weekly for assistance with bathing and dressing. The "AIDE CARE PLAN," dated 10/28/10, indicated temperature, pulse, respirations, and blood pressure would be taken with each visit.</p> <p>Aide visit notes, dated 11/03/10, 11/08/10, 11/10/10, 11/12/10, 11/14/10, 11/22/10, 11/24/10, 11/26/10, 11/29/10, 12/01/10, 12/03/10, 12/10/10, 12/13/10, and 12/15/10 failed to include blood pressure measurements.</p> <p>In an interview on 12/17/10 at 10:00 AM, the DON reviewed Patient #8's record and stated the "AIDE CARE PLAN" did not reflect the needs of the patient and should have been updated.</p> <p>5. Patient #9 was a 67 year old female with a SOC of 11/08/10. Patient #9 was receiving aide visits three times weekly for bathing and assistance with dressing and personal care. The</p>	G 224	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	

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G 224	Continued From page 24 "AIDE CARE PLAN," dated 11/08/10, instructed the aide to take weight, temperature, pulse, respirations, and blood pressure once weekly. No parameters for the vital signs were included for the aide.  Aide visit notes for 11/10/10, 11/19/10, 11/22/10, 11/26/10, 11/29/10, 12/01/10, 12/03/10, 12/08/10, 12/10/10, 12/13/10, and 12/15/10 did not include weight or vital signs.  In an interview on 12/16/10 at 1:50 PM, the Home Health Aide confirmed she had not taken vital signs on Patient #9. She stated she did not know she was supposed to take weights and vital signs, although she had signed the "AIDE CARE PLAN."	G 224	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - I:</b>		
G 229	484.36(d)(2) SUPERVISION  The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.  This STANDARD is not met as evidenced by: Based on clinical record review and interview of staff, it was determined the agency failed to ensure supervisory visits by an RN or therapist were conducted at least every 2 weeks for 3 of 5 patients (#1, #2, and #8), whose clinical record was reviewed for aide services. A delay in supervisory visits resulted in a delay in assessment of the competence of the aide providing service, the satisfaction of the client, and the appropriateness of the plan of care. This resulted in the agency's inability to ensure aides were providing services in accordance with the aide POC. The findings include:	G 229			

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G 229	Continued From page 25  1. Patient #1 was a 90 year old male with a SOC on 9/01/10. His POC was to receive home health aide services at a frequency of three times weekly for assistance with bathing and dressing. Aide visits were documented between 10/29/10 and 12/14/10. The last supervisory visit was 11/20/10. Additional supervisory visits were due 12/03/10 and the week of 12/12/10. There was no documentation supervisory visits had been completed.  In an interview on 12/16/10 at 10:15 AM, the DON stated the case manager was responsible for ensuring the supervisory visits were done, and was unsure why they had not been done.  2. Patient #2 was an 87 year old female with a SOC on 11/04/10. Her POC was to receive home health aide services at a frequency of three times weekly for assistance with bathing and dressing. The first and second supervisory visits were done, and the third supervisory visit was due on or before 12/04/10 but was not made until 12/13/10, 9 days late.  In an interview on 12/16/10 at 10:20 AM, the DON stated the case manager was responsible for ensuring the supervisory visits were done, and was unsure why it was delayed.  3. Patient # 8 was a 67 year old female with a SOC of 11/08/10. Her POC included home health aide visits three times weekly to assist with bathing. Aide services were initiated on 11/10/10. The first supervisory visit was due on or before 11/24/10, but record review did not indicate supervisory visits had been done.	G 229	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  (See Attached) APPENDIX - I:		

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G 229	Continued From page 26 In an interview on 12/17/10 at 10:45 AM, the DON reviewed the record and confirmed no supervisory visits had been done.	G 229	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  (See Attached) <b>APPENDIX - I:</b>	
G 236	484.48 CLINICAL RECORDS  A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure accuracy of Aide documentation of time in 3 of 5 patients (#1, #2, and #4) who received Aide services whose records were reviewed. This impacted the clarity of the course of care. Findings include:  The following Aide notes indicated services were provided during the night (early am). During an interview on 12/15/10 at 9:30 AM, the DON and Administrator stated that all CNA visits were done during the day and any notes timed during the night were incorrect. They thought perhaps the CNA did not know how to read military time.  a. CNA notes documented visits to Patient #1 on	G 236		

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G 236	Continued From page 27 12/03/10 at 1:35 AM , 12/10/10 at 3:00 AM, and 12/13/10 at 2:50 AM.  b. CNA notes documented visits to Patient #2 on 12/08/10 at 2:30 AM, 12/10/10 at 2:30 AM, and 12/13/10 at 2:30 AM.  c. CNA notes documented visits to Patient #4 on 12/08/10 at 3:20 AM, 12/10/10 at 1:45 AM, and 12/13/10 at 1:30 AM.	G 236	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - I:</b>	
G 250	Documentation of time was inaccurate. 484.52(b) CLINICAL RECORD REVIEW  At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.  This STANDARD is not met as evidenced by: Based on staff interview and documentation of chart audits, it was determined the agency failed to include all health professionals in chart audits representing the scope of the program and failed to include a sample of closed clinical records in the review in 1 of 1 quarterly record review. This resulted in an incomplete review and had the potential to negatively impact the utility and effectiveness of the review. Findings include:  A summary of chart audits, dated 9/29/10, included results of 26 open records that were reviewed. Services represented in the records included skilled nursing, home health aide, physical therapy, and occupational therapy. The chart audits were completed and signed by an	G 250		

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G 250	Continued From page 28 RN. There was no evidence other appropriate professionals, such as physical therapists or occupational therapists, participated in the chart audits.  During an interview on 12/17/10 at 12:05 PM, the Administrator confirmed record reviews (audits) had been exclusively completed by an RN. He stated he began as Administrator in 07/10 and prior to his arrival, chart audits, to his knowledge, had not been done. He stated the focus of record review had been on open records and he did not believe they had audited closed records.  Quarterly record reviews did not include all appropriate professionals in the review or include review of closed records.	G 250	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - I:</b>		
G 330	484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS  Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the	G 330			

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G 330	Continued From page 29 language and groupings of the OASIS items, as specified by the Secretary  This CONDITION is not met as evidenced by: Based on record review, observation, patient and staff interview, it was determined the agency failed to ensure staff performed comprehensive assessments, including drug regime review, and incorporated OASIS data elements into the agency's own comprehensive assessment tool. These failures resulted in incomplete assessments and had the potential to negatively impact quality and safety of patient care. Findings include:  1. Refer to G331 as it relates to the failure of the agency to ensure SOC assessments were thoroughly completed.  2. Refer to G337 as it relates to the agency's failure to ensure comprehensive reviews of patients' drug regimes were completed.  3. Refer to G338 as it relates to the failure of the agency to ensure patients' recertification assessments were thoroughly completed.  4. Refer to G342 as it relates to the agency's failure to incorporate OASIS data items into patients' comprehensive assessments.  The cumulative effect of these negative systemic agency practices seriously impeded the ability of the agency to provide services of adequate quality.	G 330	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - I:</b>	
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT  A registered nurse must conduct an initial assessment visit to determine the immediate care	G 331		

