



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
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September 6, 2016

Dr. Susie Jones, Administrator
Avalon Home Health
403 1st St
Idaho Falls, ID 83401-3928

RE: Avalon Home Health, Provider #137057

Dear Dr. Jones:

Based on the survey completed at Avalon Home Health, on August 22, 2016, by our staff, we have determined the agency is out of compliance with the Medicare Home Health Agency (HHA)

Conditions of Participation:

- **Organization, Services & Administration (42 CFR 484.14)**
- **Evaluation of the Agency's Program (42 CFR 484.52)**

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

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

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the 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 **September 16, 2016**. It is suggested that the Credible Allegation of Compliance/Plan of Correction for each Condition of Participation and related standard level deficiencies show compliance no later than **October 6, 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 will be recommended to the Centers for Medicare/Medicaid (CMS) Region X Office:

- Civil Monetary Penalty (42 CFR 488.820(a))
- Termination (42 CFR 488.865)

We must recommend to the CMS Regional Office and /or State Medicaid Agency that your provider agreement be terminated [42 CFR 488.865] on **February 18, 2017**, if substantial compliance is not achieved by that time.

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.

Dr. Susie Jones, Administrator
September 6, 2016
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In accordance with 42 CFR 488.745, you have one opportunity to question the deficiencies that resulted in the Conditions of Participation being found out of compliance through an informal dispute resolution (IDR) process. To be given such an opportunity, you are required to send your written request and all required information as directed in the IDR Guidelines. The IDR Guidelines can be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NonLongTermCare/tabid/427/Default.aspx>

Scroll down to Home Health Agencies (HHA) and select the following:

Informal Dispute Resolution (IDR)

IDR Guidelines

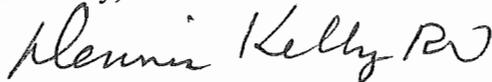
IDR Request Form

This request must be received by **September 16, 2016**. If your request for IDR is received after **September 16, 2016**, the request will not be granted. An incomplete IDR process will not delay the effective date of any enforcement action. If the agency wants the IDR panel to consider additional evidence, the evidence and six (6) copies of the evidence must be received 15 calendar days before the IDR meeting (Refer to page 6 of the attached IDR Guidelines).

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, RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosures

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

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

PRINTED: 09/02/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2016
NAME OF PROVIDER OR SUPPLIER AVALON HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 403 1ST ST IDAHO FALLS, ID 83401	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your agency conducted from 8/15/16 to 8/22/16. The surveyors conducting the recertification were:</p> <p>Gary Guiles, RN, HFS, Team Leader Brian Osborn, RN, HFS Rebecca Lara, RN, HFS Jennifer Davis, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>ALF - Assisted Living Facility ADLs - Activities of Daily Living BLS - Basic Life Support certification BP - Blood Pressure CEO - Chief Executive Officer CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease COTA - Certified Occupational Therapy Assistant DM - Diabetes Mellitus EMR - Electronic Medical Record FNP - Family Nurse Practitioner HHA - Home Health Agency LMSW - Licensed Medical Social Worker LPN - Licensed Practical Nurse MSW - Medical Social Worker mg - milligram OASIS - Outcome and Assessment Information Set OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy PTA - Physical Therapy Assistant Q - every RN - Registered Nurse SN - Skilled Nursing</p>	G 000	<p>See attached Plan of Correction</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE **9/16/2016**

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 000	Continued From page 1	G 000			
G 122	SW - Social Worker UTI - Urinary Tract Infection 484.14 ORGANIZATION, SERVICES & ADMINISTRATION	G 122			
G 128	<p>This CONDITION is not met as evidenced by: Based on staff interview and review of agency policies, personnel files, and meeting minutes, it was determined the agency failed to provide effective oversight of the home health agency. This resulted in a lack of support and guidance to agency personnel. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to G128 as it relates to the failure of the agency to ensure the Governing Body oversaw the agency's activities and to ensure the Governing Body's activities and actions were documented. 2. Refer to G134 as it relates to the failure of the agency to ensure the administrator maintained timely and thorough staff evaluations. <p>The cumulative effect of these systemic failures seriously impeded the ability of the agency to provide services of sufficient scope and quality.</p> <p>484.14(b) GOVERNING BODY</p> <p>A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.</p> <p>This STANDARD is not met as evidenced by:</p>	G 128			

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G 128	<p>Continued From page 2</p> <p>Based on staff interview, and review of meeting minutes, policies, and the agency evaluation, it was determined the Governing Body failed to oversee the agency's activities and failed to document the Governing Body's activities and actions. This resulted in a lack of leadership and direction to agency personnel. Findings include:</p> <p>1. Governing Body meeting minutes between 8/01/15 and 8/15/16 were requested. Two sets of Governing Body meeting minutes, dated 3/10/16 and 7/19/16, were provided. The 3/10/16 minutes stated the OASIS process, mileage reimbursement, time off, change in ownership, and financials were discussed. The 7/19/16 minutes stated the "21st Century" and a new EMR were discussed. None of the minutes included discussion of patient care, policy review, or a review of the agency's services.</p> <p>The CEO was interviewed on 8/18/16 beginning at 1:45 PM. He stated other Governing Body meeting minutes were stored off site but said they were not accessible. These minutes were not produced during the survey.</p> <p>The Governing Body failed to document its efforts to oversee the agency's activities.</p> <p>2. There was no documentation the agency had reviewed or revised agency policies.</p> <p>Policies were purchased from a corporation that consults with and advises non-acute health care providers. All of the policies reviewed included a copyright dated 2003 and stated they were revised by the corporation in either October 2012 or April 2013. These included policies titled:</p>	G 128			

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G 128	Continued From page 3 <ol style="list-style-type: none"> 1. Hand Hygiene 2. Standard Precautions 3. Coordination of Services with Other Providers 4. Continuity of Care 5. Case Conference/Progress Summary 6. Verification of Physician Orders 7. Orientation of Assigned Home Health Aide 8. Nutritional Assessment 9. Pain Assessment 10. Home Health Aide Supervisory Visits 11. Nutrition Care Planning 12. Home Health Aide Plan of Care 13. Ongoing Assessments 14. Patient Education Process 15. Care Planning Process 16. Physician Participation in Plan of Care 17. Rehabilitation Care Planning 18. Discharge Planning 19. 60-Day Summary Report 20. Initial and Comprehensive Assessment 21. Reassessments/Recertification 22. Administration and Documentation of Medications 23. Home Glucose Monitoring 24. Safe/Effective Use of Medications 25. Drug-Food Interactions 26. Pain Management Education 27. Safe/Effective Use of Equipment and Supplies 28. Basic Home Safety 29. Patient Education Related to Discharge Planning 30. Infection Control Precautions 31. Physical Therapist Job Description 32. Annual Core Competency 33. Competency Based Orientation 34. Home Health Aide Training 35. Core Competency Skills 36. Competency Assessment 	G 128		

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G 128	Continued From page 4 37. Training/In-service Education 38. Certified Home Health Aide Job Description 39. Licensed Practical/Vocational Nurse Job Description 40. Registered Nurse Job Description 41. Medical Social Worker Job Description 42. Occupational Therapist Job Description 43. COTA Job Description The CEO was interviewed on 8/18/16 beginning at 1:45 PM. He stated the policies were reviewed at some point in 2015. However, he stated there was no record of this review or of any changes to policies to match the agency's unique practices. The Governing Body did not review policies to ensure they reflected the agency's practices.	G 128			
G 134	3. Refer to G 242 as it relates to the failure of the Governing Body to ensure an evaluation of the agency's program was conducted. 484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. This STANDARD is not met as evidenced by: Based on agency policy review, personnel file review, and staff interview, it was determined the agency administrator failed to ensure timely and thorough staff evaluations for 21 of 30 staff members, (Staff A, B, C, E, M, N, O, P, Q, R, S, T, U, V, W, X, Z, AA, BB, CC, and DD) whose personnel records were reviewed. This had the	G 134			

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G 134	<p>Continued From page 5</p> <p>potential to interfere with the quality and safety of patient care. Findings include:</p> <p>An agency policy "COMPETENCY ORIENTATION," undated, was reviewed. The policy included "A preceptor(s) will be assigned to each orientee. Organization personnel are given the appropriate job category Orientation Checklist during the orientation process. When the Competency Orientation Skills Checklist is completed, it is reviewed by the preceptor and the Clinical Supervisor. Additional training and education is performed as indicated until competence is determined."</p> <p>Additionally, an agency policy "TRAINING/INSERVICE EDUCATION," undated, was reviewed. The policy included "During the ongoing supervision and competency reviews, the supervisors will evaluate if the training and education has improved the competence of the organization personnel."</p> <p>A third agency policy "COMPETENCY ASSESSMENT," undated, was reviewed. The policy included "During the annual performance evaluation, personnel's competence in performing specified activities will be evaluated. ...Improving skills for competency will be part of the annual performance evaluation and performance plans for the next year, as well as establishing individual goals for personal/professional growth and development."</p> <p>The agency administrator failed to follow their policies and ensure staff personnel files contained documentation of assigned preceptors, orientation, skills competency, and/or evaluations.</p>	G 134			

