IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

February 3, 2014

CERTIFIED MAIL #7000 1670 001 3315 2009

Jake Bryan, Administrator
Avalon Home Health
403 1st St
Idaho Falls, Idaho 83401-3928

RE: Avalon Home Health, Provider #137057

Dear Mr. Bryan:

Based on the revisit at Avalon Home Health on January 17, 2014, by our staff, we have determined that Avalon Home Health continues to be out of compliance with the Medicare Conditions of Participation on Acceptance of Patients, Plan of Care, & Medical Supervision (42 CFR 484.18).

The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies. Your copy of a Post-Certification Revisit Report (CMS-2567B), listing deficiencies that have been corrected is attached.

In our letter to you dated November 27, 2013, we stated: "failure to correct the deficiencies and achieve compliance will result in our recommending that the Centers for Medicare and Medicaid Services (CMS) Region X Office, Seattle, Washington, terminate your approval to participate in the Medicare program." Because of your failure to correct, we have made that recommendation. At a later date, CMS will be in contact with you regarding the procedures, timelines, and appeal rights associated with this recommendation that must be followed.

You have an opportunity to correct those deficiencies that 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 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 2567 forms.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by February 17, 2014.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

ec: Kate Mitchell, RN, MHA, CMS Region X
Debra Ransom, R.N., R.H.I.T., Bureau Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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}	INITIAL COMMENTS The following deficiencies were cited during the follow up survey of your home health agency on 1/15/14 through 1/17/14. Surveyors conducting the follow up were: Libby Doane RN, BSN, HFS - Team Leader Susan Costa, RN, HFS Acronyms used in this report include: BP - Blood Pressure C-diff - Clostridium difficile, a bacteria which may cause antibiotic-associated diarrhea CHF - Congestive Heart Failure CPAP - Continuous Positive Airway Pressure, A machine to treat sleep apnea DME - Durable Medical Equipment DM II - Type 2 Diabetes HHA - Home Health Aide IV - intravenous lbs - pounds LPN - Licensed Practical Nurse mg - milligram ml - milliliter NS - Normal Saline OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy PTA - Physical Therapy Assistant PT/INR - Prothrombin Test/ International Normalized Ratio RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	{G 000}		
{G 143}	484.14(g) COORDINATION OF PATIENT SERVICES	{G 143}	Please see attached plan for G 143.	

RECEIVED
FEB 19 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Exec. Director — (X6) DATE: 02/17/14

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

Exec Director 2/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 143}	Continued From page 1 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 staff interview and review of medical records and the agency's 12/04/13 Plan of Correction, it was determined the agency failed to ensure care coordination between disciplines for 2 of 10 patients reviewed (#2 and #4) who received services from more than one discipline. This interfered with quality and continuity of patient care. Findings include: 1. Patient #2's medical record documented a 52 year old female admitted to the agency on 12/22/13, following hospitalization for failure to thrive, cirrhosis of the liver, abdominal pain, and metabolic encephalopathy (altered mental status related to liver dysfunction). Additional diagnoses included chronic hepatitis C, bipolar disorder, insulin dependent DM II, dehydration, and cachexia (general physical wasting and malnutrition usually associated with chronic disease). Patient #2's medical record and POC for the certification period of 12/22/13 through 2/19/14, were reviewed. The POC noted she was on a diabetic diet and was to receive high protein Glucerna shakes, 1000 ml daily. Four SN visits were ordered, (once for 1 week, two for the second week, and once for the third week), with an additional 2 visits as needed for complications. PT was ordered twice a week for 9 weeks. Coordination of Patient #2's care did not occur in the following examples:	{G 143}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 143}	Continued From page 2 a. Patient #2's POC stated her insulin was to be held if her blood sugar level was less than 100. In a SN visit note, dated 1/02/14 at 2:00 PM, the LPN documented Patient #2's blood sugar was 82. The LPN noted "patient remains knowledge deficit about diet." She also noted that Patient #2 was not drinking the protein shakes because she did not have any. There was no documentation to indicate the LPN notified the the RN case manager or the physician regarding Patient #2's low blood sugar, or her difficulty obtaining the Glucerna shakes. b. During the last ordered SN visit, dated 1/08/14 at 10:30 AM, the RN documented Patient #2's blood sugar was 475. The visit note stated she was drinking Ensure 3 times a day. (According to Abbott, the maker of Ensure and Glucerna, Ensure, while it is also a nutritional supplement, is not formulated for diabetics. It contains almost twice the carbohydrate content of Glucerna and 4 times the amount of sugar. Glucerna is formulated for people with diabetes, and contains slowly digestible carbohydrates to help minimize blood sugar spikes). The RN documented she called Patient #2's physician's office to report the elevated blood sugar on 1/08/14 at 1:00 PM. She wrote there was no answer, and she left a message. The SN visit was the last routine nursing visit ordered. There was no documentation of communication between the RN case manager, and the physical therapist providing care for Patient #2, to discuss the transition of her care to therapy services and her history of diet non-compliance and unstable blood sugars. There were no further nursing visits to Patient #2. c. A PTA, on 1/07/14 at 3:00 PM, documented	{G 143}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 143}	Continued From page 3 Patient #2 refused treatment due to discomfort from swelling in both lower legs and feet. Her vital signs were not taken. The PTA documented communication with his supervising physical therapist, however, there was no documentation of communication with the RN case manager or the physician regarding Patient #2's discomfort and lower extremity swelling, and inability to tolerate physical therapy. d. During a visit on 1/10/14 at 10:15 AM, the PT documented Patient #2's pulse rate of 105/min. (According to the American Heart Association, a normal heart rate is 60-80 beats per minute, and high heart rate may indicate an underlying health problem). The physical therapist documented Patient #2's pain at 10/10, noting it was concentrated in both her feet and sacral area. The therapist noted Patient #2 appeared agitated. His note stated she was frustrated with her inability to get her anti-anxiety medication refilled. There was no documentation of communication with the RN case manager or the physician regarding Patient #2's pain, change in mental status, or her medication needs. e. An "INTER-OFFICE COMMUNICATION NOTE," dated 1/15/14, written by the Clinical Director, noted Patient #2 was hospitalized 1/14/14 for possible medication overdose. During an interview on 1/16/14 beginning at 11:45 AM, the Clinical Director reviewed Patient #2's record and confirmed the documentation of blood sugar ranges from 80 to 475. She confirmed the RN had documented Patient #2 was drinking Ensure shakes, and not Glucerna. Upon reviewing the PT visit notes, the Clinical Director stated she was unaware of Patient #2 having	{G 143}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 143}	Continued From page 4 increased agitation or medication refill concerns. The Clinical Director confirmed there was no documentation of communication between the nursing and therapy staff in transitioning Patient #2's care to therapy services only. The agency did not ensure nursing and therapy staff coordinated care for Patient #2. 2. Patient #4's medical record documented an 83 year old female, admitted to the agency on 12/04/13, for SN, HHA, PT, and OT services following hospitalization for CHF, C. diff, and pneumonia. Patient #4's medical record and POC for the certification period 12/04/13 to 2/03/14, were reviewed. The POC noted Patient #4 was to remain on oxygen continously at 2 liters per minute, and she was to keep a daily log of her blood pressure, weight, and bowel movements. Additionally, the POC ordered weights to be monitored every SN visit, with instructions to notify the physician for weight changes of plus or minus 5 pounds in a week. The patient care plan, established by the RN for the HHA to follow, was dated 12/04/13. The plan included instructions to report any significant changes in weight gain or loss, elevated blood pressure, or change in bowel movements, to the RN. Patient #4's care was not effectively coordinated as follows: The RN documented Patient #4's weight as 86 pounds on the Start of Care assessment, dated 12/04/13. During a SN visit on 12/18/13, the LPN documented Patient #4's weight as 100 pounds, which indicated a 14 pound weight gain over 13 days. Additionally, the LPN nursing note documented Patient #4's oxygen saturation level	{G 143}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 143}	Continued From page 5 was 91%, and she was not using her oxygen at that time. The LPN noted she placed Patient #4 back on her oxygen, but did not obtain an additional reading. There was no documentation to indicate the LPN notified the RN or the physician of Patient #4's increased weight, non-compliance with oxygen use, or low oxygen saturation level. During the last scheduled SN visit, completed on 12/30/13, the RN documented Patient #4's weight as 81 pounds, indicating a loss of 19 pounds over 12 days. The RN documented Patient #4's oxygen saturation was 87%, and she was not using her oxygen. The RN noted she placed Patient #4 back on oxygen and her saturation level increased to 94%. No documentation was found that the RN notified Patient #4's physician of the weight loss. There was no documentation to indicate the RN and the physical therapist providing care for Patient #4, discussed Patient #4's care, including HHA supervision, monitoring of unstable weights, oxygen non-compliance with low saturation levels, and worsening CHF, as she transitioned to therapy services only. The agency's Plan of Correction, dated 12/30/13, included a policy "Vital Sign Safety Parameters." It included acceptable oxygen saturation ranges of 88-100%. The policy noted "...if any vital sign readings fall outside the published safety parameters the director of nursing, or case manager designee, will be contacted and physician notified for guidance on how to address the issue." During an interview on 1/16/14 at 10:15 AM, the Clinical Director reviewed Patient #4's record and confirmed nursing and therapy visit notes did not	{G 143}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 143}	Continued From page 6 include documentation of care coordination. The agency did not ensure nursing and therapy staff coordinated care for Patient #4.	{G 143}		
{G 156}	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on staff and patient interview, and review of medical records and agency policies, it was determined the agency failed to ensure systems to plan for care and supervise the medical care of patients were implemented. These failures resulted in unmet patient needs and negatively impacted the continuity and quality of patient care. Findings include: 1. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with patients' POCs. 2. Refer to G159 as it relates to the failure of the agency to ensure the POC included all pertinent information. 3. Refer to G164 as it relates to the agency's failure to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter their POCs. The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs.	{G 156}		
{G 158}	484.18 ACCEPTANCE OF PATIENTS, POC,	{G 158}	Please see attached Plan for G 158	