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G 331	<p>Continued From page 30 and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>This STANDARD Is not met as evidenced by: Based on record review and faxed staff communication it was determined the agency failed to ensure the initial SOC comprehensive assessment included a thorough examination of identified items of concern for 1 of 12 patient, (#7) who received admission assessments and whose records were reviewed. This failure placed the patient at risk of inadequate care and negative outcomes. Findings include:</p> <p>Patient #7 was a 52 year old diabetic female admitted to the agency on 12/07/10 primarily for wound care. Additional diagnoses listed on the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 12/07/10 to 2/04/11, included morbid obesity, depression, CHF, and abnormality of gait. The SOC assessment, completed by an RN on 12/08/10, stated Patient #7 had an open wound on her buttock, although there was no documentation of a measurement of the wound. Additionally, there was no documentation of Patient #7's weight. Measurements of weight and the wound would have allowed a baseline to demonstrate progress toward nutritional status and wound healing.</p> <p>On a fax communication, dated 1/06/11, the DON explained the nurse who provided care was a new nurse. She confirmed the weight and wound measurements had not been completed on SOC. She stated the wound was measured on 12/17/10 when the agency discovered the omission.</p>	G 331	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>		

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G 331	Continued From page 31	G 331	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - I:</b>		
G 337	484.55(c) DRUG REGIMEN REVIEW  The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.  This STANDARD is not met as evidenced by: Based on review of medical records, agency policies, and staff interview, it was determined the agency failed to ensure the comprehensive assessment included a thorough medication review to evaluate for drug interactions, identify significant side effects, and identify duplicative therapy for 3 of 12 patients, (#1, #3, and #8) whose records were reviewed. Failure to complete a thorough medication review had the potential to place patients at risk for adverse events and potential drug reactions. Findings include:  1. Patient #1 was a 90 year old male with a SOC of 9/01/10. His primary diagnosis was dehydration, with additional diagnoses listed as prostate cancer, Alzheimer's disease, hypertension, and generalized muscle weakness. During a home visit on 12/15/10 at 2:00 PM, the POC was compared with the medications Patient #1 was taking in his home. Patient #1's wife provided information and clarification as well during the medication review. Discrepancies noted were as follows:  Patient #1 had a Port-a-cath, (a vascular access	G 337			

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NAME OF PROVIDER OR SUPPLIER  TETON HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 3101 VALENCIA DRIVE 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 337	<p>Continued From page 32</p> <p>device implanted under the skin), located in his upper right chest area, through which IV fluids could be administered. The device was documented as being flushed with 5 ml of Heparin 100 units/ml after each use. Heparin was not listed as a medication on Patient #1's POC.</p> <p>Dexamethasone 4 mg two tablets, twice daily, and Lomotil one to two tablets four times daily were listed on the plan of care. Patient #1's wife stated the medications were ordered to be taken only during the first three days of chemotherapy when it was started in September.</p> <p>Vitamin B 12 was listed as a medication to be administered on a weekly basis.</p> <p>In an interview on 12/16/10 at 10:15 AM, the DON reviewed the medications listed on the plan of care, and confirmed Heparin should have been listed. She stated Vitamin B 12 was administered to Patient #1 in his physician's office, and should not have been on the plan of care.</p> <p>2. Patient #8 was a 92 year old male with a SOC of 8/31/10. His primary diagnosis was Vitamin B deficiency, with additional diagnosis of atrial fibrillation, testicular hypofunction, and depression. The POC did not list nitroglycerin as a medication for Patient #8, although there were orders for the SN to observe and assess the patient for chest pain and note the use of nitroglycerin.</p> <p>In an interview on 12/17/10 at 10:00 AM, the DON reviewed the record of Patient #8 and was unable to explain why the nitroglycerin was not listed on the medication area of the plan of care. She</p>	G 337	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>		

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G 337	Continued From page 33 provided a list from the pharmacy of medications that Patient #8 was reported to be taking. The medication list provided by the pharmacy did include nitroglycerin.  3. Patient #3 was a 51 year old female admitted to the agency on 9/15/10 primarily for wound care. During a home visit on 12/15/10 beginning at 11:00 AM, Patient #3 was observed to ask the visiting RN if she (Patient #3) was really supposed to be on 4 inhalers. The RN did not have Patient #3's POC with her to compare against a medication list. The surveyor provided the visiting RN with a copy of the most recent "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/14/10 to 1/12/11, which had a medication list that included 2 inhalers (Albuteral and Spiriva). When Patient #3 was asked by the surveyor how long she had been using 4 inhalers, she responded she had been on one for 4 weeks, one since October, one for 3 months, and another for about a year. The recertification assessment did not include a thorough assessment of all medications Patient #3 was taking.  During an interview after the home visit on 12/15/10 at 12:35 PM, the visiting RN stated she had been unaware of the additional Inhalers.  During an interview on 12/15/10 at 4:25 PM, the DON stated nursing staff are expected to go through medications one by one.	G 337	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  (See Attached) APPENDIX - I:		
G 338	484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT  The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's	G 338			

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G 338	<p>Continued From page 34</p> <p>condition warrants due to a major decline or improvement in the patient's health status.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and faxed staff communication it was determined the agency failed to ensure patients' comprehensive assessments were thoroughly updated during recertification for 2 of 6 patients (#3 and #5) who required recertification assessments and whose records were reviewed. This resulted in the lack of weight and/or weight measurements. Findings include:</p> <p>1. Patient #3 was a 51 year old female admitted to the agency on 9/15/10 primarily for wound care. Additional diagnoses listed on the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/14/10 to 01/12/11, included nutritional deficiency and dehydration. The recertification assessment, completed by an RN on 11/12/10, stated Patient #3 had a lack of appetite and decreased weight and a wound on her coccyx. There was no documentation of Patient #3's weight or measurement of the wound on her coccyx. Measurement of weight and the wound would have allowed for a baseline to demonstrate progress toward nutritional status and wound healing.</p> <p>On 1/06/11, the DON confirmed by fax the weight had not been taken. A second fax, also dated 1/06/11, from an RN stated the wound measurements for the coccyx had been done but were in her personal possession rather than in Patient #3's record.</p> <p>The recertification assessment failed to include</p>	G 338	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>		

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G 338	Continued From page 35 weight and wound measurements.  2. Patient #5 was a 49 year old diabetic male admitted to the agency on 6/27/10 primarily for wound care. The recertification assessment, dated 10/20/10, for recertification 10/25/10 through 12/23/10 was completed by an LPN and RN. The assessment documented 4 skin ulcers on Patient #5's abdomen. The wound assessment did not include measurement of the wounds. Measurement of the abdominal wounds would have allowed a baseline to demonstrate progress toward wound healing.  On 1/06/11, the DON confirmed by fax communication that no measurements had been taken for Patient #5's abdominal wounds during the recertification assessment, dated 10/20/10.  The recertification assessment failed to include wound measurements.	G 338	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  (See Attached) APPENDIX - I:		
G 342	484.55(e) INCORPORATION OF OASIS DATA ITEMS  The OASIS data items determined by the Secretary must be incorporated into the HHA's own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.  This STANDARD is not met as evidenced by: Based on staff interview and record review, it was determined the agency failed to ensure OASIS	G 342			

