

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
2201 Sixth Avenue, RX-48
Seattle, WA 98121



TERMINATION NOTICE – PLEASE READ CAREFULLY

March 26, 2014

Jake Bryan, CEO
Avalon Home Health
403 1st Street
Idaho Falls, ID 83401

CMS Certification Number: 13-7057

**Re: Recertification survey 11/15/2013 found CoPs Not Met
 Revisit survey 03/06/2014 found CoPs still not met
 Termination projected if CoPs found not met during next unannounced revisit survey
 Submit Plan of Correction for 03/06/2014 revisit survey**

Dear Mr. Bryan:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Avalon Home Health no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. This is to notify you that the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with Avalon Home Health if Conditions of Participation (CoP) are still not met during the next unannounced revisit survey. We will publish a legal notice in the local newspaper at least fifteen days prior to the termination date.

I. BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a home health agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a home health agency is found to be out of compliance with the home health agency Conditions of Participation, the facility no longer meets the requirements for participation as a provider of services in the Medicare program.

The Social Security Act Section 1866(b) authorizes the Secretary to terminate a home health agency's Medicare provider agreement if the provider no longer meets the requirements for a home health agency. Regulations at 42 Code of Federal Regulations (CFR) § 489.53 authorize the Centers for Medicare and Medicaid Services (CMS) to terminate Medicare provider agreements when a provider, such as Avalon Home Health no longer meets the Conditions of Participation.

On November 15, 2013, the Idaho Bureau of Facility Standards (State agency) completed a recertification survey at your facility. Based on a review of deficiencies identified during the survey, the following home health agency Conditions of Participation were not met: (1) Acceptance of Patients, Plan of Care and Medical Supervision [42 CFR § 484.18] and (2) Home Health Aide Services [42 CFR § 484.36].

Subsequent revisit surveys were completed January 17, 2014 and March 6, 2014 which found that the following CoPs are not met:

42 CFR § 484.14 Organization, Services & Administration

42 CFR § 484.18 Acceptance of Patients, Plan of Care and Medical Supervision

The identified deficiencies have been determined to be of such a serious nature as to substantially limit Avalon Home Health's ability to provide adequate and safe care.

II. PLAN OF CORRECTION (PoC)

Avalon Home Health can avoid the termination action by correcting the deficiencies prior to the next revisit survey. CMS and the State agency must receive and approve a credible allegation of compliance, in sufficient time to verify, with an unannounced revisit by the State survey agency, that the deficiencies have been corrected. Complete your plan of correction in the space provided on the CMS-2567 within the next 10 calendar days. An acceptable plan of correction, which includes acceptable completion dates, must contain 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 regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the 2567 form.

CMS strongly encourages Avalon Home Health to have its plan of correction fully implemented by no later than **April 11, 2014**. Please send your corrective actions to the State survey agency and to:

Kate Mitchell, CMS – Division of Survey and Certification
Fax: (443) 380-6183 or
Email: Catherine.mitchell@cms.hhs.gov

Once your plan of correction is received and reviewed, you will be notified if it is a credible allegation of compliance. If the State Agency determines it is a credible allegation of compliance, an unannounced revisit will be conducted. Failure to meet all the Conditions of Participation will result in termination from the Medicare program as a home health agency.

III. APPEAL RIGHTS

Avalon Home Health has the right to appeal this determination by requesting a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR § 498.40 et seq. A written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to:

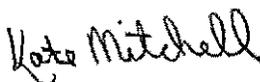
Chief, Civil Remedies Division
Departmental Appeals Board MS 6132
Cohen Building, Room 637-D
330 Independence Avenue, SW
Washington, D.C. 20201

Please also send a copy to: Chief Counsel
Office of General Counsel, DHHS
2201 Sixth Avenue, M/S RX-10
Seattle, WA 98121-2500

A request for a hearing must identify the specific issues, and findings of fact and conclusions of law with which Avalon Home Health disagrees. Additionally, Avalon Home Health must specify the basis for contending that the findings and conclusions are incorrect. Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense.

If you have further questions, please contact Kate Mitchell of my staff at (206) 615-2432 or at Catherine.mitchell@cms.hhs.gov.

Sincerely,



for Steven Chickering
Associate Regional Administrator
Western Consortium Division of Survey and Certification

cc: Idaho Bureau of Facility Standards
DHHS Office of General Counsel



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 208-384-1888

March 28, 2014

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

RE: Avalon Home Health, Provider #137057

Dear Mr. Bryan:

This is to advise you of the findings of the Medicare/Licensure survey at Avalon Home Health, which was concluded on March 6, 2014.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

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

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

Jake Bryan, Administrator
March 28, 2014
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by April 10, 2014, and keep a copy for your records.

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

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures

Teton Home Health, LLC

DBA

Avalon Home Health

Plan of Correction

04/10/14

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APR 15 2014

FACILITY STANDARDS

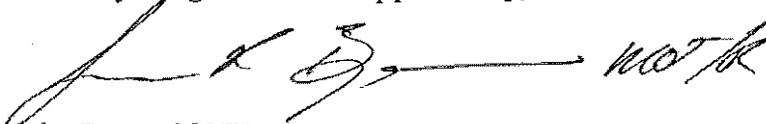
To the Idaho Bureau of Facility Standards and the Center for Medicare and Medicaid Services,

The following is the proposed plan of correction by Avalon Home Health to address the findings in the most recent survey performed by the state of Idaho's Bureau of Facility Standards. I hope you find that the effort and intent put into this plan demonstrates our desire to meet the regulations necessary to participate in the Medicare program. Attached to this plan are several different addendums that illustrate both written policy and procedure. Attached also are certain tools we have prepared to help us in the process. Since many of the items addressed in this document have been repetitive, I hope these attachments will show progress as well as a concerted effort to follow direction.

This process has also been frustrating in several different ways. In addition to confronting our own inadequacies, we have come to realize that many of our issues are closely tied to the limitations of our current EMR as it relates to the size of our agency. The EMR that we are using is a glorified paper system in the context of an electronic server. It does not give us the luxuries of other EMR's that cue or prompt our clinicians to take action when certain triggers are detected. In order for us to find deficiencies, we have to physically lay eyes on the problem. With the volume of forms completed for each patient each day throughout this company, the time required to cover that much material is extremely prohibitive. Please note that I am not using EMR as an excuse or diversion from our own inadequacy, but rather an explanation as to why it is taking so much time for us to ensure compliance with Medicare standards. Within the last month since survey has left, we have been able to create systems, create audit tools, and implement checks and balances centered around our new leadership with the knowledge set to handle these issues. In addition to that, we feel as if we have been able to make it through our entire Snake River Valley census with high confidence that it meets Medicare standards. We have also made great gains in our Salmon area census, however, we may have a couple more weeks to ensure that all existing charts in that region meet full compliance. All recent and new patients however are operating within our new systems and going forward should meet all the requirements Medicare has outlined.

I want to express my gratitude for the opportunity to do better. I understand that this is a unique circumstance and want to assure you that we are taking it seriously and using it as an opportunity to create an incredible agency for the people that we serve everyday.

Thank you again for this opportunity,



Jake Bryan, MOTR
Exec. Director
Avalón Home Health

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APR 15 2014

FACILITY STANDARDS

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/06/2014
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NAME OF PROVIDER OR SUPPLIER AVALON HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 403 1ST ST IDAHO FALLS, ID 83401
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(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
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{G 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the follow up survey of your home health agency on 3/04/14 through 3/06/14.</p> <p>Surveyors conducting the follow up were:</p> <p>Susan Costa, RN, HFS - Team Leader Nancy Bax, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>BP - Blood Pressure CHF - Congestive Heart Failure CLD - Chronic Lung Disease DM - Diabetes Mellitus DME - Durable Medical Equipment DPC - Director of Patient Care ER - Emergency Room GI - Gastrointestinal HHA - Home Health Aide MSW - Medical Social Worker OT - Occupational Therapy POC - Plan of Care PTA - Physical Therapy Aide PT - Physical Therapy RN - Registered Nurse ROM - Range of Movement ROP - Retinopathy of Prematurity RSV - Respiratory Syncytial Virus SN - Skilled Nursing SOC - Start of Care TED hose - Thrombo Embolic Deterrent (compression stockings) V.A.C. - Vacuum Assisted Closure</p> <p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION</p>	{G 000}		
G 122		G 122		

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APR 15 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 4/10/14

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 122	<p>Continued From page 1</p> <p>This CONDITION is not met as evidenced by: Based on staff interview, review of patient records, and review of administrative documents, it was determined the Governing Body failed to provide necessary organizational and administrative controls and oversight of agency practices, policies, and procedures. This failure resulted in a lack of support and guidance to agency personnel and repeated Condition Level noncompliance. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to G128 as it relates to the Governing Body's failure to ensure the overall effective operation of the HHA. 2. Refer to G143 as it relates to the Governing Body's failure to ensure agency personnel coordinated services. 3. Refer to G145 as it relates to the Governing Body's failure to ensure physicians received 60 day summaries for those patients who received care for more than 1 certification period. 3. Refer to G156 Condition of Participation: Acceptance of Patients, Plan of Care, Medical Supervision not met and related standard level deficiencies as they relate to the Governing Body's failure to ensure POCs were developed, followed, and updated. <p>The cumulative effect of these systemic failures seriously impeded the ability of the agency to provide services of sufficient scope and quality.</p>	G 122			

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G 128	<p>484.14(b) GOVERNING BODY</p> <p>A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, review of governing body minutes, staff training records, and the agency's compliance history, it was determined the governing body failed to ensure the overall effective operation of the agency. This resulted in repeated noncompliance with the Condition of Participation of Acceptance of Patients, POC, and Medical Supervision. Due to the agency's failure to achieve compliance negative systemic practices continued which impeded the agency's ability to provide quality care in accordance with established POCs. Findings include:</p> <p>1. During an 11/15/13 recertification survey the agency was found out of compliance with 2 Conditions of Participation (COPs), including the COP of Acceptance of Patients, POC, and Medical Supervision.</p> <p>A follow-up survey was completed on 1/17/14. The agency was, again, found out of compliance with the COP of Acceptance of Patients, POC, and Medical Supervision.</p> <p>A second follow-up survey was completed on 3/06/14. The COP of Acceptance of Patients, POC, and Medical Supervision was found out of compliance for the third time.</p> <p>During an interview on 3/06/14 starting at 8:45 AM, documentation of the Board of Director's actions taken to bring the COP of Acceptance of</p>	G 128		