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G 134	<p>Continued From page 6</p> <p>The following personnel files were reviewed in the presence of the Office Manager on 8/17/16, beginning at 1:55 PM. Personnel file examples include:</p> <ol style="list-style-type: none"> 1. Staff A, a Home Health Aide, had a documented hire date of 7/29/15. She did not have a documented assigned preceptor, orientation, skills competency, or evaluations. 2. Staff B, a Home Health Aide, had a documented hire date of 10/01/14. She did not have a documented assigned preceptor, orientation, skills competency, or evaluations. 3. Staff C, a Home Health Aide, had a documented hire date of 10/08/15. She did not have a documented assigned preceptor, orientation, skills competency, or evaluations. 4. Staff E, a Home Health Aide, had a documented hire date of 9/14/14. She did not have a documented orientation or evaluations. 5. Staff M, an FNP, had a documented hire date of 10/14/14. She did not have a documented assigned preceptor, orientation, skills competency, or evaluations. 6. Staff N, an RN, had a documented hire date of 6/18/13. She did not have a documented assigned preceptor, orientation, or evaluations. 7. Staff O, an RN, had a documented hire date of 4/06/16. He did not have a documented assigned preceptor, orientation, or evaluations. 8. Staff P, an LMSW, had a documented hire date of 8/01/14. He did not have a documented 	G 134		

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G 134	Continued From page 7 assigned preceptor, orientation, skills competency, or evaluations. 9. Staff Q, a Physical Therapist, had a documented hire date of 11/04/15. She did not have a documented assigned preceptor, orientation, skills competency, or evaluations. 10. Staff R, a PTA, had a documented hire date of 11/01/12. She did not have a documented assigned preceptor, orientation, or evaluations. 11. Staff S, a Physical Therapist, had a documented hire date of 8/27/13. He did not have a documented assigned preceptor, orientation, skills competency, or evaluations. 12. Staff T, an LPN, had a documented hire date of 7/23/14. She did not have a documented assigned preceptor, orientation, skills competency, or evaluations. 13. Staff U, an RN, had a documented hire date of 9/01/14. She did not have a documented assigned preceptor, orientation, skills competency, or evaluations. 14. Staff V, an RN, had a documented hire date of 4/21/14. She did not have a documented assigned preceptor, skills competency, or evaluations. 15. Staff W, an RN, had a documented hire date of 4/10/15. She did not have a documented assigned preceptor, orientation, skills competency, or evaluations. 16. Staff X, an Occupational Therapist, had a documented hire date of 4/04/16. She did not	G 134			

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G 134	<p>Continued From page 8</p> <p>have a documented assigned preceptor, orientation, skills competency, or evaluations.</p> <p>17. Staff Z, a PTA, had a documented hire date of 7/13/15. He did not have a documented assigned preceptor, orientation, skills competency, or evaluations.</p> <p>18. Staff AA, an LPN, had a documented hire date of 6/18/13. She did not have a documented assigned preceptor, orientation, skills competency, or evaluations.</p> <p>19. Staff BB, a Physical Therapist, had a documented hire date of 9/11/13. He did not have a documented assigned preceptor, orientation, or evaluations.</p> <p>20. Staff CC, an RN, had a documented hire date of 5/20/15. She did not have a documented assigned preceptor, orientation, skills competency, or evaluations.</p> <p>21. Staff DD, an LPN, had a documented hire date of 1/07/16. He did not have a documented competency or evaluations.</p> <p>The Office Manager was interviewed on 8/17/16, beginning at 1:55 PM. She confirmed the personnel files reviewed in her presence were missing documentation of staff evaluations and policy related requirements listed above.</p> <p>The Executive Director was interviewed on 8/18/16, beginning at 2:00 PM. She confirmed the personnel files reviewed in the presence of the Office Manager were missing documentation of staff evaluations and policy related requirements listed above.</p>	G 134			

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G 134	Continued From page 9	G 134			
G 158	<p>The agency administrator failed to follow their policies and ensure staff had adequate evaluations.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and a review of medical records and job descriptions, it was determined the agency failed to ensure care followed a physician's written POC for 3 of 12 patients (#5, #6, and #10) whose records were reviewed for POCs. This resulted in unauthorized treatments and potential unmet patient needs. Findings include:</p> <p>1. Patient #5 was a 61 year old male admitted to the agency on 8/19/15 for SN services related to a stage 3 pressure ulcer on the bottom of the left foot. Additional diagnoses included a kidney and pancreas transplant on 6/13/16 secondary to DM, legal blindness, peripheral artery disease and contractures of bilateral hands. His record, including the POC, for the certification period 6/14/16 to 8/12/16, was reviewed.</p> <p>Patient #5's record included a physician's verbal order taken on 8/12/16, and signed by an RN. It stated "...wound care to stage III ulcer to bottom of left foot and burn/wound on right knee. SN to perform sterile wound care, cast care, and dressing change if not in cast to left foot and right</p>	G 158			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 158	<p>Continued From page 10 knee..."</p> <p>During a visit to the home of Patient #5 on 8/17/16, beginning at 11:00 AM, the RN was observed changing the dressings that covered 7 small wounds on Patient #5's right lower leg and foot. The RN did not use sterile technique (a strict infection prevention technique used to maintain an area that is germ free) when changing the dressings.</p> <p>The RN was interviewed during the visit and stated she was unaware that sterile dressing changes were ordered and had used only aseptic technique when changing Patient #5's dressings.</p> <p>Patient #5 did not receive sterile dressing changes as ordered by his physician.</p> <p>2. Patient #6 was an 85 year old female admitted to the agency on 6/01/16 for SN services for care related to a wound to her right lateral leg. Additional diagnoses included chronic pain, DM Type II, hypertension, and frequent urinary tract infections. Her record, including the POC, for the certification period 7/31/16 to 9/28/16, was reviewed.</p> <p>Patient #6's record included a "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 7/26/16, and signed by an agency RN. The form included 9 items to be addressed on every SN visit by agency staff:</p> <ul style="list-style-type: none"> i. Wound care ii. Vital signs iii. Assess body systems iv. Assess disease process knowledge v. Assess medication knowledge 	G 158			

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G 158	<p>Continued From page 11</p> <p>vi. Education on blood pressure vii. Education on low sodium diet viii. Education on signs and symptoms of urinary tract infections ix. Educate on DM and DM diet</p> <p>An agency policy "PATIENT EDUCATION PROCESS," undated, was reviewed. The policy included "Patients and family/caregivers will receive education in verbal, visual, and written format, as appropriate. Education will be the responsibility of each clinician and will focus on:... Unless otherwise ordered by the physician (or other authorized licensed independent practitioner), the patient and family/caregiver will receive verbal and, as appropriate, written instructions on:... The medication regimen... Medication management and administration... Nutrition interventions, modified diets, and oral health..."</p> <p>An agency administrative document "Job Descriptions Licensed Practical/Vocational Nurse," undated, was reviewed. The document included "Implements plan of care initiated by the registered nurse. Assesses and provides patient and family/caregiver education and information pertinent to diagnosis and plan of care."</p> <p>An LPN was observed providing care to Patient #6 on 8/17/16, at 10:00 AM. The LPN failed to assess Patient #6's medication knowledge and failed to provide education on blood pressure, low sodium diet, and signs and symptoms of urinary tract infections.</p> <p>The LPN was interviewed on 8/17/16, beginning at 10:45 AM. When asked if she reviewed the POC prior to each SN visit, she stated she tried to</p>	G 158			