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G 342	<p>Continued From page 36</p> <p>data items were incorporated into the agency's own assessment for 12 of 12 patients (#s 1-12) whose records were reviewed. This resulted in OASIS data items being segregated from other elements of a comprehensive assessment. The lack of integration and standardization of a comprehensive assessment tool had the potential to allow for incomplete and inconsistent assessments. Findings include:</p> <p>The agency failed to ensure nursing staff used an integrated comprehensive assessment tool at SOC and recertification to allow for standardization among data collection and to cue nursing staff to clinical information necessary as a part of a comprehensive assessment for patients.</p> <p>OASIS data items were collected and entered in the computer by nursing staff at start of care, recertification, and other appropriate times. After being entered, OASIS data items printed on a form which identified each OASIS data item and the corresponding code number. Additional skilled nursing assessment information collected during skill nursing visits was documented on separate skilled nursing visit notes. The OASIS assessment was not integrated into the agency's own comprehensive assessment tool.</p> <p>This was confirmed during an interview on 12/16/10 at 1:50 PM with the Managing Coordinator. She stated the administrators of the computer documentation program they used told them the agency could add items to the OASIS assessment items in the computer in order to make the tool comprehensive, but they had not yet done so. She stated the nursing staff elected to enter the bulk of their assessments primarily in narrative fashion in skilled nursing notes.</p>	G 342	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	

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G 342	<p>Continued From page 37</p> <p>An integrated assessment tool was not used when the following assessments were completed for Patient #s 1-12:</p> <p>Patient #1: Recertification 10/29/10; Patient #2: SOC of 11/04/10; Patient #3: Recertification on 11/14/10; Patient #4: SOC 11/29/10; Patient #5: Recertification 10/25/10; Patient #6: Recertification 11/05/10; Patient #7: SOC of 12/07/10; Patient #8: Recertification 10/28/10; Patient #9: SOC of 11/08/10 and Resumption of Care 11/17/10. Patient #10: SOC 11/12/10; Patient #11: Recertification 11/17/10; Patient #12: SOC 10/22/10;</p> <p>The Administrator and Managing Coordinator were interviewed on 12/16/10 at 3:10 PM. The Administrator provided a paper copy of a comprehensive assessment tool, and a printed computer copy of an electronic comprehensive assessment tool. He stated nurses had been trained in the use of the electronic assessment tool. He stated the agency had them available but nursing staff were not using them. During the same interview, the Managing Coordinator stated the nurses did not like the electronic system and had not been using the comprehensive assessment tool available on the computer. She also confirmed nursing staff did not use the non-electronic comprehensive assessment tool as they each had their own systems for collecting information.</p> <p>During an interview on 12/17/10 at 10:00 AM, an RN Case Manager acknowledged not using the</p>	G 342	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - I:</b></p>	

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G 342	Continued From page 38 forms for the comprehensive assessments. She stated although she had not used the forms, her assessments were comprehensive and were summarized in narrative format, in addition to the OASIS items collected.  OASIS data items were not integrated into the agency's own assessment tool, nor were nursing staff consistently using the agency's assessment tools.	G 342	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - I:</b>		

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**G156** The DON is responsible for ensuring that the clinicians are fully completing a plan of care on SOC and updating the plan of care as needed with changes in the pt's condition, such as falls and at least every 60 days and to ensure that the POC was authorized by a physician. The clinical staff received training on 1/19/11 regarding the requirements of the plan of care, when and how to notify the physician. During the in-service they received training regarding how to appropriately conduct a review of the pt's POC, how to accurately complete a POC, and how to verify that the physician has authorized the POC. The DON began, on 1/20/11, conducting an audit of all POCs on SOC and upon recert to verify that all POCs were accurate and contained all of the required areas, that the physician was notified of any changes and that the physician did authorize the POC. Also to ensure that the POC was thorough enough to cover all the needs of the pts in regards to diagnoses, medications, IV treatments, interventions, goals, supplies, assessments and education. The findings of these audits will be reviewed with each clinician that completed the POC. In the event that the clinical has not adequately completed the POC documentation then the DON will provide the clinician with additional training at that time to ensure that the clinician fully understands how to accurately complete a POC. The DON will prepare a report that contains the findings of these audits and the DON will review the findings with the administrator on a monthly basis. All necessary corrections and new procedures will be in place by 2/11/11.

**G158** The DON is responsible for ensuring that each medical record has the necessary medical supervision. The clinical staffs received training on 1/19/11 regarding the requirements of having a physician review and approve the plan of care. A new tracking tool was put in place on 1/20/11 that will be used by the office manager to document when a POC has been sent to the physician, when it was received back from the physician, and if a physician, not another employee, signed the POC. The POC for pt #6 was sent back to the physician's office on 1/17/11 to have the physician review and sign the POC. The office manager will prepare a report based on the findings of the tracking tool and review it with the administrator on a monthly basis. The DON will conduct a review of all physician orders once they are received into the office and upon recert and discharge to ensure that the physician has signed each of the orders/POC.

**G159** The DON is responsible for ensuring that the clinicians are fully completing a plan of care on SOC and updating the plan of care as needed with changes in the pt's condition and at least every 60 days. The clinical staff received training on 1/19/11 regarding the requirements of the plan of care. During the in-service they received training regarding how to appropriately conduct a review of the pt's POC and how to accurately complete a POC. The DON began, on 1/20/11, conducting an audit of all POCs on SOC and upon recert to verify that all POCs were accurate and contained all of the required areas. Also to ensure that the POC was thorough enough to cover all the needs of the pts in regards to diagnoses, medications, IV treatments, interventions, goals, supplies, assessments, education, etc. The findings of these audits will be reviewed with each clinician that completed the POC. In the event that the clinician has not adequately completed the POC documentation then the DON will provide the clinician with additional training at that time to ensure that the clinician fully understands how to accurately complete a POC. The DON will prepare a report that contains the findings of these audits and the DON will review the findings with the administrator on a monthly basis. All necessary corrections and new procedures will be in place by 2/11/11.

**G164** The DON is responsible for ensuring that the clinicians are alerting the physician with any change in condition. The staff received training on 1/19/11 regarding the need to notify the physician with any change in condition, how to appropriately notify the physician, how to appropriately document the notification and the process that will be used to ensure that the physician is notified of all changes in condition. During each case conference meeting the DON will review with all of the clinicians the current state of the pts on the agenda and will discuss whether or not each of the pts on service have had any change in condition, in particularly if the pt has had a fall. If the pt has had a fall the case manager will, at that point, document the incident and then will be required to notify the physician by the end of the meeting and then document the fall and physician notification and then place the document in the pt's medical record. The DON began on 1/20/11 to conduct a review of at least 90% of all charts upon recert and discharge to verify that the physician has been notified of any and all changes in the pt's condition.

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The chart audit report will be prepared and reviewed with the QA team and the administrator on a monthly basis. All necessary corrections and new procedures will be in place by 2/11/11.

**G173** The DON is responsible for ensuring that an update of the plan of care is completed at least every 60 days if not sooner due to a change in the patient's condition. The DON has implemented a tracking tool that will be used to track each patient's certification period. This tool will be used to identify when an updated plan of care is required. The DON will notify the clinical staff at least 5 days prior to the end of the certification period that an update to the plan of care is due and the date it is due. The DON will then follow up with the clinical staff to ensure that the clinical staff member has in fact contacted the physician and completed an updated plan of care by the 60<sup>th</sup> day. The DON will also conduct ongoing audits of each updated plan of care to verify that the form has been accurately and completely filled out. The findings of these audits will be reviewed with the clinician that completed the form. The new tracking tool was put in place on 1/20/11. The clinical staff received training on 1/19/11 regarding the requirements of updating the plan of care at least every 60 days if not sooner due to a change in the patient's condition and the new tracking process that will be used. The staff also received training on how to accurately complete the plan of care. The tracking sheet will identify when the updated POC is due, when the staff member was notified, and when the POC was completed. This tracking tool will be reviewed with the administrator on a monthly basis so that the administrator can ensure that the POCs are being updated as required by regulation. The tracking tool will also be reviewed with the QA team. In the event that a staff member fails to complete an updated POC the staff member will be contacted and will be required to come into the office to meet with the DON and receive additional training regarding the requirements of this regulation. All necessary corrections and new procedures will be in place by 2/11/11.