Exec. Director 02/17/14

Exec. Dir. 2/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 158}	Continued From page 7 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 physician's written POC for 4 of 10 patients (#3, #6, #8, and #10) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care. Findings include: 1. Patient #6 was 75 year old male admitted to the agency on 12/24/13, for SN and PT services following coronary bypass surgery. His medical record, including the POC for the certification period of 12/24/13 through 2/21/14, was reviewed. Care was not provided in accordance with the POC as follows: a. The POC included instructions to notify the physician if Patient #6's systolic BP was over 160 or below 80, or his diastolic BP was over 100 or below 50. Patient #6's physician was not notified of BPs beyond the parameters identified in his POC as follows: - The PT evaluation, documented 12/27/13, noted Patient #6's BP was 184/93. There was no documentation to indicate the physician was notified of his elevated BP in accordance with the POC. - A PT visit note, dated 12/30/13, documented Patient #6's initial BP was 167/95. The physical	{G 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 158}	Continued From page 8	{G 158}		

therapist documented she checked Patient #6's BP seven minutes after exercise was completed and obtained a reading of 180/110. The physical therapist documented she instructed Patient #6 to monitor his BP and to call the physician if his BP was above 165/110. However, there was no documentation to indicate the physical therapist contacted the physician about Patient #6's BP. In addition, there was no documentation to indicate the physician had approved the change in established parameters from those listed on the POC to 165/110.

- A PT visit note, dated 12/31/13, documented Patient #6's initial BP was 165/99. The physical therapist documented she chose not to have Patient #6 do his exercise due to his BP. There was no documentation to indicate the physician was notified of Patient #6's high BP level.

- A PT visit note, dated 1/02/14, did not include an initial BP. The physical therapist documented Patient #6's BP was monitored throughout the visit to ensure it stayed below 165/100, but there was no documentation to indicate what Patient #6's BP actually was throughout the visit.

- A PT visit note, dated 1/03/14, indicated Patient #6's initial BP was 172/86. There was no documentation to indicate the physician was notified of the elevated BP.

