IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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September 7, 2012

Mark Deis, Administrator
Teton Home Health
3101 Valencia Drive
Idaho Falls, ID 83404

RE: Teton Home Health, Provider #137061

Dear Mr. Deis:

This is to advise you of the findings of the Medicare/Licensure survey at Teton Home Health, which was concluded on August 23, 2012.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health agency into compliance, and that the home health agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **September 20, 2012**, and keep a copy for your records.
9/28/12

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

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137061	A. BUILDING _____ B. WING _____	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON HOME HEALTH	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 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency. Surveyors conducting the recertification were: Rebecca Lara, RN, BA, HFS, Team Leader Gary Guiles, RN, HFS Acronyms used in this report include: DME = Durable Medical Equipment HHA = Home Health Aide OT = Occupational Therapy POC = Plan of Care PT = Physical Therapy q = every RN = Registered Nurse SOC = Start of Care	G 000	Refer to attach P.o.C for all tags. se RECEIVED SEP 2 8 2012 FACILITY STANDARDS	
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on observation, staff interview and review of medical records, it was determined the agency failed to ensure care was coordinated between staff for 2 of 8 patients (#1 and #4), who receivied services by more than one discipline and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. Findings include: 1. Patient #4's medical record documented a 52	G 143		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/25/12

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 143	Continued From page 1 year old male who was admitted to the home health agency on 7/30/12. The SOC assessment, dated 7/30/12 but not timed, documented Patient #4 experienced a ruptured brain aneurysm (an abnormal bulge in the wall of an artery in the brain) in 1995 that resulted in paraplegia (paralysis of the lower part of the body.) He was admitted to home health for care related to muscle weakness. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 7/30/12 to 9/27/12, included orders for skilled nursing and physical therapy services. A Physical Therapist was observed while providing care for Patient #4 on 8/21/12, beginning at 2:15 PM. During the visit, the PT explained Patient #4 was in need of a new mattress due to his changing condition and decreased ability to reposition himself when in bed. The PT stated an older specialized mattress was now in place, but was no longer adequate to meet the needs of Patient #4. Additionally, the PT said Patient #4 had not acquired any skin break down thus far, but was developing a reddened area on his coccyx (tailbone.) The surveyor asked the PT how and to whom he planned to convey the need for a new mattress. The PT stated the staff who obtained authorization for DME was best to make those arrangements. There was no mention of communicating the need for a new mattress or coordinating care with the RN Case Manager assigned to Patient #4. The Administrator, an RN, was interviewed on 8/22/12, beginning at 9:15 AM. He reviewed Patient #4's medical record and confirmed	G 143		

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G 143	Continued From page 2 coordination of care between disciplines had not occurred. The Administrator said care coordination should take place during case conferences, which were scheduled twice a month. However, he stated there was no evidence Patient #4 or his need for a new, specialty mattress were discussed at the last case conference meeting on 8/07/12. Coordination of care had not occurred between the PT and RN Case Manager. 2. Patient #1's medical record documented an 86 year old female whose SOC was 8/11/11. She was currently a patient as of 8/21/12. Her diagnosis was diabetes. Her "OASIS Follow-Up" assessment, dated 8/04/12 at 10:30 AM, stated she "...continues on hospice." A joint POC or other documentation of coordination of care was not present in the medical record. Nursing progress notes from 11/15/11 and 8/16/12, documented the hospice had been given report by the home health agency 4 times during that period, on 11/16/11, 6/05/12, 8/01/12, and 8/16/12. None of these notes documented who the nurse spoke with at the hospice agency or any specific exchange of information between the 2 agencies. The RN Case Manager for Patient #1 was interviewed on 8/21/12 beginning at 2:30 PM. She confirmed coordination of care was not documented. She stated staff had requested meeting with the hospice agency to discuss Patient #1 but this had not occurred. She stated the meeting requests were not documented.	G 143		