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G 158	<p>Continued From page 12</p> <p>review the POC before each visit. The LPN confirmed she did not address Patient #6's medication knowledge, did not educate on blood pressure, low sodium diet, and signs and symptoms of urinary tract infections.</p> <p>The agency failed to follow the established, written POC.</p> <p>3. Patient #10 was an 82 year old male admitted to the agency on 6/30/16 after hospitalization. He was currently a patient as of 8/17/16. Diagnoses included UTI, DM Type II, and CHF. He received SN, PT, and social services. His record, including the POC, for the certification period 6/30/16 to 8/28/16, was reviewed.</p> <p>Patient #10's referral for home health services, dated 6/28/16, was signed by a local FNP. Patient #10's "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period 6/30/16 to 8/28/16 stated the "Physician's Name and Address" was the FNP. Two orders dated 6/30/16, and single orders dated 7/12/16, and 8/02/16, were issued by the FNP. No orders were documented by a physician. Nothing was documented in the record to indicate Patient #10 was under the care of a physician.</p> <p>The Executive Director was interviewed on 8/18/16 beginning at 3:10 PM. She stated there was no documentation to show Patient #10's POC was established and periodically reviewed by a physician.</p> <p>Patient #10's POC was not established or reviewed by a physician.</p>	G 158			
G 182	484.30(b) DUTIES OF THE LICENSED	G 182			

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G 182	<p>Continued From page 13 PRACTICAL NURSE</p> <p>The licensed practical nurse prepares equipment and materials for treatments, observing aseptic technique as required.</p> <p>This STANDARD is not met as evidenced by: Based on observation, agency policy review, and staff interview, it was determined the agency failed to ensure the LPN observed aseptic technique while providing wound care for 1 of 1 patients (Patient #6) who was observed having a wound dressing change. This placed Patient #6 at risk of infection. Findings include:</p> <p>Patient #6 was an 85 year old female admitted to the agency on 6/01/16 for SN services for care related to a wound to her right lateral leg. Additional diagnoses included chronic pain, DM Type II, hypertension, and frequent urinary tract infections. Her record, including the POC, for the certification period 7/31/16 to 9/28/16, was reviewed.</p> <p>An agency policy "HAND HYGIENE," undated, was reviewed. The policy stated "Hand decontamination using alcohol-based hand rub should be performed: ... After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient... After removing gloves..."</p> <p>Additionally, an agency policy "STANDARD PRECAUTIONS," undated, was reviewed. The policy stated "Gloves are to be changed:... Between tasks and procedures on the same patient..."</p>	G 182			

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G 182	Continued From page 14 An LPN was observed providing Patient #6's wound care on 8/17/16, beginning at 10:00 AM. The LPN failed to maintain aseptic technique. Examples include: a. The LPN failed to perform hand hygiene before gloving prior to removing Patient #6's old wound dressing. b. The LPN failed to change gloves between applying a new dressing to Patient #6's wound and touching/manipulating clean items/medical equipment. The LPN was interviewed on 8/17/16, beginning at 10:45 AM. She confirmed she did not use alcohol-based hand rub before gloving prior to removing Patient #6's old wound dressing. Additionally, the LPN confirmed she did not change gloves between applying a new dressing to Patient #6's wound and touching/manipulating clean items/medical equipment.	G 182		
G 212	484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. This STANDARD is not met as evidenced by: Based on observation and review of medical records, personnel files, policy review, and staff interview, it was determined the agency failed to	G 212		

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G 212	<p>Continued From page 15</p> <p>ensure the skills of 4 of 5 home health aides (Staff A, B, C, and D) hired after 8/06/14, whose personnel files were reviewed, were evaluated by qualified staff. This had the potential to negatively impact the quality and safety of patient services. Findings include:</p> <p>An agency policy "COMPETENCY BASED ORIENTATION," undated, was reviewed. The policy stated "Organization personnel are given the appropriate job category Orientation Checklist during the orientation process."</p> <p>Additionally, an agency policy "CORE COMPETENCY SKILLS," undated, was reviewed. The policy stated "The organization will define the mandatory core competency skills for each discipline based upon the nature of their job responsibilities and complexity of care required... Core competency skills will be reviewed with new personnel during their orientation... Each core competency skill has a corresponding set of performance criteria..."</p> <p>A third agency policy "COMPETENCY ASSESSMENT," undated, was reviewed. The policy stated "Using a Competency Skills Performance Checklist developed specifically for each clinical job category, the Clinical Supervisor will evaluate the competence in performing and rendering care according to organization policies and standards of practice."</p> <p>1. Agency personnel files for Staff A, B, C, and D were reviewed in the presence of the Office Manager on 8/17/16, beginning at 1:55 PM. The Office Manager confirmed Staff A, B, C, and D's personnel file did not include documentation of a competency evaluation. She stated the</p>	G 212	

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G 212	<p>Continued From page 16</p> <p>competency evaluations were performed for all staff; however she was unable to provide a copy for Staff A, B, C, or D. Additionally, the Office Manager confirmed the personnel files did not include a Competency Skills Performance Checklist or Orientation Checklist for Staff A, B, C, or D.</p> <p>The agency failed to ensure home health aides met competency evaluation requirements.</p> <p>2. Patient #4 was a 68 year old female admitted to the agency on 7/18/16 for SN, PT and home health aide services related to abnormality of gait and mobility. Additional diagnoses included generalized muscle weakness, abnormal heart rhythm, elevated blood pressure, respiratory disease and major depressive disorder. Her record, including the POC, for the certification period 7/18/16 to 9/15/16, was reviewed.</p> <p>Patient #4's POC included a section for discipline and treatment orders that stated "HHA [home health aide] Visit Frequency 1 w 8 to assist w/personal care/ADLs/light housekeeping as needed..." Her POC also included specific orders for the home health aide. The orders included "... BP Q visit, report if outside of agency parameters..."</p> <p>During a visit to the home of Patient #4 on 8/17/16, beginning at 8:45 AM, Staff D, a home health aide, was observed while providing care for Patient #4. The home health aide made unsuccessful attempts to obtain Patient #4's BP. The BP cuff did not remain in place when pumped full of air. The home health aide placed a smaller BP cuff around Patient #4's right forearm, filled it with air and placed her</p>	G 212			

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G 212	Continued From page 17 stethoscope in her antecubital space (elbow pit), opposite from the side of the cuff where a pulse can be heard. The home health aide deflated the cuff slowly and listened without obtaining a blood pressure. The home health aide was interviewed during the visit. She stated in the past, she had been able to successfully obtain Patient #4's BP with a large BP cuff. She said she knew placing the smaller cuff around Patient #4's forearm and listening at the antecubital space was incorrect, but she was nervous. She said she had been trained to obtain "wrist BPs on an obese patient if I'm unable to take a normal BP." When asked where she received training in this technique, she said "at another agency I worked at before this one."	G 212			
G 213	The agency failed to ensure home health aides met competency evaluation requirements. 484.36(b)(2)(i) COMPETENCY EVALUATION & IN-SERVICE TRAI The competency evaluation must address each of the subjects listed in paragraphs (a)(1)(ii) through (xiii) of this section. This STANDARD is not met as evidenced by: Based on review of personnel files, agency policy review, and staff interview, it was determined the agency failed to ensure the skills of 4 of 5 home health aides (Staff A, B, C, and D) hired after 6/06/14, whose personnel files were reviewed, were evaluated by qualified staff. This had the potential to negatively impact quality and safety of patient services. Findings include:	G 213			

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G 213	Continued From page 18 An agency policy "COMPETENCY BASED ORIENTATION," undated, was reviewed. The policy stated "Organization personnel are given the appropriate job category Orientation Checklist during the orientation process." Additionally, an agency policy "CORE COMPETENCY SKILLS," undated, was reviewed. The policy stated "The organization will define the mandatory core competency skills for each discipline based upon the nature of their job responsibilities and complexity of care required... Core competency skills will be reviewed with new personnel during their orientation... Each core competency skill has a corresponding set of performance criteria..." A third agency policy "COMPETENCY ASSESSMENT," undated, was reviewed. The policy stated "Using a Competency Skills Performance Checklist developed specifically for each clinical job category, the Clinical Supervisor will evaluate the competence in performing and rendering care according to organization policies and standards of practice." Agency personnel files for Staff A, B, C, and D were reviewed in the presence of the Office Manager on 8/17/16, beginning at 1:55 PM. The Office Manager confirmed Staff A, B, C, and D's personnel file did not include documentation of competency evaluation. She stated the competency evaluations were performed for all staff; however she was unable to provide a copy for Staff A, B, C, or D. Additionally, the Office Manager confirmed the personnel files did not include a Competency Skills Performance Checklist or Orientation Checklist for Staff A, B,	G 213			