**G195** The DON is responsible for ensuring that all disciplines have a physician ordered POC that includes the frequency, duration, interventions and goals of the care that will be provided. The staff received training on 1/19/11 regarding the need of a complete care plan, how to accurately document and create a care plan, the need for physician orders, and the appropriate process for obtaining orders and creating a care plan. The DON began on 1/20/11 to conduct an audit of all SOC paperwork and new or updated care plans to verify that all care plans contain all of the required information and that the appropriate process was followed. In the event that the DON identifies a break down in this system the Don will contact both the MSW and the Nurse Case Manager to inform them of the issues, provide additional training regarding the process that is required, and to make any necessary and appropriate corrections. All necessary corrections and the new procedure will be in place by 2/11/11.

**G224** The DON is responsible for ensuring that the documentation completed by the clinical staff is accurate and that the staff follows the care plans. On 1/19/11 the clinical staff members received training on how to completely and accurately fill out the clinical documentation forms, the need to constantly review the POC, and that the staff can only do what is ordered on the care plan. Upon admission and recert the HHA POC will be given to the HHA that is assigned to the pt. Also a copy of the HHA POC will be placed in the pt's home. This process will ensure that the HHAs are fully aware of what services have been ordered. The DON began on 1/20/11 complete chart audits of all documentation within the medical record that specifically reviewed whether or not the aide has in fact followed the HHA POC. The DON will review at least 90% of all charts upon discharge or recert. In the event that during these audits it is found that that an error has been made by one of the employees, that employee will be immediately contacted and will be required to come into the office to review the error with their supervisor and make any necessary and appropriate corrections. Additional one-on-one training will be provided to that employee regarding the requirements of this regulation and how to accurately complete the documentation. All necessary corrections and new procedures will be in place by 2/11/11.

**G229** The DON is responsible for ensuring that the RNs are conducting an aide supervisory visit at least every 14 days. On 1/19/11 the staff received training on the requirements of the aide supervisory visits and how to complete the documentation required. When HHA are providing service to the patients the office will add specific aide supervisory visits to the RN's schedules beginning on 1/20/11. The DON

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began on 1/20/11 to conduct an audit of the charts to verify that the RNs have in fact conducted an aide supervisory visit at least every 14 days. The DON will review at least 90% of all charts upon discharge or recert. In the event that the aide supervisory visit was not completed the DON will contact the RN and provide additional training regarding this requirement and how to conduct the visits and inform them of the new scheduling process. The nurse will also be required at that time to conduct an aide supervisory visit in the pt's home. The DON will prepare a chart audit summary report that includes the aide supervisory visit and will review the findings of the chart audit report on a monthly basis with the administrator. All necessary corrections and new procedures will be in place by 2/11/11.

**G236** The DON is responsible for ensuring that the documentation completed by the clinical staff is accurate. On 1/19/10 the clinical staff members received training on how to completely and accurately fill out the clinical documentation forms. The DON began on 1/20/10 complete chart audits of all documentation within the medical record. The DON will review at least 90% of all charts upon discharge or recert. The office Manager also began at this time to conduct a review of each employee's time card in conjunction with the notes when the employees turn in the timecard and note. This is to verify that the times of the visits are appropriate and match the times on the time card. In the event that during these audits it is found that that an error has been made by one of the employees, that employee will be immediately contacted and will be required to come into the office to review the error with their supervisor and make any necessary and appropriate corrections. All necessary corrections and new procedures will be in place by 2/11/11.

**G250** The DON is responsible for ensuring that chart reviews are completed at least quarterly. Beginning the week 1/24/11 the DON has had the Physical therapists conduct a peer review of the PT notes within the charts. The Occupational Therapists will conduct a peer review of the OT notes within the charts. Each of the PT and OT employees that attend the case conference will conduct at least one peer review of the therapy documentation per meeting. On 1/19/11 the therapists received training regarding how to accurately conduct a chart audit. Prior to case conference the DON will identify which charts are due for an audit and she will prepare the chart and the audit tool for the therapists, so that during the case conference meeting, they are able to complete the chart audits. The results of the chart audits will be reviewed as part of the QA review. A report will be created on a monthly basis to identify which charts have been audited, by whom, and what the findings were. This report will be reviewed with the administrator and the QA team on a monthly basis. . All necessary corrections and new procedures will be in place by 2/11/11.

**G330** The DON is responsible for ensuring that the clinical team uses an integrated comprehensive/OASIS assessment form on SOC. A new integrated comprehensive/OASIS assessment tool was purchased on 1/17/11 and the clinical staff received training on 1/19/11 on how to accurately complete the new integrated comprehensive assessment form. The DON began conducting ongoing audits of all SOC paperwork on 1/20/11 of all SOC paperwork to verify that the staff has used the new integrated OASIS/comprehensive assessment form and that the form has been accurately completed. Monthly reports of the chart audits will be completed and reviewed with the administrator and the QA team so that the administrator and QA team can ensure that the new form is being used and accurately completed. If found, during the SOC audits of the comprehensive assessment, that a clinician has not fully completed he integrated comprehensive assessment tool then the clinician will be contacted and the necessary and appropriate corrections will be made and additional training will be provided to that employee at that time. All necessary corrections and new procedures will be in place by 2/11/11.

**G331** The DON is responsible to ensure that the clinical staff is completing a comprehensive assessment of the patients during the initial visit and identifying the immediate care and support needs of the patient. The clinical staff received training on 1/19/11 regarding the requirements of the initial visit and how to accurately and completely fill out the comprehensive assessment form. The DON began on 1/20/11 conducting an audit of all paperwork completed during the initial visits to ensure that the staff has adequately and appropriately assessed the immediate care and support needs of the patient and has determined the eligibility of homecare including the homebound status. The findings of these audit results will be reviewed with each clinician that completed the initial assessment. In the event that the clinician

## **APPENDIX - I:**

has not adequately completed the initial visit assessment documentation then the DON will provide the clinician with additional training at that time to ensure that the clinician fully understands how to accurately conduct an initial visits and how to accurately complete the documentation. The DON will prepare a report that will be reviewed with the administrator on a monthly basis. All necessary corrections and new procedures will be in place by 2/11/11.

**G337** The DON is responsible for ensuring that the clinicians are fully completing a drug profile and conducting a med review on SOC and updating the med profile as needed with medications changes and at least every 60 days. The clinical staff received training on 1/19/11 regarding the requirements of the drug profile. During the in-service the staff received training regarding how to appropriately conduct a review of ALL of the pt's medications and how to accurately complete a drug profile. The DON began, on 1/20/11, conducting an audit of all medications profiles on SOC and upon recert to verify that all medications that the pt is using are listed on the medication profile. The findings of these audits will be reviewed with each clinician that completed the med profile. In the event that the clinical has not adequately completed the medication profile documentation then the DON will provide the clinician with additional training at that time to ensure that the clinician fully understands how to accurately complete a medication profile. The DON will prepare a report that contains the findings of these audits and the DON will review the findings with the administrator on a monthly basis. All necessary corrections and new procedures will be in place by 2/11/11.