- A PT visit note, dated 1/07/14, documented Patient #6's initial BP was 180/88. The physical therapist also documented that Patient #6's BP was 178/98 after exercise. There was no documentation to indicate the physician was notified as required in the POC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 158}	Continued From page 9 - In a PT visit note, dated 1/13/14, Patient #6's initial BP was documented as 169/92. The physical therapist documented Patient #6's BP after exercise was 171/97. There was no documentation to indicate the physician was notified of Patient #6's elevated BP. The RN Clinical Director reviewed the record and was interviewed on 1/16/14, beginning at 9:30 AM. She confirmed the physical therapist did not notify the physician when Patient #6's blood pressure was outside established parameters identified in his POC. Patient #6's physician was not notified of elevated BP in accordance with the POC. b. An LPN visit note, dated 12/31/13 at 3:00 PM, indicated the LPN cleansed the wounds with NS and applied an antibiotic ointment to the wounds, then covered the wounds with a non stick dressing. The POC contained an order for wound care to be provided to 3 abdominal incisions twice a week and as needed. The POC included orders for SN to cleanse the wound with NS and cover with a non-stick dressing. The ointment was not included on the POC. The LPN was interviewed via phone on 1/16/14 at 9:45 AM. The LPN stated she used the ointment because Patient #6's wife asked that it be used and she agreed it was a good idea. The Clinical Director was present during the interview with the LPN on 1/16/14 at 9:45 AM. She confirmed the ointment had been applied without an order.	{G 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 158}	Continued From page 10 Ointment was applied to Patient #6's wounds without physician authorization. 2. Patient #8 was an 88 year old male admitted to the agency on 1/09/14, for treatment of CHF, shortness of breath with exertion and weakness. His medical record, including the POC, for the certification period of 1/09/14 through 3/09/14 was reviewed. Patient #9 was receiving SN, PT, OT, and HHA services. To monitor for worsening of Patient #8's CHF, the POC included orders for SN to weigh Patient #8 during each SN visit and report a weight gain of more than 5 pounds to the physician. Patient #8 was weighed during the RN SOC visit on 1/09/14. The next SN visit was made on 1/14/15 by an LPN. There was no documentation to indicate Patient #8 was weighed during the visit in accordance with the POC. In addition, the POC included orders for HHA visits 3 times a week for 8 weeks, starting week 2. The POC included orders for the HHA to weigh Patient #8 during each visit and report a weight gain of 3-5 pounds to the physician and the RN. The HHA visit note, dated 1/15/14 at 8:00 AM, did not contain documentation to indicate Patient #8 had been weighed in accordance with the POC. The Clinical Director reviewed the record and was interviewed on 1/16/14 at 9:30 AM. She confirmed there was no documentation to indicate Patient #8 was weighed by the LPN and HHA during the above visits.	{G 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 158}	Continued From page 11 Patient #8's weight was not monitored as indicated in his POC; creating the potential for worsening of his CHF to go undetected. 3. Patient #10 was a 72 year old male admitted to the agency on 9/27/13, for SN and PT services related to weakness, bladder cancer, and chronic pain. His medical record and POC for the certification period 11/26/13 through 1/24/14, were reviewed. a. Patient #10's POC's for the certification period included SN visits. However, the POC was not approved by his physician. Therefore, 3 nursing visits completed between 12/23/13 and 1/17/14, were completed without physician approval. The SN visits were completed on 12/27/13, 1/02/14, and 1/13/14. b. A written order request by the Physical Therapist, dated 11/17/13, was signed by the physician on 11/19/13. The order requested an additional visit on 11/20/13 for evaluation for re-certification. The order request did not include a plan or request for PT services for the certification period 11/26/13 through 1/24/14. Patient #10 received 7 therapy visits without a physician's order between 12/23/13 and 1/17/14. The PT visits were completed on 12/23/13, 12/24/13, 12/27/13, 1/02/14, 1/03/14, 1/07/14, and 1/14/14. During an interview on 1/16/14 at 11:00 AM, the Clinical Director reviewed Patient #10's record and confirmed the POC was not signed by Patient #10's physician and he received nursing and therapy visits before orders were secured.	{G 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 158}	Continued From page 12 Patient #10 received nursing and therapy services without physician authorization. 4. Patient #3 was a 79 year old male admitted to the agency on 1/06/14, for SN, PT, and OT services related to generalized muscle weakness, HTN, and dementia. Patient #3's medical record and POC for the certification period 1/06/14 through 3/06/14, were reviewed. Patient #3's record included a faxed referral dated 1/02/14, from his physician for home health services. A Start of Care Assessment, dated 1/06/14, was performed by an RN. A verbal order dated 1/08/14, and signed by Patient #3's physician on 1/14/14, stated "Patient admitted to Home Health. No SN needed at this time. PT and OT will evaluate and treat as needed. They will set frequencies." A PT evaluation was performed on 1/08/14. No physician orders for further PT visits were documented. Additional PT visits were performed on 1/13/14 and 1/15/14, without physician orders. An OT evaluation was performed on 1/07/14. No physician orders for further OT visits were documented. An additional OT visit was performed on 1/09/14, without physician orders. In an interview on 1/16/14 at 10:40 AM, the Clinical Director reviewed Patient #3's medical record and confirmed OT and PT services were provided before physician orders had been secured for the therapy visits. Therapy services were provided without orders.	{G 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 159}	Continued From page 13	{G 159}		
{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 review of patient records and staff interview, it was determined the agency failed to ensure POCs included all pertinent information, including equipment , wound care instructions and all pertinent treatments for 4 of 10 patients (#3, #4, #5, and #8) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care Findings include: 1. Patient #8 was an 88 year old male admitted to the agency on 1/09/14, for treatment of CHF, shortness of breath with exertion and weakness. His medical record, including the POC, for the certification period of 1/09/14 through 3/09/14 was reviewed. Patient #9 was receiving SN, PT, OT, and HHA services. Patient #8's POC included orders for warfarin 6 mg daily. The National Institute of Health website notes that patients on warfarin require frequent PT/INR testing to determine the clotting efficiency of their blood so the physician may titrate the warfarin dose correctly. There was no	{G 159}		

Exec. Dir. 02/17/14

Exec. Dir. 02/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 159}	Continued From page 14 documentation on the POC to indicate PT/INR testing was included as part of Patient #8's warfarin management. The RN Case Manager was interviewed via phone in the presence of the Clinical Director on 1/16/14 at 9:30 AM. She stated Patient #8 required monthly PT/INR testing and she would coordinate this with Patient #8's pharmacist. She confirmed this was not noted on the POC. The Clinical Director, also, reviewed the record and confirmed PT/INR testing was not included on the POC. Patient #8's POC did not include pertinent blood tests to manage his warfarin dosage. 2. Patient #5 was an 85 year old male admitted to the agency on 1/04/14, following a toe amputation. Patient #5 had a history of diabetes, osteomyelitis, and peripheral vascular disease. His medical record, including the POC, for the certification period of 1/04/14 through 3/04/14, was reviewed. The POC included a walker, alcohol pads, and exam gloves as DME and supplies. However, additional DME not included on the POC was noted as follows: - An LPN visit note, dated 1/10/14, documented Patient #5 had a walking boot. - A PT visit note, dated 1/13/14, documented Patient #5 had a walking boot. - A PT visit note, dated 1/15/14, documented Patient #5 had a walking boot. The Clinical Director reviewed the record and was interviewed on 1/16/14 at 9:30 AM. She	{G 159}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 159}	Continued From page 15 confirmed the walking boot had not been included on the POC. Patient #5's POC did not contain all pertinent medical equipment related to his care. 3. Patient #3 was a 79 year old male admitted to the agency on 1/06/14, for SN, PT, and OT services related to generalized muscle weakness, HTN, sleep apnea, and dementia. Patient #3's medical record and POC, for the certification period 1/06/14 through 3/06/14, was reviewed. The medical record included a copy of a physician's office visit report dated 11/18/13. The form documented Patient #3 had sleep apnea and used CPAP every night. Patient #3's CPAP machine was not included on his POC. During an interview on 1/16/14 beginning at 10:40 AM, the Clinical Director reviewed Patient #3's record and confirmed the CPAP was not included on the POC. Patient #3's POC did not include all relevant information related to his sleep apnea. 4. Patient #4's medical record documented an 83 year old female admitted to the agency on 12/04/13 for SN, HHA, PT, and OT services following hospitalization for CHF, C. diff, and pneumonia. Patient #4's medical record and POC for the certification period 12/04/13 to 2/03/14, was reviewed. The POC included oxygen at 2 liters per minute, however, oxygen equipment and safety precautions were not included on the POC.	{G 159}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 159}	Continued From page 16 During an interview on 1/16/14 beginning at 10:15 AM, the Clinical Director reviewed Patient #4's record and confirmed her POC did not include oxygen equipment. All pertinent information related to Patient #4's oxygen therapy was not included on her POC.	{G 159}		
{G 164}	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the physician was notified of changes in patients' conditions for 3 of 10 patients (#2, #4, and #6) whose records were reviewed. This resulted in missed opportunities to alter the POC to meet patient needs. Findings include: 1. Patient #6 was 75 year old male admitted to the agency on 12/24/13, for SN and PT services following coronary bypass surgery. His medical record, including the POC, for the certification period of 12/24/13 through 2/21/14, was reviewed. The POC included instructions to notify the physician if Patient #6's systolic BP was over 160 or below 80, or his diastolic BP was over 100 or below 50. Patient #6's physician was not notified of BPs beyond the parameters identified his POC as follows:	{G 164}		