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G 128	<p>Continued From page 3</p> <p>Patients, POC, and Medical Supervision into compliance was requested from the Administrator. The Administrator was a member of the Board, having part ownership in the agency. One Board note was documented on 12/17/13. The note included 3 sentences related to the hospice agency, under common ownership. The note did not address the home health agency's Condition Level noncompliance.</p> <p>Another Board of Director's note was dated 1/23/14. It noted the person who was the Director of Patient Care (DPC) during the prior surveys was no longer working in that position. A Board note, dated 1/27/14, indicated a new DPC was hired to start in two weeks.</p> <p>The last Board note was dated 2/06/14, and referenced the hospice only.</p> <p>Meeting minutes of a PAC meeting held on 1/14/14, was also provided to surveyors. The Administrator was PAC member and led the meeting. The meeting minutes indicated the group was informed 12 federal deficiencies were cited during the 11/15/13 survey and as part of the plan to correct deficiencies, the agency adopted an accrediting organization's policies and procedures. The minutes referenced extensive chart audits and staff education being completed by the DPC. The minutes also stated PAC members were given copies of the survey results and the agency's plan of correction. Further information related to oversight and actions by the Board of Directors, was not documented.</p> <p>During the interview on 3/06/14 at 8:45 AM, the Administrator stated the survey results and subsequent follow up surveys were discussed</p>	G 128		
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G 128	<p>Continued From page 4</p> <p>during the PAC and Governing Board meetings. He indicated that after the follow up survey was conducted on 1/17/14, he realized leadership changes were needed to correct deficiencies. The Administrator stated during the 6 week period between the first follow up survey to the current one, the agency recruited, interviewed, and hired a new DPC. He stated the new DPC was in her role for approximately two weeks. He confirmed the new DPC had not been at the agency long enough to show sufficient progress, but she had made changes in clinical processes and started staff education.</p> <p>The surveyors requested staff education and training records for the period of time from the recertification survey, dated 11/15/13, to present. The Administrator stated agency staff was informed of survey results and of policy and procedural changes during weekly staff meetings, but it was on an informal basis and not recorded. He stated the new DPC was providing education to the clinicians individually as she reviewed the patient care records daily.</p> <p>During an interview on 3/06/14 beginning at 9:15 AM, the current DPC confirmed she was reviewing all patient records and providing staff education related to compliance with the Medicare guidelines for documentation and other agency activities. She stated she had identified many of the same deficiencies the surveyors had found during the survey, and was actively working with the staff to ensure compliance. The current DPC stated her style of staff education was to communicate with them by communication notes when she reviewed their documentation. If problems were found or revisions were needed, the current DPC stated she would have the</p>	G 128		

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G 128	Continued From page 5 clinician make the correction. The DPC confirmed she did not have sufficient time to ensure the agency was in compliance during her 2 weeks in that role. The governing body did not provide sufficient management, supervision, and evaluation of the agency to ensure compliance with all COPs and that Condition Level deficiencies found out of compliance were promptly corrected.	G 128			
G 143	2. Refer to G156 COP of Acceptance of Patients, POC, and Medical Supervision, and related standard level deficiencies, as it relates to the failure of the agency to ensure a) POCs were developed, followed, and updated, b) that all pertinent information was included in patients' POCs, c) the physician was notified of changes in patients' conditions, and d) verbal orders were put in writing, signed and dated. 484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure care coordination between disciplines for 2 of 7 patients (#5 and #10) who received services from more than one discipline. This interfered with quality and continuity of patient care and resulted in a repeat deficiency. Findings include:	G 143			



Exec. Director

4/10/14

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G 143	<p>Continued From page 6</p> <p>1. Patient #10 was a 76 year old male admitted to the agency on 2/11/13, for HHA and PT services related to pathological fractures of his vertebrae, paralysis, and generalized muscle weakness.</p> <p>In a PTA visit note, dated 2/11/14, the therapy aide noted Patient #10 complained of back discomfort and was questioning if he had a kidney infection. There was no documentation the PTA notified the RN Case Manager or physician regarding Patient #10 concerns.</p> <p>Patient #10's record included results from a urinalysis obtained on 2/12/14. An order to obtain a specimen for a urinalysis was not in Patient #10's record.</p> <p>A form titled "PHYSICIAN'S ORDER VERBAL," dated 2/13/14, unsigned as of 3/06/14, indicated verbal orders were secured for a SN evaluation and treatment to follow up with UTI resolution, teaching, and medication management.</p> <p>A form titled "CARE COORDINATION NOTE," written by the Clinical Director and dated 2/13/14, noted an RN was contacted and would evaluate Patient #10 on 2/14/14.</p> <p>As of 3/06/14 Patient #10's record did not contain documentation the RN performed a visit.</p> <p>During an interview on 3/06/14 beginning at 9:15 AM, the Administrator and Clinical Director reviewed the record and confirmed Patient #10's urinalysis specimen was sent to the lab without a physician's order. The Clinical Director stated she spoke with the RN and confirmed a visit was scheduled for 2/14/14, but could not find evidence</p>	G 143			

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G 143	<p>Continued From page 7 in Patient #10's record the nurse had performed a visit.</p> <p>Patient #10's care was not coordinated to insure orders were obtained, and nursing visits occurred.</p> <p>2. Patient #5 was a 71 year old female admitted to the agency on 2/19/14, for SN, PT, OT and HHA services after lumbar fusion surgery. Additional diagnoses included CHF, uncontrolled DM Type II, and neuropathy.</p> <p>The PTA visit note, dated 3/03/14, included the documentation "During treatment, the patient had emotional breakdown and ended therapy." The documentation also indicated Patient #5 rated her pain as 7 on a scale of 1 to 10, with 10 being the worst pain.</p> <p>There was no indication in the record that the PTA notified the Physical Therapist or the RN Case Manager of Patient #5's emotional state or increased level of pain. The PTA note contained an area to document a conference with other staff and the area was blank.</p> <p>During an interview on 3/05/14 at 4:15 PM, the Administrator reviewed the record and confirmed the PTA did not notify RN Case Manager and Physical Therapist of Patient #5's pain level and emotional status during the PTA's 3/03/14 visit.</p> <p>Patient #5's PTA did not communicate with the Physical Therapist and RN Case Manager to ensure coordination of care.</p>	G 143			
G 145	484.14(g) COORDINATION OF PATIENT	G 145			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/06/2014
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NAME OF PROVIDER OR SUPPLIER AVALON HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 403 1ST ST IDAHO FALLS, ID 83401
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(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
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G 145	Continued From page B SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure a written summary report was sent to the attending physician at least every 60 days for 1 of 2 patients (#9) who received home health services for more than 1 certification period and whose records were reviewed. This had the potential to result in decreased physician awareness of patient conditions and reduce the quality of patient care. Findings include: A recertification assessment for Patient #9's second certification period, from 2/21/14 through 4/21/14, was performed on 2/20/14. Her record did not include documentation a 60 day summary was created and provided to her physician. During an interview on 3/05/14 at 3:40 PM, the Administrator reviewed Patient #9's record and confirmed no 60 day summary was created or sent to the physician. A written summary report was not sent to Patient #9's physician at the end of her 60 day certification period.	G 145		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 156		

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G 156	Continued From page 9 This CONDITION is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure POCs were developed, followed, and updated. This resulted in continued COP Level noncompliance, care provided without physician orders, necessary patient information omitted from patients' POCs, lack of physician notification of changes in patients' status, and lack of, and untimely documentation of, verbal orders. Findings include: 1. Refer to G158 as it relates to the failure of the agency to ensure care followed the written POC. 2. Refer to G159 as it relates to the failure of the agency to ensure all pertinent information was included in patients' POCs. 3. Refer to G164 as it relates to the failure of the agency to notify the physician with changes in patients' conditions. 4. Refer to G166 as it relates to the failure of the agency to ensure verbal orders were put in writing, signed and dated. The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POC's.	G 156			
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	G 158			



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G 158	<p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation, and patient and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 6 of 10 patients (#1, #2, #3, #7, #8, and #9) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care. Findings include:</p> <p>1. Patient #2 was a 75 year old male admitted to the agency on 2/17/14, for SN, PT and HHA services after a hospitalization for GI bleeding. Additional diagnoses included chronic alcoholism, cirrhosis, anemia, anxiety, depression, dementia, prostate enlargement and urinary retention.</p> <p>-In a nursing visit note dated 2/18/14, the RN documented she contacted Patient #2's physician and received orders which included an MSW evaluation. The MSW visit was conducted on 2/28/14, 10 days after the order was received by the RN.</p> <p>-The POC for the certification period 2/18/14 through 4/17/14, included an order for OT to consult, evaluate and treat. As of 3/05/14, an OT evaluation had not been performed.</p> <p>During an interview on 3/06/14 beginning at 8:30 AM, the Administrator reviewed Patient #2's record and confirmed the MSW evaluation occurred 10 days after it was ordered. He stated the agency policy was to see the patient within 3 days of the order. The Administrator was able to provide documentation that on 2/22/14, the MSW spoke with Patient #2 and he declined a visit as it was a Saturday. The MSW noted in a communication note she would contact Patient #2</p>	G 158		
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G 158	<p>Continued From page 11 on Monday 2/24/14. The Administrator was unable to determine why the MSW evaluation did not occur until 2/28/14. The Administrator confirmed the POC included an order for an OT evaluation, which was not completed. He stated the RN who developed the POC did not relay that information to the appropriate staff.</p> <p>Patient #2's care was not provided as ordered on his POC.</p> <p>2. Patient #3 was a 4 month old male admitted to the agency on 2/03/14, following his premature delivery at 27 weeks and extended hospital stay. SN visits were ordered to monitor his growth and weight gain.</p> <p>Patient #3's record included a POC for the certification period 2/03/14 through 4/03/14, that was not signed by a physician. A referral from the hospital Patient #3 was discharged from, dated 1/29/14, was sent to the agency on 1/30/14. The referral was signed by a neonatologist, and indicated Patient #3 was to have SN services twice weekly.</p> <p>A SOC comprehensive assessment was completed on 2/03/14, however, Patient #3's medical record did not include verbal or written orders after the assessment was performed.</p> <p>Patient #3 received 7 nursing visits on 2/06/14, 2/10/14, 12/14/14, 2/17/14, 2/20/14, 2/24/14, and 2/27/14.</p> <p>A "Verbal" order dated 2/25/14, and signed by a physician on the same day, indicated Patient #3 was to be discharged from Home Health services, the final SN visit would be 2/27/14. This</p>	G 158		

