IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7003 0500 0003 1966 8602

March 21, 2011

Tami Slatter, Administrator
Visions Home Health
209 Shoup Avenue West
Twin Falls, ID 83301

RE: Visions Home Health, Provider #137107

Dear Ms. Slatter:

Based on the survey completed at Visions Home Health, on March 7, 2011, by our staff, we have determined Visions Home Health is out of compliance with the Medicare Home Health Agency (HHA) **Condition of Participation on Reporting OASIS Information (42 CFR 484.20)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Visions 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 each form.

Such corrections must be achieved and compliance verified by this office, before April 21, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than April 13, 2011.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **April 3, 2011**.

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

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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

VISIONS
HOME HEALTH, LLC
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The Best of Care Coming to Your Home!

RECEIVED
MAR 3 1 2011
FACILITY STANDARDS

March 29, 2011

Ms. Sylvia Creswell
Co Supervisor, Non-long term care
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720-0036

Dear Ms. Creswell:

Your survey team completed a Medicare Licensure and certification survey at Visions Home Health provider number 137107 in Twin Falls on February 28th thru March 4th, 2011. In response to your findings, we have developed a plan of correction. Enclosed is our plan. If you have any questions regarding the plan, you may contact me by phone (208) 732-5365.

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

Sincerely,

Tamala Slatter RN BSN

Tamala Slatter, RN BSN
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	03/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH	209 SHOUP AVENUE WEST TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency. Surveyors conducting the recertification were: Susan Costa, RN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS Karen Robertson, RN, BS, HFS Acronyms used in this report include: DME = Durable Medical Equipment HHA = Home Health Agency LPN = Licensed Practical Nurse MD = Medical Doctor mg = milligram ml = milliliter NC = Nasal Cannula OASIS = Outcome and Assessment Information Set OT = Occupational Therapy POC = Plan of Care PT = Physical Therapy RN = Registered Nurse ROC = Resumption of Care SOC = Start of Care SN = Skilled Nursing	G 000	RECEIVED MAR 3 1 2011 FACILITY STANDARDS	
G 114	484.10(e)(1(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to	G 114		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jamale Slatter — Administrator — 3/29/11

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 114	Continued From page 1 pay. This STANDARD is not met as evidenced by: Based on review of clinical records, agency forms and staff interview, it was determined the agency failed to ensure 1 of 1 patient (#13) reviewed, who had private health insurance as the primary health insurance, and Medicaid as the secondary health insurance, was informed in writing the extent to which payment could be required from the patient. This had the potential to interfere with the patient's right to make informed decisions about whether to precede with home care services. Findings include: Patient #13 was admitted to HHA services on 8/28/07, for SN services related to a progressive neurological disorder. A form, titled "ADMISSION CONSENT," with a subtitle "AUTHORIZATION FOR PAYMENT," had a section which addressed financial responsibility. The section included a statement that claimed the patient may be responsible for co-payment and any charges that the insurance may not cover. It did not state the payment Patient #13 would be expected to pay. There was no documentation that this omission had been corrected at a later date. In an interview on 3/03/11 at 11:00 AM, the Director stated Patient #13 had not received information regarding financial liability. The HHA did not inform Patient #13 of the amount of the fees the patient might be expected to pay.	G 114	G114 Billing Manager will check Insurance verification/coverage on all non-traditional Medicare patients. Insurance Verification form will be given to admitting RN who will review with the patient so that they are aware of what co-pays they will be expected to pay. Patient will at the time of admission sign the form and be given a copy. Please see attached Insurance Verification form(addendum 1)The Patient Care Coordinator will review all admissions for 100% compliance. Deficiency will be corrected 4/1/2011.	
G 143	484.14(g) COORDINATION OF PATIENT SERVICES	G 143		

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G 143	Continued From page 2 All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure staff coordinated efforts effectively for 1 of 8 sample patients (#12) receiving SN and therapy services. This resulted in failure to assess an incision. Findings include: Patient #12 was an 84 year old male who was admitted to the agency on 2/11/11 for care after joint surgery. An RN "OASIS C SOC/ROC ASSESSMENT," dated 2/11/11 at 11:15 AM, documented Patient #12's right hip incision was healed with a scab on the lower end of the incision. It further documented PT/OT would evaluate and treat the incision as there was no need for skilled nursing. There was no documentation to indicate the RN communicated with PT or OT staff regarding this expectation. There was no documentation on the POC or in PT or OT visit notes to indicate the incision site had been assessed by PT or OT. On 3/02/11 at 4:20 PM, the Director and Patient Care Coordinator were interviewed together. They reviewed Patient #12's record and stated the RN should have communicated with therapy services regarding the need to assess Patient #12's incision. They confirmed there was no documentation that coordination had occurred. The RN Case Manager was not available for interview.	G 143	G143 All disciplines have been inserviced about the importance of coordination of care by all disciplines involved in the patients care. An inservice on complete documentation to include date, time and context of any conversation regarding coordination of care between disciplines. Documentation will be charted on therapy visit note, nursing note, or in Suncoast under communicator. See attached Therapy meeting minutes. Patient care coordinator will review patient charts to assure coordination is being done and doeumented. Deficiency will be corrected 4/1/2011.	

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G 143	Continued From page 3 SN and PT/OT did not coordinate effectively to ensure an incision had been assessed.	G 143		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care followed a written plan of care established and reviewed by a doctor for 4 of 16 patients (#9, #10, #12, and #15) whose records were reviewed. This had the potential to negatively impact quality and coordination of patient care. Findings include: 1. Patient #10 was an 80 year old female who was admitted to the agency on 2/04/11 for care primarily related to a stroke. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 2/04/11 to 4/04/11 included orders for home health aide services for personal care and bathing. There was no documentation of aide visits or patient refusal of aide visits. On 3/03/11 at 1:00 PM, the Director and Patient Care Coordinator were interviewed together. They reviewed the record and stated Patient #10 had refused services after the initial order from the referring facility. They confirmed documentation was missing regarding Patient #10's refusal. They also confirmed the physician had not been alerted to the refusal.	G 158	G158 All Patients will receive care according to established written POC reviewed by the physician. In the case of missed visits by the nurse, therapist or HH aide the missed visit note will be faxed to the physician. At any time services provided are different then what is stated on the POC the physician will be notified by either phone call or fax. An Inservice was conducted for nursing and therapy staff that POC must be discussed with physician or physicians representative. Staff will document who the POC was discussed with. See Attached Therapy POC. Patient Care Coordinator will review all POC's and physician orders for documentation that a physician or physician representatives name is listed. Monthly chart reviews will be conducted to ensure that compliance with staff following the POC. See Therapy meeting minutes. Deficiency will be corrected 4/1/2011.	