Exec. Dir. 02/17/14

Exec. Dir. 02/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 164}	Continued From page 17 - The PT evaluation, documented 12/27/13, noted Patient #6's BP was 184/93. There was no documentation to indicate the physician was notified of his elevated BP in accordance with the POC. - A PT visit note, dated 12/30/13, documented Patient #6's initial BP was 167/95. The physical therapist documented she checked Patient #6's BP seven minutes after exercise was completed and obtained a reading of 180/110. The physical therapist documented she instructed Patient #6 to monitor his BP and to call the physician if his BP was above 165/110. However, there was no documentation to indicate the physical therapist contacted the physician about Patient #6's elevated BP. - A PT visit note, dated 12/31/13, documented Patient #6's initial BP was 165/99. The physical therapist documented she chose not to have Patient #6 do his exercise due to his BP. There was no documentation to indicate the physician was notified that Patient #6's BP was above the parameters identified on his POC. - A PT visit note, dated 1/03/14, indicated Patient #6's initial BP was 172/86. There was no documentation to indicate the physician was notified of the elevated BP reading. - A PT visit note, dated 1/07/14, documented Patient #6's initial BP was 180/88. The physical therapist also documented that Patient #6's BP was 178/98 after exercise. There was no documentation to indicate the physician was notified of Patient #6's elevated BP as required in the POC.	{G 164}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 164}	Continued From page 18 - In a PT visit note, dated 1/13/14, Patient #6's initial BP was documented as 169/92. The physical therapist documented Patient #6's BP after exercise was 171/97. There was no documentation to indicate the physician was notified in accordance with the POC. The RN Clinical Director reviewed the record and was interviewed on 1/16/14 beginning at 9:30 AM. She confirmed the physical therapist had not notified the physician when Patient #6's blood pressure was outside established parameters noted in the POC. Patient #6's physician was not notified of Patient #6's elevated BP readings as required in his POC. 2. Patient #2's medical record documented a 52 year old female admitted to the agency on 12/22/13, following hospitalization for failure to thrive, cirrhosis, abdominal pain, and metabolic encephalopathy (altered mental status related to liver dysfunction). Additional diagnoses included chronic hepatitis C, bipolar disorder, insulin dependent DM II, dehydration, and cachexia (general physical wasting and malnutrition usually associated with chronic disease). Patient #2's medical record and POC for the certification period of 12/22/13 through 2/19/14, were reviewed. The POC noted she was on a diabetic diet and was to receive high protien Glucerna shakes, 1000 ml daily. Four SN visits were ordered (once for 1 week, two for the second week, and once for the third week), with an additional 2 visits as needed for complications. PT was ordered twice a week for 9 weeks.	{G 164}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 164}	Continued From page 19 Patient #2's physician was not ntoified of changes in her condition that may suggest a need to alter her POC, as follows: a. During a SN visit on 1/02/14 at 2:00 PM, the LPN documented Patient #2's blood sugar was 82. Her POC ordered the insulin to be held for a blood sugar less than 100. The LPN noted "patient remains knowledge deficit about diet." She also noted that Patient #2 was not drinking the protein shakes because she did not have any. There was no evidence Patient #2's physician was notified of her low blood sugar, or that she had difficulty obtaining the Glucerna shakes. b. During the last ordered SN visit, dated 1/08/14 at 10:30 AM, the RN documented Patient #2's blood sugar was 475. The visit note stated she was drinking Ensure 3 times a day. (According to Abbott, the maker of Ensure and Glucerna, Ensure, while it is also a nutritional supplement, is not formulated for diabetics. It contains almost twice the carbohydrate content of Glucerna and 4 times the amount of sugar. Glucerna is formulated for people with diabetes, and contains slowly digestible carbohydrates to help minimize blood sugar spikes). The RN documented she called Patient #2's physician's office to report the elevated blood sugar on 1/08/14 at 1:00 PM. She wrote there was no answer, and she left a message. There no evidence of physician reponse. There was no documentation the physician was notified of Patient #4's dietary non-compliance. c. A PTA visit, dated 1/07/14 at 3:00 PM, documented Patient #2 refused treatment due to discomfort from swelling in both lower legs and feet. Her vital signs were not taken. The PTA	{G 164}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 164}	Continued From page 20 documented communication with the supervising physical therapist, however, there was no documentation of communication with the physician regarding Patient #2's discomfort and lower extremity swelling, and inability to tolerate physical therapy. d. A PT visit, dated 1/10/14 at 10:15 AM, documented Patient #2's pulse rate of 105/min. (Adult normal heart rates are less than 100. A high heart rate may indicate an underlying health problem). The therapist documented Patient #2's pain at 10/10, noting it was concentrated in both her feet and sacral area. The therapist noted Patient #2 appeared agitated. His note stated she was frustrated with her inability to get her anti-anxiety medication refilled. There was no documentation that Patient #2's physician was notified of the intensity of her pain, change in her mental status, or possible medication needs. e. An "INTER-OFFICE COMMUNICATION NOTE," dated 1/15/14, noted Patient #2 was hospitalized 1/14/14, for possible medication overdose. During an interview on 1/16/14 beginning at 11:45 AM, the Clinical Director reviewed Patient #2's record and confirmed the physician had not been alerted to her blood sugar ranges, agitation, and possible medication needs. Patient #2's physician was not notified of changes in her status that may suggest a need to alter her POC. 2. Patient #4's medical record documented an 83 year old female admitted to the agency on 12/04/13 for SN, HHA, PT, and OT services	{G 164}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 164}	Continued From page 21 following hospitalization for CHF, C. diff, and pneumonia. Patient #4's medical record and POC for the certification period 12/04/13 to 2/03/14, were reviewed. The POC ordered weights to be monitored every SN visit, with instructions to notify the physician for weight changes of plus or minus 5 pounds in a week. During the Start of Care assessment completed by the RN on 12/04/13, Patient #4's weight was documented as 86 pounds. During a SN visit completed on 12/18/13, the LPN documented Patient #4's weight as 100 pounds, which indicated a 14 pound weight gain over 13 days. The LPN nursing note documented Patient #4 was not using her oxygen, and her oxygen saturation level was 91%. There was no documentation to indicate Patient #4's physician was notified of her increased weight, non compliance with oxygen use, or low oxygen saturation levels. During the last scheduled nursing visit, completed 12/30/13, Patient #4's weight was documented as 81 pounds, indicating a loss of 19 pounds over 12 days. The RN documented Patient #4's oxygen saturation was 87%, and she was not using her oxygen. There was no documentation Patient #4's physician was notified of her weight loss and non-compliance with oxygen use. During an interview on 1/16/14 at 10:15 AM, the Clinical Director reviewed Patient #4's record and confirmed the physician had not been alerted to the fluctuations in weight, non-compliance with oxygen use, and low oxygen saturations. Patient #4's physician was not alerted to her significant weight fluctuations, low oxygen	{G 164}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 164}	Continued From page 22 saturation levels, and non-compliance with oxygen use.	{G 164}		
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 record review and staff interview, it was determined the agency failed to ensure the HHA provided services in accordance with the POC for 2 of 3 patients (#4 and #8) who were receiving HHA services and whose records were reviewed. This had the potential to interfere with safety and quality of patient care. Findings include: 1. Patient #8 was an 88 year old male admitted to the agency on 1/09/14 for treatment of CHF, shortness of breath with exertion and weakness. His medical record, including the POC, for the certification period of 1/09/14 through 3/09/14, was reviewed. Patient #8 was receiving SN, PT, OT, and HHA services. Patient #8's POC included orders for the HHA to weigh Patient #8 daily and report a weight gain of more than 5 pounds to the physician and the RN. The HHA patient care plan, developed by the RN, also included instructions for the HHA to weigh Patient #8 every visit and to "report weight gain of 3 to 5 lbs over 3 day period of time to RN." The HHA visit note, dated 1/15/14 at 8:00 AM, did	G 225		