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G 143	Continued From page 3 The agency did not coordinate the care of Patient #1 with the hospice agency that also provided care for her.	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on observation, staff interview and review of medical records, it was determined the agency failed to ensure care coordination between staff was documented for 2 of 8 patients (#5, and #8) who receivied services by more than one discipline and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. Findings include: 1. Patient #5's medical record documented a 76 year old female whose SOC was 6/05/12. She was currently a patient as of 8/21/12. Her diagnoses included abnormal gait and weight loss. Progress notes documented Patient #5 received 12 nursing visits between 6/5/12 and 8/02/12. Progress notes documented Patient #5 received 20 PT visits between 6/8/12 and 8/02/12. Progress notes documented Patient #5 received 3 OT visits between 6/13/12 and 6/27/12. Progress notes documented Patient #5 received 24 aide visits between 6/7/12 and 8/03/12. Progress notes documented Patient #5 received	G 144		

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G 144	Continued From page 4 1 social work visit on 7/26/12. No documentation was present that coordination of care occurred between any of the above services except nursing and home health aide. The RN Case Manager for Patient #5 was interviewed on 8/21/12 beginning at 3:30 PM. He stated he thought coordination was occurring between caregivers but was not sure. He confirmed coordination of care was not documented. Coordination of care among personnel furnishing care to Patient #5 was not documented. 2. Patient #8's medical record documented an 84 year old male whose SOC was 8/07/12. He was currently a patient as of 8/21/12. His diagnosis was post total knee replacement. Progress notes documented Patient #8 received 4 nursing visits between 8/07/12 and 8/21/12. Progress notes documented Patient #8 received 6 PT visits between 8/08/12 and 8/20/12. No documentation was present that coordination of care occurred between the nurse and the therapist. The Administrator was interviewed on 8/22/12 beginning at 9:30 AM. He confirmed coordination of care was not documented. Coordination of care among personnel furnishing care to Patient #8 was not documented.	G 144		
G 145	484.14(g) COORDINATION OF PATIENT SERVICES	G 145		

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G 145	Continued From page 5 A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure a written summary report was sent to the attending physician at least every 60 days for 2 of 6 patients (#1 and #11) who had received home health services for longer than 60 days and whose records were reviewed. This had the potential to result in decreased physician awareness of patient conditions and reduce the quality of patient care. Findings include: 1. Patient #1's medical record documented an 86 year old female whose SOC was 8/11/11. She was currently a patient as of 8/21/12. Her diagnosis was diabetes. No summary reports to the physician were documented in Patient #1's medical record. The Administrator was interviewed on 8/22/12 beginning at 8:00 AM. He reviewed the record and confirmed the summary reports for Patient #1 were not documented. The agency did not send summary reports to the physician. 2. Patient #11's medical record documented a 73 year old male whose SOC was 4/19/12. He was currently a patient as of 8/22/12. His diagnoses included diabetes and bladder cancer.	G 145		

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G 145	Continued From page 6 No summary reports to the physician were documented in Patient #11's medical record. The Administrator was interviewed on 8/22/12 beginning at 8:00 AM. He reviewed the record and confirmed the summary reports for Patient #11 were not documented. The agency did not send summary reports to the physician.	G 145		
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 record review and staff interview, it was determined the agency failed to ensure care followed a written plan of care for 5 of 12 patients (#2, #5, #6, #7, and #9) whose records were reviewed. This had the potential to negatively impact patient outcomes. Findings include: 1. The agency did not conduct therapy visits in a timely manner after the POC was developed. Examples include a. Patient #2's medical record documented a 91 year old female who was admitted to the agency on 7/10/12. Her diagnoses included abnormality of gait, general muscle weakness, senile dementia, and osteoporosis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 7/10/12 to 9/07/12, included orders for occupational therapy to	G 158		