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G 158	Continued From page 4 Care for home health aide services did not follow the written plan of care. The physician was not notified of patient refusal of services. 2. Patient #15 was a 72 year old male who was admitted to the agency on 12/09/10 to receive home IV infusion therapy due to dehydration. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 12/09/10 to 2/06/11, included orders for SN to admit Patient #15 to home health services and to call for further orders after admit. There were no additional orders in the record for SN visits. However, there were two documented nursing visits after the initial order, including RN visits on 12/10/10 at 9:00 PM and 12/14/10 at 2:00 PM. The Admitting RN was interviewed on 3/03/11 at 9:50 AM. She reviewed Patient #15's record and stated there should have been physician orders for additional visits. A physician was not contacted according to the plan of care for additional nursing orders after admitting Patient #15. This resulted in two unauthorized nursing visits. 3. Patient #12 was an 84 year old male who was admitted to the agency on 2/11/11 for care after joint surgery. A "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 2/11/11 to 4/11/11, included orders for PT and OT to evaluate and treat Patient #12. An OT evaluation was completed on 2/11/11 at 4:15 PM. An OT "Therapy Plan of Treatment," included a plan for a visit frequency of 1-2 times per week for 9 weeks. A PT evaluation was completed on 2/14/11 at 1:01 PM. The PT "Therapy Plan of Treatment," dated	G 158		

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G 158	Continued From page 5 2/14/11, included a plan for a visit frequency of 2 times per week for 8 weeks. These frequencies were transferred to the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 2/11/11 TO 4/11/11. There was no documentation the PT or OT had contacted the physician to approve the POC prior to initiation of additional visits. A PT visit was made on 2/16/11 at 4:09 PM. OT visits were made on 2/15/11 at 10:30 PM and 2/24/11 at 2:25 PM. On 3/02/11 at 4:20 PM, the Director and Patient Care Coordinator were interviewed together. The Director stated it was agency expectation that nurses and therapists contact the MD to get approval for the POC. They reviewed Patient #12's record and confirmed evidence was missing that the physician had been contacted to approve the POC. PT and OT POCs were not established or approved by the physician prior to providing care. 4. Patient #9 was an 89 year old female who was admitted to the agency for skilled nursing and physical therapy following a knee replacement. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/18/11 to 4/18/11 contained orders for "PT to evaluate and treat within 1 week." A "PHYSICAL THERAPY EVALUATION," and "Therapy Plan of Treatment," both dated 2/23/11, stated Patient #9 would be seen per plan of treatment 2 times per week for 4 weeks. There was no indication the therapist contacted the physician to review and approve the projected plan of care.	G 158		

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G 158	Continued From page 6 In an interview on 2/28/11 at 4:50 PM, the Director reviewed the record and confirmed the findings. The Director stated it was her understanding the therapist would conduct the evaluation and then contact the physician for collaboration with developing a plan of treatment and visit schedule. The therapist did not contact the physician to develop the plan of care for therapy services.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review, staff interview, home visit, and patient interview, it was determined the agency failed to ensure plans of care covered all pertinent information for 10 of 16 patients (#1, #3, #5, #6, #7, #11, #12, #13, #15, and #16) whose records were reviewed. This had the potential to negatively impact quality, coordination, and completeness of patient care. Findings include: 1. Patient #5 was an 81 year old female who was admitted to the agency on 1/17/11. The "OASIS C SOC/ROC Assessment," completed by the RN on 1/17/11 at 11:20 AM, stated Patient #5 was	G 159		

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G 159	Continued From page 7 taking Coumadin for treatment of atrial fibrillation (a heart condition characterized by irregular, fast heart beat, shortness of breath and weakness). The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 1/17/11 to 3/17/11, included orders for Coumadin tablets 5 days per week. It did not include a diagnosis of atrial fibrillation. The POC also included orders for oxygen at 2 liters via NC "as directed." The order for oxygen was incomplete and did not provide direction for staff as to whether the oxygen was continuous or intermittent. The Director and Patient Care Coordinator were interviewed together on 3/02/11 at 3:40 PM. They reviewed Patient #5's record and confirmed the diagnosis of atrial fibrillation should have been included on the POC. They explained the coding of diagnoses was outsourced and they may have run out of space to include it on the POC. They agreed the diagnosis was pertinent and belonged in the POC. They also stated the oxygen should have been listed as continuous. The POC did not include a pertinent diagnosis or a complete order for oxygen use. 2. Patient #15 was a 72 year old male who was admitted to the agency on 12/09/10 to receive home IV infusion therapy due to dehydration. RN "OASIS C SOC/ROC Assessment," dated 12/09/10 at 4:15 PM, documented Patient #15 was on 2 liters of oxygen. An MD History and Physical report, dated 12/09/10, included a list of medications Patient #15 was taking. The list included Pepcid 20 mg daily, Flomax 0.4 mg daily, citalopram 40 mg daily, Advair 250/50 1 puff 2 times per day, aspirin 81 mg daily, Detrol 4 mg daily, meloxicam 7.5 mg per day, acetaminophen	G 159	G159 Home Health Director will inservice Nurse case managers, Patient care coordinator and therapist in developing the POC to cover all pertinent diagnosis, medications, oxygen, equipment, and treatments ordered by the physician. This will include notifying MD and updating the POC if changes in patient status occur during a certification period. All nurse case managers, LPNs, and therapist will be inserviced on the revised Plan of Care policy. Inserviced all staff on clear and complete documentation of all findings when providing patient care. Patient care coordinator will thoroughly review each new admission/plan of care to ensure that all appropriate and pertinent diagnosis, medications, oxygen, equipment and treatments that apply to that patient is on the plan of care. See revised POC policy. Deficiency will be corrected 4/1/2011.	

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G 159	Continued From page 8 2 tabs in the morning/1 in the evening, ketoconozole cream applied to the face as needed, Restasis eye drops, Bactroban ointment applied to the groin area 2 times per day, Triamicinolone 0.1% cream applied to the groin area 2 times per day. These medications were not included on Patient #15's POC for certification period of 12/09/10 to 2/06/11. The Admitting RN was interviewed on 3/03/11 at 9:50 AM. She reviewed Patient #15's record and confirmed medications were missing on the POC. She stated she was not sure why they were not there; she thought she had entered them in the computer but had not kept a hard copy. The POC did not include medications. 3. Patient #12 was an 84 year old male who was admitted to the agency on 2/11/11 for care after joint surgery. A PT evaluation, dated 2/16/11 at 4:09 PM, stated equipment included a raised toilet seat, shower chair, and grab bars. None of these items were included in the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 2/11/11 to 4/11/11. During an interview on 3/02/11 at 4:20 PM, the Director and Patient Care Coordinator were asked if the agency had a policy that described what DME items should go on the POC. They stated there was no policy. The Director expressed an opinion that just the "bigger items," such as a hospital bed and walker should be on the POC. She acknowledged there might be different interpretations among staff as to what belonged on the POC. The POC did not include required equipment.	G 159		

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G 159	Continued From page 9 4. Patient #11 was a 74 year old male who was admitted to the agency on 1/12/11 for care related to an intestinal infection and an abnormality of gait. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 1/12/11 to 3/12/11, included conflicting orders for aide services. The first order was for bathing and personal cares 2 times per week for 9 weeks. The second order (on the same POC) was for home health aide service 1 time per week for one week and 2 times per week for 8 weeks, to include bathing, dressing, grooming, hair washing, hygiene, and light housekeeping. The POC included inconsistent orders for home health aide services. 5. Patient #3 was a 90 year old female who was admitted to the agency on 1/17/11 for care primarily related to osteoarthritis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 1/17/11 to 3/17/11 included as an additional diagnosis, "Other dependence on machines, supplemental oxygen." Oxygen was not listed on the POC as a medication. A physician dictated history and physical on 1/19/11 noted Patient #3 was using oxygen 2 liters on an "as needed" frequency. In an interview on 3/03/11 at 10:45 AM, the RN Case Manager confirmed Patient #3 was using oxygen nightly, and during the day as needed. The RN Case Manager reviewed the record and confirmed she had not included oxygen use by Patient #3 in the admission assessment on the SOC or the medication section on the POC.	G 159		