Exec. Dir. 2/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 225	Continued From page 23 not contain documentation to indicate Patient #8 had been weighed in accordance with the POC. The Clinical Director reviewed the record and was interviewed on 1/16/14 at 9:30 AM. She confirmed there was no documentation to indicate Patient #8 had been weighed during the HHA visit in accordance with the POC. Patient #8's weight was not recorded in accordance with the POC. 2. Patient #4's medical record documented an 83 year old female admitted to the agency on 12/04/13 for SN, HHA, PT, and OT services following hospitalization for CHF, C. diff, and pneumonia. Patient #4's medical record and POC for the certification period 12/04/13 to 2/03/14, were reviewed. Patient #4's POC noted she was to keep a daily log of her blood pressure, weight, and bowel movements. Additionally, the POC ordered weights to be monitored every SN visit, with instructions to notify the physician for weight changes of plus or minus 5 pounds in a week. The HHA 12/20/13 patient care plan, developed by the RN, included instructions for the HHA to report any significant changes in weight gain or loss, elevated blood pressure, or change in bowel movements to the RN. HHA "PROGRESS NOTES" dated 12/20/13, 12/23/13, 12/27/13, 12/30/13, 1/03/14, 1/06/14, and 1/10/14 were reviewed. There was no documentation Patient #4's weight was monitored by the HHA. During an interview on 1/16/14 at 10:15 AM, the	G 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 225	Continued From page 24 Clinical Director reviewed Patient #4's record and confirmed the HHA visits did not document Patient #4's weights were monitored. She stated the HHA "PROGRESS NOTES" form did not have a specific section to record patient weights. Patient #4's weight was not recorded in accordance with the POC.	G 225		
{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 and staff interview, it was determined the agency failed to ensure an accurate comprehensive drug regimen review was performed for 2 of 10 patients (#6 and #10) whose records were reviewed. This had the potential to place patients at risk for adverse events or negative drug interactions. Findings include: 1. Patient #10 was a 72 year old male admitted to the agency on 9/27/13, for SN and PT services related to weakness, bladder cancer, and chronic pain. His medical record and POC for the certification periods 9/27/13 through 11/25/13 and 11/26/13 through 1/24/14, were reviewed. Patient #10's POCs for both certification periods included IV medications that are not administered in the home environment:	{G 337}		

Exec. Dir. 02/17/14

Exec. Dir. 02/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 337}	Continued From page 25 -Ephedrine Sulfate 50 mg/ml, give 5 mg diluted in 10 ml normal saline IV push, every 10 minutes for blood pressure systolic <90. - Naloxone HCL 4 mg/ml vial, give 0.1 mg/0.25 ml IV push, every 2 minutes as needed for respiratory rate <8. - Ondansetron HCL 4 mg/2 ml vial, give IV push, every 6 hours as needed for nausea/vomiting. - Promethazine HCL 25 mg/ml ampule, give 6.25 mg/0.25 ml IV push, every 6 hours as needed for nausea/vomiting. - Diphenhydramine HCL 50 mg/1 ml vial, give 12.5 mg/0.25 ml IV push, every 4 hours as needed for itching, rash. During an interview on 1/16/14 at 11:00 AM, the Clinical Director reviewed Patient #10's record and confirmed the above listed medications would not be administered in a home environment. She contacted the RN who had performed the Start of Care assessment on 9/27/13 and the recertification assessment on 11/25/13, and developed both POC's for Patient #10. In a phone interview with the RN and the Clinical Director on 1/16/14 at 11:10 AM, the RN stated the IV medications included on the POC's had been entered in error. Patient #10's POCs were inaccurate and contained drugs Patient #10 was not currently taking.	{G 337}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137057	A. BUILDING _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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 337}	Continued From page 26 2. Patient #6 was 75 year old male admitted to the agency on 12/24/13 for SN and PT services following coronary bypass surgery and recovery at a skilled nursing facility. His medical record, including the POC, for the certification period of 12/24/13 through 2/21/14, was reviewed. The POC contained an order for wound care to be provided to 3 abdominal incisions twice a week and as needed. The POC included orders for SN to cleanse the wound with NS and cover with non-stick dressing. An LPN visit note, dated 12/31/13 at 3:00 PM, indicated the LPN cleansed the wounds with NS and applied an antibiotic ointment to the wound, then covered the wounds with a non-stick dressing. The LPN was interviewed via phone on 1/16/14 at 9:45 AM. She stated she used the ointment because it was present in the home and Patient #6's asked her to do so and she thought it was "a good idea." Patient #6's POC did not include all medications.	{G 337}		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001610	A. BUILDING: _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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) COMPLETE DATE
{N 000}	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the follow up survey of your home health agency on 1/15/14 through 1/17/14. Surveyors conducting the follow up were: Libby Doane RN, BSN, HFS - Team Leader Suzi Costa, RN, HFS	{N 000}		
{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: Refer to G 159 as it related to the failure of the agency to ensure the plan of care included all pertinent information.	{N 156}	See Attached Plan of Correction addressing G-159 that corresponds to N-156 RECEIVED FEB 19 2014 FACILITY STANDARDS	
{N 170}	03.07030.04.PLAN OF CARE N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or podiatric medicine. This Rule is not met as evidenced by: Refer to G 158 as it relates to the failure of the agency to ensure care followed a physician's written POC.	{N 170}	See Attached Plan for G 158 corresponding to N-170	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 02/17/14