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G 158	<p>Continued From page 12 was the only order in Patient #3's record.</p> <p>During an interview on 3/06/14 beginning at 9:30 AM, the Administrator reviewed Patient #3's record and confirmed there were no orders obtained from a physician to provide ongoing services. He stated the RN who performed the SOC comprehensive assessment on 2/03/14 was no longer employed at the agency. The Administrator was unable to find documentation Patient #3's pediatrician had been consulted after the SOC visit was performed to obtain further orders for his care.</p> <p>Seven nursing visits were provided for Patient #3 without physician orders.</p> <p>3. Patient #8 was a 52 year old male admitted to the agency on 2/24/14, for SN and PT services following hospitalization related to respiratory failure. Additional diagnoses included hypoxia, lymphedema, obesity and gout.</p> <p>Patient #8's POC for the certification period 2/24/14 through 4/24/14, did not include orders for wound care or interventions related to his lymphedema. The following interventions were initiated without physician orders:</p> <ul style="list-style-type: none"> - The SOC assessment performed on 2/24/14, documented skin lesions in two areas on Patient #8's abdomen. The assessment included documentation the areas were cleansed with normal saline, zinc based barrier ointment was applied, and gauze was applied. - Patient #8's record included nursing visits on 2/25/14, 2/26/14, 2/28/14, and 3/04/14. The visit notes documented application of compression 	G 158		
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G 158	<p>Continued From page 13 wraps to each leg for the treatment of his lymphedema.</p> <p>During an interview on 3/06/14 beginning at 9:40 AM, the Administrator and Clinical Director reviewed Patient #8's record and confirmed the POC did not include orders for the wound care and lymphedema treatments.</p> <p>Services provided to Patient #8 were not consistent with his POC.</p> <p>4. Patient #1 was an 81 year old female admitted to the agency on 2/18/14, for SN, PT and HHA services after a hospitalization for Gi Bleeding. Additional diagnoses included diverticulitis, stage 5 renal failure and hypertension.</p> <p>a. A verbal order dated 2/18/14, and signed by the physician, stated SN and PT to evaluate and treat. Patient #1's initial assessment was completed by the RN on 2/18/14. A verbal order dated 2/19/14, and signed by the physician included:</p> <p>-SN frequency of 1 visit weekly for 1 week, 2 visits weekly for 1 week, and 1 visit weekly for 1 week.</p> <p>-HHA frequency of 1 visit weekly for 1 week and 2 visits weekly for 6 weeks.</p> <p>Patient #1's record included a verbal order for visit frequency and duration, however, the verbal order did not include treatments or interventions for the SN or HHA visits.</p>	G 158			

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G 158	<p>Continued From page 14</p> <p>An RN provided care for Patient #1 on 3/01/14 and 3/05/14. Her visit notes included diet education, medication review, and assessment of health status. The visit interventions were not ordered by Patient #1's physician.</p> <p>During an interview on 3/05/14 at 3:10 PM, the Administrator confirmed the RN did not get specific orders which included interventions specific to Patient #1's needs. The Administrator also confirmed the POC was not complete and had not been sent to the physician.</p> <p>Services provided to Patient #1 were not part of a physician authorized POC.</p> <p>b. Patient #1's orders for week 2 of the 2/18/14 - 4/18/14 certification period included 2 SN visits and 2 HHA visits. However, her record included documentation of 1 SN visit and 1 HHA visit for week 2.</p> <p>During an interview on 3/05/14 at 3:10 PM, the Administrator stated the SN visit was not completed because there was no staff available due to weather conditions. He stated the HHA visit was not completed because the HHA had been injured. The Administrator confirmed the physician was not notified of the missed visits.</p> <p>Patient #1 did not receive visits as ordered.</p> <p>5. Patient #7 was a 65 year old female admitted to the agency on 1/30/14, for SN services related to wound care following breast reconstruction. She developed an infection in her left breast, which required re-hospitalization. Additionally, Patient #7 had a surgical wound as a result of a</p>	G 158			

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G 158	<p>Continued From page 15</p> <p>procedure in which a flap of skin from her abdomen was relocated during the breast reconstruction. She was discharged from the hospital on 1/29/14 with a wound VAC to her left breast and abdominal wound. Additional diagnoses included DM Type II.</p> <p>a. Patient #7's POC for the certification period 1/30/14 - 3/30/14, did not include a physician name or address. Verbal orders, orders for SOC, and discharge instructions indicated Patient #7's physician practiced in another state and was licensed in that state. No Idaho physician was listed. According to the definitions contained in the federal regulations for home health care at 42 CFR 484.4, a physician is a doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed. Because the attending physician was not licensed to practice in the state of Idaho, he did not meet the regulatory definition of physician.</p> <p>- Patient #7's record included verbal orders dated 1/30/14, obtained after the SOC assessment visit, that were signed by the same out-of-state physician on 2/03/14.</p> <p>- A verbal order dated 2/21/14, and signed by the out-of-state physician on 2/25/14, included clarification of SN visit frequency and wound care orders.</p> <p>During an interview on 3/05/14 at 4:35 pm, the Administrator reviewed Patient #7's record and confirmed the orders were from Patient #7's surgeon in another state.</p>	G 158		
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G 158	<p>Continued From page 16</p> <p>Orders for Patient #7's care were not from a qualified physician who had an Idaho license and practiced in Idaho.</p> <p>b. The RN obtained verbal orders dated 1/30/14, following the SOC assessment. The orders included SN visit frequency for wound VAC changes. However, the order did not specify the locations of the wounds, how many wounds were to receive wound VAC therapy, specific dressing supplies and the vacuum settings for the wound VAC.</p> <p>- Wound care was provided on 2/17/14, 2/18/14, 2/19/14, 2/20/14, and 2/21/14. However, as of 3/04/14, orders to direct the nurse on specific wound care for those dates, could not be found in Patient #7's record.</p> <p>- Patient #7 had 2 wound VAC sites, one on her abdomen, and one on her left breast area. These were noted in a SN visit note dated 2/03/14.</p> <p>- In a "Verbal" order written 2/24/14, and signed by Patient #7's physician 2/25/14, wound VAC changes were to be performed Monday, Wednesday and Friday. The order did not specify where the wound VAC was to be applied, or further details of the dressing changes.</p> <p>- In nursing visit notes dated 2/17/14, 2/19/14, 2/20/14, 2/21/14, 2/24/14, 2/25/14, 2/26/14, 2/27/14, and 2/28/14, the nurse documented she provided wound care to a wound in the right breast area. Patient #7's record did not include physician orders for wound care to the right breast area.</p> <p>During an interview on 3/05/14 at 4:35 PM, the</p>	G 158			

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G 158	<p>Continued From page 17</p> <p>Administrator reviewed Patient #7's record. He confirmed the lack of specific wound care orders and that there was no physician order for wound care to the right breast.</p> <p>Wound care was provided to Patient #7 without clear and complete physician orders.</p> <p>6. Patient #9 was a 66 year old female admitted to the agency on 12/23/14, and recertified on 2/21/13. Her record, including the POC, for the certification period of 2/21/14 to 4/24/14, was reviewed. During this certification she received SN, PT and HHA services for foley catheter care, wound care, pain management and weakness. Additional diagnoses included hypertension and depression.</p> <p>a. Patient #9's record for the certification period of 2/21/14 to 4/24/14, did not include orders for PT visits. However, PT visits were documented on 2/26/14, 2/27/14 and 3/03/14.</p> <p>During an interview on 3/05/14 at 3:40 PM, the Administrator confirmed there was no order for PT visits in the new certification period.</p> <p>PT services were provided to Patient #9 without a physician's order.</p> <p>b. Patient #9's orders for week 1 of her certification period included 1 SN visit and 2 HHA visits.</p> <p>Patient #9's record documented no SN visit and 1 HHA visit for week 1 of the certification period.</p> <p>During an interview on 3/05/14 at 3:40 PM, the Administrator stated the frequency orders for</p>	G 158		

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G 158	Continued From page 18 week 1 were written incorrectly. He confirmed the visits did not follow the physician order.	G 158		
G 159	<p>484.18(a) PLAN OF CARE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the POC covered all pertinent diagnoses, equipment required, nutritional requirements, activities permitted, or other appropriate items in 6 of 10 patients (#2, #3, #6, #7, #8, and #9) whose records were reviewed. This had the potential to negatively impact quality, coordination, and completeness of patient care. Findings include:</p> <p>1. Patient #2 was a 75 year old male admitted to the agency on 2/17/14, for SN, PT and HHA services after a hospitalization for GI bleeding. Additional diagnoses included chronic alcoholism, cirrhosis, anemia, anxiety, depression, dementia, prostate enlargement and urinary retention.</p> <p>a. The SOC assessment dated 2/17/14,</p>	G 159		

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G 159	<p>Continued From page 19</p> <p>documented Patient #2 had a weight loss of >30 pounds over the last 6 months, had dementia, lived alone, and was unable to prepare his own meals. The nutritional health screen section on the assessment resulted in a score of 30, which indicated a moderate nutritional risk. The instructions on the screening tool were to consult with physician and dietitian, discuss need for dietary supplement, and provide the patient with appropriate dietary instructions. Interventions as instructed on the nutritional screening tool were not included on Patient #2's POC.</p> <p>b. Patient #2's record included documentation he had been hospitalized for GI bleeding, as well as, obstructive urinary retention related to an enlarged prostate. Before his discharge from the hospital on 2/17/14, a urinary catheter was inserted into his bladder through an opening in his abdomen. Patient #2's POC included interventions related to the urinary catheter, however, the POC did not include interventions related to his recent GI bleeding, cirrhosis, chronic alcoholism, or anemia.</p> <p>During an interview on 3/06/14 beginning at 8:30 AM, the Administrator confirmed Patient #2 had a recent documented weight loss and confirmed the POC did not include interventions which would address his nutritional and other medical needs.</p> <p>As of 3/06/14, Patient #2's POC did not include interventions related to his illness and other pertinent diagnoses.</p> <p>2. Patient #3 was a 4 month old male admitted to the agency on 2/03/14, following a premature delivery and extended hospital stay. SN visits</p>	G 159			