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G 213	Continued From page 19 C, or D.	G 213		
G 214	<p>The agency failed to ensure home health aides met competency evaluation requirements.</p> <p>484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA must complete a performance review of each home health aide no less frequently than every 12 months.</p> <p>This STANDARD is not met as evidenced by: Based on agency personnel file review, agency policy review, and staff interview, it was determined the facility failed to ensure yearly evaluations were conducted for 4 of 5 home health aides (Staff A, B, D, and E), who had been employed for more than one year. This had the potential to negatively impact quality and safety of patient care. Findings include:</p> <p>An agency policy "HOME HEALTH AIDE TRAINING," undated, was reviewed. The policy stated "Home health aide personnel files will be reviewed regularly... All files must contain:... Annual performance reviews, which will include:... On-site skills assessments for supervisory visits done every six (6) months... Updating of skills checklist... Compliance with inservice requirements. Avalon Home Health will complete a performance and competency evaluation for each home health aide at least once annually."</p> <p>1. Personnel files for Staff A were reviewed with the Office Manager on 8/17/16, beginning at 1:35 PM. The home health aide had been employed for more than one year, with a hire date of</p>	G 214		

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G 214	<p>Continued From page 20</p> <p>7/29/15. Staff A's personnel file did not include an annual performance review. The Office Manager confirmed the annual evaluation had not been completed for 2016. Additionally, she confirmed Staff A's personnel file did not include on-site skills assessments or skills checklist.</p> <p>2. Personnel files for Staff B were reviewed with the Office Manager on 8/17/16, beginning at 1:35 PM. The home health aide had been employed for more than one year, with a hire date of 10/01/14. Staff B's personnel file did not include an annual performance review. The Office Manager confirmed the annual evaluation had not been completed for 2015. Additionally, she confirmed Staff B's personnel file did not include on-site skills assessments or skills checklist.</p> <p>3. Personnel files for Staff D were reviewed with the Office Manager on 8/17/16, beginning at 1:35 PM: The home health aide had been employed for more than one year, with a hire date of 6/06/14. Staff D's personnel file did not include an annual performance review. The Office Manager confirmed the annual evaluation had not been completed for 2015 or 2016. Additionally, she confirmed Staff D's personnel file did not include on-site skills assessments or skills checklist.</p> <p>4. Personnel files for Staff E were reviewed with the Office Manager on 8/17/16, beginning at 1:35 PM. The home health aide had been employed for more than one year, with a hire date of 9/14/14. Staff E's personnel file did not include an annual performance review. The Office Manager confirmed the annual evaluation had not been completed for 2015. Additionally, she confirmed Staff E's personnel file did not include</p>	G 214			

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G 214	Continued From page 21 on-site skills assessments or skills checklist.	G 214			
G 225	Home health aide performance reviews were not conducted at least every 12 months. 484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on record review, observation and staff interview, it was determined the agency failed to ensure the home health aide provided services in accordance with the POC for 1 of 4 patients (Patient #4) who were receiving home health aide services and whose records were reviewed. This had the potential to interfere with the safety and quality of patient care. Findings include: Patient #4 was a 68 year old female admitted to the agency on 7/18/16 for SN, PT and home health aide services for care related to abnormality of gait and mobility. Additional diagnoses included generalized muscle weakness, abnormal heart rhythm, elevated blood pressure, respiratory disease and major depressive disorder. Her record, including the POC, for the certification period 7/18/16 to 9/15/16, was reviewed. Patient #4's record contained an "AIDE/HOMEMAKER CARE PLAN," completed on 7/18/16 and signed by an RN. The POC indicated Patient #4's BP should be taken during	G 225			

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G 225	Continued From page 22 each home health aide visit. During a visit to the home of Patient #4 on 8/17/16, beginning at 8:45 AM, Staff #D, a home health aide, was observed while providing care for Patient #4. The home health aide made unsuccessful attempts to obtain Patient #4's BP. The BP cuff did not fit Patient #4's upper arm and would not remain in place when pumped full of air. The home health aide placed a smaller BP cuff on Patient #4's right forearm. The home health aide filled the smaller BP cuff with air, placed the diaphragm of her stethoscope in the antecubital space (elbow pit), the opposite side of the cuff to hear pulse sounds. The home health aide deflated the cuff slowly, and listened however, she was unable to obtain a BP. The home health aide was interviewed during the visit. She stated in the past, she had been able to successfully obtain Patient #4's BP with a large BP cuff. She said she knew placing the smaller cuff around Patient #4's forearm and listening at the antecubital space was incorrect, but she was nervous.	G 225			
G 229	The home health aide did not provide services as ordered in the home health aide Care Plan. 484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by:	G 229			

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G 229	<p>Continued From page 23</p> <p>Based on clinical record review, policy review, and staff interview, it was determined the agency failed to ensure on-site home health aide supervisory visits were conducted by an RN or qualified therapist at least every 2 weeks for 1 of 4 patients (Patient #2), who received home health aide services and whose records were reviewed. This had the potential to prevent the agency from identifying and correcting substandard care by home health aides. Findings include:</p> <p>An agency policy, "HOME HEALTH AIDE SUPERVISORY VISITS," undated, stated "The frequency of supervisory visits will be based upon the needs of the patient after the plan of care is established. They must be conducted at least every two (2) weeks."</p> <p>Patient #2 was a 76 year old male admitted to the agency on 6/09/16 for SN and PT services following repeated falls. He was currently a patient as of 8/17/16. Additional diagnoses included DM Type II and CHF. He received SN, PT and home health aide services. His record, including the POC, for the certification period 6/09/16 to 8/07/16, was reviewed.</p> <p>Patient #2's POC included an order for aide visits 1 time a week for 1 week, then 2 times a week for 8 weeks. The first aide visit was documented on 6/10/16. An aide supervisory visit was documented on 6/15/16, signed by the RN. Aide visits were documented 2 times a week beginning 6/13/16. However, no aide supervisory visit was documented until 7/20/16, 35 days after the previous aide supervisory visit.</p> <p>The Executive Director was interviewed on 8/18/16 beginning at 3:10 PM. She stated except</p>	G 229		

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G 229	Continued From page 24 for 6/15/16 and 7/20/16, aide supervisory visits were not documented.	G 229		
G 236	<p>The agency failed to conduct supervisory visits at least every 2 weeks.</p> <p>484.48 CLINICAL RECORDS</p> <p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, record review, and agency policy review, it was determined the agency failed to ensure medical records were complete and accurate for 8 of 12 patients (#1, #2, #3, #4, #6, #7, #8, and #10) whose records were reviewed. This had the potential to interfere with clarity, coordination, and safety of care. Findings include:</p> <p>An agency policy "VERIFICATION OF PHYSICIAN ORDERS," undated, was reviewed. The policy stated "Signed orders will be in the clinical record within 30 days of initiation of care or interim order, unless otherwise specified by applicable state law and regulation."</p> <p>Additionally, an agency policy "PHYSICIAN</p>	G 236		

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G 236	<p>Continued From page 25</p> <p>PARTICIPATION IN PLAN OF CARE," undated, was reviewed. The policy stated "The attending physician will sign the plan of care/treatment within 30 days of the start of care."</p> <p>1. Patient #1 was an 88 year old female admitted to the agency on 5/22/16. She was currently a patient as of 8/16/16.</p> <p>Patient #1's record included a "Release of Medical Information Authorization," dated and signed by Patient #1. The form stated "I hereby authorize: [blank line] to release my medical records to: Avalon Home Health and Hospice." The line "Dates requested" was blank. The form included 8 choices of records to request including "Discharge Summary" and "Other.", however none were checked.</p> <p>2. Patient #2 was a 76 year old male admitted to the agency on 6/09/16. He was currently a patient as of 8/17/16.</p> <p>Patient #2's record included a "Release of Medical Information Authorization," not dated but signed by Patient #2. The form stated "I hereby authorize: [blank line] to release my medical records to: Avalon Home Health and Hospice." The line "Dates requested" was blank. The form included 8 choices of records to request including "Discharge Summary" and "Other" however, none were checked.</p> <p>3. Patient #3 was a 78 year old female admitted to the agency on 7/17/16 for SN, home health aide, PT, and OT services due to metastatic cancer and related complications. Additional diagnoses included malnutrition, abnormalities of gait and mobility, and muscle weakness. Her</p>	G 236			

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G 236	Continued From page 26 record, including the POC, for the certification period 7/17/16 to 9/14/16, was reviewed. a. Patient #3's record included a "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 6/01/16, and signed by an RN. The form did not include a physician signature or date. b. Patient #3's record included a "Release of Medical Information Authorization," dated 6/01/16, and signed by Patient #3. The section "I hereby authorize:" and "Dates requested:" were blank. 4. Patient #4 was a 68 year old female admitted to the agency on 7/18/16 for SN, PT and home health aide services related to abnormality of gait and mobility. Additional diagnoses included generalized muscle weakness, abnormal heart rhythm, elevated blood pressure, respiratory disease and major depressive disorder. Her record, including the POC, for the certification period 7/18/16 to 9/15/16, was reviewed. a. Patient #4's record included a "Release of Medical Information Authorization," dated 7/18/16, and signed by Patient #4. The sections "I hereby authorize:" and "Dates requested:" were blank. 5. Patient #6 was an 85 year old female admitted to the agency on 6/01/16 for SN services for care related to a wound to her right lateral leg. Additional diagnoses included chronic pain, DM Type II, hypertension, and frequent urinary tract infections. Her record, including the POC, for the certification period 7/31/16 to 9/28/16, was reviewed. a. Patient #6's record included a "HOME	G 236		