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G 159	Continued From page 10 The POC did not include oxygen. 6. Patient #6 was an 82 year old female who was admitted to the agency on 11/29/10 for care primarily related to congestive heart failure. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 1/28/11 to 3/28/11 included oxygen concentrator usage under "Safety Measures" on the POC. Oxygen was not listed on the POC as a medication. During a home visit on 3/01/11 at 9:30 AM, Patient #6 stated she used oxygen every night, and sometimes during the day if she felt like she needed it. In an interview on 3/03/11 at 10:50 AM, the RN Case Manager reviewed the record and confirmed she had not included oxygen use by Patient #6 in the recertification assessment or the medication section on the POC. The RN Case Manager stated she should have included the information regarding Patient #6's use of oxygen on the POC. The POC did not include oxygen. 7. Patient #13 was a 21 year old female who was admitted to the agency on 8/28/07 for care primarily related to a progressive degenerative neurological disease. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/08/11 to 4/08/11 included Fleets Enema on the list of DME and supplies. The Fleets Enema was not listed under medications and there was no direction provided on frequency, or when to use the enema included.	G 159		

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G 159	Continued From page 11 In an interview on 3/03/11 at 10:45 AM, the RN Case Manager reviewed Patient #13's record, and confirmed there was no direction as to the use of the Fleets Enema. The RN Case Manager stated she worked as a hospice nurse as well, and was used to including Fleets Enema as a DME for those patients. The POC did not list the enema as a medication, and did not provide specific instructions for its use. 8. Patient #16 was an 82 year old male who was admitted to the agency on 11/11/10 for care primarily related to wound care for a heel pressure ulcer. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 1/10/11 to 3/10/11 did not include information that Patient #16 was on oxygen. During a home visit on 3/03/11 at 9:00 AM, Patient #16 stated he used oxygen every night. He was unsure of the liter flow; he stated his wife just turned on the concentrator. In an interview on 3/03/11 at 10:30 AM, Patient #16's RN Case Manager reviewed the record and confirmed Patient #16 used oxygen although it was not listed on the POC. The POC did not include oxygen. 9. Patient #7 was a 4 year old female who was admitted to the agency on 12/11/06 for care primarily related to congenital cardiac anomalies. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period	G 159		

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G 159	Continued From page 12 1/19/11 to 3/19/1, included incomplete medication orders. Examples include: a) "9/08/2009 Take 1 1/2 ml (0.5mg/ml) by oral at bedtime as needed (sleep/anxiety)." No medication was listed, the dosage in mg was not listed, and the significance of the date was unclear. b) "9/02/2010 Take 1.2 mg of Enalapril Maleate Tablet (5mg Tab) by oral 2 x Day." The process of scoring and cutting a 5 mg tablet to insure 1.2 mg would not be possible. c) "9/02/2010 Take 15 mg of Zantac Tablet (150 mg Tab) by oral 2 x Day." It was unclear how the process of an accurate dosage of 1/10th of the tablet would be possible. d) "2/20/2009 Take 5 Syrup of DEC-CHLORPHEN DM (4mg-12.5 mg-15 mg/5 ml Syrup) by Oral 4 x Day as needed. (Cough) The dosage was unclear. In an interview on 3/03/11 at 10:45 AM, Patient #7's RN Case Manager reviewed the record and confirmed the lack of clarity with the medications listed on the POC. She explained the date preceding the medication was the original date the medication was ordered. The RN Case Manager stated that the 9/08/2009 order was actually for Ativan, and confirmed the lack of information as it was presented on the POC. She stated the computer software program was not designed to work with pediatric medications. The POC lacked clarity for the medications and dosages listed. 10. Patient #1 was a 99 year old male who was admitted to the agency on 1/07/11 for care primarily related to dizziness and giddiness.	G 159		

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a) The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period of 1/07/11 to 3/07/11 included secondary diagnoses of urinary and fecal incontinence, but did not address their management. The POC did not include interventions and goals related to the pertinent diagnoses of urinary and fecal incontinence.

In an interview with Patient #1's RN Case Manager on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager reported that she could not remember if Patient #1 was using incontinence supplies or if he was having continence issues at SOC.

The POC did not include pertinent interventions or goals to address the diagnosis of urinary/fecal incontinence.

b) The "OASIS C SOC/ROC Assessment," completed by the RN on 1/07/11 at 11:00 AM, documented Patient #1 used an Albuterol Sulfate nebulizer. He was also assessed as having crackles in the lower lobes of his lungs and had diminished lung sounds in all lobes.

The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period of 1/07/11 to 3/07/11, did not include a respiratory diagnosis, intervention, or goal related to the nebulizer treatments.

In an interview with Patient #1's RN Case Manager on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager reported she had noticed that there was no respiratory diagnosis listed on the POC. When asked why Patient #1 was on

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G 159	Continued From page 14 nebulizer treatments, the RN Case Manager said she was not sure. The RN Case Manager stated that Patient #1 had been on breathing treatments prior to starting home health services. She agreed that she should have clarified Patient #1's respiratory status with the physician. The POC did not include a pertinent respiratory diagnosis, intervention, or goal related to the use of the nebulizer. 11. Patient #8 was a 72 year old male who was admitted to the agency on 11/09/10 for care primarily related to obstructive chronic bronchitis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period of 1/08/10 to 3/08/11 had two rates of oxygen documented. On the POC under "Medications," oxygen was ordered as 2.5 liters of oxygen as directed. Under "Orders for Discipline and Treatments," the order was for continuous oxygen at 3 liters via NC. In an interview on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager stated that Patient #8 was on 3 liters of oxygen at SOC. She reported that she did not know how 2.5 liters of oxygen ended up on the medication list on the POC. The POC included inconsistent orders for oxygen use and dosage.	G 159		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by:	G 170		

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G 170	Continued From page 15 Based on staff interview and record review, it was determined the agency failed to ensure skilled nursing services were furnished in accordance with the plan of care for 1 of 2 patients (#4) who were receiving wound care and whose records were reviewed. This resulted in inconsistent wound care treatment and had the potential to negatively affect wound healing. Findings include: Patient #4 was an 82 year old male who was admitted to the agency on 1/27/11 for care primarily related to atherosclerosis with ulceration of the leg. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period of 1/27/11 to 3/27/11 included physician orders for wound care of an unhealed ulcer. The wound care orders were for SN to clean the ulcer with 4x4 gauze and normal saline, place antibiotic cream on the wound and then cover the wound with allevyn (foam pad/composite dressing). When the wound drainage decreased, SN was to use telfa (non-adherent dressing) to cover the wound instead of foam. The following are examples of wound care performed and documented by the RN that differed from the ordered wound care regimen: 2/10/11 at 10:00 AM - "Cleansed with alcohol pad helped to remove sluff [sic]. Placed allevyn dressing over wound." The wound was not cleansed with 4x4 gauze and normal saline as ordered. 2/22/11 at 9:30 AM - "Wound to R outer foot was cleansed and gauze dressing applied." The	G 170	G170 Home Health Director will inservice all skilled nurses and wound care specialist on importance of following physicians orders. Any changes to patient treatments will require a physicians order and communication between disciplines currently in the home. An audit of all wound care patients will be completed monthly until 100% compliance for three consecutive months is achieved. Deficiency will be covered by 4/1/2011. 4-4-11 This will be monitored by the ~~Patient Care Coordinators~~ Home Health Director. Jammie Harr RN	

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G 170	Continued From page 16 wound was not covered with a foam pad as ordered in the POC. 2/24/11 at 12:35 PM - "Cleansed with alcohol pad, applied triple abx, and covered with composite dressing." The wound was not cleansed with 4x4 gauze and normal saline as ordered in the POC. During an interview on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager agreed that the wound care provided was not the same as the wound care ordered by the physician. The RN Case Manager verified the physician had not ordered changes in the wound care. Wound care was not provided in accordance with the POC.	G 170		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure nursing staff effectively coordinated services on behalf of 2 of 16 patients (#4 and #15) whose records were reviewed. This resulted in an incomplete drug assessment at SOC, a failure to obtain orders for SN services, and unauthorized nursing visits. Findings include: 1. Patient #15 was a 72 year old male who was admitted to the agency on 12/09/10 for IV infusion	G 176		