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G 159	<p>Continued From page 20</p> <p>were ordered to monitor his growth and weight gain. Patient #3's medical record, including the POC for the certification period 2/03/14 through 4/03/14, were reviewed.</p> <p>Patient #3 was discharged on 2/27/14. As of 3/06/14, Patient #3's POC had not been updated to address his needs as follows:</p> <p>a. A SOC comprehensive assessment was performed by an RN on 2/03/14. The RN listed Patient #3's primary diagnosis as Chronic Airway Obstruction, although the discharge summary from the hospital noted Patient #3 had Chronic Lung Disease (CLD). The National Institute of Health, (NIH) defines Chronic Airway Obstruction as a progressive disease, which usually includes emphysema and chronic bronchitis. NIH defines CLD as most commonly occurring in infants born prematurely, who are treated for respiratory distress syndrome and have required oxygen usage for greater than 28 days. The POC included interventions related to Patient #3's respiratory diagnosis of "Instruct methods to recognize pulmonary dysfunction & relieve complications." There was no detail of what the instruction to Patient #3's parents would include.</p> <p>b. The discharge summary from the hospital, dated 2/02/14, noted Patient #3 had recurrent kidney infections related to a back up of his urine into his kidneys, called "urinary reflux," he was to continue on Bacrim until further instruction by his urologist. The 2/03/14 SOC assessment and POC for the certification period 2/03/14 through 4/03/14, did not include information related to Patient #3's urinary reflux and prophylactic antibiotic treatment. Bacrim was not included in the medication section of the POC. The POC did</p>	G 159			

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G 159	<p>Continued From page 21</p> <p>not include interventions to ensure Patient #3's parents were instructed on administering the antibiotic. Patient #3 remained on Bactrim until his discharge from home health services 2/27/14.</p> <p>c. Patient #3's hospital discharge summary dated 2/02/14, noted he had received Synagis (an antibody to prevent RSV) each month while he was in the hospital. The summary noted Patient #3 was to receive his next injection 3/01/14. The POC did not include this information, or of interventions to ensure Patient #3's parents were educated regarding the importance of continuing with the monthly injections throughout the RSV season.</p> <p>d. The SOC comprehensive assessment and discharge summary noted Patient #3's right hand had a bifid thumb and syndactyly of his 2nd and 3rd fingers, (bifid means the digit is split into two, in this case a "double thumb," and syndactyly means the joining of digits, in Patient #3's case his 2nd and 3rd fingers were joined together). His left hand had an amniotic band deformity which resulted in a partial amputation of his 3rd finger. Additionally, Patient #3's right arm and wrist had limited range of motion. The POC included instruction to Patient #3's parents in positioning body alignment techniques and ROM exercises. There was no detail in the POC as to what the ROM exercises would include, and what areas would require the ROM.</p> <p>e. The hospital discharge summary, dated 2/02/14, documented Patient #3 had difficulties with stooling and experienced an ileus on 1/21/14, two weeks before his discharge from the hospital. (An ileus is a blockage of the intestines caused by a lack of peristalsis.) The POC did not</p>	G 159			

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G 159	<p>Continued From page 22</p> <p>include interventions to educate Patient #3's parents regarding symptoms of GI dysmotility.</p> <p>f. Patient #3's hospital discharge summary dated 2/02/14, documented he was sent home on oxygen at 1/8 liter per minute by nasal cannula. The 2/03/14 SOC assessment noted Patient #3 experienced a desaturation to 72% and became cyanotic when he was moved. The RN noted Patient #3 returned to a pink color and his oxygen saturations increased after he was allowed to recover approximately 10 seconds. The POC did not include parameters for oxygen saturations and physician notification.</p> <p>During an interview on 3/06/14 beginning at 9:30 AM, the Administrator reviewed Patient #3's record and confirmed the POC did not include medications, treatments, and interventions related to his identified needs. The Administrator stated the agency had recently decided to not accept pediatric patients, and the RN who performed the SOC assessment was no longer employed by the agency.</p> <p>Patient #3's POC did not include all relevant information necessary for his care.</p> <p>3. Patient #7 was a 65 year old female admitted to the agency on 1/30/14, for SN services for wound care. She previously had bilateral mastectomies and breast reconstruction, and developed an infection in the left breast. She was hospitalized for additional surgery to her left breast and was discharged with a wound VAC to her left breast and to her abdominal trans-flap (lay definition) site. Additional diagnoses included DM Type II.</p>	G 159		

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G 159	<p>Continued From page 23</p> <p>Patient #7's POC for the certification period 1/30/14 through 3/30/14, was reviewed. As of 3/04/14, the POC remained incomplete, lacking diagnoses, surgical procedures, and the name and address of Patient #7's physician.</p> <p>The POC also lacked specific wound care orders. The RN obtained verbal orders dated 1/30/14, following the SOC assessment. The orders included SN visit frequency for wound VAC changes. However, the order did not specify the locations of the wounds, how many wounds were to receive wound VAC therapy, or the settings for the wound VAC system.</p> <p>In a "Verbal" order written 2/24/14, and signed by Patient #7's physician 2/25/14, wound VAC changes were to be performed Monday, Wednesday and Friday. The order did not specify where the wound VAC was to be applied, or further details of the dressing changes. The order did not indicate Patient #7 actually had 2 wound VAC sites, one on her abdomen, and one on her left breast area. These were noted in a SN visit note dated 2/03/14.</p> <p>During an interview on 3/05/14 at 4:35 pm, the Administrator reviewed Patient #7's record. He stated the POC was incomplete as they were waiting for it to be "Coded." He confirmed the POC for Patient #7 was incomplete for greater than 1 month after the SOC.</p> <p>4. Patient #6 was a 50 year old male admitted to the agency on 2/22/14, for SN and PT services following a surgical procedure on his left knee.</p> <p>The SOC assessment, dated 2/22/14, noted</p>	G 159			

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G 159	<p>Continued From page 24</p> <p>Patient #6 refused to wear TED hose, and an order was received for Tubigrips. Patient #6's POC for the certification period 2/22/14 through 4/22/14, did not include TED hose or tubigrips.</p> <p>During an interview on 3/06/14, beginning at 11:45 AM, the Administrator reviewed Patient #6's record and confirmed tubigrips and TED hose were not included on the POC.</p> <p>Patient #6's POC did not include all pertinent information.</p> <p>5. Patient #8 was a 52 year old male admitted to the agency on 2/24/14, for SN and PT services following hospitalization related to respiratory failure. Additional diagnoses included hypoxia, lymphedema, obesity and gout. Patient #8's POC for the certification period 2/24/14 through 4/24/14, was reviewed. The following omissions were noted:</p> <p>a. The SOC assessment performed 2/24/14, included an oxygen concentrator.</p> <p>-In a nursing visit note dated 2/25/14, Patient #8 was documented as being on 2.0 liters oxygen by nasal cannula.</p> <p>-In a nursing visit note dated 2/26/14, Patient #8 was documented as being on 2.0 liters oxygen by nasal cannula.</p> <p>-In a nursing visit note dated 2/28/14, Patient #8 was documented as being on 2.0 liters oxygen by nasal cannula.</p> <p>-In a nursing visit note dated 3/04/14, Patient #8 was documented as being on 2.5 liters oxygen by</p>	G 159		
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G 159	<p>Continued From page 25 nasal cannula.</p> <p>Patient #8's POC for the certification period 2/24/14 through 4/24/14, did not include oxygen, or the supplies associated with oxygen usage.</p> <p>b. A 2/24/14 Clinical Summary completed by the RN Case Manager, stated one of the reasons Patient #8 was homebound was related to lymphedema leg wraps. The "History" section of the Clinical Summary stated "SN will change Lymphedema leg wraps as ordered." However, Patient #8's POC did not include a SN order for wrapping both of his legs as a treatment for lymphedema. Further it did not include nursing interventions related to his lymphedema such as monitoring leg measurements, elevation, or massage.</p> <p>c. Patient #8 was 6'8" and approximately 460 pounds, however, Patient #8's POC did not include an extended size blood pressure cuff which would be needed for an individual of this size. Including a larger blood pressure cuff would direct other clinicians to include this device during patient care visits to ensure accuracy with measurements.</p> <p>d. The SOC assessment dated 2/24/14, included an abdominal wound dressing regime which included use of zinc ointment and normal saline. These were not included on the medication list on Patient #8's POC.</p> <p>During an interview on 3/06/14 beginning at 9:40 AM, the DPC and Administrator reviewed Patient #8's record and confirmed the discrepancies. The DPC confirmed the documentation of Patient #8's oxygen usage. She also confirmed Patient</p>	G 159		
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G 159	Continued From page 26 #8's POC did not include oxygen and related supplies. Additionally, the DPC confirmed Patient #8's lymphedema in his legs was treated with compression wraps, and specific SN interventions were not included on the POC. Patient #8's POC did not include all pertinent information and interventions. 6. Patient #9 was a 66 year old female admitted to the agency on 12/23/13. The POC for the certification period of 2/21/14 to 4/24/14, noted Patient #9 had an indwelling foley catheter, and it was to be changed monthly. The POC did not specify the dates the foley catheter was to be changed. Her record did not include dates when the foley was changed last, and when it was due to be changed again. The Administrator was interviewed on 3/05/14 at 3:40 PM. He reviewed Patient #9's record and confirmed there was no direction to nursing when the next catheter change would occur.	G 159			
G 164	Patient #9's POC was not complete. 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 staff interview and review of policies and patient records, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in	G 164			



Exec. Dir.