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G 236	Continued From page 27 HEALTH CERTIFICATION AND PLAN OF CARE," dated 7/19/16, and signed by an RN. The form did not include a physician signature or date. b. Patient #6's record included a "PHYSICIAN'S ORDER VERBAL," dated 7/17/16, and 2 dated 7/18/16. The 3 forms did not include a physician signature or date. c. Patient #6's record included a "Release of Medical Information Authorization," dated 7/17/16, and signed by Patient #6. The section "I hereby authorize:" and "Dates requested:" were blank. 6. Patient #7 was a 65 year old female admitted to the agency on 6/28/16 for home health aide, MSW, PT, and SN services due to pneumonia and related complications. Additional diagnoses included DM Type II, COPD, CHF, and hypertension. Her record, including the POC, for the certification period 6/28/16 to 8/26/16, was reviewed. a. Patient #7's record included a "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 6/28/16, and signed by an RN. The form did not include a physician signature or date. b. Patient #7's record included a "PHYSICIAN'S ORDER VERBAL," dated 6/28/16 and 6/30/16. The forms did not include a physician signature or date. c. Patient #7's record included a "Release of Medical Information Authorization," dated 6/28/16, and signed by Patient #7. The section "I hereby authorize:" and "Dates requested:" were blank.	G 236			

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G 236	<p>Continued From page 28</p> <p>7. Patient #8 was a 79 year old female admitted to the agency on 7/12/16 for SN, PT, SW and home health aide services related to a pressure ulcer on the left buttock. Additional diagnoses included gait and mobility abnormalities, generalized muscle weakness, Alzheimer's disease, dementia and heart failure. Her record, including the POC, for the certification period 7/12/16 to 9/09/16, was reviewed.</p> <p>a. Patient #8's record included a "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 7/12/16, and signed by an RN. The form did not include a physician signature or date.</p> <p>b. Patient #8's record included a "Release of Medical Information Authorization," undated, but signed by Patient #8. The sections "I hereby authorize:" and "Dates requested:" were blank.</p> <p>8. Patient #10 was an 82 year old male admitted to the agency on 6/30/16 after hospitalization. He was currently a patient as of 8/17/16.</p> <p>Patient #10's record included a "Release of Medical Information Authorization," dated 6/01/16, and signed by Patient #10. The form stated "I hereby authorize: [blank line] to release my medical records to: Avalon Home Health and Hospice." The "Dates requested" was blank. The form included 8 choices of records to request including "Discharge Summary" and "Other" however, none were checked. The date of signature line was blank.</p> <p>The Executive Director was interviewed on 8/17/16, beginning at 9:45 AM. She reviewed</p>	G 236			

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G 236	<p>Continued From page 29</p> <p>patient #4's record and confirmed the form "Release of Medical Information Authorization" was incomplete. She also acknowledged the potential for a breach of patient privacy.</p> <p>The Executive Director was interviewed on 8/18/16, beginning at 10:05 AM. She reviewed patient #8's record and confirmed the missing physician signatures and dates. She also confirmed the form "Release of Medical Information Authorization" was incomplete, allowing for a potential breach of patient privacy.</p> <p>The Executive Director was interviewed on 8/18/16, beginning at 2:30 PM. The records for Patients #3, #6, and #7 were reviewed in her presence. The Executive Director confirmed the missing physician signatures and dates. She also confirmed the missing information on the "Release of Medical Information Authorization" forms and acknowledged the potential for a breach of patient privacy.</p> <p>The Executive Director was interviewed on 8/18/16, beginning at 3:10 PM. She stated the agency had patients sign blank "Release of Medical Authorization" forms at the time of admission. She stated if staff wished to obtain personal health information later, nurses would fill in the blanks and request the information. She stated patients were not necessarily informed of a request for personal health information at the time it was requested. She agreed this made the record inaccurate by making it appear as if the patient specifically requested information.</p> <p>The agency failed to ensure patient medical records were complete and accurate.</p>	G 236			

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G 242 G 242	Continued From page 30 484.52 EVALUATION OF THE AGENCY'S PROGRAM This CONDITION is not met as evidenced by: Based on staff interview and review of policies and administrative documents, it was determined the agency failed to ensure an evaluation of Avalon Home Health was conducted . This impaired the Governing Body's ability to make decisions about the quality of care that was provided to patients. Findings include: 1. Refer to G243 as it relates to the agency's failure to develop agency specific policies requiring an evaluation of the agency's total program. 2. Refer to G244 as it relates to the agency's failure to ensure an evaluation, including a policy and administrative review and a clinical record review, was conducted. 3. Refer to G245 as it relates to the agency's failure to ensure an evaluation was conducted that assessed the extent to which the agency's program was appropriate, adequate, effective and efficient. 4. Refer to G246 as it relates to the agency's failure to ensure an agency evaluation was conducted and the results of the evaluation were reported to persons responsible for the operation of the agency. 5. Refer to G248 as it relates to the agency's failure to ensure an evaluation was conducted which included an assessment of the policies and	G 242 G 242			

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G 242	Continued From page 31 administrative practices of the agency.	G 242			
G 243	The cumulative effect of these systemic practices seriously impeded the ability of the agency to determine the adequacy and quality of its services. 484.52 EVALUATION OF THE AGENCY'S PROGRAM The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and administrative documents, it was determined the agency failed to develop an agency specific policy requiring an evaluation of the agency's total program. This prevented the agency from evaluating its processes and overall program. Findings include: The policy "ANNUAL ORGANIZATION EVALUATION" was a policy purchased from a corporation that consults with and advises non-acute health care providers. The policy was copywritten. The policy stated it was revised in October 2012 but this appeared to be revised by the corporation rather than by Avalon Home Health. The policy stated "The organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's Program." The policy	G 243			

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G 243	Continued From page 32 had not been tailored to Avalon Home Health. For example, the policy did not specify who the "authorized group or oversight committee" was that was responsible for the evaluation. An evaluation of the agency's total program was not documented since at least 8/01/15. The CEO was interviewed on 8/18/16 beginning at 1:45 PM. He stated an evaluation of the agency's total program was not documented. He stated the policies were reviewed at some point in 2015. However, he stated there was no record of this review or of personalization to the evaluation policy.	G 243		
G 244	484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and administrative documents, it was determined the agency failed to ensure an evaluation, including a policy and administrative review and a clinical record review, was conducted. This resulted in a lack of direction to staff and contributed to the agency's inability to conduct an evaluation of the overall program. Findings include: The policy "ANNUAL ORGANIZATION EVALUATION" was a policy purchased from a	G 244		

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G 244	Continued From page 33 corporation that consults with and advises non-acute health care providers. The policy was copywritten. The policy stated it was revised in October 2012 by the corporation rather than by Avalon Home Health. The policy stated "The organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's Program." The policy had not been tailored to Avalon Home Health. For example, the policy did not specify who the "authorized group or oversight committee" was that was responsible for the evaluation. An evaluation of the agency's total program was not documented since at least 8/01/15. The CEO was interviewed on 8/18/16 beginning at 1:45 PM. He stated an evaluation of the agency's total program was not documented. He stated the policies were reviewed at some point in 2015. However, he stated there was no record of this review or of personalization to the evaluation policy. The agency had not conducted an evaluation, including a policy and administrative review and a clinical record review.	G 244			
G 245	484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient. This STANDARD is not met as evidenced by:	G 245			

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G 245	Continued From page 34 Based on staff interview and review of administrative documents, it was determined the agency failed to ensure an evaluation was conducted that assessed the extent to which the agency's program was appropriate, adequate, effective and efficient. This resulted in a lack of feedback to the agency. Findings include: An evaluation of the agency's total program that assessed the extent to which the agency's program was appropriate, adequate, effective and efficient was not documented since at least 8/01/15. The CEO was interviewed on 8/18/16 beginning at 1:45 PM. He stated an evaluation of the agency's total program was not documented. He stated there was no record the Governing Body had received the results of such an evaluation. The agency had not conducted an evaluation that assessed the extent to which the agency's program was appropriate, adequate, effective and efficient.	G 245			
G 246	484.52 EVALUATION OF THE AGENCY'S PROGRAM Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency failed to ensure an agency evaluation was conducted and the results of the evaluation were reported to persons responsible for the operation	G 246			

