IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

March 28, 2014

Tami Slatter, Administrator
Visions Home Health
1770 Park View Drive
Twin Falls, ID 83301-3252

RE: Visions Home Health, Provider #137107

Dear Ms. Slatter:

This is to advise you of the findings of the Medicare/Licensure survey at Visions Home Health, which was concluded on March 14, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar 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 Form CMS-2567 and State Form 2567.

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,

Sylvia Creswell for

DON SYLVESTER
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

DS/pmt
Enclosures

VISIONS
HOME HEALTH, LLC
1770 Park View Drive
Twin Falls, ID 83301-3252

April 1, 2014

Ms. Sylvia Creswell
Co-Supervisor, Non-Long Term Care
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720-0036

Dear Ms. Creswell:

Your survey team completed a Medicare Licensure and Certification survey at Visions Home Health, LLC, provider number 137107 in Twin Falls, Idaho on March 10th thru March 14th, 2014. In response to your findings, we have developed a plan of correction. Enclosed is our plan. If you have any questions regarding the plan, you may contact me by phone (208)732-5365.

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

Sincerely,

Tamala Slatter RN BSN

Tamala Slatter, RN BSN
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	03/14/2014

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

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G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your home health agency from 3/10/14 through 3/14/14. The surveyors conducting the recertification were: Don Sylvester, BSN, RN, HFS, Team Leader Gary Guiles, RN, HFS Sylvia Creswell, LSW, Non-Long Term Care Supervisor Acronyms include: CT scan - Computed Tomography, a radiology scan DM II - Diabetes Mellitus type II DVT - Deep Vein Thrombosis LPN - License Practical Nurse mm hg - millimeters of mercury MSW - Masters Social Work POC - Plan of Care PT - Physical Therapy ROC - Resumption of Care RN - Registered Nurse SOC - Start of Care SW - Social Worker UTI - Urinary Tract Infection wound vac - wound vacuum assisted closure	G 000		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.	G 144		

RECEIVED
APR - 8 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamala Hatton	Administrator	4/07/14

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 144	Continued From page 1 This STANDARD is not met as evidenced by: Based on staff interview, review of agency policies, and review of medical records, it was determined the agency failed to ensure care coordination was documented for 2 of 13 patients (#1 and #8), whose records were reviewed. This had the potential to result in unmet patient needs. Findings include: The agency policy 3002 titled "COORDINATION OF SERVICES," dated 6/07/13, stated, "The content and results of any coordination activity is documented in the clinical record. This documentation includes, but is not limited to, the following: Telephone communication between individual staff members seeing the same patient. Use of voice mail and/or text messaging between disciplines, staff and/or supervisors". This policy was not followed, examples include: 1. Patient #8 was an 88 year old male, admitted to the agency on 2/21/14, with diagnoses pressure ulcers stage IV, fatigue, fitting urinary device, history of UTI, DVT and spinal stenosis. His medical record and POC for the certification period 2/21/14 through 4/21/14, were reviewed. The LPN visit note, dated 2/26/14, documented in Patient #8's medical record, "Urine full of sediment, but patent. RN notified of visit." Documentation of care coordination between the LPN and RN Case Manager regarding the sediment in Patient #8's urine was not present in Patient #8's medical record. The LPN who wrote the visit note was interviewed	G 144	* * Patient Care Coordinator(PCC) in-serviced staff on importance of documenting all communication between staff, Physicians, contract therapist, and office personnel. This will be documented using the communicator in the Brightree system and/or using the Brightree texting app. This documentation can and should be tied to the patients medical record. This process will be evaluated by the PCC using monthly chart audits. This deficiency will be corrected by 4/2/2014. RECEIVED APR - 8 2014 FACILITY STANDARDS	

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G 144	Continued From page 2 on 3/13/14 beginning at 11:10 AM. She stated she calls the RN Case Manager after each patient visit, but this was not documented. When asked if instructions given to her by the RN Case Manager would be documented, she said no, not unless it was an order (new/revised physician order). The RN Case Manager was interviewed on 3/13/14 beginning at 2:10 PM. She confirmed the LPN who wrote the visit note, had spoken with her about his status, but she did not documented this. Coordination of care was not documented for Patient #8. 2. Patient #1's medical record documented a 77 year old female who was admitted for home health services on 2/19/14 following back surgery. She was currently a patient as of 3/14/14. Patient #1 received nursing and PT services. A PT visit note, dated 3/06/14 at 12:00 noon, stated Patient #1 refused her PT visit. A PT visit note, dated 3/11/14 at 12:00 PM, stated Patient #1 missed her PT visit due to a scheduling conflict. A PT visit note, dated 3/13/14 at 12:00 PM, stated Patient #1's PT was on hold while awaiting the results of a CT scan. Documentation of care coordination between PT and the RN Case Manager regarding the status of Patient #1 was not present in Patient #1's medical record. Patient #1's Physical Therapist, was interviewed on 3/14/14 beginning at 9:10 AM. He confirmed the missed visits. He stated he had spoken with Patient #1's RN about her status but said he had	G 144		

