IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

June 21, 2016

Tamala Slatter, Administrator
Visions Home Health
1770 Park View Drive
Twin Falls, ID 83301

RE: Visions Home Health, Provider #137107

Dear Ms. Slatter:

On June 7, 2016, an on-site follow-up revisit was conducted to verify that Visions Home Health was in compliance with all Conditions of Participation. The agency's allegation of compliance indicated your agency was in substantial compliance as of April 15, 2016. However, based on our on-site revisit conducted June 7, 2016, your agency remains out of compliance with the following Condition of Participation:

- **Acceptance of Patients, Poc, Med Super (42 CFR 484.18)**

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

The deficiencies, which caused the condition to be unmet, substantially limit the capacity of Visions Home Health to furnish services of sufficient level and quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies. Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing corrected deficiencies, is also enclosed.

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

An acceptable Plan of Correction contains the following elements:

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

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **July 5, 2016**. It is strongly recommended that the agency's Credible Allegation /Plan of Correction for the Condition of Participation and related standard level deficiences show compliance no later than **July 22, 2016** (45 days from survey exit). We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies compliance.

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

Consistent with the provisions of 42 CFR 488, Alternative Sanctions for Home Health Agencies, the following remedies were recommended to the Centers for Medicare/Medicaid (CMS) Region X Office, following the (date of original survey),recertification survey of your agency:

- Termination [42 CFR 488.865]
- Suspension of payment for all new Medicare admissions [42 CFR 488.820(b)]

You were notified of these recommendation in our March 16, 2016, letter, sent following the March 1, 2016, recertification survey.

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

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

We urge you to begin correction immediately.

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

Sincerely,

Dennis Kelly

DENNIS KELLY, RN
Co-Supervisor
Non-Long Term Care

DK/pmt
Enclosures

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS RX-400
Seattle, WA 98104

Western Division of Survey and Certification

DRAFT July 18, 2016

Tamala Slatter,
Visions Home Health
1770 Park View Drive
Twin Falls, ID 83301

CMS Certification Number: 137107

CIVIL MONEY PENALTY-PLEASE READ CAREFULLY

Dear Ms. Slatter:

The Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), has determined that Visions Home Health no longer meets the requirements for participation as a provider of services in the Health Insurance Program for the Aged and Disabled (Medicare) established under Title XVIII of the Social Security Act (the Act), and Medicaid, Title XIX of the Act.

To participate as a provider of services in the Medicare program, a home health agency must meet all of the provisions of section 1861(o) of the Act [42 U.S.C. § 1395x], be in compliance with each of the conditions of participation established by the Secretary of Health & Human Services at 42 C.F.R. Part 484, be free of hazards to the health and safety of patients, and meet such other requirements as shall be established by law or regulation. Under Medicaid, it must also meet all of the provisions of Section 1929 of the Act [42 U.S.C. § 1396t]. Section 1891(e) through (f) of the Act [42 U.S.C. §§ 1395bbb(e) through (f)] authorizes the Secretary to take actions to remove and correct deficiencies in a home health agency through an alternative sanction (including a civil money penalty) or termination or both.

Background

As you recall, on **March 1, 2016,** a recertification survey was completed at Visions Home Health by Bureau Of Facility Standards (State survey agency) to determine compliance with the Federal requirements for HHAs participating in the Medicare and/or Medicaid programs. That survey found the agency was not in substantial compliance with three Conditions of Participation. CMS agreed with the State survey agency that the following Conditions of Participation were not met, as stated in the summary of deficiencies (CMS 2567) that was sent to you:

42 C.F.R. § :

484.14 Organization, Services & Administration
484.18 Acceptance of Patients, Plan of Care, and Medical Supervision
484.30 Skilled Nursing Services

Now

On June 7, 2016, Follow-Up/revisit (revst) survey was completed at your agency by the Bureau Of Facility Standards (State survey agency) to determine if your agency was in compliance with the

Federal participation requirements for participating in the Medicare and/or Medicaid programs. That survey found that your agency was not in substantial compliance with the participation requirements, and that the most serious deficiencies in your agency constituted non-compliance with the Conditions of Participation for home health agencies. Specifically, your agency was not in compliance with the following Condition(s):

42 C.F.R. § :

484.18 -- Acceptance Of Patients, Poc, Med Super

We must impose a civil money penalty (CMP) on your agency, as a result of the survey findings listed on the Statement of Deficiencies (Form CMS 2567), which were forwarded to you by the State survey agency after the surveys listed above, in accordance with the enforcement regulations specified at 42 C.F.R. §§ 488.820 and 488.830(a).

Amount of Civil Money Penalty

We are imposing a CMP effective June 7, 2016 in the amount of $3,000.00 for each day that your agency is not in substantial compliance with the participation requirements. In addition, we are imposing a per instance CMP effective March 1, 2016 in the total amount of $3,500.00.

In determining the amount of the CMP, we considered all of the applicable factors listed at 42 C.F.R. § 488.845(b)(1) including but, not limited to, the nature of the deficiency/ies, the agency's history of non-compliance (including repeated deficiencies), the extent to which the deficiencies are directly related to a failure to provide quality patient care, indications of system-wide failures to provide quality care, the size of the agency, and the financial condition of the agency to the extent it is known.

The CMP will continue to accrue at the amount specified above until you have made the necessary corrections to achieve substantial compliance with the participation requirements or your provider agreement is terminated. Should non-compliance continue, the maximum amount of time that would be permitted to elapse between the date of the survey and the date of termination is six months.
Termination could occur sooner than six months dependent on changing conditions in the agency.

Appeal Rights

If you do not agree with this determination, you may request a hearing before an administrative law judge (ALJ) of the Departmental Appeals Board in accordance with 42 C.F.R. §§ 498.40 through 498.78. A request for hearing must be filed electronically no later than sixty (60) calendar **days after the date you receive this notice.** 42 C.F.R. § 498.40. You should file your request for an appeal (accompanied by a copy of this letter) through the Departmental Appeals Board Electronic Filing System website (DAB E-file) at https://dab.efile.hhs.gov.

Please note: All documents must be submitted in Portable Document Format ("pdf"). You are **required** to e-file your appeal request unless you do not have access to a computer or internet service. In such circumstances, you may file in writing, but must provide an explanation as to why you cannot file submissions electronically and request a waiver from e-filing in the mailed copy of your request for a hearing.

A written request for appeals must also be filed no later than sixty **(60) calendar days** from the date you receive this notice, and must be submitted to the following address:

Chief, Civil Remedies Division **Departmental Appeals Board MS** **6132 Cohen Building, Room 637-D** **330 Independence Avenue,** **SW Washington, D.C. 20201**	**Please also send a copy to:**	**Chief Counsel** **DHHS Office of General Counsel 701 Fifth Avenue, Suite 1620 M/S RX-10** **Seattle, WA 98104**

A request for a hearing must contain the information specified in 42 CFR § 498.40(b) (1) and must identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. 42 C.F.R. § 498.40(b)(2). You may be represented by counsel at a hearing at your own expense. If a hearing is requested, the civil money penalty will not be collected until after an administrative hearing decision upholding its imposition has been made.