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G 176	Continued From page 17 of fluids due to dehydration. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 12/09/10 to 2/06/11, included orders for SN to admit Patient #15 to home health and to call the MD after admit for further orders. There was no documentation to indicate nursing staff had contacted the MD for further orders. However, two additional RN visit notes were present in Patient #15's record, one on 12/10/10 9:00 PM and another on 12/14/10 at 2:00 PM. An MD History and Physical report, dated 12/09/10, included a list of medications Patient #15 was taking: Pepcid 20 mg daily, Flomax 0.4 mg daily, citalopram 40 mg daily, Advair 250/50 1 puff twice per day, aspirin 81 mg daily, Detrol 4 mg daily, meloxicam 7.5 mg daily, acetaminophen 2 tabs in the morning/1 in the evening, ketoconozole cream applied to the face as needed, Restasis eye drops, Bactroban ointment applied to the groin area twice per day, Triamicinolone 0.1% cream applied to the groin area twice per day. None of these medications were listed on the "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 12/09/10 to 2/06/11. During an interview on 3/03/11 at 9:50 AM, the RN who admitted Patient #15 to home health services stated she had admitted Patient #15 for the assigned RN Case Manager. She further stated it was her understanding that once admitted Patient #15's care would be turned over to the RN Case Manager. She confirmed medications were missing on the POC and was not sure why. She stated she thought she had entered them in the computer; however, she was unsure because she did not keep a hard copy of	G 176	G176 Clinical staff were inserviced regarding the need to document changes in patients condition thoroughly in the patient record and to notify the physician of any changes in the patient's condition. Documentation needs to include any physician feedback regarding these changes. Clinical staff inserviced on the extreme importance of communicating these changes to other disciplines involved in patients care. This deficiency will be monitored ongoing during monthly/quarterly chart reviews and case conferences. Deficiency will be corrected by 4/1/2011. 4-4-11 This will be monitored by the Patient Care Coordinator. Jammi Harr RN	

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G 176	Continued From page 18 the medication list. She said she also thought the RN Case Manager would get orders for additional nursing visits. A second RN (the RN Case Manager) was interviewed on 3/03/11 at 10:55 AM. She stated she thought the Admitting RN was functioning as the RN Case Manager. Two RNs did not maintain liaison to ensure their efforts were effectively coordinated on behalf of Patient #15. 2. Patient #4 was an 82 year old male who was admitted to the agency on 1/27/11 for care primarily related to atherosclerosis with ulceration of the leg. An LPN visit note, dated 2/22/11 at 9:30 AM, documented "aspiration precautions" under "medical safety," followed by the comment, "Pt encouraged to tilt head forward when swallowing to prevent aspiration." There was no documentation that the LPN had discussed the need for or implementation of aspiration precautions with the RN. In an interview on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager reported that she was unaware of the LPN documentation related to aspiration precautions. The RN Case Manager stated that the LPN did not contact her about Patient #4 needing to be on aspiration precautions. During an interview on 3/03/11 from 1:00 PM to 1:25 PM, the Patient Coordinator (an RN) explained she provided LPN supervision and took responsibility for reading the LPN notes and	G 176		

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G 176	Continued From page 19 completing LPN supervision documentation. She explained she had not noticed the LPN documentation related to aspiration precautions. She said she lets the RN Case Manager know when she has completed review of the LPN notes and talks with the LPN about any charting concerns. Care was not coordinated between the SN staff.	G 176		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the RNs prepared written patient care instructions for the home health aide for 3 of 6 patients who were receiving home health aide services (#3, #4, and #11) whose records were reviewed. This resulted in aides providing services not included on the plan of care. Findings include: 1. Patient #11 was a 74 year old male who was admitted to the agency on 1/12/11 for care related to an intestinal infection and an abnormality of gait. The "HOME HEALTH AIDE PLAN OF CARE,"dated 1/12/11, did not include direction for the home health aide to provide nail care, ambulation assistance, or shaving. However, home health aide visit notes documented providing one or more of these	G 224		

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G 224	Continued From page 20 services during aide visits: 1/12/11 at 10:30 AM (nail care, shave, and ambulation), 1/17/10 at 12:25 PM (shave and ambulation), 1/20/11 at 12:20 PM (shave and ambulation), 1/24/11 at 12:19 PM (nail care, shave, and ambulation), 1/27/11 at 12:22 PM (shave), 1/31/11 at 12:10 (shave and ambulation), 2/03/11 at 12:24 PM (shave and ambulation), 2/07/11 at 12:15 PM (shave and ambulation), 2/10 11 at 11:30 AM shave and ambulation), and 2/14/11 at 11:05 AM (nail care, shave, and ambulation). During an interview on 3/03/11 at 11:00 AM, the RN Case Manager stated she approved the services the home health aide was providing. She stated the written "HOME HEALTH AIDE PLAN OF CARE" should have been updated. Shaving, nail care, and ambulation were not included on the written plan of care. 2. Patient #3 was a 90 year old female who was admitted to the agency on 1/17/11 for care primarily related to osteoarthritis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 1/17/11 to 3/17/11, included orders for home health aide services twice weekly for bathing and personal cares. The "HOME HEALTH AIDE PLAN OF CARE," dated 1/17/11, provided instructions for the home health aide related to personal care and hygiene for Patient #3. The box beside "Nail Care" was not checked, indicating the home health aide was	G 224	G224 Inserviced C.N.A's to reference aide POC every visit prior to performing any cares to ensure the aide will safely and adequately be able to provide the care as ordered. Aide POC will now be placed in every admit packet so that the admitting RN can fill it out on the admission visit. Inserviced aide that if the patient requests services that are not on the POC the aide must first seek approval from the case managing RN. Aide must document that this coordination took place. Case managing RN will be responsible for updating the aide POC. Case managing RN's will review the aide POC every 2 weeks for compliance. Please see response to State ID N156. Deficiency will be corrected by 4/1/2011	

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G 224	Continued From page 21 not to provide nail care. A "HOME HEALTH AIDE DAILY VISIT," dated 1/18/11, listed the activities performed by the home health aide. "Nail Care" was checked, indicating the home health aide provided nail care for Patient #3. In an interview on 3/03/11 at 10:45 AM, the RN Case Manager for Patient #3 reviewed the record and confirmed nail care was provided although it was not included in the "HOME HEALTH AIDE PLAN OF CARE." The home health aide provided nail care although it was not included in the written plan of care. 3. Patient #4 was an 82 year old male who was admitted to the agency on 1/27/11 for care primarily related to atherosclerosis with ulceration of the leg. The "HOME HEALTH AIDE PLAN OF CARE," dated 1/31/11, did not include ambulation or nail care as tasks to be performed. > On 2/03/11 at 8:00 AM, the home health aide documented assisting Patient #4 with ambulation. > On 2/10/11 at 7:56 AM, the home health aide documented assisting Patient #4 with nail care and ambulation. > On 2/17/11 at 7:50 AM, the home health aide documented assisting Patient #4 with ambulation. The RN routine assessment, dated 2/03/11 at 1:00 PM, documented the home health aide was to assist Patient #4 with "ADLs, Ambulation, Bathing, Dressing, Foot care, Grooming, Hair Washing, Hygiene, Incontinence care."	G 224		