**G338** The DON is responsible for ensuring that an update of the comprehensive assessment is completed at least every 60 days if not sooner due to a change in the patient's condition. The DON has implemented a tracking tool that will be used to track each patient's certification period. This tool will be used to identify when an updated comprehensive assessment is required. The DON will notify the clinical staff at least 5 days prior to the end of the certification period that an update to the comprehensive assessment is due and the date it is due. The DON will then follow up with the clinical staff to ensure that the clinical staff member has in fact completed an updated comprehensive assessment by the 60<sup>th</sup> day. The DON will also conduct ongoing audits of each updated comprehensive assessment to verify that the form has been accurately and completely filled out. The findings of these audits will be reviewed with the clinician that completed the form. The new tracking tool was put in place on 1/19/11. The clinical staff received training on 1/19/11 regarding the requirements of updating the comprehensive assessment at least every 60 days if not sooner due to a change in the patient's condition and the new tracking process that will be used. The staff also received training on how to accurately complete the comprehensive assessment. The tracking sheet will identify when the updated assessment is due, when the staff member was notified, and when the assessment was completed. This tracking tool will be reviewed with the administrator on a monthly basis so that the administrator can ensure that the assessments are being updated as required by regulation. The tracking tool will also be reviewed with the QA team. In the event that a staff member fails to complete an updated comprehensive assessment the staff member will be contacted and will be required to come into the office to meet with the DON and receive additional training regarding the requirements of this regulation. All necessary corrections and new procedures will be in place by 2/11/11.

**G342** The DON is responsible for ensuring that the clinical team uses an integrated comprehensive/OASIS assessment form on SOC. A new integrated comprehensive/OASIS assessment form was purchased on 1/17/11 and the clinical staff received training on 1/19/11 on how to accurately complete the new integrated comprehensive assessment form. The DON began conducting ongoing audits of all SOC paperwork on 1/20/11 of all SOC paperwork to verify that the staff has used the new integrated OASIS/comprehensive assessment form and that the form has been accurately completed. Monthly reports of the chart audits will be completed and reviewed with the administrator and the QA team so that the administrator and QA team can ensure that the new form is being used and accurately completed. If found, during the SOC audits of the comprehensive assessment, that a clinician has not fully completed the integrated comprehensive assessment tool then the clinician will be contacted and the necessary and appropriate corrections will be made and additional training will be provided to that employee at that time. All necessary corrections and new procedures will be in place by 2/11/11.



February 7, 2011

Susan Costa, RN - Supervisor  
Non-Long Term Care Section  
Bureau of Facility Standards  
P.O. Box 83720  
3232 Elder Street  
Boise, ID 83720-0036  
Fax (208) 364-1888

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

Dear Susan,

Enclosed you will find an addendum to the following: G250, G195, G164.

Please don't hesitate to contact us with any questions.

Kind regards,

A handwritten signature in black ink, appearing to read "Chris Weston", with a long horizontal flourish extending to the right.

**Chris Weston**  
Administrator  
**Teton Home Health**  
3101 Valencia Dr.  
Idaho Falls, ID 83404  
208.529.3636 - Office  
208.528.6562 - Fax

Teton Home Health  
Plan of Correction  
Provider # 137061

Ref: January 5, 2011 Survey

### **APPENDIX - I:**

#### **Addendum to State Plan of Correction**

**G250** The DON is responsible for ensuring that chart reviews are completed at least quarterly. Beginning the week 1/24/11 the DON has had the Physical therapists, Occupational therapists, and Speech language pathologists conduct a peer review of the notes within the charts. Each of the disciplines will conduct a peer review of the other employee's, of the same discipline, notes within the charts. Each of the employees that attend the case conference will conduct at least one peer review of their peer's documentation per meeting. On 1/19/11 each of the disciplines received training regarding how to accurately conduct a chart audit. Prior to case conference the DON will identify which charts are due for an audit and will prepare the charts and the audit tool for the employees, so that during the case conference meeting, they are able to complete the chart audits. The social worker will send his documentation to the supervising MSW to review the documentation. The DON will review the nurse's documentation. The results of the chart audits will be reviewed as part of the QA review. A report will be created on a monthly basis to identify which charts have been audited, by whom, and what the findings were. This report will be reviewed with the administrator and the QA team on a monthly basis. A 90% review of all charts will be audited each quarter until a 90% compliance can be obtained within the charts. At that point the audits will be reduced to a 50% audit of all charts ongoing. All necessary corrections and new procedures will be in place by 2/11/11.

**G195** The DON is responsible for ensuring that all disciplines have a physician ordered POC which includes the frequency, duration, interventions and goals of the care that will be provided. The social worker is supervised by the MSW. Each of the notes, care plans, etc that are created by the social worker are sent to the MSW for a peer review. The staff received training on 1/19/11 regarding the need of a complete care plan, how to accurately document and create a care plan, the need for physician orders, and the appropriate process for obtaining orders and creating a care plan. The DON began on 1/20/11 to conduct an audit of all SOC paperwork and new or updated care plans to verify that all care plans contain all of the required information and that the appropriate process was followed. In the event that the DON identifies a break down in this system the DON will contact both the MSW and the Nurse Case Manager to inform them of the issues, provide additional training regarding the process that is required, and to make any necessary and appropriate corrections. The MSW will conduct the oversight of the social worker and conduct ongoing audits of the social worker's documentation to ensure that the POCs are created according to the regulations. The review will also include an oversight of the care and follow through being provided to the pts by the social worker. All necessary corrections and the new procedure will be in place by 2/11/11.

**G164** The DON is responsible for ensuring that the clinicians are alerting the physician with any change in condition. The staff received training on 1/19/11 regarding the need to notify the physician of any change in condition, how to appropriately notify the physician, how to appropriately document the notification and the process that will be used to ensure that the physician is notified of all changes in condition. During each case conference meeting the DON will review with all of the clinicians the

Teton Home Health  
Plan of Correction  
Provider # 137061  
Ref: January 5, 2011 Survey

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**Addendum to State Plan of Correction**

current state of the pts on the agenda and will discuss whether or not each of the pts on service have had any change in condition, including falls, med errors, incidents, and variance, etc. If the pt has had a fall or any other change in condition the case manager will, at that point, document the incident and will be required to notify the physician by the end of the meeting. Additionally document the fall and physician notification and then place the document in the pt's medical record. In the event that the pt has had a change in condition that, due to the immediate nature of the event, cannot wait until the next case conference meeting the staff member is required to immediately contact the DON and the physician to report the change in condition. Once the physician and DON have been contacted the employee will be required to come in the office to document the incident and/or change in condition. The DON began on 1/20/11 to conduct a review of at least 90% of all charts upon recert and discharge to verify that the physician has been notified of any and all changes in the pt's condition. The chart audit report will be prepared and reviewed with the QA team and the administrator on a monthly basis. All necessary corrections and new procedures will be in place by 2/11/11.

- Many of the other POCs for the tags included the DON conducting chart audits. The audits have begun and will continue to be done at 90% each quarter for the next year or until a minimum of 90% compliance can be achieved. Once the 90% compliance has been achieved then the DON will continue to conduct a 50% review of all charts each quarter.