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G 158	Continued From page 7 "evaluate and treat." However, an initial OT visit for evaluation was not completed until 7/25/12, 15 days after the initiation of the POC. The Administrator, a RN, was interviewed on 8/22/12, beginning at approximately 10:15 AM. He reviewed Patient #2's medical record and confirmed the OT evaluation visit was not completed in a timely manner. The Administrator said the agency expected therapy initial evaluation visits to be completed within 48 hours of the SOC. b. Patient #6's medical record documented a 74 year old male who was admitted to the home health agency on 7/13/12. His diagnoses included hypotension, malignant neoplasm (a malignant tumor that tends to grow, invade and metastasize) of the bronchus and lung, depressive disorder and muscle weakness. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 7/13/12 to 9/10/12, included orders for physical therapy and occupational therapy to "evaluate and treat." However, an initial OT visit for evaluation was not completed until 7/24/12, 11 days after the initiation of the POC. The Administrator, a RN, was interviewed on 8/22/12, beginning at approximately 10:15 AM. He reviewed Patient #6's medical record and confirmed the OT evaluation visit was not completed in a timely manner. The Administrator said the agency expected therapy initial evaluation visits to be completed within 48 hours of the SOC. The agency failed to ensure therapy visits were	G 158		

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G 158	Continued From page 8 provided in a timely manner after the initiation of POCs. 2. Visits were not conducted in accordance with the POC. Examples include: a. Patient #6's medical record documented a 74 year old male who was admitted to the home health agency on 7/13/12. His diagnoses included hypotension, malignant neoplasm (a malignant tumor that tends to grow, invade and metastasize) of the bronchus and lung, depressive disorder and muscle weakness. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 7/13/12 to 9/10/12, included orders for physical therapy to "evaluate and treat." The "PHYSICAL THERAPY EVALUATION" was completed by the PT on 7/16/12 at 3:15 PM. The evaluation documented the PT would visit Patient #6 three times a week for three weeks, then twice a week for six weeks. During the third week of the certification period, the PT should have seen Patient #3 on 3 occasions. Documentation was found indicating Patient #6 was seen by the PT only once during week 3. The Administrator, a RN, was interviewed on 8/22/12, beginning at approximately 10:15 AM. He reviewed Patient #6's medical record and confirmed the visit documentation did not match the plan of care. Visit frequency did not follow Patient #6's plan of care. b. Patient #7's medical record documented a 66	G 158		

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G 158	Continued From page 9	G 158		

year old male who was admitted to the agency on 7/09/12. His diagnoses included anxiety, intracranial injury (traumatic brain injury), depressive disorder and hypertension. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the 7/09/12 to 8/06/12, included orders for occupational therapy to "evaluate and treat."

The "OCCUPATIONAL THERAPY EVALUATION/PLAN OF CARE" was completed on 7/18/12 at 2:00 PM. The evaluation documented the OT would visit Patient #7 twice a week for four weeks. During the fourth week of the certification period, the OT should have seen Patient #7 on two occasions. Documentation for week 4 showed there was only one OT visit. The fifth week of the certification period indicated Patient #7 was seen four times, when he should have been seen twice.

The Administrator, a RN, was interviewed on 8/22/12, beginning at approximately 10:15 AM. He reviewed Patient #7's medical record and confirmed the visit documentation did not match the plan of care.

Visit frequency did not follow Patient #7's plan of care.

3. Patient #5's medical record documented a 76 year old female whose SOC was 6/05/12. She was currently a patient as of 8/21/12. Her diagnoses included abnormal gait and weight loss.

Patient #5's POC, dated 6/05/12-8/03/12, stated "Occupational Therapy: Evaluate and treat."

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G 158	Continued From page 10 Progress notes documented Patient #5 received 3 OT visits, on 6/13/12, 6/20/12, and 6/27/12. A "DISCHARGE SUMMARY" by the Occupational Therapist, dated 6/27/12, stated OT services were discontinued on that date. Patient #5's next POC, dated 8/04/12-10/02/12, stated "Occupational Therapy: Evaluate and treat." No OT visits were documented after 6/27/12. The RN Case Manager for Patient #5 was interviewed on 8/21/12 beginning at 3:30 PM. He stated the 8/04/12 order for OT was brought forward from the previous POC. He stated the order was not accurate and OT services were not provided. OT services for Patient #5 were not provided in accordance with the 6/05/12 POC. 4. Patient #9's medical record documented an 87 year old female whose SOC was 6/20/12. She was currently a patient as of 8/21/12. Her diagnoses included congestive heart failure and anemia. A "Social Work Assessment and Plan of Care" dated 7/05/12 at 10:00 AM, was documented in her medical record. An order for the social work assessment was not present in her record. The Administrator was interviewed on 8/22/12 beginning at 11:40 AM. He reviewed the record and stated an order for the social work assessment was not present. Social services were provided to Patient #9 which were not part of the POC.	G 158		
G 229	484.36(d)(2) SUPERVISION	G 229		