CMP Reduction for Waiver of Appeal Rights

Visions Home Health may waive its right to a hearing and receive a **35 percent reduced amount** of the civil money in accordance with 42 CFR § 488.436. If you intend to waive your right to a hearing, you must send written notice and payment by check payable to the Centers of Medicare and Medicaid Services no later than **60 days** from the date of this letter.

Please send your letter waiving your right to a hearing to: Manuel Bravo at manuel.bravo@cms.hhs.gov, for either the:

1) per day CMP, or
2) per instance CMP.

Do not send payment at this time. When we receive notice that you have elected the option to waive your right to appeal the civil money penalty and agree to pay the reduced amount of the CMP, or when a final administrative decision upholds imposition, we will provide payment instructions to you. If you neither submit a written request for a hearing nor formally waive your right to appeal you will be assessed the full amount of the civil money penalty and we will notify you of the payment methodology.

If you have any questions, please contact Manuel Bravo of my staff at (206) 615-2648 or atmanuel.bravo@cms.hhs.gov.

Sincerely,

Patrick Thrift
Manager, Seattle Regional Office
Division of Survey, Certification & Enforcement

Enclosure: DAB e-file instructions
cc: Bureau Of Facility Standards

VISIONS
HOME HEALTH, LLC
We're Always There For You
The Best of Care Coming to Your Home!

June 30, 2016

Mr. Dennis Kelly
Co-Supervisor, Non-Long Term Care
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720-0009

Dear Mr. Kelly:

Your survey team completed a Medicare Licensure and Certification re-survey at Visions Home Health provider number 137107 in Twin Falls on June 6th thru June 7th, 2016. In response to your findings, we have developed a plan of correction. Enclosed is our plan. If you have any questions regarding the plan, you may contact me by phone (208) 732-5365.

The Visions Home Health Team will learn from the survey and make the necessary improvements in our agency's process to ensure quality patient care. I would like to thank your staff for the professional manner in which the survey was conducted and for your guidance in assisting us in completing our plan of correction.

Sincerely,

Tamala Slatter RN BSN

Tamala Slatter, RN BSN
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	R 06/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH	1770 PARK VIEW DRIVE TWIN FALLS, ID 83301

(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 follow up survey conducted from 6/06/16 to 6/07/16. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS Kristin Inglis, RN, HFS Brian Osborn, RN, HFS Acronyms used in this report include: ABD and abd - Abdominal ALF - Assisted Living Facility BMP - Basic Metabolic Panel CHF - Congestive Heart Failure CKD - Chronic Kidney Disease cm - centimeter COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus ER - Emergency Room LPN - Licensed Practical Nurse MD - Physician mg - milligram MSW - Medical Social Worker NP - Nurse Practitioner NS - Normal Saline OT - Occupational Therapy POC - Plan of Care PRN - As needed Pt - patient PT - Physical Therapy RN - Registered Nurse SN - Skilled Nurse ST - Speech Therapy UTI - Urinary track infection wk - week	{G 000}	RECEIVED SEP 0 5 2016 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		07/05/2016

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 106}	484.10(b)(4) EXERCISE OF RIGHTS AND RESPECT FOR PROP The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so. This STANDARD is not met as evidenced by:	{G 106}		
{G 108}	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. This STANDARD is not met as evidenced by:	{G 108}		
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.	G 143		7/11/16

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G 143	Continued From page 2 This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interviews, it was determined that the agency failed to ensure care coordination between disciplines for 3 of 6 patients (Patients #3, #6 and #7) who received services from more than one discipline, and whose records were reviewed. This resulted in the potential for quality, safety and continuity of patient care to be compromised. Findings include: The agency policy "Coordination of Care," Policy Number 3002, updated 4/01/14, stated "All personnel providing patient care will provide coordination of patient care services to establish effective interchange, reporting and coordinated patient evaluation through multi-disciplinary case conferences and other interdisciplinary communication strategies." Additionally, under the Procedure Section the policy stated "To keep patient record current, visit notes not on CPOC [Comprehensive Plan of Care, the agency's electronic medical record] will be submitted to Data Processing within 48 hours of home visit." During an interview with the Nursing Director on 6/07/16, at 10:10 AM, she stated that some contracted patient care services, such as MSW, PT and ST, did not document directly into the electronic record, but wrote their visit notes separately, submitted their notes to the agency, and the visit notes were integrated into the record. She stated review of other disciplines visit notes by the RN Case Manager was used as a form of interdisciplinary communication. During an interview on 6/07/16, at 8:40 AM, an RN Case Manager stated a review of visit notes by other disciplines kept the RN Case Managers	G 143		

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G 143	Continued From page 3 updated on a patient's status, allowing for coordination of patient care. Additionally, she stated RN Case Managers were required to review and sign PT visit notes. 1. Patient #6 was a 75 year old male admitted to the agency on 5/16/16, for care related to a UTI with sepsis (the body's systemic response to an overwhelming infection). Additional diagnoses included unspecified dementia, alcohol dependence, chronic pain, weakness and repeat falls. He received SN, PT, OT, MSW, and aide services. His record, including the POC, for the certification period 5/16/16 to 7/14/16, was reviewed. Patient #6's PT and MSW visit notes were not available for review in his record by the RN Case Manager, as follows: a. Patient #6's POC included an order for an MSW to assess and evaluate between 5/17/16 and 5/24/16. There was no documentation of an MSW visit in his record as of 6/06/16 at 5:00 PM. During an interview on 6/07/16, at 8:40 AM, the RN Case Manager stated a Social Services visit was completed on 5/25/16, however, the MSW had not placed visit notes in Patient #6's record. She stated the MSW assessment and plan were not available for other disciplines providing care for Patient #6 to review and coordinate care. b. Patient #6's orders included PT visits 2 times a week for 3 weeks, beginning 5/17/16. However, 1 PT visit was documented for the week of 5/22/16, and no visits were documented for the week of 5/29/16.	G 143		