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NAME OF PROVIDER OR SUPPLIER AVALON HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 403 1ST ST IDAHO FALLS, ID 83401		
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G 246	Continued From page 35 of the agency. This resulted in the inability of those persons to identify issues affecting the agency and take action to address those issues. Findings include: An evaluation of the agency's total program that assessed the agency's program was not documented since at least 8/01/15. The CEO was interviewed on 8/18/16 beginning at 1:45 PM. He stated an evaluation of the agency's total program was not documented. He stated there was no record the Governing Body had received such an evaluation. The agency had not conducted an evaluation and had not reported the results to persons responsible for the operation of the agency.	G 246			
G 248	484.52(a) POLICY AND ADMINISTRATIVE REVIEW As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency failed to ensure an evaluation was conducted which included an assessment of the policies and administrative practices of the agency. This prevented the agency from examining its processes. Findings include:	G 248			

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G 248	Continued From page 36 An evaluation of the agency's total program that included an assessment of the policies and administrative practices was not documented since at least 8/01/15. The CEO was interviewed on 8/18/16 beginning at 1:45 PM. He stated an evaluation of the agency's total program, including an assessment of policies and administrative practices, was not documented. The agency had not conducted an evaluation of the agency's total program, including an assessment of policies and administrative practices.	G 248			
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 observation, record review, agency policy review, and staff interview, it was determined the agency failed to ensure the comprehensive assessment included a review of all medications the patient was taking for 2 of 12 patients (#6 and #10) whose records were reviewed for 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 placed patients at risk for adverse outcomes related to	G 337			

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G 337	<p>Continued From page 37</p> <p>medications. Findings include:</p> <p>1. Patient #6 was an 85 year old female admitted to the agency on 6/01/16 for SN services for care related to a wound to her right lateral leg. Additional diagnoses included chronic pain, DM Type II, hypertension, and frequent urinary tract infections. Her record, including the POC, for the certification period 7/31/16 to 9/28/16, was reviewed. At the time of the survey, Patient #6 resided in an ALF.</p> <p>Patient #6's record included an agency "MEDICATION PROFILE," dated 7/26/16, which was reviewed. Additionally, Patient #6's ALF record included an administrative document "Current Medications..." form, undated, which was reviewed. The 2 forms did not have the same medications documented for Patient #6. Examples include:</p> <p>a. Medications documented on Patient #6's agency "MEDICATION PROFILE," but not on her ALF "Current Medications..." were as follows:</p> <ul style="list-style-type: none"> i. Tylenol ii. Milk of Magnesia iii. Dulcolax (oral) iv. Vitamin D3 v. Bactrim vi. MiraLax vii. Dulcolax (rectal) viii. Zinc Oxide ix. Bacitracin <p>b. Medications documented on Patient #6's ALF "Current Medications..." but not on her agency "MEDICATION PROFILE" were as follows:</p>	G 337			

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G 337	<p>Continued From page 38</p> <p>i. Nitroglycerin ii. Calcium iii. Docusate Sodium iv. Loratadine v. Tramadol vi. Vitamin D</p> <p>c. Additionally, Patient #6's record included a "PHYSICIAN'S ORDER," dated 8/05/16, and signed by the Physician Assistant overseeing Patient #6's wound care at a wound care clinic. The order included "Use collagenase/ Santyl as the primary dressing." The medication Santyl was not documented on Patient #6's agency "MEDICATION PROFILE" or her ALF "Current Medications..."</p> <p>An agency policy "ADMINISTRATION AND DOCUMENTATION OF MEDICATION," undated, was reviewed. The policy stated "As part of the assessment process, a drug history will be taken, including prescribed and over-the-counter medications, and herbal and nutritional supplements. A comparison will be made between the physician's (or other authorized licensed independent practitioner's) orders and the current medications the patient is taking. Any discrepancies or contradictions should be reported to the physician for resolution."</p> <p>A scheduled SN visit with an LPN was observed on 8/18/16, beginning at 10:00 AM. The SN visit included wound care by the LPN.</p> <p>The LPN who performed the SN visit was interviewed on 8/18/16, beginning at 10:45 AM. When asked when a patients' medication reconciliation was performed, the LPN stated "usually every visit or when the patient states they</p>	G 337			

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G 337	<p>Continued From page 39</p> <p>are on a new medication." She stated she failed to perform a medication reconciliation during the visit. Patient #6's agency "MEDICATION PROFILE" and ALF "Current Medications..." were reviewed in the LPN's presence. She confirmed the medications on the two forms did not match. Additionally, the LPN confirmed Santyl was not present on either form. She stated she did not know who the agency's ALF liaison was or who to contact at the ALF if medication discrepancies were found between the two entities.</p> <p>The Executive Director was interviewed on 8/18/16, beginning at 2:30 PM. When asked when a patient's medication reconciliation was performed, the Executive Director stated on admission, recertification, and if the patient stated they are on new medications. Patient #6's agency "MEDICATION PROFILE" and ALF "Current Medications..." were reviewed in the Executive Director's presence. She confirmed the medications on the two forms did not match. Additionally, the Executive Director confirmed Santyl was not present on either form. She stated she did not know who the current agency ALF liaison was and "they change all the time."</p> <p>The agency failed to ensure all medications Patient #6 was taking were accurate and complete.</p> <p>2. Patient #10 was an 82 year old male admitted to the agency on 6/30/16 after hospitalization. He was currently a patient as of 8/17/16. Diagnoses included UTI, DM Type II, and CHF.</p> <p>A "MEDICATION PROFILE," dated 6/30/16 by the Case Manager, was part of the comprehensive assessment. It stated Patient #10 was taking</p>	G 337		

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G 337	<p>Continued From page 40</p> <p>Aspirin 81 mg daily in addition to taking Warfarin in varying doses. Patient #10's POC for the certification period 6/30/16 to 8/28/16 stated Patient #10 was to take Aspirin 81 mg daily in addition to his Warfarin.</p> <p>During a visit to Patient #10's home on 8/17/16 beginning at 1:10 PM, it was observed that Patient #10 had a bottle of Aspirin 325 mg. Patient #10's wife stated Patient #10 took 1/2 tablet (162.5 mg) daily.</p> <p>The Executive Director was interviewed on 8/19/16 beginning at 8:15 AM. She stated the Aspirin dose Patient #10 was taking did not match the ordered dose.</p> <p>Patient #10's comprehensive assessment did not accurately reflect all medications he was taking.</p>	G 337			

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N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your agency conducted from 8/15/16 to 8/22/16. The surveyors conducting the recertification were:</p> <p>Gary Guiles, RN, HFS, Team Leader Brian Osborn, RN, HFS Rebecca Lara, RN, HFS Jennifer Davis, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>BLS - Basic Life Support certification CPR - Cardiopulmonary Resuscitation LPN - Licensed Practical Nurse PTA - Physical Therapy Assistant RN - Registered Nurse</p>	N 000	<p><i>See attached Plan of Correction</i></p>	
N 001	<p>03.07020.01. ADMIN.GOV.BODY</p> <p>020. ADMINISTRATION - GOVERNING BODY.</p> <p>N001 01. Scope. The home health agency shall be organized under a governing body, which shall assume full legal responsibility for the conduct of the agency.</p> <p>This Rule is not met as evidenced by: Refer to G128</p>	N 001		
N 048	<p>03.07021. ADMINISTRATOR</p> <p>N048 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:</p>	N 048		

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

TITLE

(X6) DATE

Dr. David Jones

Executive Director

9/16/2016

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N 048	Continued From page 1 b. Providing staff orientation, continuing education, information on applicable laws, rules and policies, resource materials, and staff development to effectively implement and continue the program. This Rule is not met as evidenced by: Refer to G134	N 048		
N 050	03.07021. ADMINISTRATOR N050 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: d. Insuring that personnel employed shall be qualified to perform their assigned duties and that agency practices are supported by written personnel policies. This Rule is not met as evidenced by: Refer to G134	N 050		
N 051	03.07021. ADMINISTRATOR N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency	N 051		