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G 229	Continued From page 11 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 record review and staff interview, it was determined the agency failed to ensure home health aide supervisory visits were conducted every 14 days for 3 of 4 patients (#2, #5, and #11) who received home health aide services and whose records were reviewed. This had the potential to interfere with the quality and safety of patient care. Findings include: 1. Patient #2's medical record documented a 91 year old female who was admitted to the agency on 7/10/12. Her diagnoses included abnormality of gait, general muscle weakness, senile dementia and osteoporosis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 7/10/12 to 9/07/12, included orders for aide visits 5 times per week, for 9 weeks. The medical record showed aide visits had consistently occurred 5 times per week between 7/10/12 and 8/17/12. No supervisory visits were documented during this time. During an interview on 8/22/12, beginning at 10:15 AM, the Administrator, a RN, confirmed the findings. The agency did not ensure home health aide supervisory visits were conducted as required.	G 229		

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G 229	Continued From page 12 2. Patient #5's medical record documented a 76 year old female whose SOC was 6/05/12. She was currently a patient as of 8/21/12. Her diagnoses included abnormal gait and weight loss. Progress notes documented Patient #5 received aide visits 2 to 3 times a week between 6/07/12 and 8/03/12. Aide supervisory visits by an RN were only documented on 7/26/12 and on 7/30/12. The nursing progress note, dated 7/26/12 at 1:00 PM, stated "HHA Supervisory visit q 14 days when HHA involved in care plan (Done)." The nursing progress note, dated 7/30/12 at 4:00 PM, stated "HHA Supervisory visit q 14 days when HHA involved in care plan (Done)." Neither note stated how the aide supervision was conducted or what criteria was used to determine whether or not aide services were appropriate. The RN Case Manager was interviewed on 8/21/12 beginning at 3:30 PM. He stated the aide supervisory visits had not been completed for Patient #5. Aide supervisory visits were not conducted for Patient #5. 3. Patient #11's medical record documented a 73 year old male whose SOC was 4/19/12. He was currently a patient as of 8/22/12. His diagnoses included diabetes and bladder cancer. Progress notes documented Patient #11 received aide visits 2 to 3 times a week between 6/18/12 and 8/10/12. Aide supervisory visits by an RN were documented on 6/20/12, 6/29/12, 7/11/12,	G 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137061	A. BUILDING _____ B. WING _____	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON HOME HEALTH	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 229	Continued From page 13 and 8/01/12. Twenty days elapsed between the supervisory visits on 7/11/12 and 8/01/12. The Administrator was interviewed on 8/22/12 beginning at 9:30 AM. He confirmed an aide supervisory visit was not documented between 7/11/12 and 8/01/12 for Patient #11. Aide supervisory visits were not conducted at least every 14 days for Patient #11.	G 229		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001600	A. BUILDING _____ B. WING _____	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON HOME HEALTH	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 Idaho state licensure survey of your agency. Surveyors conducting the review were: Rebecca Lara, RN, BA, HFS, Team Leader Gary Guiles, RN, HFS	N 000		
N 119	03.07024.04.SK.NSG.SERV. N119 04. Supervisory Visits. A registered nurse or therapist makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days. This Rule is not met as evidenced by: Refer to G229 as it relates to the lack of home health aide supervisory visits.	N 119		
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G158 as it relates to fhe failure of the agency to ensure care followed the written plans	N 152		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001600	A. BUILDING _____ B. WING _____	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON HOME HEALTH	3101 VALENCIA DRIVE IDAHO FALLS, ID 83404