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G 143	Continued From page 4 During an interview on 6/07/16, at 8:40 AM, the RN Case Manager reviewed the agency's schedule and stated Patient #6 received PT visits on 5/26/16, 5/31/16, and 6/02/16. The RN Case Manager stated she was unable to review the PT visit notes for 5/26/16, 5/31/16, and 6/02/16, as the visit notes for the 3 visits were not in Patient #6's record. Additionally, the RN Case Manager stated there were no other communications between the RN Case Manager and the Physical Therapist regarding Patient #6's status on those dates. Patient #6's care was not coordinated between disciplines that provided care. 2. Patient #3 was a 91 year old female who was admitted for home health services on 5/09/16. She was currently a patient as of 6/07/16. Her diagnoses included acute embolism, high blood pressure, and heart failure. Her medical record, for the certification period 5/09/16 to 7/07/16, was reviewed. A physician's phone order, dated 5/16/16 stated Patient #3 had increasing coughing and ST was to evaluate her. As of 6/06/16, at 3:15 PM, no documentation was present in Patient #3's medical record that the ST evaluation had been conducted. Patient #3's RN Case Manager was interviewed on 6/06/16, beginning at 3:15 PM. She stated she thought the Speech Therapist had conducted an evaluation 1 week ago, but no visit notes had been received and she stated she did not know the results of the evaluation. On 6/07/16, at approximately 10:00 AM, ST visit	G 143		

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G 143	Continued From page 5 notes were presented to the surveyor. An ST evaluation was documented on 5/25/16. It stated Patient #3 had difficulty swallowing. Four ST visits were documented between 5/27/16 and 6/02/16. There was no documentation of coordination of care documented between ST and nursing personnel. Patient #3's RN Case Manager was not aware Patient #3 was receiving ST services. Care was not coordinated. 3. Patient #7 was an 81 year old female admitted to the agency on 5/01/16 for care related to acute on chronic CHF. Secondary diagnoses included Type 2 diabetes and COPD. Patient #7 received SN, OT, and PT services. Her record, including the POC for the certification period 5/01/16 to 6/29/16, was reviewed. Patient #7's record included a "Home Health Care Certification and Plan of Care," dated 5/01/16, and signed by the physician on 5/10/16, which stated she had CHF and Type 2 diabetes. Additionally, the POC stated she was on a "regular diet." The RN Case Manager was interviewed on 6/07/16, at 10:30 AM. She stated she entered the "regular diet" information on Patient #7's POC. The RN Case Manager stated she attempted to clarify the diet with Patient #7's physician via phone, but was unable to reach him. She stated she did not follow up with the physician or document the attempted contact. The agency failed to ensure coordination of patient care related to Patient #7's nutritional needs.	G 143		

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{G 156}	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the agency failed to ensure care was provided in accordance with patients' POCs, the physician was notified of changes in patients' conditions, and treatments were administered as ordered by the physician. This resulted in unmet patient needs, and care provided without physician authorization. Findings include: 1. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with patients' POCs. 2. Refer to G164 as it relates to the failure of the agency to notify the physician of changes in patients' conditions. 3. Refer to G165 as it relates to the failure of the agency to ensure treatments were administered only as ordered by the physician. The cumulative effect of these negative systemic practices seriously impeded the ability of the agency to provide quality care in accordance with established POCs.	{G 156}		
{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.	{G 158}		

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{G 158}	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review, policy review and staff interview, it was determined the agency failed to ensure care followed a physician's written POC for 5 of 7 patients (#2, #3, #4, #5, and #7) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include: 1. Patient #2 was an 82 year old female admitted to the agency on 4/19/16 for care related to a urinary tract infection. The POC and physician orders, for the certification period 4/19/16 to 6/17/16, were reviewed. a. A "Physician Phone Order," dated 4/26/16 included an order for a PT evaluation, which was documented as completed on 5/03/16. There were no additional PT orders included in Patient #2's medical record. However, there was documentation of 8 PT visits, on the following dates: 5/05/16, 5/09/16, 5/12/16, 5/18/16, 5/24/16, 5/26/16, 6/01/16, and 6/02/16. The Patient Care Coordinator was interviewed on 6/06/16, at 3:40 PM. She reviewed the record and confirmed there were no orders for Patient #2's PT visits. PT visits did not follow the written plan of care approved by Patient #2's physician. b. The POC included orders for SN to monitor Patient #2's weight and assess for changes in weight. There was no documentation weights had been assessed on the initial SN visit, dated 4/19/16, or subsequent visits, dated 4/26/16, 4/29/16, 5/03/16, 5/17/16, 5/24/16 or 5/31/16.	{G 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	R 06/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH	1770 PARK VIEW DRIVE TWIN FALLS, ID 83301

(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 158}	Continued From page 8 The Patient Care Coordinator was interviewed on 6/06/16, at 3:40 PM. On 6/07/16, at 10:30 AM, the Patient Care Coordinator stated she reviewed Patient #2's record and did not find documention of weights. Patient #2's weights were not monitored in accordance with her POC. c. Patient #2's POC included an order for SN to "draw BMP, urine sodium, urine osmolality on 4/25/16." There was no documented SN visit on 4/25/16, evidence of lab work, dated 4/25/16, or explanation as to why the lab work was not drawn on 4/25/16, as ordered. The Patient Care Coordinator was interviewed on 6/06/16, at 3:40 PM. She confirmed the lab was not drawn on 4/25/16. She stated if the lab was not going to be drawn on the date ordered, there should have been a communication note between the nurse and physician, which she did not see. Patient #2's lab work was not drawn on 4/25/16 in accordance with the POC. 2. Patient #4 was a 62 year old female admitted to the agency on 5/18/16 for care related to a malignant neoplasm and a surgical wound on her abdomen. The POC and physician orders, for the certification period 5/18/16 to 7/16/16, were reviewed. The POC, dated 5/18/16, included wound care orders, "Cover abdominal site with ABD pads or like dressing. Change PRN." A verbal order, dated 5/18/16, directed SN to use ABD pads and steri strips to cover wound.	{G 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{G 158}	Continued From page 9 The SN visit note, dated 5/21/16, included the following documentation: "Upon assessment of patient it was found the bottom of her incision had dehiscence [opening of an incision line.] See wound assessment for measurements. Promptly called [physician] office. Spoke to [physician staff member] and reported findings that patient was edematous, incision draining copious amount of serous fluid from about umbilicus down. Steri strips were coming loose, incision dehiscence last 2 cm of incision. [Physician staff member] instructed me to reapply steri strips and cover wound again with abd pads and change as needed." Patient #4's RN Case Manager was interviewed on 6/07/16, at 9:30 AM. She stated Patient #4's surgical abdominal wound had dehisced. She stated she tried using steri strips to pull edges together based on guidance of a staff member in the physician's office. She stated when the steri strips did not hold, she used Medipore tape over the incision to pull edges together and she called back and let the physician's office know. She confirmed she did not have a specific order for Medipore tape. There was no physician's order for SN to apply Medipore tape directly on Patient #4's incision site. Wound care did not follow the written plan of care. 3. Patient #3 was a 91 year old female who was admitted for home health services on 5/09/16. Her diagnoses included acute embolism, high blood pressure, diabetes, and heart failure. Her medical record for the certification period 5/09/16 to 7/07/16 was reviewed.	{G 158}		