4/10/14

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G 164	<p>Continued From page 27</p> <p>patients' conditions that suggested a need to alter the plan of care for 5 of 10 patients (#2, #5, #6, #7, and #8) whose records were reviewed. This resulted in 1) wound cross-contamination, 2) delayed physician notification of a fall with injury, 3) wound care provided without orders, 4) lack of physician notification of blood pressure and blood sugar reading beyond parameters identified in patients' POCs, and a patient's intense pain not reported to the physician. Findings include:</p> <p>1. Patient #7 was 65 year old female admitted to the agency on 1/30/14, for SN services for wound care. The patient previously had bilateral mastectomies and breast reconstruction, and developed an infection in the left breast. She was hospitalized for additional surgery to her left breast and was discharged with a wound VAC to her left breast and to her abdominal wound site. Additional diagnoses included DM Type II.</p> <p>In a SN visit note, dated 2/05/14, the RN documented she did not have adequate wound VAC supplies to complete the wound dressing change as in prior visits. She documented a "Y" connector was not available to connect each wound to the VAC device. The "Y" device would allow drainage from each wound to flow to the VAC system without cross contamination. The nurse stated in her note "wound Vacs tracked to single track pad, with sponge tracking from breast to abdomen for continuity." Patient #7's SOC assessment, dated 1/30/14, noted an infection in her left breast area, and tracking the sponges in this fashion would cause the drainage from the infected breast wound to cross into the clean abdominal wound.</p>	G 164		
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G 164	<p>Continued From page 28</p> <p>No documentation was found that the RN contacted the physician during the visit or notified him later of the lack of supplies and the modified wound management.</p> <p>During an interview on 3/05/14 at 4:35 PM, the Administrator reviewed Patient #7's record and confirmed her physician was not notified of the lack of wound care supplies that resulted in a change in the POC.</p> <p>The agency did not ensure that Patient #7's physician was notified of a change in the POC.</p> <p>2. Patient #2 was a 75 year old male admitted to the agency on 2/17/14, for SN, PT and HHA services after a hospitalization for GI bleeding. Additional diagnoses included chronic alcoholism, cirrhosis, anemia, anxiety, depression, dementia, prostate enlargement and urinary retention.</p> <p>The POC for the certification period 2/17/14 through 4/17/14, was reviewed. The POC included orders to instruct and train Patient #2 and his caregivers to perform wound care/dressing changes 3 times weekly.</p> <p>In a SN visit note dated 2/19/14, the RN documented Patient #2 was unable to safely change the dressing on his abdomen. She noted he had a hand tremor and would inadvertently pull on the catheter which was sutured in place.</p> <p>In a SN visit note dated 2/27/14, the RN documented Patient #2's longtime friend would occasionally come to his home and assist with meals, etc. The RN noted the friend had a 16 year old daughter who lived in Patient #2's home,</p>	G 164		

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G 164	<p>Continued From page 29</p> <p>however, the friend did not want her to learn how to perform the dressing change. The record indicated the RN did not train other caregivers to perform the dressing change.</p> <p>No documentation was found in Patient #2's medical record that his physician was notified he and his friends were unable to perform the dressing change.</p> <p>During an interview on 3/06/14 beginning at 8:30 AM, the Administrator reviewed Patient #2's record and confirmed the physician was not notified of the inability of the patient or his friends to perform the dressing changes.</p> <p>Patient #2's physician was not alerted to a need to alter the POC.</p> <p>3. Patient #6 was a 50 year old male admitted to the agency on 2/22/14, for SN and PT services following a surgical procedure on his left knee. Patient #6's POC for the certification period 2/22/14 through 4/22/14, included instructions related to his vital sign parameters and when to notify his physician. The B/P ranges included Systolic <90 and >180, and Diastolic <50 and >90.</p> <p>On 2/27/14 visit note, the PTA documented Patient #6's B/P as 166/100. In an inter-office communication note dated 2/27/14, the PTA documented she alerted the physician's office nurse of the elevated B/P. The PTA noted she was told by the nurse at the office to instruct Patient #6 to go to an urgent care facility to be evaluated. The PTA documented she notified Patient #6's RN Case Manager, and the RN Case Manager responded that she would call Patient</p>	G 164			

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G 164	<p>Continued From page 30</p> <p>#6 to notify him to seek medical attention for his elevated B/P.</p> <p>In an inter-office communication note dated 3/05/14, the RN Case Manager documented "On 2/23 patient was advised to go to ER or Urgent care for BP, he refused against advisement." There was no documentation Patient #6's physician was notified of his refusal to have his elevated blood pressure evaluated further. Note: In the inter-office communication note the RN referred to 2/23/14, however, the blood pressure was not documented as being out of range until the PTA visit on 2/27/14.</p> <p>During an interview on 3/06/14 beginning at 11:45 AM, the Administrator reviewed Patient #6's record and confirmed the elevated blood pressure. The Administrator stated Patient #6's physician should have been alerted of his refusal to have the blood pressure further evaluated.</p> <p>Patient #6's physician was not informed of his refusal to further evaluate his elevated blood pressure.</p> <p>4. Patient #8 was a 52 year old male admitted to the agency on 2/24/14, for SN and PT services following hospitalization related to respiratory failure. Additional diagnoses included hypoxia, lymphedema, obesity and gout.</p> <p>- Patient #8's SOC assessment, dated 2/24/14, indicated he was discharged from the hospital on 2/22/14. The SOC assessment documented Patient #8 fell in his bathroom the evening he was discharged. The RN noted Patient #8 fell and hurt his right knee and left eye. The record did not include documentation Patient #8's physician</p>	G 164			

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G 164	<p>Continued From page 31 was notified of the fall.</p> <p>In a 2/25/14 SN visit note the LPN documented Patient #8's left eye was black and blue and that he had bruising on bilateral upper extremities. Although the note indicated Patient #8's physician was notified of Patient #8's INR results, there was no documentation the physician was notified of Patient #8's bruising and discolored eye.</p> <p>In a 2/26/14 SN visit note, the RN who completed the SOC assessment, noted Patient #8's left eye was discolored on the upper lid from the fall on 2/24/14. It also stated Patient #8's right knee had bruising 14 cm wide and almost all the way around. It further noted Patient #8 had seen the physician that day and an X-ray was done to assess the fall related injuries. The RN documented that per the physician, the bruising was worse related to the lymphedema and coumadin. The delayed physician notification of Patient #8's fall, may have resulted in delayed examination of Patient #8's injuries.</p> <p>- The SOC assessment performed on 2/24/14, documented skin lesions in two areas on Patient #8's abdomen. The assessment included documentation the areas were cleansed with normal saline, zinc based barrier ointment was applied, and gauze was applied. However, Patient #8's record did not indicate his physician was contacted for wound care orders.</p> <p>- Patient #8's record included nursing visits on 2/25/14, 2/26/14, 2/28/14, and 3/04/14. The visit notes documented application of compression wraps to each leg for the treatment of his lymphedema. Patient #8's record did not contain documentation his physician was contacted for</p>	G 164		

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NAME OF PROVIDER OR SUPPLIER AVALON HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 403 1ST ST IDAHO FALLS, ID 83401		
(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	<p>Continued From page 32 orders related to lymphedema treatment.</p> <p>During an interview on 3/06/14, beginning at 9:40 AM, the Administrator and Clinical Director reviewed Patient #8's record and confirmed the physician was not contacted for wound care orders, orders for the lymphedema wraps, or of his fall the day he was discharged from the hospital.</p> <p>Patient #8's physician was not notified of the need to change his POC.</p> <p>5. Patient #5 was a 71 year old female admitted to the agency on 2/19/14, for SN, PT and OT services after undergoing lumbar fusion surgery. Additional diagnoses included CHF, uncontrolled DM Type II and neuropathy.</p> <p>a. The POC for the certification period 2/19/14 to 4/19/14, included an order to notify the physician of blood sugars greater than 250 and less than 50. A SN visit note, dated 3/03/14, included documentation of a blood sugar reading of 300. There was no documentation Patient #5's physician was notified of the elevated blood sugar.</p> <p>During an interview on 3/5/14 at 4:15 PM, the Administrator reviewed the record and confirmed Patient #5's physician had not been notified of the elevated blood sugar.</p> <p>b. In a visit note, dated 3/03/14, a PTA documented Patient #5 reported her pain as a 7 on a scale of 1-10, with 10 being the worst pain. There was no indication the physician was notified of Patient #5's elevated pain level.</p>	G 164			

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G 164	Continued From page 33 During an interview on 3/5/14 at 4:15 PM, the Administrator stated the agency does not have a policy defining severe pain, but they were currently writing a policy and educating the staff regarding pain management. The Administrator confirmed the physician should have been notified of level 7 pain.	G 164		
G 166	Patient #5's physician was not notified of changes that suggested a need to alter her POC. 484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review, staff interview, and patient interview, it was determined the agency failed to ensure verbal orders were put in writing for 2 of 10 patients (#7 and #10) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include: 1. Patient #10 was a 76 year old male admitted to the agency on 2/11/13, for HHA and PT services related to pathological fractures of his vertebrae, paralysis, and generalized muscle weakness. In a PTA visit note dated 2/11/14, the therapy aide noted Patient #10 complained of back discomfort and was questioning if he had a kidney infection.	G 166		

[Handwritten Signature]

Exec. Dir

4/10/14

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G 166	<p>Continued From page 34</p> <p>Patient #10's record included results from a urinalysis that was noted as submitted by the agency on 2/12/14. An order to obtain a specimen for a urinalysis was not in Patient #10's record.</p> <p>During an interview on 3/06/14 beginning at 9:45 AM, the Clinical Director reviewed Patient #10's record and confirmed a physician order for the urinalysis was not obtained.</p> <p>The agency did not obtain a verbal order order from Patient #10's physician to obtain the specimen for urinalysis.</p> <p>2. Patient #7 was a 65 year old female admitted to the agency on 1/30/14, for SN services for wound care. The patient previously had bilateral mastectomies and breast reconstruction, and had developed an infection in the left breast. She was hospitalized for additional surgery to her left breast and was discharged with a wound VAC to her abdominal trans-flap site and her left breast. Additional diagnoses included DM Type II.</p> <p>On 2/11/14, in a SN visit note, the RN documented Patient #7's wound care orders were changed, however, a 2/11/14 verbal order was not found in Patient #7's record.</p> <p>Wound care instructions were noted later on a form titled "PHYSICIAN'S ORDER VERBAL." The form included a "Visit Date" of 2/21/14, electronically signed by the RN on 2/24/14, and signed by Patient #7's physician on 2/25/14. It was unclear when the RN actually received the verbal order.</p>	G 166		

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G 166	Continued From page 35 During an interview on 3/05/14 at 4:35 PM, the Administrator confirmed the verbal order written on 2/24/14, and signed by Patient #7's physician on 2/25/14, was not written in a timely manner. The Administrator was not able to explain the delay between the receipt of the verbal order and the writing of the order. The agency did not ensure verbal orders were put in writing and signed and dated with the date of receipt.	G 166		
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 4 patients (#1 and #9) 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 #1 was an 81 year old female admitted to the agency on 2/18/14, for SN, PT and HHA services after a hospitalization for GI bleeding. Additional diagnoses included diverticulitis, stage 5 renal failure and hypertension. Patient #1's record included an HHA Care Plan	G 225		