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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  01/05/2011
NAME OF PROVIDER OR SUPPLIER  TETON HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 VALENCIA DRIVE IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	16.03.07 INITIAL COMMENTS  The following deficiencies were cited during the state licensure follow up survey of your Home Health agency.  The surveyors who conducted the follow up were:  Teresa Hamblin, RN, MS, HFS, Team Leader Suzi Costa, RN, HFS  Abbreviations used in this report include:  COPD = Chronic Obstructive Pulmonary Disease C-PAP = Continuous Positive Airway Pressure DME = Durable Medical Equipment IV = Intravenous DON = Director of Nursing POC = Plan of Care SN = Skilled Nursing SOC = Start of Care	N 000	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  (See Attached) APPENDIX - II:	
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: Based on record review and staff interview, it was determined the agency failed to ensure the POC included all pertinent diagnoses for 6 of 12 sample patients (#1, #7, #8, #9, #11, and #12). This had the potential to interfere with the completeness of patient care. Findings include:	N 153		

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

TITLE  
*Administrator*

(X8) DATE  
1/24/2011

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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  01/05/2011
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N 153	Continued From page 1  1. Patient #11 was a 90 year old male admitted to the agency on 7/21/10 for care related to muscle weakness. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/18/10 to 1/16/10, was incomplete. It did not include Patient #11's diagnosis of diabetes. During an interview on 12/17/10 at 11:30 AM, the DON reviewed the record and confirmed the findings.  2. Patient #1 was a 90 year old male with a SOC of 9/01/10. His primary diagnosis was dehydration, with additional diagnosis listed as prostate cancer, Alzheimer's disease, hypertension, and generalized muscle weakness.  The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/31/10 to 12/29/10, indicated Patient #1 was to be observed and assessed every nursing visit for signs and symptoms of depression and mood. Patient #1's medications included Seroquel SR, which is a medication used for schizophrenia or bipolar disorders. There were no diagnoses listed, such as depression, schizophrenia, or bipolar disorder, to explain the medication and interventions.  In an interview on 12/17/10 at 10:00 AM, the DON confirmed Patient #1's record did not include a diagnosis which reflected his mental status and included his need for antipsychotic medication.  3. Patient #8 was a 92 year old male with a SOC of 8/31/10. His primary diagnosis was Vitamin B deficiency, with additional diagnosis of atrial fibrillation, testicular hypofunction, and depression. The "HOME HEALTH	N 153	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  (See Attached) <b>APPENDIX - II:</b>	

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N 153	<p>Continued From page 2</p> <p>CERTIFICATION AND PLAN OF CARE," for the certification period 10/30/10 to 12/28/10, directed the SN to assess Patient #8 for pain with each visits, and instruct the patient in proper use of pain medication for safety. Patient #8's plan of care did not include a diagnosis related to pain.</p> <p>In an interview on 12/17/10 at 10:00 PM, the DON reviewed the record and confirmed the findings.</p> <p>4. Patient #7 was a 52 year old female with a SOC of 12/07/10. Her primary diagnosis was open wound, with additional diagnosis of chronic depression, type 2 diabetes, morbid obesity, and CHF. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 12/07/10 to 2/04/11, directed the SN to instruct Patient #7 how to take her pulse and about alterations in rate and rhythm to report to MD. There was no diagnosis listed that explained the abnormal heart rate. The plan of care medication list included Methadone as well as Oxycodone, and there was diagnosis listed to explain the medication. Patient #7 was on multiple antidepressant medications, there were no diagnosis listed to explain the use of antidepressants.</p> <p>In an interview on 12/16/10 at 12:00 PM, the DON reviewed Patient #7's medical record and confirmed the plan of care did not address the depression, pain management, and cardiac rhythm assessment. The DON stated the nurse had designed the plan of care to address the open wound for which the primary diagnosis listed.</p> <p>5. Patient #9 was a 67 year old female with a SOC of 11/08/10. Her primary diagnosis was</p>	N 153	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - II:</b></p>	

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N 153	Continued From page 3  renal failure, hypotension, type 2 diabetes, muscle weakness, and hyperpotassemia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/08/10 to 1/06/11, included medications for glaucoma and multiple sclerosis, although those diagnoses were not listed on the plan of care.  The DON confirmed the medications listed on the plan of care indicated Patient #9 had MS as well as glaucoma, and was unable to explain why the case manager did not include those diagnosis on the plan of care.  6. Patient #12 was a 21 year old female with a SOC of 10/22/10. Her primary diagnosis was general muscle weakness, neuromyelitis optica, paralysis, and gastroparesis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/22/10 to 12/20/10 instructed the SN to "cleanse site with NS (normal saline)/ gauze....cover with duoderm until healed." The plan of care did not include a diagnosis of a wound.  In an interview on 12/17/10 at 1:30 PM, the DON stated Patient #12 was referred for wound care only, and confirmed the plan of care did not provide a comprehensive needs plan for Patient #12.	N 153	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - II:</b>	
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:	N 155		

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N 155	<p>Continued From page 4</p> <p>c. Types of services and equipment required;</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the written plan of care included equipment not required and/or failed to include types of services ordered by a physician for 11 of 12 patients (#2, #3, #4, #5, #6, #7, #8, #9, #11, #12) whose records were reviewed. This resulted in POCs that were not patient specific as to equipment/supplies and POCs that were incomplete. This had the potential to interfere with quality and coordination of patient care. Findings include:</p> <p>1. Patient #3 was a 51 year old female admitted to the agency on 9/15/10 primarily for wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/14/10 to 1/12/11, included a goal for Patient #3 to gain or maintain her weight of 90 lbs. However, there was no intervention listed to assess Patient #3's weight. The POC also listed a goal to control Patient #3's pain at a level of 4 or less. However, there was no intervention listed to assess Patient #3's rating of pain. During an interview on 12/15/10 at 4:25 PM, the DON reviewed the record and confirmed the findings.</p> <p>The POC did not include Interventions required to adequately assess the stated goals.</p> <p>2. Patient #4 was a 72 year old male admitted to the agency on 11/29/10 for post-stroke care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/29/10 to 01/27/10, did not include the type of services required by the aide during the 3 x per week</p>	N 155	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - II:</b></p>		

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N 155	<p>Continued From page 5</p> <p>physician-ordered visits. "IV Supples" were listed under "DME and Supplies." However, there was no indication Patient #4 was on IV therapy. During an interview on 12/15/10 at 4:00 PM, the DON reviewed the record and confirmed the findings.</p> <p>The type of aide services were not included in the POC. Supplies were listed on the POC that were not relevant to Patient #4.</p> <p>3. Patient #5 was a 49 year old diabetic male admitted to the agency on 6/27/10 primarily for wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 10/25/10 to 12/23/10, included a goal for the client to be compliant with performing 4 x per day accuchecks (blood glucose monitoring). However, the POC did not include corresponding SN interventions to assess Patient #5 for compliance with blood sugar monitoring. The POC did not include patient use of C-PAP (a device for treating sleep apnea) although nursing documentation on 12/06/10 at 11:45 AM indicated Patient #5 used C-PAP at night. A section, "DME and Supplies," included "IV Supplies" although Patient #5 was not on IV medications. During an interview on 12/16/10 at 11:15 AM, the DON reviewed the POC and confirmed the findings.</p> <p>The POC was missing interventions necessary to assess the stated goals. The POC was missing equipment (C-PAP) specific to Patient #5 and included IV supplies not relevant to Patient #5.</p> <p>4. Patient #11 was a 90 year old male admitted to the agency on 7/21/10 for care related to muscle weakness. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for</p>	N 155	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - II:</b></p>	