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N 152	Continued From page 1 of care.	N 152		
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: Refer to G145 as it relates to the lack of summaries of care provided to the physician.	N 186		

Teton Home Health
Provider# 137061
Plan of Correction for state survey
August 23, 2012
Appendix I

G 143 Training was provided to all of the clinicians on 9/4/12 regarding the need to coordination of care. The training included information regarding the need for all staff members that are involved with the patient care to communicate with each other throughout the course of treatment. Also the training included the documentation requirements in order to show coordination of care within the patient's medical record. Case conference notes were completed for each of the patients on 9/4/12 and reviewed with each of the clinicians. A case conference note was added to the admission packet and the admitting clinician is required to complete a case conference note for each patient upon admission. This information will be provided to all other clinicians involved in the care. All clinicians will be required to sign the case conference form to show that they have received the communication regarding the patient care. We received copies of the hospice care plan on patient #1 from the hospice agency and have added it to the medical record. Also we have met with the hospice agency and have reviewed the care and discussed the coordination of the care. Chart audits are now being conducted to identify if coordination of care is occurring. In the event that coordination of care is not occurring the appropriate staff members will be contacted and will be required to correct the medical record. The DON is responsible for conducting the chart audits and for notifying the clinicians when corrections to the medical record are required. All necessary corrections and new procedures will be in place by 9/15/12.

G144 Training was provided to all of the clinicians on 9/4/12 regarding the need to coordination of care. The training included information regarding the need for all staff members that are involved with the patient care to communicate with each other throughout the course of treatment. Also the training included the documentation requirements in order show coordination of care within the patient's medical record. Chart audits are now being conducted to identify if coordination of care is occurring. In the event that coordination of care is not occurring the appropriate staff members will be contacted and will be required to correct the medical record. Case conference notes were completed for each of the patients on 9/4/12 and reviewed with each of the clinicians. A case conference note was added to the admission packet and the admitting clinician is required to

complete a case conference note for each patient upon admission. This information will be provided to all other clinicians involved in the care. All clinicians will be required to sign the case conference form to show that they have received the communication regarding the patient care. The DON is responsible for conducting the chart audits and for notifying the clinicians when corrections to the medical record are required. All necessary corrections and new procedures will be in place by 9/15/12.

G145 Training was provided on 9/4/12 regarding the need for a 60 day summary to be sent to the physician every 60 days. A 60 day summary form was added to the recert packets that the clinicians complete every 60 days. Once the clinician completes the recert an audit is conducted of the recert documentation to ensure that a 60 day summary has been completed and that it has been sent to the physician. The DON is responsible for conducting the audits of the recert information. In the event that the clinician has not completed a 60 day summary the clinician will be notified and be required to complete the 60 day summary before the recert will be processed. All necessary corrections and new procedures will be in place by 9/15/12.

G158 Training was provided to all clinicians including the therapist on 9/4/12 regarding the need for all disciplines to be in the home within 5 days after the admission, the need for the clinicians to follow the orders listed on the plan of care, and to obtain physician orders for all disciplines and care to be provided. Upon admission of a new patient when the need for therapy is identified or the receipt of new physician orders for therapy, the clinician will immediately contact the office coordinator. The office coordinator will then immediately contact the assigned therapist and inform them of the need for therapy. The office coordinator will inform the therapist of when the order was received and inform them of the 5 day time frame they have to complete the initial evaluation. All disciplines submit their visit notes to the office coordinator. The office coordinator then enters all notes into the computer system. The computer system will then identify if there are orders for all of the visits provided. In the event that there are not orders for care then the clinician will be contacted and the clinician will be required to contact the physician to obtain orders for their care. The office coordinator does the assigning of all disciplines and she will now only assign disciplines once she has a physician order in hand in order to prevent services being provided without physician orders. Chart audits are now being conducted by the DON which include identifying if all disciplines have been in the home within the 5 day time frame, that all disciplines and services have orders for their care, and that the services provided follow the physician orders. In the event that a clinician was unable to conduct the initial evaluation within the

required timeframe then that clinician will be contacted and the DON will reeducate the clinician of the required timeframe and work with the clinician on scheduling to ensure that the clinician can conduct the initial evaluation visits within the required timeframe. The clinician will also be required to provide documentation as to why they were unable to be in the home within the required time frame. When the chart audit shows that there is not a physician order care the DON will contact the clinician and the clinician will be required to contact the physician to obtain orders. All necessary corrections and new procedures will be in place by 9/15/12.