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G 224	Continued From page 22 In an interview with the RN Case Manager on 3/03/11 from 8:45 AM to 9:45 AM, she reported that foot care was the same as nail care. She also stated that the performed tasks were ones she wanted the home health aide to do. The RN Case Manager agreed that she had not updated the "HOME HEALTH AIDE PLAN OF CARE" to reflect all the tasks the home health aide was approved to be doing. The "HOME HEALTH AIDE PLAN OF CARE" was not updated by the RN Case Manager to reflect all patient care instructions.	G 224		
G 225	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 observation, staff interview and review of medical records, it was determined the agency failed to ensure home health aides provided services in accordance with the plan of care for 1 of 2 sample patients (#6) receiving home health aide services observed during home visits. This had the potential to interfere with safety and quality of patient care. Findings include: Patient #6 was an 82 year old female who was admitted to the agency on 11/29/10 for care primarily related to congestive heart failure and diabetes. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 1/28/11 to 3/28/11 included	G 225	G225 Home Health Director inserviced C.N.A's regarding their scope of practice and not performing any task that is not listed on the aide POC. Case managing RN's will monitor this every two weeks and during case conferences. Deficiency will be corrected 3/16/11.	

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	137107	A. BUILDING _____ B. WING _____	03/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH	209 SHOUP AVENUE WEST TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 23 orders for home health aide services twice weekly for bathing and grooming. During a home visit on 3/01/11 at 9:30 AM, the home health aide was observed to clip and file Patient #6's fingernails. In an interview on 3/03/11 at 10:45 AM, the RN Case Manager for Patient #6 stated she would not want the home health aide to provide nail care to a diabetic patient. The home health aide provided nail care to a diabetic patient although it was not part of the plan of care.	G 225		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure clinical records of 5 of 16 patients (#4, #8, #10, #11, and #14) whose records were reviewed contained all pertinent findings . This had the potential to interfere with clarity of the course of care and coordination of patient care. Findings include:	G 236	G236 Please see G159	

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G 236	Continued From page 24 1. Patient #11 was a 74 year old male who was admitted to the agency on 1/12/11 for care related to an intestinal infection and an abnormality of gait. a) RN visit notes, dated 1/12/11 at 10:30 AM and 2/01/11 at 10:00 AM, documented Patient #11 had bruising. There was no description of the extent or location of the bruising. During an interview on 3/03/11 at 11:00 AM, the RN Case Manager reviewed Patient #11's record and confirmed the nursing documentation did not include extent and location of bruising. She stated it was the agency's standard to provide further description. The clinical record did not contain a clear description of the bruising. b) The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 1/12/11 to 3/12/11 included conflicting orders for home health aide services. The first order was for bathing and personal cares 2 times per week for 9 weeks. The second order (on the same POC) was for home health aide service 1 time per week for one week and 2 times per week for 8 weeks, to include bathing, dressing, grooming, hair washing, hygiene, and light housekeeping. Two sets of orders on the same POC resulted in a lack of clarity in the medical record. During an interview on 3/03/11 at 11:00 AM, the RN Case Manager reviewed Patient #11's record and confirmed the discrepancy and stated the correct order was for home health aide services 1 time per week for one week, followed by 2 times per week for 8 weeks.	G 236		

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G 236	Continued From page 25 The clinical record did not contain clear and consistent orders for home health aide services in the POC. 2. Patient #14 was a 65 year old male who was admitted to the agency on 1/06/11 for home IV therapy for a urinary tract infection. The RN "OASIS C - SOC/ROC Assessment," dated 1/06/11 at 9:00 AM, documented Patient #14 reported taking pain medication prior to bedtime for pain relief. The assessment did not indicate the name of the pain medication. During an interview on 3/03/11 at 11:25 AM, the RN Case Manager reviewed the record and confirmed the missing information. She stated she assumed it was one of the pain medications on his medication list but acknowledged she could not be sure. The clinical record did not contain the name of a medication being referenced. 3. Patient #10 was an 80 year old female who was admitted to the agency on 2/04/11 for care primarily related to a stroke. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 2/04/11 to 4/04/11, included orders for home health aide services for personal care and bathing. There was no documentation of aide visits or patient refusal of aide services. On 3/03/11 at 1:00 PM, the Director and Patient Care Coordinator were interviewed together. They reviewed the record and stated Patient #10 had refused services after the initial order from the referring facility. They confirmed Patient	G 236		

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G 236	Continued From page 26 #10's refusal had not been documented in the clinical record. The clinical record did not contain pertinent information regarding a conversation with Patient #10. The clinical record was incomplete. 4. Patient #4 was an 82 year old male who was admitted to the agency on 1/27/11 for care primarily related to atherosclerosis with ulceration of the leg. An RN visit note, dated 2/10/11 at 10:00 AM, documented Patient #4 had hematuria (blood in the urine). The next visit note, dated 2/14/11 at 1:35 PM, documented "No significant findings" related to urinary status with no charting related to the discussion and education of Patient #4 and his spouse. In an interview on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager stated that she had followed up with Patient #4's spouse on the visit dated, 2/14/11 at 1:35 PM, and found out that Patient #4 was still having "pink urine," but that it had slowed down. The RN Case Manager also stated that she had encouraged Patient #4's spouse to take a pad to Patient #4's doctor visit the next day that showed the color of Patient #4's urine. The charting did not reflect the actual assessment and interventions. The RN Case Manager did not document pertinent findings during a nursing visit. 5. Patient #8 was a 72 year old male who was admitted to the agency on 11/09/10 for care primarily related to obstructive chronic bronchitis. The clinical record lacked clarity.	G 236		

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G 236	Continued From page 27 a) The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period of 1/08/10 to 3/08/11 had two rates of oxygen documented. On the POC under "Medications," oxygen was ordered as 2.5 liters of oxygen as directed." On the POC under "Orders for Discipline and Treatments," the order was for oxygen via NC at 3 liters per minute continuously. In an interview on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager stated that Patient #8 was on 3 liters of oxygen at SOC. She reported that she did not know how 2.5 liters of oxygen ended up on the medication list on the POC. The clinical record lacked clarity related to oxygen orders on the POC. b) On the RN visit note dated 1/27/11 at 9:15 AM, Patient #8 was documented as having a sore wrist. The clinical record did not show evidence of the communication with Patient #8's physician. In an interview with the RN Case Manager on 3/03/11 from 8:45 AM to 9:45 AM, she reported that she had notified the physician regarding the new wrist pain and the doctor had not given any orders. The RN Case Manager stated she had not documented the conversation and that it was relevant to the record. The clinical record did not contain pertinent documentation of communication with the physician.	G 236		
G 320	484.20 REPORTING OASIS INFORMATION HHAs must electronically report all OASIS data collected in accordance with §484.55	G 320		

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G 320	Continued From page 28 This CONDITION is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure OASIS data was electronically reported for 1 of 1 sample patient (#13) who had Medicaid as a secondary insurance. This also had the potential to impact all agency patients who had Medicaid as a secondary insurance. This had the potential to interfere with the statistical accuracy of the agency reporting. Findings include: Patient #13 was a 21 year old female who was admitted to the agency on 8/28/07 for nursing services primarily related to cerebral lipidosis, a progressive degenerative neurological disorder. Her date of birth is 4/25/89, thus she was 18 years old at the time of admission. There was no indication OASIS data had been transmitted for Patient #13 since SOC. In an interview on 3/03/11 at 10:45 AM, the RN Case Manager stated it was her understanding that Patient #13 did not need OASIS completed, as she had private insurance as her primary and Medicaid as her secondary insurance. The RN Case Manager stated Patient #13 started receiving nursing services from the agency when she was a pediatric patient, and there was no question regarding the collection of OASIS data. The RN Case Manager stated she had not completed an OASIS assessment for Patient #13. During an interview on 3/04/11 at approximately 9:30 AM, an employee that dealt with insurance billing, confirmed Medicaid had been billed for Patient #13 and Medicaid had been paying as secondary insurer for the services provided to Patient #13..	G 320	G320 Home Health Director inserviced admitting RN's and Employee therapist that Oasis assessments will now be done on every patient 18 years of age and older regardless of payer type. Patient Care Coordinator will monitor all admissions, recertifications, and discharges for Oasis assessments. Deficiency will be corrected 3/16/2011.	