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N 155	<p>Continued From page 6</p> <p>certification period 11/18/10 to 1/16/10 had a section, "DME and Supplies," which included "IV Supplies." However, no IV medications were listed on the POC. During an interview on 12/17/10 at 11:30 AM, the DON reviewed the record and confirmed the findings.</p> <p>The POC included supplies that were not relevant to Patient #11.</p> <p>5. Patient #8 was a 92 year old male with a SOC of 8/31/10. His primary diagnosis was Vitamin B deficiency, with additional diagnosis of atrial fibrillation, testicular hypofunction, and depression.</p> <p>The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #8 was not receiving IV therapy.</p> <p>In an interview on 12/17/10 at 10:00 AM, the DON reviewed the record of Patient #8 and stated the DME and supplies listed was a software program issue that was prepopulated with the items listed. She stated the case manager was able to list additional supplies, but the needle, solution, syringe, and tape was listed for all patients.</p> <p>The POC included supplies not needed by Patient #8.</p> <p>6. Patient #2 was an 87 year old female with a SOC of 11/04/10. Her primary diagnosis was type 2 diabetes, malaise and fatigue, COPD, and arthropathy. The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #2 was not receiving IV therapy.</p>	N 155	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - II:</b></p>	

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NAME OF PROVIDER OR SUPPLIER  TETON HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 VALENCIA DRIVE IDAHO FALLS, ID 83404		
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N 155	<p>Continued From page 7</p> <p>In an interview on 12/16/10 at 10:20 AM, the DON stated the DME and supplies listed was actually a software program issue that was prepopulated with the items listed. She stated the case manager was able to adapt the list for additional supplies, but the needle, solution, syringe, and tape was initially listed for all patients.</p> <p>Patient #2's plan of care included supplies she did not need.</p> <p>7. Patient #6 was an 87 year old female with a SOC of 9/10/10. Her primary diagnosis was uncontrolled type 2 diabetes, macular degeneration, and chronic kidney disease. The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #6 was not receiving IV therapy.</p> <p>In an interview on 12/16/10 at 9:30 AM, the DON stated the DME and supplies listed was a software program issue that was prepopulated with the items listed. She stated the case manager was able to adapt the list for additional supplies, but the needle, solution, syringe, and tape was initially listed for all patients.</p> <p>The POC listed supplies not needed by Patient #6.</p> <p>8. Patient #7 was a 52 year old female with a SOC of 12/07/10. Her primary diagnosis was open wound, with additional diagnosis of chronic depression, type 2 diabetes, morbid obesity, and CHF. The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #7 was not receiving IV therapy. Nursing interventions also included that Patient #7 demonstrate use of oxygen, although oxygen</p>	N 155	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - II:</b></p>	

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NAME OF PROVIDER OR SUPPLIER  TETON HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 VALENCIA DRIVE IDAHO FALLS, ID 83404		
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N 155	<p>Continued From page 8</p> <p>was not listed on the DME or the medication list.</p> <p>In an interview on 12/16/10 at 12:00 PM, the DON stated the DME and supplies listed was a software program issue that was prepopulated with the items listed. She stated the case manager would be able to list additional supplies, but the needle, solution, syringe, and tape was initially listed for all patients.</p> <p>The POC listed supplies not needed by Patient #7.</p> <p>9. Patient #9 was a 67 year old female with a SOC of 11/08/10. Her primary diagnosis was renal failure, hypotension, type 2 diabetes, muscle weakness, and hyperpotassemia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/08/10 to 1/06/11, directed the SN to notify the physician for oxygen saturations of 86% or less while on oxygen, although the plan of care did not indicate Patient #9 was on oxygen in the medications or the DME and supplies listed. The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #9 was not receiving IV therapy.</p> <p>In an interview on 12/17/10 at 10:45 AM, the DON reviewed the medical record of Patient #9 and stated the DME and supplies listed was a software program issue that was prepopulated with the items listed. She stated the case manager was able to list additional supplies, but the needle, solution, syringe, and tape was listed for all patients.</p> <p>The POC failed to include oxygen for Patient #9, and included supplies that were not needed by Patient #9.</p>	N 155	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - II:</b></p>	

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N 155	Continued From page 9  11. Patient #12 was a 21 year old female with a SOC of 10/22/10. Her primary diagnosis was general muscle weakness, neuromyelitis optica, paralysis, and gastroparesis.  The DME and supplies listed included IV supplies, needle, and solution, syringe, and tape, although Patient #12 was not receiving IV therapy.  In an interview on 12/17/10 at 1:30 PM, the DON reviewed the record of Patient #12 and stated the DME and supplies listed was a software program issue that was prepopulated with the items listed. She stated the case manager was able to list additional supplies, but the needle, solution, syringe, and tape was listed for all patients.  The facility failed to ensure appropriate supplies were listed for Patient #12.	N 155	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  (See Attached) <b>APPENDIX - II:</b>	
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: Based on record review and staff interview, it was determined the agency failed to ensure the POCs included medication and treatment orders for 3 of 12 sample patients (#5, #8, and #11).	N 161		

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N 161	<p>Continued From page 10</p> <p>This had the potential to interfere with quality, completeness, and coordination of patient services. Findings include:</p> <p>1. Patient #5 was a 49 year old diabetic male admitted to the agency on 6/27/10 primarily for wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 10/25/10 to 12/23/10, did not include patient use of C-PAP (a device for treating sleep apnea). However, nursing documentation on 12/06/10 at 11:45 AM indicated Patient #5 used C-PAP at night. During an interview on 12/16/10 at 11:15 AM, the DON reviewed the POC and confirmed the findings.</p> <p>The POC did not include the C-PAP treatment.</p> <p>2. Patient #11 was a 90 year old male admitted to the agency on 7/21/10 for care related to muscle weakness. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/18/10 to 1/16/10, did not include the diabetic medication metformin Patient #11 was taking. During an interview on 12/17/10 at 11:30 AM, the DON reviewed the record and confirmed the findings.</p> <p>The POC did not include a medication.</p> <p>3. Patient #8 was a 92 year old male with a SOC of 8/31/10. His primary diagnosis was Vitamin B deficiency, with additional diagnosis of atrial fibrillation, testicular hypofunction, and depression. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 10/30/10 to 12/28/10, directed the SN to assess Patient #8 for pain with each visit, and instruct the patient in proper use of pain</p>	N 161	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - II:</b></p>	

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N 161	Continued From page 11  medication for safety. Patient #8's plan of care did not include pain medications.  The plan of care also included instructions for the SN to observe and assess the patient for chest pain, and note the use of nitroglycerin. The nitroglycerin was not included in the medications listed on the plan of care.  In an interview on 12/17/10 at 10:00 AM, the DON was unable to explain why the nitroglycerin was not listed in the medication area of the plan of care. She provided a list from the pharmacy of medications that Patient #8 was reported to be taking. The medication list provided by the pharmacy was different from the plan of care medication list, and included nitroglycerin, as well as, multiple pain medications.  The POC did not include all medications needed by Patient #8.	N 161	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  <b>(See Attached)</b> <b>APPENDIX - II:</b>	
N 186	03.07031.03.CLINICAL REC.  N186 03. Clinical and Progress Notes, and Summaries of Care. Clinical and progress notes must be written or dictated on the day service is rendered and incorporated into the clinical record within seven (7) days. Summaries of care reports must be submitted to the attending physician at least every sixty (60) days.  This Rule is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure clinical notes were written or dictated on the day service was rendered in 5 of 5 patients (#3, #4, #5, #10, and #11) whose records were reviewed for dates	N 186		