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N 051	<p>Continued From page 2</p> <p>and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations.</p> <p>This Rule is not met as evidenced by: Based on review of personnel files, administrative document review, and staff interview, it was determined the agency failed to ensure personnel records included current CPR certificates for 7 of 30 staff (Staff B, F, I, R, AA, CC, and DD), who provided direct patient care and whose personnel files were reviewed. Failure of the agency to ensure current CPR certification had the potential to compromise patient safety. Findings include:</p> <p>An agency administrative document "Job Descriptions, Physical Therapy Assistant," undated, was reviewed. The document included "Possess and maintains current CPR certification."</p> <p>A second agency administrative document "Job Description, Registered Nurse (RN)," undated, was reviewed. The document included "Current licensure in state and CPR certification."</p> <p>A third agency administrative document "Job Description, Licensed Practical/Vocational Nurse," undated, was reviewed. The document included "Possesses and maintains CPR certification."</p> <p>A fourth agency administrative document "Job Description, Certified Home Health Aide,"</p>	N 051		

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N 051	Continued From page 3 undated, was reviewed. The document included "Possess and maintains current CPR certification." The agency failed to ensure staff who provided direct patient care had documentation of current BLS certification. The following personnel files were reviewed in the presence of the Office Manager on 8/17/16, beginning at 1:55 PM. Personnel file examples include: 1. Staff B, a home health aide, had a documented hire date of 10/01/14. Her personnel file did not include documentation of current BLS certification. The Office Manager was unable to provide documentation of BLS certification for Staff B upon request. 2. Staff F, an RN, had a documented hire date of 1/20/16. Her personnel file did not include documentation of current BLS certification. The Office Manager was unable to provide documentation of BLS certification for Staff F upon request. 3. Staff I, a PTA, had a documented hire date of 10/12/14. Her personnel file did not include documentation of current BLS certification. The Office Manager was unable to provide documentation of BLS certification for Staff I upon request. 4. Staff R, a PTA, had a documented hire date of 11/01/12. Her personnel file did not include documentation of current BLS certification. The Office Manager was unable to provide documentation of BLS certification for Staff R upon request.	N 051		

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N 051	Continued From page 4 5. Staff AA, an LPN, had a documented hire date of 6/18/13. Her personnel file did not include documentation of current BLS certification. The Office Manager was unable to provide documentation of BLS certification for Staff AA upon request. 6. Staff CC, a home health aide, had a documented hire date of 5/20/15. Her personnel file did not include documentation of current BLS certification. The Office Manager was unable to provide documentation of BLS certification for Staff CC upon request. 7. Staff DD, a home health aide, had a documented hire date of 1/07/16. His personnel file did not include documentation of current BLS certification. The Office Manager was unable to provide documentation of BLS certification for Staff DD upon request. The Office Manager was interviewed on 8/17/16, beginning at 1:55 PM. She confirmed the personnel files reviewed in her presence were missing documentation of current staff BLS certification. The agency failed to ensure all staff providing direct patient care had current BLS certification.	N 051		
N 078	03.07023.01.POL.& PROC.MAN. N078 01. Development and Approval. A policy and procedure manual shall be developed for effectively implementing the objectives of the home care program. They shall be approved by the governing body. These policies and	N 078		

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N 078	Continued From page 5 procedures shall be reviewed annually and revised as indicated. This Rule is not met as evidenced by: Refer to G128	N 078		
N 105	03.07024. SK. NSG. SERV. N105 02. Licensed Practical Nurse. A licensed practical nurse perform the following: c. Prepares equipment and materials for treatments observing aseptic technique as required; This Rule is not met as evidenced by: Refer to G182	N 105		
N 110	03.07024.SK.NSG.SERV. N110 03.Home Health Aide. A home health aide must have completed the supplemental skills checklist approved by the Idaho State Board of Nursing and must be included on the Idaho State Board of Nursing's Home Health Aide Registry. Duties of a home health aide include the following: This Rule is not met as evidenced by: Refer to G212 and 213	N 110		
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	N 119		

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N 119	Continued From page 6 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	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	N 152		
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels,	N 173		

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N 173	Continued From page 7 drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G337	N 173		
N 194	03/07040.01.AGENCY EVAL. N194 01. Evaluation Timetable. The group of professional personnel meets as needed to advise the agency and monitor the program. The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel, or a committee of this group, HHA staff, and consumers, or by professional people working outside the agency in conjunction with consumers. This Rule is not met as evidenced by: Refer to G243	N 194		
N 195	03.07040.02 AGENCY EVAL. N195 02. Evaluation Criteria and Purpose. The evaluation consists of an overall policy and administrative review and a clinical record review and assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. This Rule is not met as evidenced by: Refer to G244, 245 and 248	N 195		

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NAME OF PROVIDER OR SUPPLIER AVALON HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 403 1ST ST IDAHO FALLS, ID 83401		
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N 196 N 196	Continued From page 8 03.07040.03 AGENCY EVAL. N196 03. Evaluation Results. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records. This Rule is not met as evidenced by: Refer to G246	N 196 N 196		

Plan of Correction for Avalon Home Health and Hospice

Condition : G122, 484.14 - Condition of Participation: Organization, Services and Administration.

Condition: G128, 484.14(b) - Standard: Governing Body. A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.

Tag: N001 – 03.07020.01 - Administration – Governing Body

Tag: N078 – 03.07023.01 – Policy and Procedure Manual

Plan/Action - The Governing Body will meet next on 9/21/2016. Discussion will include patient care, policy review, and a review of the agency's services, as well as all other usual items of business.

Procedure for Implementation: All policies and procedures will immediately undergo review and be updated or amended as appropriate.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards.

Monitoring and Tracking: CEO or Executive Director will assure compliance thru quarterly QA, assuring that the Governing Body is discussing and properly documenting oversight of the Agency's activities including, but not limited to Patient Care, Immediate and Annual Policy review, and a review of the Agency's services. Threshold for compliance is 100%, if threshold is met for two consecutive quarters, then will reduce to annual review.

Responsible Party: CEO / Executive Director will assure ongoing compliance.

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FACILITY STANDARDS

Tag: G134, 484.14(c) – The Administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.

Condition : G122, 484.14 - Condition of Participation: Organization, Services and Administration.

Tag: N048 – 03.07021 – Administrator

Tag: N050 – 03.07021 – Administrator

Tag: N051 – 03.07021 – Administrator

Plan/Action – Executive Director or designee will meet with all staff beginning the week of September 19, 2016 to complete all orientation, skills competencies, and annual evaluations that are outstanding, and complete paperwork for those activities that were previously completed.

Procedure for Implementation: The related policies: "Competency Orientation", "Training/Inservice Education", and "Competency Assessment" will be reviewed and updated as necessary to parallel our orientation and training procedures.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards.

Monitoring and Tracking: A monthly sampling of 100% of employee records will be reviewed for (1) Completion of Orientation Checklist (2) Completion of Competency Assessment (3) Probationary or annual competency completion. Review will be monthly until an expected threshold of 95% is achieved.

Responsible Party: Executive Director or designee

Tag: G242, 484.52 – Condition of Participation – Evaluation of the Agency's Program

Tag: G243, 484.52 - The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers.

Tag: N194 – 03.07040.01 – Agency Evaluation

Tag: G244, 484.52 – The evaluation consists of an overall policy and administrative review and a clinical record review.

Tag: N195 – 03.07040.02 – Agency Evaluation

Tag: G245, 484.52 - The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient.

Tag: N195 – 03.07040.02 – Agency Evaluation

Tag: G246, 484.52 - Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency

Tag: N196 – 03.07040.03 – Agency Evaluation

Tag: G248, 484.52 (a) - As part of the evaluation process, the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient.

Tag: N195 – 03.07040.02 – Agency Evaluation

Plan/Action – (1) Review and update the policy, "Annual Organization Evaluation", (2) Annual Evaluation will be completed no later than October 6th, 2016.

Procedure for Implementation: As outlined in plan/action above.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards

Monitoring and Tracking: CEO/Executive Director to assure compliance with completion date of October 6th, 2016.

Responsible Party: CEO/Executive Director and Governing Board will assure compliance annually.

Plan of Correction for Avalon Home Health and Hospice

Condition: G128, 484.14(b) - Standard: Governing Body. A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.

Tag: N001 – 03.07020.01 - Administration – Governing Body

Tag: N078 – 03.07023.01 – Policy and Procedure Manual

Plan/Action - The Governing Body will meet next on 9/21/2016. Discussion will include patient care, policy review, and a review of the agency's services, as well as all other usual items of business.

Procedure for Implementation: All policies and procedures will immediately undergo review and be updated or amended as appropriate.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards.

Monitoring and Tracking: CEO or Executive Director will assure compliance thru quarterly QA, assuring that the Governing Body is discussing and properly documenting oversight of the Agency's activities including, but not limited to Patient Care, Immediate and Annual Policy review, and a review of the Agency's services. Threshold for compliance is 100%, if threshold is met for two consecutive quarters, then will reduce to annual review.