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{G 158}	Continued From page 10 Patient #3's POC for the certification period 5/09/16 to 7/07/16 stated she was to receive nursing services including "Monitor weight and assess for weight change...Monitor vital signs including: apical, radial, and pedal pulses and orthostatic blood pressure...Assess for signs/symptoms of hypoglycemia and hyperglycemia [low and high blood sugar]." SN visit notes were documented on 5/16/16, 5/23/16, 5/31/16, and 6/06/16. The SN visit notes did not include documentation of apical or pedal pulses, weights, orthostatic blood pressures, or blood glucose levels. Patient #3's RN Case Manager was interviewed on 6/06/16, beginning at 3:15 PM. She stated she had not weighed Patient #3. She stated the ALF checked Patient #3's blood glucose levels. She stated she had not seen the results of the blood glucose checks. She stated she had not monitored Patient #3's apical and pedal pulses or her orthostatic blood pressure. The nurse failed to follow Patient #3's POC. 4. Patient #5 was an 82 year old female admitted to the agency on 5/18/16, for care related to a diabetic foot ulcer. Secondary diagnoses included chronic kidney disease with hemodialysis, insulin dependent Type 2 DM, and chronic ischemic heart disease. Patient #5 received SN services only. Her record, including the POC for the certification period 5/18/16 to 7/16/16, was reviewed. Patient #5's record included a "Home Health Care Certification and Plan of Care," dated 5/18/16,	{G 158}		

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{G 158}	Continued From page 11 and signed by the physician on 5/31/16, which documented a physician order for wound care to include "daily wound care to left foot, pack with Iodoform gauze soaked in half betadine and half NS, wrap with Kerlix, and secure with tape." An agency policy titled "Plan of Care Number 3005," revised 1/22/13, was reviewed. The policy stated "a written POC shall be developed and implemented for each patient with participation from all disciplines providing services for that patient to include treatment orders." Patient #5's POC was not followed per physician order and agency policy as follows: a. Patient #5's record included a SN visit note dated 6/02/16, and signed by the RN Case Manager. Wound documentation on the form included "packed with plain packing strip" instead of iodoform gauze per physician order, on the POC. The RN Case Manager was interviewed on 6/07/16, at 12:40 PM. She reviewed Patient #5's record and confirmed the physician's order for wound care was not followed. b. Patient #5's record included SN visit notes dated 5/28/16, 5/29/16, and 5/30/16, and signed by an LPN. Wound documentation on the form included "packed with plain packing strip" instead of iodoform gauze per physician order, on the POC. Patient #5's record included SN visit notes dated 6/01/16, 6/03/16, and 6/04/16, and signed by an LPN. Wound documentation on the form included "packed with plain packing strip and	{G 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{G 158}	Continued From page 12 saline wet-dry" instead of iodoform gauze, betadine, and half NS per physician POC order. The LPN was interviewed on 6/07/16, at 11:20 AM. She reviewed Patient #5's record and stated the physician's order for wound care was not followed. The agency failed to ensure Patient #5's wound care was provided as ordered by her physician. 5. Patient #7 was an 81 year old female admitted to the agency on 5/01/16, for care related to acute on chronic CHF. Secondary diagnoses included Type 2 diabetes and COPD. Patient #7 received SN, OT, and PT services. Her record, including the POC for the certification period 5/01/16 to 6/29/16, was reviewed. An agency policy titled "Plan of Care No. 3005," revised 1/22/13, was reviewed. The policy stated "a written POC shall be developed and implemented for each patient with participation from all disciplines providing services for that patient to include treatment orders and frequencies." Patient #7's POC was not followed per physician order and agency policy as follows: a. Patient #7's record included a "Home Health Care Certification and Plan of Care," dated 5/01/16, and signed by the physician on 5/10/16, which included a physician order to "monitor weight each visit." Patient #7's record included SN visit notes dated 5/04/16, 5/06/16, and 5/12/16, and signed by the RN Case Manager. The visit notes did not	{G 158}		

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{G 158}	Continued From page 13 include patient weights. b. Patient #7's POC included a physician order to "assess blood sugar monitoring and results. Pt to check blood sugars 2 x daily; notify MD as indicated." Patient #7's record included SN visit notes dated 5/06/16, 5/10/16, and 5/20/16, and were signed by the RN Case Manager. The visit notes did not include patient blood glucose results. c. Patient #7's POC included a physician order for "skilled nursing 3 wk 2 wk beginning during week of 5/03/16." However, only two SN visits were documented for the week of 5/08/16 through 5/14/16. The was no documentation stating her physician was notified of the missed SN visit. The RN Case Manager was interviewed on 6/07/16, at 10:30 AM. She reviewed Patient #7's record and stated her physician POC was not followed for weight monitoring, blood glucose monitoring and frequency of SN visits. Additionally, she confirmed Patient #7's physician was not notified of the missed SN visit. The agency failed to ensure Patient #7's SN services followed the physician ordered POC.	{G 158}		
{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.	{G 164}		

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{G 164}	Continued From page 14 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure agency staff promptly alerted the physician to changes in patient condition that suggested the need to alter the plan of care for 1 of 7 patients (Patient #4) whose records were reviewed. This may have resulted in a delay in interventions to address the patient's changing condition who was hospitalized the next day. Findings include: Patient #4 was a 62 year old female admitted to the agency on 5/18/16, for care related to a malignant neoplasm and a surgical wound on her abdomen. The POC, physician orders, and SN visit notes for the certification period 5/18/16 to 7/16/16, were reviewed. An SN visit note, dated 5/21/16, included a respiratory assessment that documented abnormal breath sounds, dyspnea on exertion, an initial oxygen saturation of 88% at rest on room air, and a second oxygen saturation reading of 92% at rest on room air. The narrative portion of the SN visit note stated: "Patient work for breathing has increased a small amount. Patients daughter [name] is a [nurse practitioner] NP and stayed the night with her last night. Patient denies anxiety, pain with breathing. [Patient's daughter], myself and patient discussed possible causes. I told daughter that I would normally advise they take patient into ER for chest X-ray but since she is a NP I am leaving it to her to decide if she wanted to take patient in as they have already called the St Luke's triage Nurse who also advised taking patient in if condition declines." There was no documentation stating her	{G 164}		