Exec. Director 2/17/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001610	A. BUILDING: _____ B. WING _____	R 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HOME HEALTH	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) COMPLETE DATE
{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. This Rule is not met as evidenced by: Refer to G 164 as it relates to the failure of the agency to ensure notification of a physician of any changes that suggest a need to alter the plan of care.	{N 172}	See P.O.C. for G 164 that corrisponds to N-172	
{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 as it relates to the agency's failure to ensure comprehensive medication reviews were completed.	{N 173}	See POC for G 337 that corrisponds to N-173	

Teton Home Health, LLC

DBA

Avalon Home Health

Plan of Correction

02/17/14

G 143 - Coordination of Patient Services

The findings of the recent state survey indicated that 2 out of 10 patients had issues of care coordination between the various disciplines involved in the PoC. These inconsistencies interfered with the quality and continuity of patient care.

1. Corrective Action
    a. All employees will document within 48 hours every visit provided to a patient, any communication regarding that patient's plan of care, and/or any change of condition.
    b. Avalon Home Health will require the RN case manager or designee to follow up at least weekly with all service providers assigned to each patient.
    c. The RN that provides the admitting assessment will also thoroughly review the original service orders and ensure that all prescribed services initiate care within 48 hours unless otherwise dictated by a doctor's order. This will be added as a focus area in our QA/OBQI program and will not be cleared as a focus area until 100% of care plans demonstrate compliance to the federal standard for any given quarter (3 consecutive months).

2. Company Policy
    a. It is currently the policy of this company to provide complete and accurate documentation within 48 hours of every visit or communication regarding the patient's plan of care. (Policy # HH:2-013.1) In response to the failure to follow this policy, the administrator and director of nursing will be conducting education opportunities for all staff to reinforce this policy as well as the procedure to ensure that the policy is met. Employees that fail to comply to the standard will go through disciplinary action, and if necessary, terminated.
    b. It is the policy of this company that a clinical supervisor / Case Manager will assign clinical personnel to conduct initial assessments of eligibility for services within 48 hours of acceptance of a referral information and or discharge information from her referring facility. (Policy # HH:2-003.2)
    c. It is also the policy of this company to frequently monitor the progress and execution of the plan of care, including communication and monitoring with the various disciplines that are part of that plan of care. (Policy # HH: 2-004.1-4)

3. Company Procedure
    a. Employees Will complete the necessary documentation at point of care when ever possible or will come back to the computers made available to them at the office to finish their documentation as quickly

as possible, never to exceed 48 hours for visits, communications, or changes in condition, or 72 hours for admissions. Any communication between disciplines, physicians, or family members as it pertains to the plan of care of any patient, will also be documented thoroughly within 48 hours of it occurring. (Policy # HH:2-013.1)

b. When an initial or recertification order from a doctor is received, the admitting nurse will go through the orders thoroughly and circle all disciplines ordered in the care of that patient. All disciplines ordered will then be dispatched to provide their initial evaluations. The director of nursing, or designee operating under the authority of the director of nursing, will audit initial doctor orders until 100% of the orders and Plans of care are fulfilled within that calendar month. At that point, the initial doctor order will remain a focal point in all subsequent chart audits performed in accordance to Federal guidelines and Avalon home health's OBQI program. The supervising RN / Case manager will then weekly monitor all disciplines to ensure POC compliance, appropriateness of care provided by the respective disciplines, and ensure that coordination of care is being executed effectively for maximum outcomes.

4. Responsible Parties and Compliance Dates
   The director of nursing will be the responsible party for these corrections as well as maintaining the timelines in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 17thth. Our documentation will prove to be compliant to the corrective actions identified in this section by Feb. 17th, 2014.

Condition Of Participation – G 156 – Acceptance of Patients, POC, and Medical Supervision, as indicated by G 158, G 159, and G 164.

G 158, N 170 – Care in accordance to the Plan of Care

The Findings of the State survey indicate that there were a few deficiencies that led to this G tag being applied. Vital sign parameters were also listed in this tag as well as G 143 and the same action and plans apply, OT orders were not followed through on as was also mentioned in G 143 and the action and corrective plans will also apply to this tag as well. The consistent problem that led to the other tags in this area was the failure on our part to indicate whether our orders were verbal or written.

1. **Action Taken**
    a. Avalon Home Health has published parameters for vital signs that indicate the thresholds for safety. If at any time patient readings fall outside these parameters, employees will report the findings to the DON (or designated case manager under the direction of the DON) and nursing will notify the physician and follow the physician's subsequent direction. This Communication will be required (as stated above) to be documented within 48 hours and made aware to all appropriate caregivers participating in that patient's plan of care via a care coordination note within that patients' medical record.
    b. The RN that provides the admitting assessment will also thoroughly review the original service orders and ensure that all prescribed services initiate care within 48 hours unless otherwise dictated by a doctor's order. Thereafter, the Supervising RN/ Case Manager will review the POC progress (including all respective disciplines) weekly to ensure that communication, coordination and quality care are taking place.
    c. The written and verbal orders have been added as a focus area in our OBQI program and will not be cleared as a focus area until 100% of care plans demonstrate compliance to the federal standard for any given quarter (3 consecutive months). This is also where patient parameters will be documented that are exceptions to the company published parameters.
    d. All documentation will be reviewed and cosigned by the DON or Administrator for appropriateness and sent back to the clinician for correction if needed. This 100% documentation review will continue for 1 month and then decrease to 25% for the next 2 months focusing on caregivers after who are determined to be resilient to training.