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G 320	Continued From page 29 In an interview on 3/03/11 at 8:30 AM, the Director stated she had been unaware that Patient #13 had met the criteria for OASIS data collection and submission. The agency failed to ensure systems were in place to report OASIS data on all applicable patients. This negative agency practice seriously impeded the ability of the agency to report OASIS data as required for statistical and quality improvement purposes.	G 320		
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure initial patient assessments were performed within 48 hours of referral, return home or physician-ordered start of care date for 1 of 16 patients (#5) whose records were reviewed. This had the potential to negatively impact patient care. Findings include: Patient #5 was an 81 year old female who was admitted to the agency on 1/17/11 for care primarily related to polymyalgia rheumatica (an inflammatory disorder involving pain and stiffness). According to an RN note, dated 1/14/11, Patient #5 was referred to home health on 1/13/11 (4 days prior to SOC). There was no documentation that the physician had been notified and/or had approved the delayed SOC date.	G 332	G332 Home Health Director will inserviee staff that visits must be done within 48 hours of referral, return home, or on ordered date. Patient Care Coordinator will audit new charts to ensure that all disciplines have seen patients within 48hours or on the ordered date. If visits are not able to be done within 48 hours the Patient Care Coordinator will monitor that the physician was notified of a delay in service. This deficiency will be monitored ongoing during quarterly chart reviews. Deficiency will be corrected 4/1/2011.	

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G 332	Continued From page 30 The Director and Patient Care Coordinator were interviewed together on 3/02/11 at 3:40 PM. They reviewed Patient #5's record and confirmed there was no documentation that the physician had been notified of the delayed SOC date. They explained the delay in start of care was upon the request of Patient #5. An initial assessment visit was delayed without physician knowledge or approval.	G 332		
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 record review, home visit, patient interview, and staff interview, it was determined the agency failed to ensure comprehensive drug assessments were completed at appropriate times for 2 of 16 patients (#4 and #15) whose records were reviewed. This had the potential to negatively impact quality and coordination of patient care. Findings include: 1. Patient #4 was an 82 year old male who was admitted to the agency on 1/27/11 for care primarily related to atherosclerosis with ulceration of the leg. During a home visit on 3/02/11 from 11:00 AM to 12:00 PM, a review of Patient #4's medication was completed with Patient #4's spouse who was	G 337		

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G 337	Continued From page 31 in charge of keeping track of Patient #4's medications and ensuring he took them appropriately. It was found that the home medications did not match the medications listed on the "HOME HEALTH CERTIFICATION AND PLAN OF CARE." The POC listed Cardura 1 mg daily and Zocor 5 mg at bedtime. Patient #4's spouse reported that Patient #4 was not taking Cardura and that he was actually taking Zocor 10 mg at bedtime. Patient #4's spouse reported that these had not changed since SOC on 1/27/11. In an interview on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager reported that she was unaware of the discrepancies and that she would "follow up that day." The review of medications during the home visit did not match the medication list on the POC. 2. Patient #15 was a 72 year old male who was admitted to the agency on 12/09/10 for IV infusion of fluids due to dehydration. The RN "OASIS C - SOC/ROC ASSESSMENT," dated 12/09/10, did not include a review of all medication the patient was taking. According to an MD History and Physical report, dated 12/09/10, Patient #15 was taking: Pepcid 20 mg daily, Flomax 0.4 mg daily, citalopram 40 mg daily, Advair 250/50 1 puff 2 times per day, aspirin 81 mg daily, Detrol 4 mg daily, meloxicam 7.5 mg daily, acetaminophen 2 tabs in the morning and 1 in the evening, ketoconozole cream applied to the face as needed, Restasis eye drops, Bactroban ointment applied to the groin area 2 times per day, Triamicinolone 0.1% cream applied to the groin area 2 times per day. None of these medications were listed on the SOC assessment or on the "HOME HEALTH CERTIFICATION AND PLAN	G 337	G337 All clinical staff will be inserviced on the need to include all medications on the MAR, reviewing all medications with emphasis on multiple medications for same diagnosis and medication discrepancy. Clinical staff will be inserviced on medication discrepancy form and importance of this assessment tool. See attached form. Chart audits will be performed monthly to monitor medication reconciliation until 100% compliance is achieved for three consecutive months. Deficiency will be corrected 4/1/2011. 4-4-11 This will be monitored by the patient care coordinator.	

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G 337	Continued From page 32 OF CARE" for certification period 12/09/10 to 2/06/11. The Admitting RN was interviewed on 3/03/11 at 9:50 AM. She confirmed the findings and stated she thought she had entered the medications in the computer. She further stated she was not sure as she did not keep a hard copy of the medication list. The comprehensive assessment did not include a review of all medications Patient #15 was taking at the time of admission to the home health agency.	G 337		

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the State survey of your agency. Surveyors conducting the survey were: Susan Costa, RN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS Karen Robertson, RN, BS, HFS Acronyms used in this report include: DME = Durable Medical Equipment HHA = Home Health Agency NC = Nasal Cannula OT = Occupational Therapy POC = Plan of Care PT = Physical Therapy RN = Registered Nurse ROC = Resumption of Care SOC = Start of Care	N 000	RECEIVED MAR 3 1 2011 FACILITY STANDARDS	
N 041	03.07020. ADMIN. GOV. BODY N041 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: c) The charges that the patient may have to pay; and This Rule is not met as evidenced by: Refer to G 114.	N 041	N041 Please see response to Federal ID G114	

Bureau of Facility Standards

Pamala Platta — Administrator — 3/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G 143.	N 062	N 062 Please see response to Federal ID G143	
N 092	03.07024.01. SK.NSG.SERV. N092 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: This Rule is not met as evidenced by: Refer to G 176.	N 092	N 092 Please see response to Federal ID G176	
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as	N 122	N 122 Please see response to Federal ID G224	

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N 122	Continued From page 2 appropriate. This Rule is not met as evidenced by: Refer to G 224.	N 122		
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 G 158 and G 170.	N 152	N 152 Please see response to Federal ID G158&G170	
N 153	03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: a. All pertinent diagnoses; This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the written plan of care included all pertinent diagnoses for 2 of 16 patients (#1 and #5) whose records were reviewed. This had the potential to negatively impact quality and completeness of patient care. Findings include:	N 153		

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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) COMPLETE DATE
N 153	Continued From page 3 1. Patient #1 was a 99 year old male who was admitted to the agency on 1/07/11 for care primarily related to dizziness and giddiness. The RN "OASIS C SOC/ROC Assessment," dated 1/07/11 at 11:00 AM, documented Patient #1 was on Albuterol Sulfate nebulizer. He was also assessed as having crackles in his lower lobes and was diminished in all lobes. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period of 1/07/11 to 3/07/11, did not include a respiratory diagnosis. In an interview with Patient #1's RN Case Manager on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager reported that she had noticed that there was no respiratory diagnosis listed on the POC. When asked why Patient #1 was on nebulizer treatments, the RN Case Manager said she was not sure. The RN Case Manager stated that Patient #1 had been on breathing treatments prior to starting home health. She did agree that she should have clarified with the physician regarding Patient #1's respiratory status. The POC did not include a pertinent respiratory diagnosis. 2. Patient #5 was an 81 year old female who was admitted to the agency on 1/17/11. The RN "OASIS C SOC/ROC Assessment," dated 1/17/11 at 11:20 AM, stated Patient #5 was taking Coumadin for treatment of atrial fibrillation (a heart condition characterized by irregular, fast heart beat, shortness of breath and weakness). The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 1/17/11	N 153	N 153 Patient Care Coordinator will review every 485 for accurate coding. This will be an ongoing review. Deficiency will be corrected 3/16/2011.	