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N 186	<p>Continued From page 12</p> <p>of entry for clinical notes. This had the potential to interfere with the accuracy of clinical records. Findings include:</p> <p>RN and CNA clinical notes listed the dates and times services were rendered and the dates and times visit notes were "entered" and "logged." During an interview on 12/15/10 at 9:30 AM, the DON and Administrator, after consulting with the Managing Coordinator, stated the term "entered" meant the time the note was started and "logged" meant when the note was synced with the agency's computer system. They explained it was necessary for staff to come into the office to sync their notes with the computer system. They further explained their computer documentation program did not allow staff to transmit notes in real time from a distance.</p> <p>The following clinical notes are examples of entries documented as entered and logged after the dates of services.</p> <ol style="list-style-type: none"> <li>1. Patient #3: An RN visit note, dated 9/15/10 at 9:45 AM, was documented as entered on 9/20/10 at 8:10 am and logged 9/20/10 at 8:32 AM (5 days after the date of service).</li> <li>2. Patient #4: An RN visit note, dated 11/29/10 at 2:00 PM, was documented as entered on 12/01/10 (2 days after the date of service). A CNA visit note, dated 12/08/10 at 3:20 AM was documented as entered 12/10/10 at 3:57 PM (2 days after the date of service).</li> <li>3. Patient #5: AN LPN visit note, dated 10/27/10 at 10:30 PM, was documented as entered 10/31/10 at 9:42 PM and logged at 11/01/10 at 9:03 PM (5 days after the date of service).</li> </ol>	N 186	<p>Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey</p> <p><b>(See Attached)</b> <b>APPENDIX - II:</b></p>	

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N 186	Continued From page 13  4. Patient #10: An RN visit note, dated 11/12/10 at 12:32 PM, was documented as entered on 11/15/10 at 12:24 AM and logged 11/15/10 at 1:04 AM (3 days after the date of service).  5. Patient #11: An RN visit note, dated 11/12/10 at 10:06 AM, was documented as entered on 11/15/10 at 12:04 AM and logged 11/15/10 at 12:07 AM (3 days after the date of service).	N 186	Teton Home Health Plan of Correction Provider # 137061 Ref: January 5, 2011 Survey  (See Attached) <b>APPENDIX - II:</b>		

## **APPENDIX II:**

**N153** The DON is responsible for ensuring that an update of the plan of care is completed at least every 60 days if not sooner due to a change in the patient's condition. The DON has implemented a tracking tool that will be used to track each patient's certification period. This tool will be used to identify when an updated plan of care is required. The DON will notify the clinical staff at least 5 days prior to the end of the certification period that an update to the plan of care is due and the date it is due. The DON will then follow up with the clinical staff to ensure that the clinical staff member has in fact contacted the physician and completed an updated plan of care by the 60<sup>th</sup> day. The DON will also conduct ongoing audits of each updated plan of care to verify that the form has been accurately and completely filled out. The findings of these audits will be reviewed with the clinician that completed the form. The new tracking tool was put in place on 1/20/11. The clinical staff received training on 1/19/11 regarding the requirements of updating the plan of care at least every 60 days if not sooner due to a change in the patient's condition and the new tracking process that will be used. The staff also received training on how to accurately complete the plan of care. The tracking sheet will identify when the updated POC is due, when the staff member was notified, and when the POC was completed. This tracking tool will be reviewed with the administrator on a monthly basis so that the administrator can ensure that the POCs are being updated as required by regulation. The tracking tool will also be reviewed with the QA team. In the event that a staff member fails to complete an updated POC the staff member will be contacted and will be required to come into the office to meet with the DON and receive additional training regarding the requirements of this regulation. All necessary corrections and new procedures will be in place by 2/11/11.

**N155** The DON is responsible for ensuring that the clinicians are fully completing a plan of care on SOC and updating the plan of care as needed with changes in the pt's condition and at least every 60 days. The clinical staff received training on 1/19/11 regarding the requirements of the plan of care. During the in-service they received training regarding how to appropriately conduct a review of the pt's POC and how to accurately complete a POC. The DON began, on 1/20/11, conducting an audit of all POCs on SOC and upon recert to verify that all POCs were accurate and contained all of the required areas. Also to ensure that the POC was thorough enough to cover all the needs of the pts in regards to diagnoses, medications, IV treatments, interventions, goals, supplies, assessments, education, etc. The findings of these audits will be reviewed with each clinician that completed the POC. In the event that the clinician has not adequately completed the POC documentation then the DON will provide the clinician with additional training at that time to ensure that the clinician fully understands how to accurately complete a POC. The DON will prepare a report that contains the findings of these audits and the DON will review the findings with the administrator on a monthly basis. All necessary corrections and new procedures will be in place by 2/11/11.

**N161** The DON is responsible for ensuring that the clinicians are fully completing a drug profile as part of the care plan and conducting a med review on SOC and updating the med profile as needed with medications changes and at least every 60 days and that an update to the POC is necessary. The clinical staff received training on 1/19/11 regarding the requirements of the drug profile. During the in-service the staff received training regarding how to appropriately conduct a review of ALL of the pt's medications and how to accurately complete a drug profile. The DON began, on 1/20/11, conducting an audit of all medications profiles on SOC and upon recert to verify that all medications that the pt is using are listed on the medication profile. The findings of these audits will be reviewed with each clinician that completed the med profile. In the event that the clinical has not adequately completed the medication profile documentation then the DON will provide the clinician with additional training at that time to ensure that the clinician fully understands how to accurately complete a medication profile. The DON will prepare a report that contains the findings of these audits and the DON will review the findings with the administrator on a monthly basis. All necessary corrections and new procedures will be in place by 2/11/11.

Teton Home Health  
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Ref: January 5, 2011 Survey

## **APPENDIX II:**

**N186** The DON is responsible for ensuring that the clinical team's documentation is conducted at the time of the visit and that the notes are logged into the charts within 7 days from the time of the visit. The agency has switched from an electronic documentation system to a paper system. The clinical staff received training on 1/19/11 regarding the documentation requirements. The staff was trained that the notes needed to be completed the day of the visit and turned into the office within 72 hrs of the visit so that the internal check and balance system could be run and the chart filed within 7 days of the visit. The agency implemented a point of care documentation system on 1/20/11, which now requires the clinical staff to begin their clinical documentation at the beginning of the visit and have it completed before the clinician leaves the patient's home. The office manager, during the review of the timecards and notes, will identify whether or not the clinicians are meeting the new paperwork deadlines. The office manager will notify the DON any time that a clinician has failed to meet the deadlines. The DON will then contact the clinician and inform them of the requirements of the agency and assist that employee to develop methods to effectively manage their time so that the deadlines can be met. The DON will meet with the administrator on a monthly basis and will inform the administrator of any issues with this new process. The new process will be fully in effect by 2/11/11.