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{G 164}	Continued From page 15 physician was alerted to Patient #4's changing condition, as assessed on 5/21/16. An SN visit note, dated 5/22/16, stated Patient #4's daughter had called to report she was taken to the ER, found to have multiple pulmonary embolisms (blood clots in the lungs), and was being admitted to the hospital. Patient #4's RN Case Manager was interviewed on 6/07/16, at 9:30 AM. She confirmed she did not alert the physician on 5/21/16, regarding Patient #4's respiratory status. She stated "I missed that." The SN did not alert the physician to changes in Patient #4's condition that resulted in hospitalization.	{G 164}		
{G 165}	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure wound treatments were provided as ordered by the physician for 2 of 2 patients (#4 and #5) whose records were reviewed and whose POC included wound care. This resulted in unauthorized wound care and had the potential to interfere with the quality and safety of patient care. Findings include: 1. Patient #4 was a 62 year old female admitted to the agency on 5/18/16, for care related to a	{G 165}		

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{G 165}	Continued From page 16 malignant neoplasm and a surgical wound on her abdomen. The POC and physician orders for the certification period 5/18/16 to 7/16/16, were reviewed. a. The POC, dated 5/18/16, included wound care orders, "Cover abdominal site with ABD pads or like dressing. Change PRN." A verbal order, dated 5/18/16, directed SN to use ABD pads and steri strips to cover wound. The SN visit note, dated 5/21/16, included the following documentation: "Upon assessment of patient it was found the bottom of her incision had dehiscence [opening of incision line.] See wound assessment for measurements. Promptly called [physician] office. Spoke to [physician's office staff] and reported findings that patient was edematous, incision draining copious amount of serous fluid from about umbilicus down. Steri strips were coming loose, incision dehiscence last 2 cm of incision. [Physician's office staff] instructed me to reapply steri strips and cover wound again with abd pads and change as needed." Patient #4's RN Case Manager was interviewed on 6/07/16, at 9:30 AM. She stated Patient #4's surgical abdominal wound had dehisced. She stated she tried using steri strips to pull edges together based on guidance of a staff member in the physician's office. She stated when the steri strips did not hold, she used Medipore tape directly over the incision to pull wound edges together and she called back and let the physician's office know. The RN Case Manager stated she did not have a specific order to use Medipore tape directly over Patient #4's abdominal wound.	{G 165}		

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{G 165}	Continued From page 17 Wound care treatments were not administered as ordered by a physician. 2. Patient #5 was an 82 year old female admitted to the agency on 5/18/16, for care related to a diabetic foot ulcer. Secondary diagnoses included chronic kidney disease with hemodialysis, insulin dependent Type 2 DM, and chronic ischemic heart disease. Patient #5 received SN services only. Her record, including the POC, for the certification period 5/18/16 to 7/16/16, was reviewed. Patient #5's record included a "Home Health Care Certification and Plan of Care," dated 5/18/16, and signed by the physician on 5/31/16, which included an order "daily wound care to left foot, pack with Iodoform gauze soaked in half betadine and half NS, wrap with Kerlix, and secure with tape." An agency policy titled "Plan of Care No. 3005," revised 1/22/13, was reviewed. The policy stated "a written POC shall be developed and implemented for each patient with participation from all disciplines providing services for that patient to include treatment orders." Patient #5's POC was not followed per physician order and agency policy as follows: a. Patient #5's record included an SN visit note dated 6/02/16, and signed by the RN Case Manager. Wound documentation on the visit note included "packed with plain packing strip." The RN Case Manager was interviewed on 6/07/16, at 12:40 PM. She reviewed Patient #5's	{G 165}		

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{G 165}	Continued From page 18 record and confirmed the physician's order for wound care was not followed. b. Patient #5's record included SN visit notes dated 5/28/16, 5/29/16, and 5/30/16, and signed by an LPN. Wound documentation on the form included "packed with plain packing strip." Patient #5's record included SN visit notes dated 6/01/16, 6/03/16, and 6/04/16, and signed by an LPN. Wound documentation on the form included "packed with plain packing strip and saline wet-dry." The LPN was interviewed on 6/07/16, at 11:20 AM. She reviewed Patient #5's record and confirmed the physician's order for wound care was not followed. Patient #5's wound care was not provided as ordered on her POC.	{G 165}		
{G 170}	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure SN services were provided in accordance with the POC for 5 of 7 patients (#2, #3, #4, #5 and #7) whose records were reviewed. This resulted in blood glucose levels and weights not being monitored, lab work not being drawn, and unauthorized wound care. Findings include: 1. Patient #2 was an 82 year old female admitted	{G 170}		

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{G 170}	Continued From page 19 to the agency on 4/19/16, for care related to a urinary tract infection. The POC and physician orders for the certification period 4/19/16 to 6/17/16, were reviewed. a. The POC included orders for SN to monitor Patient #2's weight and assess for changes in weight. There was no documentation weights had been assessed on the initial SN visit, dated 4/19/16, or subsequent visits, dated 4/26/16, 4/29/16, 5/03/16, 5/17/16, 5/24/16, or 5/31/16. The Patient Care Coordinator was interviewed on 6/06/16, at 3:40 PM. On 6/07/16, at 10:30 AM, the Patient Care Coordinator stated she reviewed Patient #2's record and did not find documention of weights. Patient #2's weights were not monitored in accordance with the POC b. Patient #2's POC included an order for SN to "draw BMP, urine sodium, urine osmolality on 4/25/16." There was no documented SN visit on 4/25/16, evidence of lab work, dated 4/25/16, or explanation as to why the lab work was not drawn on 4/25/16, as ordered by the physician. The Patient Care Coordinator was interviewed on 6/06/16, at 3:40 PM. She stated the lab was not drawn on 4/25/16. She stated if the lab was not going to be drawn on the date ordered, there should have been a communication note between the nurse and physician, which she did not see. Patient #2's lab work was not drawn on 4/25/16, in accordance with the POC. 2. Patient #4 was a 62 year old female admitted	{G 170}		

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{G 170}	Continued From page 20 to the agency on 5/18/16, for care related to a malignant neoplasm and a surgical wound on her abdomen. The POC and physician orders for the certification period 5/18/16 to 7/16/16, were reviewed. a. The POC, dated 5/18/16, included wound care orders, "Cover abdominal site with ABD pads or like dressing. Change PRN." A verbal order, dated 5/18/16, directed SN to use ABD pads and steri strips to cover wound. The SN visit note, dated 5/21/16, included the following documentation: "Upon assessment of patient it was found the bottom of her incision had dehiscence. See wound assessment for measurements. Promptly called [physician] office. Spoke to [physician staff member] and reported findings that patient was edematous, incision draining copious amount of serous fluid from about umbilicus down. Steri strips were coming loose, incision dehiscence last 2 cm of incision. [Physician staff member] instructed me to reapply steri strips and cover wound again with abd pads and change as needed." Patient #4's RN Case Manager was interviewed on 6/07/16, at 9:30 AM. She stated Patient #4's surgical abdominal wound had dehisced. She stated she tried using steri strips to pull edges together based on guidance of a staff member in the physician's office. She stated when the steri strips did not hold, she used Medipore tape over the incision to pull edges together and she called back and let the office know. She confirmed she did not have a specific order for Medipore tape. There was no physician's order for SN to apply Medipore tape directly on Patient #4's incision	{G 170}		