 Exec. Dir 4/10/14

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G 225	<p>Continued From page 36 dated 2/20/14. The Care Plan included duties to be performed with each visit.</p> <p>The HHA provided care on 2/20/14 and 2/24/14, however, she did not document she completed the following tasks "Shampoo hair, Comb hair, Mouth care, Assist with dressing, Clean/file nails, Perineal care, Skin care, Ambulation." No documentation was found indicating why the tasks were not completed.</p> <p>During an interview on 3/05/14 at 3:10 PM, the Administrator reviewed the record and confirmed the HHA did not complete the duties as assigned.</p> <p>The HHA did not provide services as ordered in the HHA Care Plan.</p> <p>2. Patient #9 was a 66 year old female admitted to the agency on 12/23/14. Her record, including her POC for the certification period of 2/21/14 to 4/24/14, was reviewed. During this certification period she received SN, PT and HHA services for wound care, foley catheter care, pain management and weakness. Additional diagnoses included hypertension and depression.</p> <p>Patient #9's record included an HHA Care Plan, dated 2/20/14, completed by the RN. Components of the Care Plan were incorporated in to Patient #9's POC. The Care Plan included perineal and catheter care.</p> <p>Patient #9 received HHA visits on 2/21/14, 2/25/14 and 2/28/14, however, perineal and catheter care was not documented, nor was documentation present stating why the tasks were not performed.</p>	G 225			

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G 225	Continued From page 37 During an interview on 3/05/14 at 3:40 PM, the Administrator reviewed the record and confirmed the HHA did not complete the duties as assigned. The HHA did not provide services as ordered in the POC.	G 225			

CONDITION: G-122 Organization, Coordination of Services, and Administration

A new condition level deficiency has been identified in response to repeated infractions due to the Governing Body's allowance of unqualified personnel to remain in positions of leadership and/or influence. This has created an environment where our problems had become habitual and more resilient to change despite training and in-services. It was necessary to change our clinical leadership to create the culture that was capable of providing the outcomes we desire. Two weeks prior to the last survey we were able to begin this process with a new clinical director.

Since that time we have been requiring more communication and repetitive training with our personnel. We have indeed discovered how difficult it is for the staff to break old habits, and regardless of correct training, how easily the old familiar patterns creep back in.

The following is our plan of correction to the deficiencies cited against the governing Body.

G-128 Failure by the Governing Body (GB) to ensure effective operation

The findings in this last survey demonstrated deficiencies in 3 key areas:

- A. Repeated survey findings due to insufficient GB oversight and/or action pursuant to exposed issues
 - B. The GB did not provide sufficient management, supervision, or evaluation of problems as evidenced by conditions of participation not being promptly addressed and corrected.
 - C. And lastly, the failure of the governing body to ensure medical supervision, appropriate development, and appropriate execution of patient care plans.
1. Corrective action
 - a. As indicated before, a new director of patient care has been hired with the credentials and experience to direct the clinicians to perform in a way that is compliant with federal Medicare standards.
 - b. The governing body has mandated that the new director of patient care will meet with her clinical staff on a weekly basis and discuss findings from current chart audits, patient care needs, and review of correct practices as identified in past surveys.
 - c. The minutes of these weekly care coordination / case conference meetings are provided to the GB and an action plan is made between the Director of patient care (DPC) and GB for the next week.

2. Company Policy

- a. It is the current policy of this company that the governing body will appoint qualified individuals into the management roles to ensure quality day-to-day operations are standard.
- b. It is also the policy of this company to have uniform procedures in place to notify the governing board of quality in the day-to-day operations of the company.
- c. Our governing board policy indicates that the updates should happen routinely and the governing board should be involved in day-to-day operations as needed to ensure quality throughout the company.
Policy No. C:1-002.1 (attached)

3. Company Procedure

- a. On a weekly basis, the DPC will hold a care coordination/case conference with home health clinical staff. This meeting will cover pertinent findings in our current chart audits, reinforce correct policy and procedure as pointed out by previous survey findings, and address current patient issues. The purpose of these meetings is to maintain up-to-date training and gain the exposure necessary to fix habitual problems.
- b. The minutes from this meeting will be provided to the governing body as an indication of the progress and efforts by the DPC to correct deficiencies within the home health agency.
- c. The DPC and the governing body will review these minutes on a weekly basis and determine together a plan of action for the subsequent week.

4. Responsible parties and Compliance Dates

- a. The executive director and the DPC will ensure that this procedure is followed-through. These meetings have already begun but the format indicated in this plan of correction will be fully functional by Friday, April 11 as requested by the Bureau of Facility Standards.

G-128 Failure by the Governing Body (GB) to ensure effective operation

1. **Previously Submitted Corrective Action**
 - a. As indicated before, a new director of patient care has been hired with the credentials and experience to direct the clinicians to perform in a way that is compliant with federal Medicare standards.
 - b. The governing body has mandated that the new director of patient care will meet with her clinical staff on a weekly basis and discuss findings from current chart audits, patient care needs, and review of correct practices as identified in past surveys.
 - c. The minutes of these weekly care coordination / case conference meetings are provided to the GB and an action plan is made between the Director of patient care (DPC) and GB for the next week.

2. **Additional Action Plans**
 - a. The governing board will meet at minimum once a week for at least 3 of the 4 weeks every month and review the findings of the weekly care coordination meetings. These meeting minutes will go into our QA binder and continue as mentioned above until the action items identified in this plan of correction are resolved per the metrics listed herein.
 - b. The governing board will ensure that all disciplines within the organization receive updated job descriptions that will clearly outline their duties and the GB's expectation for performance. All employees will receive and sign (indicating understanding) their respective job descriptions by April 18th, 2014.

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FACILITY STANDARDS

G-143 Coordination of Patient Services

The latest state survey indicates that this standard was not met as evidenced by the governing body failing to ensure appropriate or sufficient care coordination between disciplines. The findings that supported this conclusion include:

- A. Lack of documentation demonstrating communication between disciplines
- B. Failure by licensed professionals to address time sensitive orders.

1. Corrective Action

- a. The weekly meeting mentioned above will also address the coordination of patient services. This may sound redundant as a corrective action to all of these areas pertaining to the governing body; however, it is the most simple and direct method by which the governing body can maintain constant control of day-to-day operations.

2. Company Policy

- a. It is the current policy of this company that a case manager be appointed who is directly accountable to the DCP and coordinates all services for her/his respective patients.
- b. The case manager is responsible for the coordination between service providers.
- c. The case manager is responsible for reporting any significant changes in the patient's overall care.
- d. The case manager is responsible to monitor communication between disciplines and report to the clinical supervisor any issues that may arise with the plan of care. Policy No. HH:2-019.1 (attached)

3. Company Procedure

- a. The weekly case conference/care coordination meeting will require the case managers to be prepared to report any issues with their patients. These issues will include any noteworthy finding from any of the disciplines involved in the plan of care. The case managers are required to report if any of their patients have had findings outside company or doctor ordered care parameters pertaining to any discipline involved in the plan of care.
- b. Any findings reported by the case manager will be addressed by the DCP and reported to the governing board along with how it was resolved. If the DCP and governing board feel it was resolved appropriately, no further action will be required. However, an action plan will be established for any problem reported that is starting a trend or not resolved sufficiently to the governing boards expectations.

4. Responsible parties and Compliance Dates

- a. The executive director and the DCP will ensure that this procedure is followed-through. Though these meetings have already begun, the format indicated in this portion of the plan of correction has been in effect as of April 10th, 2014. We believe that this process will have to be refined as we find areas we can improve on as a company, however, it will be functional by Friday, April 11 as requested by the Bureau of Facility Standards.

G-143 Coordination of Patient Services

1. **Previously Submitted Corrective Action**
 - a. The weekly meeting mentioned above will also address the coordination of patient services. This may sound redundant as a corrective action to all of these areas pertaining to the governing body; however, it is the most simple and direct method by which the governing body can maintain constant control of day-to-day operations.

2. **Additional Action Plans**
 - a. At least 80% of New admissions or re-certifying patient charts will be audited within 1 week of the start date to ensure that all Plan of Care documents are complete and contain all the information outlined on the "SOC/Re-Cert Audit" forms (Attached). This will stay in our QA program until all charts audited achieve at least 90% compliance with our SOC/Re-Cert audit checklist for 3 consecutive months.
 - b. At least 50 percent of our active caseload will have a global audit performed before the respective patients are discharged. This will ensure that we are not dropping the ball after admit and the patients are continuing to be taken care of as per the plan of care. This will also stay in our QA program until all charts audited achieve at least 90% compliance with our "Global Chart Audit" checklist (Attached) for 3 consecutive months.

G-145 Failure by the governing body to ensure that the doctor received a 60-day services summary

Findings from the recent state survey indicate that the governing body failed to ensure that a physician was properly notified and given a 60-day summary of services as part of a recertification process. This negatively impacted the ability for the primary care physician to properly supervise and order a recertification for their patient to continue services.

1. Corrective Action

- a. A 60-day summary template has been created for the case managers to ensure that all pertinent information required to justify a recertification is presented in a clean format for the physicians.
- b. Patients within the recertification window are discussed at the weekly care coordination meeting and a recommendation for recertification is determined. If it is the consensus that the patient may benefit from a recertification and further treatment, the case manager will complete a 60-day summary.
- c. A procedure has been developed to provide the physician with a 60-day summary form.

2. Company Policy

- a. It is the current policy of this company that a 60 day summary will be completed for each patient at the end of the episode when the patient will be recertified. The summary will be forwarded to all physicians involved in the patient's care. Policy No. HH;2-016.1 (Attached)

3. Company Procedure

- a. Patients within the recertification window are discussed at the weekly care coordination meeting and a recommendation for recertification is determined. If it is the consensus that the patient may benefit from a recertification and further treatment, the case manager will complete a 60-day summary.
- b. The 60-day summary will be included in the request for continued care to the patient's primary care physician.
- c. The DCP will report to the governing body how many patients are coming up on recertification and that all recertifying patients have 60-day summaries sent to their respective physician.
- d. The fax confirmation page for each 60-day summary sent to a physician will be retained as part of the clinical chart.

4. Responsible Parties and Compliance Dates

- a. The executive director and the DCP will ensure that this procedure is followed-through. This process will be functional by Friday, April 11 as requested by the Bureau of Facility Standards.