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	137107	A. BUILDING _____ B. WING _____	03/07/2011

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N 153	Continued From page 4 to 3/17/11, included orders for Coumadin tablets 5 days per week. It did not include a diagnosis of atrial fibrillation. The Director and Patient Care Coordinator were interviewed together on 3/02/11 at 3:40 PM. They reviewed Patient #5's record and confirmed the diagnosis of atrial fibrillation should have been included on the POC. They explained the coding of diagnoses was outsourced and they may have run out of space to include it on the POC. They agreed the diagnosis was pertinent and belonged in the POC. The POC did not include a pertinent diagnosis.	N 153	N 155 Please see response to Federal ID G159	
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the written plan of care included types of equipment required for 1 of 16 patients (#12) whose records were reviewed. This had the potential to negatively impact quality and coordination of patient care. Findings include: Patient #12 was an 84 year old male who was admitted to the agency on 2/11/11 for care after	N 155		

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N 155	Continued From page 5 joint surgery. A PT evaluation, dated 2/16/11 at 4:09 PM, stated equipment included a raised toilet seat, shower chair, and grab bars. None of these items were included in the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 2/11/11 to 4/11/11. During an interview on 3/02/11 at 4:20 PM, the Director and Patient Care Coordinator were asked if the agency had a policy that described what DME items should go on the POC. They stated there was no policy. The Director expressed an opinion that just the "bigger items," such as a hospital bed and walker should be on the POC. She acknowledged there might be different interpretations among staff as to what belonged on the POC. The POC did not include required equipment.	N 155		
N 156	03.07030.PLAN OF CARE. N156 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: d. Frequency of visits; This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure the written plan of care included clear frequency of home health aide visits for 1 of 6 patients (#11) who received home health aide services whose records were reviewed. This resulted in a lack of clarity as to the plan of care and had the potential to interfere	N 156	N 156 Patient Care Coordinator will review Start of Care and Recertification orders to ensure that proper frequency and duration is documented in the physician orders. Patient Care Coordinator will take into consideration Visions Home Health Medicare week of Sunday to Saturday. Deficiency will be corrected on 4/1/2011.	

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N 156	Continued From page 6 with coordination of patient care. Findings include: Patient #11 was a 74 year old male who was admitted to the agency on 1/12/11 for care related to an intestinal infection and an abnormality of gait. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 1/12/11 to 3/12/11, included conflicting orders for aide services. The first order was for bathing and personal cares 2 times per week for 9 weeks. The second order (on the same POC) was for home health aide service 1 time per week for one week and 2 times per week for 8 weeks, to include bathing, dressing, grooming, hair washing, hygiene, and light housekeeping. The POC included inconsistent orders for home health aide services.	N 156		
N 161	03.07030.PLAN OF CARE N161 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: i. Medication and treatment orders; This Rule is not met as evidenced by: Based on record review, home visit, and staff and patient interview, it was determined the agency failed to ensure the written plan of care included medication and treatment orders for 8 of 16 patients (#3, #5, #6, #7, #8, #13, #15, and #16)	N 161	N 161 Please see response to Federal ID G159	

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N 161	Continued From page 7 whose records were reviewed. This had the potential to negatively impact quality, coordination, and completeness of patient care. Findings include: 1. Patient #5 was an 81 year old female who was admitted to the agency on 1/17/11. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 1/17/11 to 3/17/11, included orders for oxygen at 2 liters via NC "as directed." The order for oxygen was incomplete and did not provide direction for staff as to whether the oxygen was continuous or intermittent. The Director and Patient Care Coordinator were interviewed together on 3/02/11 at 3:40 PM. They stated the oxygen should have been listed as continuous. The POC did not include a complete order for oxygen use. 2. Patient #15 was a 72 year old male who was admitted to the agency on 12/09/10 to receive home IV infusion therapy due to dehydration. RN "OASIS C SOC/ROC Assessment," dated 12/09/10 at 4:15 PM, documented Patient #15 was on 2 liters of oxygen. An MD History and Physical report, dated 12/09/10, included a list of medications Patient #15 was taking. The list included Pepcid 20 mg daily, Flomax 0.4 mg daily, citalopram 40 mg daily, Advair 250/50 1 puff 2 times per day, aspirin 81 mg daily, Detrol 4 mg daily, meloxicam 7.5 mg per day, acetaminophen 2 tabs in the morning/1 in the evening, ketoconozole cream applied to the face as needed, Restasis eye drops, Bactroban ointment applied to the groin area 2 times per day, Triamicinolone 0.1% cream applied to the	N 161		

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N 161	Continued From page 8 groin area 2 times per day. The Admitting RN was interviewed on 3/03/11 at 9:50 AM. She reviewed Patient #15's record and confirmed medications were missing on the POC. She stated she was not sure why they were not there; she thought she had entered them in the computer but had not kept a hard copy. The POC did not include medications. 3. Patient #3 was a 90 year old female who was admitted to the agency on 1/17/11 for care primarily related to osteoarthritis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 1/17/11 to 3/17/11 included as an additional diagnosis, "Other dependence on machines, supplemental oxygen." Oxygen was not listed on the POC as a medication. A physician dictated history and physical on 1/19/11 noted Patient #3 was using oxygen 2 liters on an "as needed" frequency. In an interview on 3/03/11 at 10:45 AM, the RN Case Manager confirmed Patient #3 was using oxygen nightly, and during the day as needed. The RN Case Manager reviewed the record and confirmed she had not included oxygen use by Patient #3 in the admission assessment on the SOC or the medication section on the POC. The POC did not include oxygen. 4. Patient #6 was an 82 year old female who was admitted to the agency on 11/29/10 for care primarily related to congestive heart failure. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 1/28/11 to 3/28/11 included oxygen concentrator usage under "Safety Measures" on the POC. Oxygen	N 161		

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N 161	Continued From page 9 was not listed on the POC as a medication. During a home visit on 3/1/11 at 9:30 AM, Patient #6 stated she used oxygen every night, and sometimes during the day if she felt like she needed it. In an interview on 3/03/11 at 10:50 AM, the RN Case Manager reviewed the record and confirmed she had not included oxygen use by Patient #6 in the recertification assessment or the medication section on the POC. The RN Case Manager stated she should have included the information regarding Patient #6's use of oxygen on the POC. The POC did not include oxygen. 5. Patient #13 was a 21 year old female who was admitted to the agency on 8/28/07 for care primarily related to a progressive degenerative neurological disease. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/08/11 to 4/08/11 included Fleets Enema on the list of DME and supplies. The Fleets Enema was not listed under medications and there was no direction provided on frequency, or when to use the enema included. In an interview on 3/03/11 at 10:45 AM, the RN Case Manager reviewed Patient #13's record, and confirmed there was no direction as to the use of the Fleets Enema. The RN Case Manager stated she worked as a hospice nurse as well, and was used to including Fleets Enema as a DME for those patients. The POC did not list the enema as a medication, and did not provide specific instructions for its	N 161		