2. **Company Policy**
    a. Avalon has added Vital Sign Safety Parameters to our policy and procedures. It is now the policy of this company that if any vital sign readings fall outside the published safety parameters that the director of nursing, or case manager designee, will be contacted and physician notified for guidance on how to address the issue. (Policy # HH:2-015.1)
    b. It is currently the policy of this company to provide complete and accurate documentation within 48 hours of every visit or communication regarding the patient's plan of care. In response to the failure to follow this policy, the administrator and director of nursing will be conducting education opportunities for all staff to reinforce this policy as well as the procedure to ensure that the policy is met. Employees that fail to comply to the standard will go through disciplinary action, and if necessary, termination. (Policy # HH:2-013.1)
    c. It is currently the policy of this company that all aspects of patient care are directed and signed off by a physician. Orders to clarify initial orders, frequency, disciplines, etc. all fall under this policy that a physician directs and signs off on all aspects of the plans of care. It is the policy of this company to call and received orders verbally before documenting it on a verbal order or modifying the plan of care in any way or wait until a physician signature is applied to proceed with what was ordered. (Policy # HH:2-005.1)

a. It is the policy of this company to have RN supervision for every patient and to have frequent review of the POC for effectiveness and appropriate care coordination to ensure safety and maximize outcomes. (Policy # HH: 2-004.1-4)

3. **Company Procedure**
    b. Nurses and CNA's will know and follow all Dr. ordered or company published safety parameters. This company's official procedure indicates that the patient's physician will be contacted on the same day any of the following occur: (Policy # HH:2-015.1.3.A-C)
        i. Significant changes in the patient's condition
        ii. Vital sign readings that fall outside of the published safety parameters.
        iii. Significant changes in the patient's psychosocial status, family/caregiver support, home environment.

        This Communication will be required (as stated above) to be documented within 48 hours and made aware to all appropriate caregivers participating in that patient's plan of care via a care coordination note within that patients' medical record.
    c. It is the official procedure of this company that employees will complete the necessary documentation at point of care when ever possible or will come back to the computers made available to them at

the office to finish their documentation as quickly as possible, never to exceed 48 hours for visits, communications, or changes in condition, or 72 hours for admissions. Any communication between disciplines, physicians, or family members as it pertains to the plan of care of any patient, will also be documented thoroughly within 48 hours of it occurring. (Policy # HH:2-013.1)

d. It is the official procedure this company that physician orders will be individualized and based on patient needs. The attending physician's verbal orders will be obtained at the time the plan of care is established. The attending physician will sign the plan of care/treatment within 30 days of the start of care. The attending physician's recertification will be obtained in intervals of at least every 60 days, when the patient's plan of care is reviewed, the patient recertified, and more often if warranted. (Policy # HH:2-005.1)

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 17thth. Our documentation will prove to be compliant to the corrective actions identified in this section by Feb. 17th, 2014.

G 159, N 156 – Plan of Care

The findings of the state survey that triggered these deficiencies were based on two areas. The first area was lazy charting resulting in poor documentation on a few medication profiles. Secondly, prominent DME was missed on the initial admit documentation. The actions listed below addresses these issues.

1. Action taken
    a. Re-education has been performed with all RN staff that may be asked to perform an OASIS document or nursing visit regarding medication profiles. RNs are educated to review all medications in the home as well as any other list that comes from a hospital, Clinic, or care facility and reconcile them to an accurate and safe regimen. RNs are aware that communication with multiple physicians is probable, as well as the pre-discharge facilities. The director of nursing will be reviewing every medication list for quality and consistency and providing education / guidance as needed.
    b. Education has been performed with all our and staff that may be asked to perform an oasis assessment or nursing visit regarding durable medical equipment. RNs are educated to review all durable medical equipment in the home as well as any new piece of durable medical equipment that may have been issued by the discharging entity. Nursing staff has been educated that without a complete list of DME, they will not have a complete understanding of what is required to address each respective diagnosis.

2. Company Policy
    a. It is currently the policy of this company that a comprehensive medication profile is part of the initial assessment done by an RN. Medication profile updates are also performed anytime the comprehensive assessments are performed, patient care is resumed after patient is been placed on hold, and with the addition of new medication. The medication profile is then used as a care planning and teaching guide to ensure that the patient and family/caregiver as well as other clinicians understand the medication regimen. (HH:2-028.1)
    b. It is the policy of this company to compile an extensive list of durable medical equipment required by the patient for treatment of the diagnoses in question. All DME will be accounted for so that clinicians understand the whole picture of what needs to be addressed for comprehensive treatment for each respective diagnosis. (Policy # HH:2-004)

3. **Correcting Procedure**
    a. The company policy and procedure have been reviewed and found to be correct and inclusive. The drug regimen review will be performed at the time of admission, but updates to the comprehensive assessment are performed, when care is resumed after patient has been placed on hold, and with the addition of new medication. The review will identify drug/food interactions, potential adverse effects and drug reactions, and effective drug therapy, duplicative drug therapy, and noncompliance with drug therapy. Deviations from taking medications as ordered will be documented in the clinical notes, and the physician (or other authorized licensed independent practitioner) will be notified. (Policy # HH:2-028.1-7) The director of nursing, or designee operating under the authority of the director of nursing, will audit medications and Plans of care until 100% of the profiles are accurate and inclusive within that calendar month. At that point, the medication profile will remain a focal point in all subsequent chart audits performed in accordance to Federal guidelines and Avalon home health's OBQI program.
    b. The company's policy and procedure in regards to durable medical equipment has been reviewed and found to be correct. The plan of care will be based upon the physicians orders and will encompass the equipment, supplies, and services required to meet the patients needs. (Policy # HH:2-004.3(5)) The director of nursing, or designee operating under the authority of the director of nursing, will audit Plans of care and nursing visit notes until 100% of DME is accounted for and functionally part of the patient's plan of care within that calendar month. At that point, the DME will remain a focal point in all subsequent chart audits performed in accordance to Federal guidelines and Avalon home health's OBQI program.

4. **Responsible Parties and Compliance Dates**
The director of nursing will be the responsible party for these corrections as well as maintaining the timelines in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 17thth. Our documentation will prove to be compliant to the corrective actions identified in this section by Feb. 17th, 2014.

G 164, N 172 – Periodic Review of Plan of Care

The recent state survey indicates 2 primary issues that fall under this G tag/ N Tag that necessitate the deficiency being cited. The first is the previously identified issue of not communicating or clarifying to the physician a blood pressure that fell outside safe parameters. The second issue was a lack of communication with the physician as well as other involved disciplines when patient status deviates from that which is medically safe or otherwise ordered by the physician. The following plan is in place to correct the issues that led to this citation:

1. Action Taken
    a. Avalon Home Health will reeducate staff about published parameters for vital signs that indicate the thresholds for safety. Education will also be given on the parameters as well as the procedure that needs to be followed if any readings are outside of normal.
    b. Policy and procedure regarding timely filing has been reviewed and found to be compliant with federal and state standards.
    c. Re-Education will be provided to all clinical personnel to realign actions of clinical staff with the existing policy of this company to Communicate with physicians within 24 hrs. of any breach in safety parameters and complete documentation / interdisciplinary / physician communication within 48 hours of the actual visit.
    d. Tracking of the timeliness of documentation / communication will be a focus area for our QA/OBQI program. Checking timeliness of documentation can be measured by comparing form dates/visit dates to the electronic signature date on the bottom of each form. This focus area will remain as part of the QA/OBQI program until 90% of documentation meets timeliness guidelines for any given quarter (3 consecutive months).