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	137107	A. BUILDING _____ B. WING _____	R 06/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH	1770 PARK VIEW DRIVE TWIN FALLS, ID 83301

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{G 170}	Continued From page 21 site. Wound care did not follow a written plan of care. 3. Patient #3 was a 91 year old female who was admitted for home health services on 5/09/16. Her diagnoses included acute embolism, high blood pressure, diabetes, and heart failure. Her medical record, for the certification period 5/09/16 to 7/07/16, was reviewed. Patient #3's POC stated she was to receive SN services including "Monitor weight and assess for weight change...Monitor vital signs including: apical, radial, and pedal pulses and orthostatic blood pressure...Assess for signs/symptoms of hypoglycemia and hyperglycemia [low and high blood glucose]." SN visit notes dated 5/16/16, 5/23/16, 5/31/16, and 6/06/16 did not contain documentation of apical or pedal pulses, weights, or blood glucose levels. Patient #3's RN Case Manager was interviewed on 6/06/16, beginning at 3:15 PM. She stated she had not weighed Patient #3. She stated the ALF checked Patient #3's blood glucose levels. She stated she had not seen the results of the blood glucose checks. She stated she had not monitored Patient #3's apical and pedal pulses or her orthostatic blood pressure. The agency failed to furnish SN services to Patient #3 in accordance with her POC. 4. Patient #5 was an 82 year old female admitted to the agency on 5/18/16, for care related to a diabetic foot ulcer. Secondary diagnoses included CKD with hemodialysis, insulin	{G 170}		

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{G 170}	Continued From page 22 dependent Type 2 diabetes, and chronic ischemic heart disease. Patient #5 received SN services only. Her record, including the POC for the certification period 5/18/16 to 7/16/16, was reviewed. Patient #5's record included a "Home Health Care Certification and Plan of Care," dated 5/18/16, and signed by the physician on 5/31/16, which included the order "daily wound care to left foot, pack with Iodoform gauze soaked in half betadine and half NS, wrap with Kerlix, and secure with tape." An agency policy titled "Plan of Care No. 3005," revised 1/22/13, was reviewed. The policy stated "a written POC shall be developed and implemented for each patient with participation from all disciplines providing services for that patient to include treatment orders." Patient #5's POC was not followed per physician order and agency policy as follows: a. Patient #5's record included a SN visit note dated 6/02/16, and was signed by the RN Case Manager. Wound documentation on the visit note included "packed with plain packing strip." The RN Case Manager was interviewed on 6/07/16, at 12:40 PM. She reviewed Patient #5's record and stated the physician's order for wound care was not followed. b. Patient #5's record included SN visit notes dated 5/28/16, 5/29/16, and 5/30/16, and signed by an LPN. Wound documentation on the visit notes included "packed with plain packing strip."	{G 170}		

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{G 170}	Continued From page 23 Patient #5's record included SN visit notes dated 6/01/16, 6/03/16, and 6/04/16, and signed by an LPN. Wound documentation on the visit notes included "packed with plain packing strip and saline wet-dry." The LPN was interviewed on 6/07/16, at 11:20 AM. She reviewed Patient #5's record and stated the physician's order for wound care was not followed. The agency failed to ensure Patient #5's wound care was performed as ordered by her physician. 5. Patient #7 was an 81 year old female admitted to the agency on 5/01/16, for care primarily related to acute on chronic CHF. Secondary diagnoses included Type 2 diabetes and COPD. Patient #7 received SN, OT, and PT services. Her record, including the POC for the certification period 5/01/16 to 6/29/16, was reviewed. Patient #7's POC was not followed per physician order and agency policy as follows: a. Patient #7's record included a "Home Health Care Certification and Plan of Care," dated 5/01/16, and signed by the physician on 5/10/16, which included a physician order to "monitor weight each visit." Patient #7's record included SN visit notes dated 5/04/16, 5/06/16, and 5/12/16, and signed by the RN Case Manager. The visit notes did not include patient weights. b. Patient #7's record included a "Home Health Care Certification and Plan of Care," dated 5/01/16, and signed by the physician on 5/10/16,	{G 170}		

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{G 170}	Continued From page 24 which included a physician order to "assess blood sugar monitoring and results. Pt to check blood sugars 2 x daily; notify MD as indicated." Patient #7's record included SN visit notes dated 5/06/16, 5/10/16, and 5/20/16, and signed by the RN Case Manager. The visit notes did not include patient blood glucose results. The RN Case Manager was interviewed on 6/07/16, at 10:30 AM. She reviewed Patient #7's record and stated her physician POC was not followed for blood glucose monitoring. The agency failed to follow Patient #7's POC.	{G 170}		
{G 176}	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the registered nurse coordinated services and informed the physician of changes in the patient's condition and needs for 1 of 7 patients (Patient #4) whose records were reviewed. Patient #4 was a 62 year old female admitted to the agency on 5/18/16, for care related to a malignant neoplasm and a surgical wound on her abdomen. The POC and physician orders for the certification period 5/18/16 to 7/16/16, were reviewed.	{G 176}		

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{G 176}	Continued From page 25 a. Patient #4's initial POC, dated 5/18/16, included an order for Lasix 20 mg, 1 tab 3 times per week. The RN Case Manager was interviewed on 6/07/16, at 9:30 AM. She stated an old Lasix prescription was found in Patient #4's home during the initial SN visit on 5/18/16. The RN Case Manager stated it was her understanding all medications found in the patient's home were to be included on the medication reconciliation list, regardless if the patient was actually taking the medication or not. She stated she did not contact the physician to clarify the Lasix. The registered nurse failed to coordinate services with Patient #4's physician. b. Patient #4's POC, dated 5/18/16, included wound care orders, "Cover abdominal site with ABD pads or like dressing. Change PRN." A verbal order, dated 5/18/16, directed SN to use ABD pads and steri strips to cover the wound. The SN visit note, dated 5/21/16, included the following documentation: "Upon assessment of patient it was found the bottom of her incision had dehiscence. See wound assessment for measurements. Promptly called [physician] office. Spoke to [physician's office staff] and reported findings that patient was edematous, incision draining copious amount of serous fluid from about umbilicus down. Steri strips were coming loose, incision dehiscence last 2 cm of incision. [Physician's office staff member] instructed me to reapply steri strips and cover wound again with abd pads and change as needed."	{G 176}		