G229 Training was provided to all clinicians on 9/4/12 regarding the regulations for conducting HHA supervisory visits every 14 days. The therapist received training that they must complete the HHA supervisory visits when nursing services are no longer involved in the patient's care. Chart audits are now being conducted by the DON to identify if the HHA supervisory visits are being conducted at least every 14 days. The receptionist, who does the filing, is now tracking the HHA supervisory visits on a 60 day calendar. As she completes the filing she informs the clinicians of when the next supervisory visits is due and the supervisory visit is added to the clinician's schedule. The DON is responsible for conducting the chart audits and ensuring that the clinicians are completing the HHA supervisory visits. All necessary corrections and new procedures will be in place by 9/15/12.

N119 Training was provided to all clinicians on 9/4/12 regarding the regulations for conducting HHA supervisory visits every 14 days. The therapist received training that they must complete the HHA supervisory visits when nursing services are no longer involved in the patient's care. Chart audits are now being conducted by the DON to identify if the HHA supervisory visits are being conducted at least every 14 days. The receptionist, who does the filing, is now tracking on a 60 day calendar the HHA supervisory visits. As she completes the filing she informs the clinicians of when the next supervisory visits is due and the supervisory visit is added to their schedule. The DON is responsible for conducing the chart audits and ensuring that the clinicians are completing the HHA supervisory visits. All necessary corrections and new procedures will be in place by 9/15/12.

N152 Training was provided to all clinicians including the therapist on 9/4/12 regarding the need for all disciplines to be in the home within 5 days after the admission, the need for the clinicians to follow the orders listed on the plan of care, and to obtain physician orders for all disciplines and care to be provided. Upon admission of a new patient when the need for therapy is identified or the receipt of new physician orders for therapy, the clinician will immediately contact the office coordinator. The office coordinator will then immediately contact the assigned therapist and inform them of the need for therapy. The office coordinator will inform the therapist of

when the order was received and inform them of the 5 day time frame they have to complete the initial evaluation. All disciplines submit their visit notes to the office coordinator. The office coordinator then enters all notes into the computer system. The computer system will then identify if there are orders for all of the visits provided. In the event that there are not orders for care then the clinician will be contacted and the clinician will be required to contact the physician to obtain orders for their care. The office coordinator does the assigning of all disciplines and she will now only assign disciplines once she has a physician order in hand in order to prevent services being provided without physician orders. Chart audits are now being conducted by the DON which include identifying if all disciplines have been in the home within the 5 day time frame, that all disciplines and services have orders for their care, and that the services provided follow the physician orders. In the event that a clinician was unable to conduct the initial evaluation within the required timeframe then that clinician will be contacted and the DON will reeducate the clinician of the required timeframe and work with the clinician on scheduling to ensure that the clinician can conduct the initial evaluation visits within the required timeframe. When the chart audit shows that there is not a physician order care the DON will contact the clinician and the clinician will be required to contact the physician to obtain orders. All necessary corrections and new procedures will be in place by 9/15/12.

N186 Training was provided on 9/4/12 regarding the need for a 60 day summary to be sent to the physician every 60 days. A 60 day summary form was added to the recert packets that the clinicians complete every 60 days. Once the clinician completes the recert an audit is conducted of the recert documentation to ensure that a 60 day summary has been completed and that it has been sent to the physician. The DON is responsible for conducting the audits of the recert information. In the event that the clinician has not completed a 60 day summary the clinician will be notified and be required to complete the 60 day summary before the recert will be processed. All necessary corrections and new procedures will be in place by 9/15/12.