2. Correcting the Policy
    a. Avalon has added Vital Sign Safety Parameters to our policy and procedures. It is now the policy of this company that if any vital sign readings fall outside the published safety parameters that the director of nursing, or case manager designee, will be contacted and physician notified for guidance on how to address the issue. (Policy # HH:2-015.1) The vital sign parameters that are now published within our Policy and Procedures that have been suggested and endorsed by our Medical Director are as follows:
        i. Blood pressure: Systolic range must be between 80 - 180 and Diastolic must be between 50 - 90
        ii. SPO2%: 88-100%
        iii. Pulse: 60 - 120 beats per minute

iv. Temperature: 96 - 100.5 degrees Fahrenheit
v. Blood Sugar: Must stay between 60 and 250

b. It is currently the policy of this company to communicate any breach in parameters within 24 hours and provide complete and accurate documentation within 48 hours of every visit. (Policy # HH:2-013.1)

3. Correcting the Procedure
   a. This company's official procedure indicates that the patient's physician will be contacted on the same day one any of the following occur: (Policy # HH:2-015.1.3.A-C)
      i. Significant changes in the patient's condition
      ii. Vital sign readings that fall outside of the published safety parameters.
      iii. Significant changes in the patient's psychosocial status, family/caregiver support, home environment.

      This Communication will be required (as stated above) to be documented within 48 hours and made aware to all appropriate caregivers participating in that patient's plan of care via a care coordination note within that patients' medical record.
   b. As outlined above, education will take place regarding timeliness of communication as well as corrective action or punitive action as necessary. Any communication between disciplines, physicians, or family members as it pertains to the plan of care of any patient must be communicated to physician and interdisciplinary staff within 24 hours and will also be documented thoroughly within 48 hours of it occurring.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 17thth. Our documentation will prove to be compliant to the corrective actions identified in this section by Feb. 17th, 2014.

G 225 Assignment of Duties to the Home Health Aide

The recent state survey indicates a deficiency in this area due to a lack of communication / documentation from the CNA in monitoring different thresholds included in the HHA care plan. The following actions have been taken to ensure this deficiency will not be repeated and ongoing compliance will be maintained.

1. Action Taken
    a. Our company policies and procedures regarding HHA care plans and visit notes have been reviewed and found to be compliant to state and federal standards.
    b. Reeducation has been provided to our nurses as well as our home health aides regarding appropriate HHA care plans as well as appropriate communication and documentation while following through on HHA a care plan.
    c. Home health aide Care plans have been added to a 100% audit list as well as home health aide visit notes. The director of nursing (or designee acting under the direction of the director of nursing) Will review every care plan and every visit note for accuracy, appropriateness, and timely communication. This auditing will continue until 90% has been achieved in any given month. Thereafter it will be a focus point in our OBQI program.

2. Company Policy
    a. It is the current policy of this company to ensure that all HHA care plans are created by an RN and overseen by appropriate licensed professionals to ensure that the HHA care plan is being executed appropriately. (HH: 2-009.1)
    b. This company's official procedure indicates that the patient's physician and case manager will be contacted on the same day one any of the following occur: (Policy # HH:2-015.1.3.A-C)
        i. Significant changes in the patient's condition
        ii. Vital sign readings that fall outside of the published safety parameters.
        iii. Significant changes in the patient's psychosocial status, family/caregiver support, home environment.

        This Communication will be required (as stated above) to be documented within 48 hours and made aware to all appropriate caregivers participating in that patient's plan of care via a care coordination note within that patients' medical record.

3. Company Procedure
    a. The patient's case manager, upon initialization of a services, will develop the home health aide plan of care, consistent with the comprehensive plan of care and physician orders. (HH: 2-009.1(1))

Home health aide care plan will be revised at least every 60 days based upon a professional reassessment of the patient and at any time the patients change of condition warrants revision. (HH: 2-009.1(4)) the case manager or other appropriate clinician will supervise the home health aide at least every two weeks to ensure care is provided according to plan. (HH: 2-009.1(8))

b. As outlined above, education will take place regarding timeliness of communication as well as corrective action or punitive action as necessary. Any communication between disciplines, physicians, or family members as it pertains to the plan of care of any patient must be communicated to physician and interdisciplinary staff within 24 hours and will also be documented thoroughly within 48 hours of it occurring.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 17thth. Our documentation will prove to be compliant to the corrective actions identified in this section by Feb. 17th, 2014.

G 337, N 173 – Drug Regimen Review

The recent state survey indicates a deficiency in this area due medication profiles that 2 out of 10 patients profiles were not complete or accurate. The following actions have been taken to ensure this deficiency will not be repeated and ongoing compliance will be maintained.

1. Action Taken
    a. Our company policies and procedures regarding the medication profile and medication review have been reviewed and found to be compliant to state and federal standards.
    b. Education has been provided to our nurses performing initial and ongoing assessments to be compliant with our policy procedure on developing and maintaining a medication profile. This education has already taken place on November 20th and 21st of 2013 and again on Feb. 4th, 2014.
    c. Medication profiles have been added to our OBQI program and will not be cleared as a focus area until 100% of care plans demonstrate compliance to the federal standard for any given quarter (3 consecutive months).

2. Company Policy
    a. It is our company policy that a patient receiving medications administered by the organization will have a current, accurate medication profile in the clinical record. Medication profiles will be updated for each change to reflect current medications, new, &/or discontinued medications. Policy # HH:2-028.1.

3. Company Procedure
    a. It is the current procedure of this company that upon admission to the organization, the admitting clinician will initiate a medication profile to document the current medication regimen. A drug regimen review will be performed at the time of admission, when the updates to the comprehensive assessments are performed, when care is resumed after a patient has been placed on hold, and with the addition of new medication. The review will identify drug/food interactions, potential adverse effects and drug reactions, ineffective drug therapy, duplicative drug therapy, and noncompliance with drug therapy. During subsequent home visits, the medication profile will be used as a care planning teaching guide to ensure that the patient and family/caregiver as well as other clinicians understand the medication regimen. (HH:2-028.1.1-3)

4. Responsible Parties and Compliance Dates
   The director of nursing will be the responsible party for these corrections as well as maintaining the timelines outlined in this plan of correction. All of

the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.