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N 161	Continued From page 10 use. 6. Patient #16 was an 82 year old male who was admitted to the agency on 11/11/10 for care primarily related to wound care for a heel pressure ulcer. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 1/10/11 to 3/10/11 did not include information that Patient #16 was on oxygen. During a home visit on 3/03/11 at 9:00 AM, Patient #16 stated he used oxygen every night. He was unsure of the liter flow; he stated his wife just turned on the concentrator. In an interview on 3/03/11 at 10:30 AM, Patient #16's RN Case Manager reviewed the record and confirmed Patient #16 used oxygen although it was not listed on the POC. The POC did not include oxygen. 7. Patient #7 was a 4 year old female who was admitted to the agency on 12/11/06 for care primarily related to congenital cardiac anomalies. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 1/19/11 to 3/19/1, included incomplete medication orders. Examples include: a) "9/08/2009 Take 1 1/2 ml (0.5mg/ml) by oral at bedtime as needed (sleep/anxiety)." No medication was listed, the dosage in mg was not listed, and the significance of the date was unclear. b) "9/02/2010 Take 1.2 mg of Enalapril Maleate Tablet (5mg Tab) by oral 2 x Day." The process of scoring and cutting a 5 mg tablet to insure 1.2 mg would not be possible.	N 161		

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N 161	Continued From page 11 c) "9/02/2010 Take 15 mg of Zantac Tablet (150 mg Tab) by oral 2 x Day." It was unclear how the process of an accurate dosage of 1/10th of the tablet would be possible. d) "2/20/2009 Take 5 Syrup of DEC-CHLORPHEN DM (4mg-12.5 mg-15 mg/5 ml Syrup) by Oral 4 x Day as needed. (Cough) The dosage was unclear. In an interview on 3/03/11 at 10:45 AM, Patient #7's RN Case Manager reviewed the record and confirmed the lack of clarity with the medications listed on the POC. She explained the date preceding the medication was the original date the medication was ordered. The RN Case Manager stated that example a) was actually for Ativan, and confirmed the lack of information as it was presented on the POC. She stated the computer software program was not designed to work with pediatric medications. The POC lacked clarity for the medications and dosages listed. 8. Patient #8 was a 72 year old male who was admitted to the agency on 11/09/10 for care primarily related to obstructive chronic bronchitis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period of 1/08/10 to 3/08/11 had two rates of oxygen documented. On the POC under "Medications," oxygen was ordered as 2.5 liters of oxygen as directed. Under "Orders for Discipline and Treatments," the order was for continuous oxygen at 3 liters via NC. In an interview on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager stated that Patient #8 was on 3 liters of oxygen at SOC. She reported	N 161		

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N 161	Continued From page 12 that she did not know how 2.5 liters of oxygen ended up on the medication list on the POC. The POC included inconsistent orders for oxygen use and dosage.	N 161		
N 168	03.07030.02. PLAN OF CARE N168 02. Goals of Patient Care. The goals of patient care must be expressed in behavioral terms that provide measurable indices for performance. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the written plan of care included measurable goals for 1 of 16 patients (#1) whose records were reviewed. This had the potential to interfere with evaluation of outcomes. Findings include: Patient #1 was a 99 year old male who was admitted to the agency on 1/07/11 for care primarily related to dizziness and giddiness. a) The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period of 1/07/11 to 3/07/11 included secondary diagnoses of urinary and fecal incontinence, but did not address their management. The POC did not include interventions and goals related to the pertinent diagnoses of urinary and fecal incontinence. In an interview with Patient #1's RN Case Manager on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager reported that she could not remember if Patient #1 was using incontinence supplies or if he was even having	N 168	N 168 Home Health Director inserviced RN Case managers that all pertinent diagnosis need to address interventions and measurable goals identified in the POC. Patient Care coordinator will review all 485's for completeness. Deficiency will be corrected 4/1/2011.	

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N 168	Continued From page 13 continence issues at SOC. The POC did not include interventions or goals to address the diagnosis of urinary/fecal incontinence. b) The RN "OASIS C SOC/ROC Assessment," dated 1/07/11 at 11:00 AM, documented Patient #1 was on Albuterol Sulfate nebulizer. He was also assessed as having crackles in his lower lobes and was diminished in all lobes. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period of 1/07/11 to 3/07/11, did not include a respiratory diagnosis, intervention, or goal related to the nebulizer treatments. In an interview with Patient #1's RN Case Manager on 3/03/11 from 8:45 AM to 9:45 AM, the RN Case Manager reported that she had noticed that there was no respiratory diagnosis listed on the POC. When asked why Patient #1 was on nebulizer treatments, the RN Case Manager said she was not sure. The RN Case Manager stated that Patient #1 had been on breathing treatments prior to starting home health. She did agree that she should have clarified with the physician regarding Patient #1's respiratory status. The POC did not include pertinent interventions or goals related to the use of the nebulizer.	N 168		
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.	N 172		

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N 172	Continued From page 14 This Rule is not met as evidenced by: Refer to G 164.	N 172	N 172 Patient Care Coordinator will inservice RN Case Managers, LPN, and Therapist regarding promptly alerting the physician to any changes in the patients POC. At that time the patients POC will be updated to ensure that the patients needs are being met, documented and communicated appropriately with orders and updates to the physician and other disciplines in the home. Patient Care Coordinator will be monitored with all physician orders and with monthly chart audits. Deficiency will be corrected 4/1/2011.	
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, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G 337.	N 173	N 173 Please see response to Federal ID G337	
N 174	03.07031.01 CLINICAL RECORDS N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services. This Rule is not met as evidenced by: Refer to G 236.	N 174	N 174 Please see response to Federal ID G236	

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N 199	Continued From page 15	N 199		
N 199	Criminal History and Background Check 009.CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS. 01. Compliance with Department ' s Criminal History and Background Check. A home health agency must comply with IDAPA 16.05.06, " Criminal History and Background Checks. " (3-26-08) 02. Direct Patient Access Individuals. These rules apply to employees and contractors hired or contracted with after October 1, 2007, who have direct patient access. (3-26-08) 03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must complete an application before having access to patients. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any patient without a clearance by the Department. Once the notarized application is completed the individual can only work under supervision until the individual has been fingerprinted. The individual must have his fingerprints submitted to the Department within twenty-one (21) days of completion of the notarized application. (3-26-08) This Rule is not met as evidenced by: Based on personnel record review and staff interview, it was determined the facility failed to ensure 1 of 4 contracted therapists (D) who were required to have criminal history background checks that the checks were completed. Lack of background checks had the potential to result in care delivered by individuals with criminal	N 199	N 199 Visions Home Health will adopt a policy and procedure outlining the requirement for a criminal history and background check to occur on every contract staff prior to direct patient contact. Education on the new policy will be provided to all contract staff. All contract records will be reviewed for the criminal history and background check. The records that are out of compliance will be corrected at that time. Home Health Director will be responsible to monitor records for compliance. Deficiency will be corrected 4/1/2011.	

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VISIONS HOME HEALTH	209 SHOUP AVENUE WEST TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 199	Continued From page 16 records. Findings include: Personnel records were reviewed for all staff members who had direct patient care. An Occupational Therapist with a hire date of 10/01/2010 did not have a completed criminal background check. In an interview on 3/07/11 at 12:45 PM, the Home Health Director stated that criminal background check had not been completed for this contracted staff member.	N 199		