G-145 Failure by the governing body to ensure that the doctor received a 60-day services summary

1. Previously Submitted Corrective Action

- a. A 60-day summary template has been created for the case managers to ensure that all pertinent information required to justify a recertification is presented in a clean format for the physicians.
- b. Patients within the recertification window are discussed at the weekly care coordination meeting and a recommendation for recertification is determined. If it is the consensus that the patient may benefit from a recertification and further treatment, the case manager will complete a 60-day summary.
- c. A procedure has been developed to provide the physician with a 60-day summary form.

2. Additional Action Plans

- a. 100% of re-certifying patient charts will be audited to ensure that all charts will contain a comprehensive 60-Day Summary in the patient record as well as proof that it was sent to the physician before the end of the 60-day certification. This will stay in our QA program until 100% of our patient records are compliant with this standard for 3 consecutive months.

G-156 Failure by the Governing Board to ensure that the Plan of Care was developed, followed, and/or updated appropriately.

This area refers to the condition level deficiency that has been our repetitive issue in the previous surveys. The role of the governing board in the development, execution, and maintenance of each patient's plan of care should be one of oversight and guidance. The GB's consistent presence will create an environment of accountability, and in time, mutual trust. The weekly reports from the DCP will provide that contact and communication.

1. Corrective Action

- a. Avalon Home Health has instated weekly accountability meetings between the DCP and the Governing Body. These meetings help create an environment of accountability and mutual trust. They are designed to give the Governing body the confidence that the management team is on track and the opportunity to assist in any capacity they can to reinforce the desired outcomes.
- b. An agenda with specific reporting Items has been developed to guide these meetings and ensure that all the pertinent information is being tracked and discussed. This agenda is populated in large part with the information from the clinical team taught and received in the weekly care coordination meeting.

2. Company Policy

- a. It is the current policy of this company that the Governing Body receives updates routinely and should be involved in day-to-day operations as needed to ensure quality throughout the company.
- b. It is also the policy of this company to have procedures in place to notify the governing board of quality in the day-to-day operations of the company. Policy No. C:1-002.1 (attached after G-128).

3. Company Procedure

- a. After the care coordination meeting each week the DCP will compile the information she needs to report on the agenda items outlined on the GB Meeting Form. We have decided to hold the clinical coordination meetings on Wednesday and the GB Meetings on Thursday. This allows us the remainder of the business week to take action with other entities relying on normal business hours if need be.
- b. The information compiled by the DCP is shared with the Governing Body and mutually discussed to ensure that it meets the standards of practice outlined by Medicare.
- c. A plan of action is cooperatively created from the findings and executed by the DCP to be followed up on in the subsequent meeting.

4. Responsible Parties and Compliance Dates

- a. The executive director and the DCP will ensure that this procedure is followed-through. This process will be functional by Friday, April 11 as requested by the Bureau of Facility Standards.

G-156 Failure by the Governing Board to ensure that the Plan of Care was developed, followed, and/or updated appropriately.

1. Previously Submitted Corrective Action

- a. Avalon Home Health has instated weekly accountability meetings between the DCP and the Governing Body. These meetings help create an environment of accountability and mutual trust. They are designed to give the Governing body the confidence that the management team is on track and the opportunity to assist in any capacity they can to reinforce the desired outcomes.
- b. An agenda with specific reporting Items has been developed to guide these meetings and ensure that all the pertinent information is being tracked and discussed. This agenda is populated in large part with the information from the clinical team taught and received in the weekly care coordination meeting.

2. Additional Action Plans

- a. At least 80% of New admissions or re-certifying patient charts will be audited within 1 week of the start date to ensure that all Plan of Care documents are complete and contain all the information outlined on the "SOC/Re-Cert Audit" forms (Attached). This will stay in our QA program until all charts audited achieve at least 90% compliance with our SOC/Re-Cert audit checklist for 3 consecutive months.
- b. At least 50 percent of our active caseload will have a global audit performed before the respective patients are discharged. This will ensure that we are not dropping the ball after admit and the patients are continuing to be taken care of as per the plan of care. This will also stay in our QA program until all charts audited achieve at least 90% compliance with our "Global Chart Audit" checklist (Attached) for 3 consecutive months.

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 is provided in accordance to the Plan of Care

Several issues were discovered in this area during the last survey. It was evident that the clinician responsible for these patients did not prioritize involving the physician in the plans of care. Infractions included:

- A. Orders given but not follow through on
- B. A failure to procure orders for ongoing care after the initial referral was obtained
- C. Orders for specific interventions that were not part of the initial plan of care were not clarified or requested and follow-up orders
- D. Positions were not notified of missed visits
- E. Orders to accept direction from doctors (other than the supervising doctor who signed the plan of care) were not procured
- F. And the case manager did not verify that the doctors giving orders or licensed in the state of Idaho.

The following plan of correction is proposed to address these issues.

1. Company Action

- a. The employee in question, that the governing body mistakenly allowed to be in authoritative positions, has been relieved of her duties as a case manager as well as previously being relieved as a director of nursing.
- b. A weekly care coordination meeting is now mandatory for case managers and therapists to review orders, services, recertification's, missed visits, vital parameters, and initial care ordination for new admissions.
- c. Multiple levels of clinical and clerical staff are auditing charts to ensure the presence and content of appropriate documentation.
- d. Multiple audit tools been created to guide both clinical and clerical staff through the auditing process to ensure bottle documentation exists.

2. Company Policy

- a. 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)

- b. 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

- a. A care coordination meeting/case conference is held weekly to ensure case managers are meeting Medicare requirements on each patient. Each case manager is responsible to come to the meeting prepared with their care coordination forms complete to facilitate an efficient and productive meeting.
- b. Education is provided on an ongoing basis and repeated as necessary in these meetings to ensure compliance to the federal regulation.
- 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. 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.
- d. The written and verbal orders will continue 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.
- e. All charts will be reviewed 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.
 - 1. **Side Note:** In past plans of correction, I have listed 100% chart audits with every note being read, addressed, and Co-signed by the DPC and or the Executive director. Since then we have strived to do exactly that and have found that it is not only too much volume to do with a high level of confidence on every form, but also does not create an environment of accountability around the case manager. The weekly meetings (with their respective forms) are designed to re-focus the responsibility back on the Case Manager and provide accountability back to the DCP and the governing body. Chart audits will still be an active part of our QA and compliance process, however, I am hoping to create more accountability in this way to our case managers with less work in an actual audit.

4. Responsible Parties and Compliance Dates

- a. The executive director and the DCP will ensure that this procedure is followed-through. This process will be functional by Friday, April 11 as requested by the Bureau of Facility Standards.**

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 is provided in accordance to the Plan of Care

2. Previously Submitted Corrective Action

- a. The employee in question, that the governing body mistakenly allowed to be in authoritative positions, has been relieved of her duties as a case manager as well as previously being relieved as a director of nursing.
- b. A weekly care coordination meeting is now mandatory for case managers and therapists to review orders, services, recertification's, missed visits, vital parameters, and initial care ordination for new admissions.
- c. Multiple levels of clinical and clerical staff are auditing charts to ensure the presence and content of appropriate documentation.
- d. Multiple audit tools been created to guide both clinical and clerical staff through the auditing process to ensure bottle documentation exists.

3. Additional Action Plans

- a. At least 80% of New admissions or re-certifying patient charts will be audited within 1 week of the start date to ensure that all Plan of Care documents are complete and contain all the information outlined on the "SOC/Re-Cert Audit" forms (Attached). This will stay in our QA program until all charts audited achieve at least 90% compliance with our SOC/Re-Cert audit checklist for 3 consecutive months.
- b. At least 50 percent of our active caseload will have a global audit performed before the respective patients are discharged. This will ensure that we are not dropping the ball after admit and the patients are continuing to be taken care of as per the plan of care. This will also stay in our QA program until all charts audited achieve at least 90% compliance with our "Global Chart Audit" checklist (Attached) for 3 consecutive months.

G-159 Failure to ensure all pertinent info is on the POC

Most recent state survey indicated that this standard was not met as evidenced by key information being omitted from the plan of care. The findings included services being left off, equipment/DME, Medication/Oxygen, and nutritional requirements. The following is a plan of action to ensure these key elements are not omitted from future plans of care.

1. Company Action

- a. A weekly care coordination meeting is now mandatory for case managers and therapists to review orders, services, recertification's, missed visits, vital parameters, and initial care ordination for new admissions once a week.
- b. Multiple audit tools been created to guide both clinical and clerical staff through the auditing process to ensure correct documentation exists. One of these Audit checklists is an inclusive step by step guide through the opening process, including coordination of services.
- c. Multiple levels of clinical and clerical staff are auditing charts to ensure the presence and content of appropriate documentation.
- d. Re-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, medication profiles, and ensuring diagnosis are addressed with specific interventions.

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) (Attached)
- 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) (Previously Attached)
- c. It is the policy of this company that the care plan be created around the specific needs of the patient and that the review of such is continual and ongoing. Policy No. HH:2-004.1 (Attached)

3. Company Procedure

- a. The weekly case conference/care coordination meeting will require the case managers to be prepared to report any issues with their patients. Part of this meeting will ensure that case managers come prepared to talk about new clients and all the services those new clients are going to need to be successful.
- b. Case managers will be required to use the admit audit checklist (attached) to ensure that all bases were covered during the admission process.
- c. All admissions will be reviewed by the DPC and corrections made in real time to ensure the patient is not going without key services until we prove competence to the state and CMS. At such time the POC development process will remain part of the QA program.

4. Responsible Parties and Compliance Dates

- a. The executive director and the DCP will ensure that this procedure is followed-through. This process will be functional by Friday, April 11 as requested by the Bureau of Facility Standards.

G-159 Failure to ensure all pertinent info is on the POC

1. Previously Submitted Corrective Action

- a. A weekly care coordination meeting is now mandatory for case managers and therapists to review orders, services, recertification's, missed visits, vital parameters, and initial care ordination for new admissions once a week.
- b. Multiple audit tools been created to guide both clinical and clerical staff through the auditing process to ensure correct documentation exists. One of these Audit checklists is an inclusive step by step guide through the opening process, including coordination of services.
- c. Multiple levels of clinical and clerical staff are auditing charts to ensure the presence and content of appropriate documentation.
- d. Re-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, medication profiles, and ensuring diagnosis are addressed with specific interventions.