Responsible Party: CEO / Executive Director

Tag: G134, 484.14(c) – The Administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.

Tag: N048 – 03.07021 – Administrator

Tag: N050 – 03.07021 – Administrator

Tag: N051 – 03.07021 – Administrator

Plan/Action – Executive Director or designee will meet with all staff beginning the week of September 19, 2016 to complete all orientation, skills competencies, and annual evaluations that are outstanding, and complete paperwork for those activities that were previously completed.

Procedure for Implementation: The related policies: "Competency Orientation", "Training/Inservice Education", and "Competency Assessment" will be reviewed and updated as necessary to parallel our orientation and training procedures.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards.

Monitoring and Tracking: A monthly sampling of 100% of employee records will be reviewed for (1) Completion of Orientation Checklist (2) Completion of Competency Assessment (3) Probationary or annual competency completion. Review will be monthly until an expected threshold of 95% is achieved.

Responsible Party: Executive Director or designee

Tag: G158, 484.18 - Acceptance of Patients, Plan of Care, and Medical Supervision. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

Tag: N152 – 03.07030.01 – Plan of Care

Plan/Action – Patient # 5 orders were corrected to assure that dressing changes were aseptic, and not sterile – as this was written incorrectly on the initial order. Patient # 6 plan of care was not followed by LPN (agency failed to follow established, written POC). Patient # 10 was not established or reviewed by a physician. This patient was referred by a FNP, and the orders and plan of care were not signed by the supervising MD. The Home Health Coordinator was educated on the week of September 12, 2016 that all patients must have an MD signature for all orders and plans of care. All licensed staff will be educated at a mandatory meetings (beginning week of September 19, 2016) regarding development, implementation, and tracking Plans of Care.

Procedure for Implementation: Avalon Home Health will be implementing a new software system – Home Care Home Base. This will enable staff to track the patient's plan of care at each visit, which our current software, Devero does not afford.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards

Monitoring and Tracking: A monthly sampling of 10% of charts, or 10 charts (whichever is greater) will be reviewed for (1) All orders are completed and executed as written, (2) POC is correctly and completely implemented by staff, and (3) All patients will have an MD, DO, or DPM as their primary provider. Review will be monthly until an expected threshold of 95% is achieved.

Responsible Party: Executive Director or designee

Tag: G182, 484.30 (b) - Duties of the Licensed Practical Nurse. The licensed practical nurse furnishes services in accordance with agency policies. The agency failed to ensure the LPN observed aseptic technique.

Tag: N105 – 03.07024 – Skilled Nursing Service

Plan/Action - Beginning the week of September 19, 2016, all clinical staff will attend inservice training regarding (1) Aseptic Technique, (2) Hand Hygiene (including the use of alcohol-based hand rubs), and (3) Standard precautions (to include when gloves are to be changed).

Procedure for Implementation: Inservice training will begin the week of September 19, 2016. Relias training class, "Hand Hygiene" will be repeated by all clinical staff no later than October 6, 2016.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards

Monitoring and Tracking: Executive Director or designee will assure completion of Relias traing class for all clinical staff by October 6th, 2016, as well as attendance at above mentioned inservice training.

Responsible Party: Executive Director of Designee.

Tag: G212, 484.36 (b) (1) - Competency Evaluation and In-Service Training – The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirement of this section.

Tag: G213, 484.36 (b) (2) (1) – Content and frequency of evaluations and amount of In-Service Training.

Tag: G214, 484.36 (b) (2) (ii) – The HHA must complete a performance review of each home health aide no less frequent than every 12 months.

Tag: N110 – 03.07024 – Skilled Nursing Service

Plan/Action - Beginning the week of September 16, 2016, all home health aides and their preceptor will document completion of their competency based orientation, and all core competency skills will be checked off by a qualified RN. Additional training will be provided on BP measuring for all home health aides as a result of unsuccessful attempts by HHA to obtain a BP on patient #4 during survey process.

Procedure for Implementation: Inservice training will begin the week of September 19, 2016 as mentioned above under plan/action.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards

Monitoring and Tracking: All HHA files will be reviewed monthly to assure that all HHA have received orientation, completed an orientation checklist, competency skills performance checklist, competency evaluation, and if appropriate have received an annual evaluation. Once a threshold of 95% is achieved the QA will be completed quarterly.

Responsible Party: Executive Director or designee.

Tag: G225, 484.36 (c) (2) – Assignment and Duties of the Home Health Aide – The HHA provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.

Plan/Action – Beginning the week of September 16, 2016, all home health aides will receive training on BP measuring as a result of unsuccessful attempts by HHA to obtain a BP on patient #4 during survey process.

Procedure for Implementation: Inservice training will begin the week of September 19, 2016 as mentioned above under plan/action.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards

Monitoring and Tracking: Home health aide employee file will be reviewed for evidence of in-service training on blood pressure measurement. Expected threshold is 100%. Once threshold is achieved, review will change to quarterly.

Responsible Party: Executive Director or designee.

Tag: G229, 484.36 (d) (2) – Supervision - the registered nurse (or another professional described in paragraph (d) (1) of this section) must make on on-site visit to the patient's home no less frequently than every 2 weeks.

Tag: N119 – 03.07024.04 – Skilled Nursing Service

Plan/Action – Home Health Clinical coordinator will assure that supervisory visits are schedule with the RN or other professional no less frequent that every 2 weeks. This is not something that is available on our current software – so presently this is a manual process.

Procedure for Implementation: Home Health clinical coordinator will schedule all supervisory visits manually until we go live with our new software, Home Care Home Base, the third week of October.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards

Monitoring and Tracking: A monthly sampling of 10% of charts (Home Health Aide patients), or 10 charts (whichever is greater) will be reviewed for documentation of supervisory visit no less frequent than every 2 weeks. Review will be monthly until an expected threshold of 95% is achieved, then will continue quarterly.

Responsible Party: Executive Director or designee.

Tag: G236, 484.48 - A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician, drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.

Plan/Action – This standard was not met as evidenced by (1) The Release of Medical Information Authorization form was not completed appropriately for patient #1, #2, #4, #6, #7, #8. MD signatures not being obtained within 30 days was evidenced on patient #3, #6, #7, #8, #10.

Procedure for Implementation: Inservice training will begin the week of September 19, 2016. The content will be as follows: (1) In-service education for all RN's on the proper completion of the "Release of Medical Information Authorization", (2) review policy, "Obtaining MD Signatures within 30 Days".

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards

Monitoring and Tracking: A monthly sampling of 10% of charts (new admits), or 10 charts (whichever is greater) will be reviewed for appropriate completion of "Release of Medical Information Authorization" form. Review will be monthly until an expected threshold of 95% is achieved, then will continue quarterly.

Responsible Party: Executive Director or designee.

Tag: G242, 484.52 – Condition of Participation – Evaluation of the Agency's Program

Tag: G243, 484.52 - The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers.

Tag: N194 – 03.07040.01 – Agency Evaluation

Tag: G244, 484.52 – The evaluation consists of an overall policy and administrative review and a clinical record review.

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Tag: G245, 484.52 - The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient.

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Tag: G248, 484.52 (a) - As part of the evaluation process, the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient.

Tag: N195 – 03.07040.02 – Agency Evaluation

Plan/Action – (1) Review and update the policy, "Annual Organization Evaluation", (2) Annual Evaluation will be completed no later than October 6th, 2016.

Procedure for Implementation: As outlined in plan/action above.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards

Monitoring and Tracking: CEO/Executive Director to assure compliance with completion date of October 6th, 2016.

Responsible Party: CEO/Executive Director

Tag: G337, 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.

Tag: N173 – 03.07030.07 – Plan of Care

Plan/Action – Per review of patient #6 (ALF patient) and #10, a comprehensive assessment of medications was not performed. Inservice training for RN and LPN staff will begin the week of September 19th, 2016, including a review of policy, "Safe/Effective Use of Medication". We will also review the process for medication reconciliation (in the home or ALF), and reporting of potential adverse effects and drug reactions, including ineffective therapy, significant side effects, noncompliance with drug therapy, duplicate therapies, or major interactions.

Procedure for Implementation: Inservice training as mentioned in plan/action will be initiated the week of September 19th, 2016.

Completion Date: October 6, 2016 as requested by the Bureau of Facility Standards

Monitoring and Tracking: A monthly sampling of 10% of charts, or 10 charts (whichever is greater) will be reviewed for completion of medication reconciliation documentation. Review will be monthly until an expected threshold of 95% is achieved, then will continue quarterly.

Responsible Party: Executive Director or designee.