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{G 176}	Continued From page 26 Patient # 4's RN Case Manager was interviewed on 6/07/16, at 9:30 AM. She stated Patient #4's surgical abdominal wound had dehisced. She stated she tried using steri strips to pull edges together based on the guidance of a staff member in the physician's office. She stated when the steri strips did not hold, she used Medipore tape over the incision to pull the edges together and she called back and let the physician's office know. There was no documentation the SN had coordinated with the physician regarding Patient #4's steri strips failing or to obtain approval to use the Medipore tape over Patient #4's incision.	{G 176}		
{G 186}	484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by:	{G 186}		
{G 187}	484.32 THERAPY SERVICES The qualified therapist prepares clinical and progress notes. This STANDARD is not met as evidenced by:	{G 187}		
{G 188}	484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel.	{G 188}		

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{G 188}	Continued From page 27 This STANDARD is not met as evidenced by:	{G 188}		
{G 321}	484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set. This STANDARD is not met as evidenced by:	{G 321}		
{G 322}	484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is not met as evidenced by:	{G 322}		
{G 331}	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the initial SOC comprehensive assessment included a thorough examination of identified items of concern for 2 of 7 patients (#2 and #3) whose records were reviewed. This failure placed	{G 331}		

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{G 331}	Continued From page 28 patients at risk for negative outcomes. Findings include: 1. Patient #3 was a 91 year old female who was admitted for home health services on 5/09/16. Her diagnoses included acute embolism, high blood pressure, diabetes, and heart failure. Her medical record, for the certification period 5/09/16 to 7/07/16, was reviewed. A physician progress note from a clinic, dated 5/04/16, was faxed to the agency with the home health referral order on 5/06/16. The progress note stated Patient #3 was seen in the clinic for "...follow up on hyperglycemia. Daughter thinks that her AM BG [blood glucose] has been in the 110s-140s. Afternoon/evening BG is getting higher, sometimes up to 200s." The clinic note also stated Patient #3 had swelling of both legs which was likely due to CHF. The note stated she also had "crackles" in her lungs (a symptom indicative of excess fluids in her lungs). Patient #3's comprehensive nursing assessment, dated 5/09/16, at 2:00 PM, stated she was diabetic and her blood glucose was checked daily. The assessment stated the levels were "...within expected/normal range" but actual glucose levels were not documented. Additionally, a baseline weight was not documented. Patient #3's RN Case Manager was interviewed on 6/06/16, beginning at 3:15 PM. She stated she had not weighed Patient #3. She stated the ALF checked Patient #3's blood glucose levels. She stated she had not seen the results of the blood glucose checks.	{G 331}		

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{G 331}	Continued From page 29 Patient #3's initial SOC assessment was not sufficient to determine her immediate care and needs. 2. Patient #2 was an 82 year old female admitted to the agency on 4/19/16, for care related to a urinary tract infection. Secondary diagnoses included hypo-osmolality, hyponatremia, and chronic kidney disease. The initial nursing assessment and POC for the certification period beginning 4/19/16, were reviewed. The POC included orders for SN to monitor Patient #2's weight and assess for changes in weight. There was no documentation a baseline weight was obtained at the initial SN visit on 4/19/16. An initial baseline weight was necessary in order to determine if changes in weight occurred. The Patient Care Coordinator was interviewed on 6/07/16, at 10:30 AM. She stated there was no baseline weight documented for Patient #2. Patient #2's initial assessment was not comprehensive.	{G 331}		
{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 staff interview, policy review, and	{G 337}		

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{G 337}	Continued From page 30 review of clinical records it was determined the agency failed to ensure a medication review was conducted to identify potential adverse effects and drug reactions. This affected the care of 3 of 7 patients (#3, #4, and #5) whose records were reviewed. The failure to identify potential drug reactions increased the risks patients would suffer adverse effects. Findings include: 1. Patient #3 was a 91 year old female who was admitted for home health services on 5/09/16. Her diagnoses included acute embolism, high blood pressure, and heart failure. Her medical record, for the certification period 5/09/16 to 7/07/16, was reviewed. A physician note, dated 5/04/16, and faxed to the agency on 5/06/16, stated Patient #3 had swelling of both legs which was likely due to congestive heart failure. The note stated she also had "crackles" in her lungs (a symptom indicative of excess fluids in her lungs). Patient #3's medication list included prednisone and "Thermotabs (a salt supplement) 450 mg-30 mg oral tablet" 3 times a day. The website Medline Plus, a division of the National Institutes of Health, was queried on 6/13/16. It stated a side effect of prednisone was swelling and stated patients taking prednisone may need to follow a low salt diet. Patient #3's medical record did not document her physician had been contacted to determine if she should receive the Thermotabs. Patient #3's RN Case Manager was interviewed on 6/06/16, beginning at 3:15 PM. She stated	{G 337}		

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{G 337}	Continued From page 31 she did not know why Patient #3 was taking Thermotabs. She also stated the physician was not questioned to determine if the Thermotabs were appropriate. The agency failed to conduct a drug regimen review that identified medications that were contraindicated for Patient #3. 2. Patient #4 was a 62 year old female admitted to the agency on 5/18/16, for care related to a malignant neoplasm and an abdominal surgical wound. The POC, physician orders, and SN visit notes for the certification period 5/18/16 to 7/16/16, were reviewed. The initial POC and initial medication list, dated 5/18/16, included an order for Lasix 20 mg, 1 tab 3 times per week. The RN Case Manager was interviewed on 6/07/16, at 9:30 AM. She stated an old Lasix prescription was found in Patient #4's home during the initial SN visit on 5/18/16. The RN Case Manager stated it was her understanding all medications found in the patient's home were to be included on the medication reconciliation list, regardless if the patient was actually taking the medication or not. She stated she did not contact the physician to clarify the Lasix. The drug regime review was incomplete for Patient #4. 3. Patient #5 was an 82 year old female admitted to the agency on 5/18/16, for care related to a diabetic foot ulcer. Secondary diagnoses included CKD with hemodialysis, insulin dependent Type 2 diabetes, and chronic ischemic	{G 337}		

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{G 337}	Continued From page 32 heart disease. Patient #5 received SN services only. Her record, including the POC, for the certification period 5/18/16 to 7/16/16, was reviewed. Patient #5's record included a "Medication Profile," dated 5/19/16. The form stated she was allergic to "sulfas." However, her record included Glipizide 5 mg, which contains sulfa. An agency policy titled "Medication Reconciliation No. 3007," revised 2/17/16, was reviewed. The policy included "upon admission, it is the responsibility of the RN to complete a comprehensive review of prescription medications, over-the-counter and herbal preparations. The medication review includes drug allergies. The physician is to be notified of any drug allergy or sensitivity issues that are observed by caregivers." The RN Case Manager was interviewed on 6/07/16, at 12:40 PM. She reviewed Patient #5's record and stated it included a medication with Sulfa listed as an allergy. Additionally, the RN Case Manager stated she did not notify Patient #5's physician of the medication contraindication. The agency failed to identify potential adverse drug reactions.	{G 337}		
{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 condition warrants due to a major decline or improvement in the patient's health status.	{G 338}		