2. Additional Action Plans

- a. At least 80% of New admissions or re-certifying patient charts will be audited within 1 week of the start date to ensure that all Plan of Care documents are complete and contain all the information outlined on the "SOC/Re-Cert Audit" forms (Attached). This will stay in our QA program until all charts audited achieve at least 90% compliance with our SOC/Re-Cert audit checklist for 3 consecutive months.
 - i. I understand that I am using the same metric for multiple deficiencies; however, I want to be able to address multiple items with one action item to ensure that the plan is realistic within our timeframe and budget. I believe that by following our SOC/Re-Cert checklist, we will catch all pertinent info that should be on the plan of Care. The reason that this action item contains the time restriction of "1 week of the start of care" is to ensure that we can still catch errors early on and modify the POC with additional orders from the doctor if necessary.
- b. At least 50 percent of our active caseload will have a global audit performed before the respective patients are discharged. This will ensure that we are not dropping the ball after admit and the patients are continuing to be taken care of as per the plan of care. This will also stay in our QA program until all charts audited achieve at least 90% compliance with our "Global Chart Audit" checklist (Attached) for 3 consecutive months.
 - i. I don't have guilt copying this one on either since catching ongoing issues is also part of this G-tag. This metric will help cue us if we stray off point.

G-164 Periodic Review of the Plan of Care

The latest survey findings indicate that we are deficient in this area due to incorrect wound care and wound care without orders, and delayed physician alerts to changes in condition. The following is a plan of action to ensure these mistakes are not made in future plans of care.

1. Company Actions

- a. The employee in question, that the governing body mistakenly allowed to be in authoritative positions, has been relieved of her duties as a case manager as well as previously being relieved as a director of nursing.
- b. An environment of accountability has been created through these weekly case manager meetings in which the case manager must report on any and all changes or significant events in any of their patients care plans.

2. Company Policy

- a. It is the policy of this company that the case manager continuously reviews the patient's needs throughout the certification to ensure that the plan of care is adequate for the patients needs. Policy No. HH:2-015.1 (attached)

3. Company Procedure

- a. A care coordination meeting/case conference is held weekly to ensure case managers are meeting Medicare requirements on each patient. Each case manager is responsible to come to the meeting prepared with there care coordination forms complete to facilitate an efficient and productive meeting.
- b. Education is provided on an ongoing basis and repeated as necessary in these meetings to ensure compliance to the federal regulation.
- 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. 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.

4. Responsible Parties and Compliance Dates

- a. The executive director and the DCP will ensure that this procedure is followed-through. This process will be functional by Friday, April 11 as requested by the Bureau of Facility Standards.

G-164 Periodic Review of the Plan of Care

1. Previously Submitted Corrective Action

- a. The employee in question, that the governing body mistakenly allowed to be in authoritative positions, has been relieved of her duties as a case manager as well as previously being relieved as a director of nursing.
- b. An environment of accountability has been created through these weekly case manager meetings in which the case manager must report on any and all changes or significant events in any of their patients care plans.

2. Additional Action Plans

- a. At least 50 percent of our active caseload will have a global audit performed before the respective patients are discharged. This will ensure that we are not dropping the ball after admit and the patients are continuing to be taken care of as per the plan of care. This will also stay in our QA program until all charts audited achieve at least 90% compliance with our "Global Chart Audit" checklist (Attached) for 3 consecutive months.
- b. 100% of discharged patient medical records will be reviewed by the RN Case Manager using the "discharge Audit Checklist" (Attached) in preparation to closeout the chart and bill for services provided. This will be an ongoing practice to ensure that all necessary items are in their place prior to billing and thus have no end date.

G-166 Conformance with physician orders

In the latest state survey findings indicated that we are deficient in this area because of verbal orders that failed to be put in writing and signed in a timely manner.

1. Company actions

- a. Orders will be reviewed in real time by the office manager and tracked to ensure verbal orders are sent to the physician and returned with the appropriate signatures
- b. A weekly care coordination meeting is now mandatory for case managers and therapists to review orders, services, recertification's, missed visits, vital parameters, and initial care ordination for new admissions once a week.
- c. Multiple audit tools have been created to guide both clinical and clerical staff through the auditing process to ensure correct documentation exists.

2. Company Policy

- a. 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) (previously attached)

3. Company Procedure

- a. An internal process within our office has been created to track verbal and written orders. The procedure is as follows:
 - i. The respective discipline will write the order in compliance with company policies and send the order to the office manager
 - ii. The office manager will then review the order.
 1. If there are errors, the order will be sent back to the disciplined for corrections
 2. If there are no errors, the order will be pushed to the clinical director for review
 3. If the order contains frequencies, the office manager will put the frequencies into the EMR
 - iii. When the clinical director as reviewed and cosigned the order, he/she will send back to the office manager
 - iv. The office manager will then print out the order so it is ready to be faxed
 - v. The order will be given a tracking number and logged into the order tracking log book.

- vi. The order will then be faxed to the doctor and a fax confirmation sheet will be attached to the electronic medical record
- vii. If the order is not received back into the office signed by the doctor within one week, the physicians office will be called for follow-up
- viii. When the orders received back into the office with a signature from the physician, it will be sent to the clinical director for noting
- ix. Once noted by the clinical director the order will be uploaded into the electronic medical record

4. Responsible Parties and Compliance Dates

- a. The executive director and the DCP will ensure that this procedure is followed-through. This process will be functional by Friday, April 11 as requested by the Bureau of Facility Standards.

G-166 Conformance with physician orders

1. **Previously Submitted Corrective Action**
 - a. Orders will be reviewed in real time by the office manager and tracked to ensure verbal orders are sent to the physician and returned with the appropriate signatures
 - b. A weekly care coordination meeting is now mandatory for case managers and therapists to review orders, services, recertifications, missed visits, vital parameters, and initial care ordination for new admissions once a week.
 - c. Multiple audit tools have been created to guide both clinical and clerical staff through the auditing process to ensure correct documentation exists.

2. **Additional Action Plans**
 - c. At least 80% of New admissions or re-certifying patient charts will be audited within 1 week of the start date to ensure that all Plan of Care documents are complete and contain all the information outlined on the "SOC/Re-Cert Audit" forms (Attached). This will stay in our QA program until all charts audited achieve at least 90% compliance with our SOC/Re-Cert audit checklist for 3 consecutive months.
 - d. At least 50 percent of our active caseload will have a global audit performed before the respective patients are discharged. This will ensure that we are not dropping the ball after admit and the patients are continuing to be taken care of as per the plan of care. This will also stay in our QA program until all charts audited achieve at least 90% compliance with our "Global Chart Audit" checklist (Attached) for 3 consecutive months.

G-225 CNA Care Plan Compliance

State survey found that two out of four patients surveyed with HHA care plans did not complete their plans of care as outlined by the RN. The following is a plan of action to ensure that we do not repeat the same mistakes.

1. Company Action
 - 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. Re-education has been provided to our nurses as well as our home health aides regarding appropriate HHA care plans as well as appropriate documentation of visits following through on HHA a care plan.
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. Policy No. HH:2-009.1 (Attached)
3. Company Procedure
 - a. The patient's case manager, upon initialization of aide services, will develop the home health aide care plan consistent with the comprehensive plan of care and physician orders.
 - b. The home health aide care plan will be individualized to the specific needs of the patient.
 - c. The case manager will review the home health aide care plan with the aid assigned to the patient.
 - d. The home health aide care plan will be revised at least every 60 days based upon a professional assessment of the patient and at any time the patient's condition may change or weren't revision.
 - e. If any changes are made, those changes are reviewed with the assigned home health aide before the changes are officially put into effect.
4. Responsible Parties and Compliance Dates
 - a. The executive director and the DCP will ensure that this procedure is followed-through. This process will be functional by Friday, April 11 as requested by the Bureau of Facility Standards.

G-225 CNA Care Plan Compliance

1. Previously Submitted Corrective Action

- 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. Re-education has been provided to our nurses as well as our home health aides regarding appropriate HHA care plans as well as appropriate documentation of visits following through on HHA a care plan.

2. Additional Action Plans

- a. A documented occurrence of the RN reviewing the HHA care plan with the Aide will be present in 100% of charts whose patients receive services from the HHA. This will remain in our QA program until this is achieved for 3 consecutive months.
- b. HHA daily notes will be audited as part of our 50% "Global Chart Audit" action item mentioned earlier. 90% of charts audited must show that the HHA is documenting/executing exactly what the RN had outlined in the HHA care plan. This 100% compliance from charts audited must last for 3 consecutive months before it is removed from our QA program.
- c. Patient Medical record must include documentation of HHA supervisory visits by the appropriate licensed medical professionals as part of the 50% "Global Chart Audit" action item mentioned earlier. 90% of charts audited must show that the HHA is supervised at least every 2 weeks. This 100% compliance from charts audited must last for 3 consecutive months before it is removed from our QA program.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001610	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/06/2014
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NAME OF PROVIDER OR SUPPLIER
AVALON HOME HEALTH

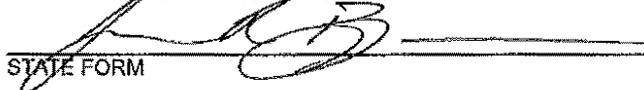
STREET ADDRESS, CITY, STATE, ZIP CODE
**403 1ST ST
IDAHO FALLS, ID 83401**

(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 A state licensing follow up survey was completed at your agency 3/04/14-3/06/14. Surveyors completing the survey were: Susan Costa, RN, HFS, Team Leader Nancy Bax, RN, HFS	N 000		
N 001	03.07020.01. ADMIN.GOV.BODY 020. ADMINISTRATION - GOVERNING BODY. N001 01. Scope. The home health agency shall be organized under a governing body, which shall assume full legal responsibility for the conduct of the agency. This Rule is not met as evidenced by: Refer to G128.	N 001	<i>Please refer to G-128 in the proposed Plan of Correction for this area.</i>	
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 G159.	N 156	<i>Please refer to the proposed plan of Correction for G-159 to address this deficiency.</i> RECEIVED APR 15 2014 FACILITY STANDARDS	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Executive Director

4/10/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001610	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/06/2014
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NAME OF PROVIDER OR SUPPLIER AVALON HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 403 1ST ST IDAHO FALLS, ID 83401
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(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 170	Continued From page 1	N 170		
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 G158.	N 170	<i>Please refer to the proposed plan of correction for G-158 to address our deficiencies in this area.</i>	
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 G164.	N 172	<i>Please refer to our proposed plan of correction for G-164 to address our deficiencies in this area. Thank you.</i>	