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{G 338}	Continued From page 33 This STANDARD is not met as evidenced by:	{G 338}		

VISIONS
HOME HEALTH LLC

4/8/2016	**Plan of Correction-Visions Home Health, LLC Provider #13-7107.** **Response to: Medicare/Licensure Survey-State of Idaho** **State Re-Survey Date: June 6-7, 2016.**		Donnala Slatter RN BSN 6/30/16	
Deficiency Tag #	**How the deficiency will be corrected**	**Who will be responsible for making the corrections**	**What will be done to prevent reoccurrence and how we will monitor for continued compliance**	**When the correction will be completed**
G 143 N 062 N 093	**484.14 COORDINATION OF PATIENT SERVICES** Mandatory Meeting was held on June 8, June 15, and June 29th educated staff importance of coordination of care with other disciplines involved in the patients care. Coordination of Care will ensure continuity of care. Instructed staff on entering in their schedules at the time a physicians order is written. Case managers will have a set 2 hour schedule that they will be in the office to contact other disciplines and document that coordination.	Director, Patient Care Coordinator, Clinicians, or Delegate	Case managers are required to be in the office at least 2 hours/week to contact other disciplines that are involved in the patient's care. This COC will be documented in the client record. All Scheduled visits will be entered into the client record by case manager or office staff prior to 485 being mailed to the physician. Three times a week the report "clinical visits by status" will be printed to ensure all contract therapy notes are being faxed to the agency in a timely manner. Case managers will continue to review and sign off on all therapy notes to ensure coordination of care. This will be monitored weekly until 100% compliance and then quarterly with agency chart audits. Hired Quality Improvement RN to assist with chart audit.	7/11/2016
G 156	**484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER** Refer to G158, G164, G165,			

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G 158 N152	**484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER** Mandatory Meetings for clinicians on June 8th June 15th, and June 29th to review the importance of following the physician's orders. Clinicians were educated on the importance of monitoring patient's blood sugars and weights at least weekly unless otherwise documented. Clinicians educated on contacting the physician for any changes in the patient's condition that warrants a change in the plan of care. Therapies educated that verbal orders received after 5 days of SOC or Recertification has to be entered into the medical record as a verbal order.	Director, Patient Care Coordinator, Clinicians, or Delegate	Patient Care Coordinator will review all orders for completeness and review that orders are being followed. Patient Care Coordinator will review every plan of care for new and recertified patients before the plan of care is completed and sent to the MD for signature. All therapy verbal orders received 5 days after SOC or Recertification will be entered into the medical record as a "Verbal order" to ensure that the order gets sent to the physician for signature. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing. Hired Quality Improvement RN to assist with chart audit.	7/11/2016
G 164 N172	**484.18(b) PERIODIC REVIEW OF PLAN OF CARE** Mandatory Meetings for clinicians on June 8th June15th and June 29th. Educated clinicians on promptly notifying the physician of changes in the patient's condition that may require a change in the plan of care. Educated clinicians on ensuring that the patient's ongoing needs are being met, documented, and communicated promptly to the physician.	Director, Patient Care Coordinator, Clinicians, or Delegate.	Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing. Hired Quality Improvement RN to assist with chart audit.	7/11/2016

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G 165 N173	**484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS** Mandatory Meetings for clinicians on June 8th June 15th and June 29th. Educated Clinicians on importance of following all medication and treatment orders as specified by the physician. All wound care orders will have specific dressing change instructions. Clinicians will document according to the physicians orders. Educated on promptly notifying the physician when there is a change of condition that may warrant a change in the patient's plan of care.	Director, Patient Care Coordinator, Clinicians, or Delegate.	Patient Care Coordinator will monitor all new admissions, recertification orders, and 100% verbal orders for completeness ongoing. Monitoring will occur via 100% medical record review on all wound care patients until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing. Hired Quality Improvement RN to assist with chart audit.	7/11/2016
G 170	**484.30 SKILLED NURSING SERVICES** Mandatory Meetings for clinicians on June 8th June 15th and June 29th. Educated Clinicians on following the physician orders. Orders needs to have patient specific instructions that address the patient's clinical needs. Educated clinicians that all patients need to have blood sugars and weights documented weekly unless otherwise documented. Lab work that is ordered by the physician must be done on the exact date it is ordered.	Director, Patient Care Coordinator, Clinicians, or Designate	Monitoring will occur via 100% medical record review of all visits until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing. Hired Quality Improvement RN to assist with chart audit.	7/11/2016
G 176 N097 N098	**484.30(a) DUTIES OF THE REGISTERED NURSE** Mandatory Meetings for clinicians on June 8th, June 15th and June 29th. Educated Clinicians that the patient's physician must be notified if the patient has a change of condition that warrants a change in the Plan of Care. Clinicians need to notify other services of any changes in patient's condition. Educated Staff on accurate and precise medication reconciliation.	Director, Patient Care Coordinator, Clinicians, or Designate.	Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing. Hired Quality Improvement RN to assist with chart audit.	7/11/2016

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G 331 N093	**484.55(a)(1) INITIAL ASSESSMENT VISIT** Mandatory Meetings for clinicians on June 8th June 15th and June 29th. Educated clinicians on the importance of the Comprehensive Assessment. Clinicians were educated on importance of monitoring patient's condition and documenting all aspects of the patients care. Educated clinicians that all patients need to have blood sugars and weights documented weekly unless otherwise documented.	Director, Patient Care Coordinator, Clinicians, or Designate	Patient Care Coordinator will monitor all new admissions to ensure complete and accurate documentation. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly. Hired Quality Improvement RN to assist with chart audit.	7/11/2016
G 337 N173	**484.55(c) DRUG REGIMEN REVIEW** Mandatory Meetings for clinicians on June 8th, June 15thand June 29th. Educated Clinicians on medication reconciliation. Clinicians are required to do a thorough medication review. Medication assessment at Start of Care, Resumption of Care, and Recertification will include visualization of the actual medication bottles, review of the medication list provided in the referral, as well as interview with the patient and/or caregiver. Clinicians must notify the physician of any issues regarding medication reconciliation. Educated Clinicians that every routine visit will include medication review. Clinicians need to interview patients every visit to see if they have had any new or changed medications. Clinicians need to pay very close attention to patients drug allergies.	Director, Patient Care Coordinator, Clinicians, or Designate	Medication list will be printed by the Patient Care Coordinator at SOC and with all new medication orders. This list will be reviewed for any interactions, allergies, and/or discrepancies. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% chart audits will be done quarterly ongoing. Hired Quality Improvement RN to assist with chart audit.	7/11/2016