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G 144	Continued From page 3 not documented this. Coordination of care was not documented for Patient #1.	G 144	* * * * *	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records, it was determined the agency failed to ensure care followed a POC established by a physician for 4 of 13 patients (#1, #2, #6, and #13) whose records were reviewed. This resulted in unauthorized visits and had the potential to result in negative patient outcomes. Findings include: 1. Patient #2's medical record documented a 74 year old male who was admitted for home health services on 2/24/14 with diagnoses of heart failure and type II diabetes. He was currently a patient as of 3/14/14. A home health referral order, titled "PHYSICIAN'S ORDERS" and dated 2/23/14 at 1:00 PM, stated Patient #2 was to receive nursing services, PT services, and OT services. While nursing and PT services were documented in Patient #2's medical record, OT services was not documented. The Patient Care Coordinator was interviewed on 3/11/14 beginning at 3:50 PM. She reviewed	G 158	* * * All patients will receive care according to established written POC reviewed by the Physician. PCC in-serviced staff that the POC MUST be discussed with the physician or the physicians representative. Staff will document who the POC was discussed with. PCC will review all POC's and physician orders to ensure that the physician or physicians representatives name is listed as a verbal order. All Face to Face forms will have a date received stamped on them. PCC upon receipt of Face to Face will review what disciplines were checked by the physician. PCC will then make the referral or notify physician as to why the referral wasn't done. This process will be evaluated by monthly chart audits until 100% compliance. Deficiency will be corrected by 4/2/2014.	

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G 158	Continued From page 4 Patient #2's medical record. She confirmed OT services had not been provided to Patient #2. She stated no documentation was included in the record to explain why OT services were not provided. Care was not provided in accordance with Patient #2's POC. 2. Patient #13's medical record documented a 68 year old female who was admitted for home health services on 3/16/13 for the treatment of a pressure ulcer and other wounds. She was currently a patient as of 3/12/14. Her "HOME HEALTH CARE CERTIFICATION AND PLAN OF CARE" for the certification period 11/11/13 to 1/09/14 called for nursing visits 5 times a week for 1 week. The POC was signed by the physician on 11/18/13. No orders were present for visits made prior to 11/18/13. Nursing visits were documented to Patient #13 on 11/11/13, 11/13/13, 11/14/13, and 11/15/13. Physician authorization for these visits was not documented. The Patient Care Coordinator was interviewed on 3/13/14 beginning at 11:40 AM. She reviewed Patient #2's medical record. She stated physician orders authorizing the above nursing visits were not present in the medical record. Care was not provided in accordance with a POC established by the physician. 3. Patient #1's medical record documented a 77 year old female who was admitted for home health services on 2/19/14 following back	G 158		

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G 158	Continued From page 5 surgery. She was currently a patient as of 3/14/14. Patient #1's "HOME HEALTH CARE CERTIFICATION AND PLAN OF CARE" for the certification period 2/19/14 to 4/19/14 stated the aide would provide services 1 time a week for 4 weeks. The POC was signed by the physician on 2/28/14. No aide visits were provided to Patient #1. "Cancelled/Missed Visit Reports," dated 2/24/14 and 2/27/14, documented Patient #1 refused aide visits on those dates. No other aide visits were documented. The Patient Care Coordinator was interviewed on 3/13/14 beginning at 11:40 AM. She reviewed Patient #2's medical record. She stated Patient #1 refused aide visits so they were discontinued. She stated this was not documented. She stated the physician was not notified of Patient #1's refusal of aide services. Care was not provided in accordance with the POC established by the physician. 4. Patient #6's medical record documented a 47 year old female whose SOC was 10/29/13. Her POC for the certification period beginning 2/26/14 through 4/26/14, stated her diagnoses included abdominal wall hernia repair, after surgical dressing, and depend-supplement oxygen. A physician's order dated 11/22/13, for wound care, stated, "Don't change negative pressure from 125". Patient #6's POC for the certification 2/26/14	G 158		

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G 158	Continued From page 6 through 4/26/14, stated, "vac suction at 100 hhmg". On 3/13/14, the RN Case Manager confirmed the POC had not been updated. She stated the incorrect settings on the POC must have been missed typed. She confirmed Patient #6's POC wound vacuum setting should have been updated to 125 mm hg. The agency failed to change the wound vacuum settings on Patient #6's POC .	G 158	* * * * * * * * * * * * * * *	
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on staff, patient, and caregiver interviews and medical record review, it was determined the agency failed to ensure types of services and equipment required were included on POCs for 2 of 13 patients (#4, #7) whose records were reviewed. This had the potential to result in unmet patient needs. Findings include: 1. Patient #7's medical record documented a 74 year old male who was admitted for home health services on 10/21/09 with diagnoses of	G 159	* PCC will review all POC's to ensure that patient's have documentation to support medications(ie; Diabetes d(x) when patient is on diabetes medication). Staff will be educated on ensuring that patient's have all supplies, equipment, and monitors for the patients to remain safe and independent at home. Deficiency will be corrected 4/2/2014.	

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G 159	Continued From page 7 pulmonary hypertension and blindness. He was currently a patient as of 3/14/14. Patient #7's "HOME HEALTH CARE RECERTIFICATION AND PLAN OF CARE," for the certification period 1/28/14 to 3/28/14, stated he took Metformin 500 mg twice a day. Metformin is a drug a used to lower blood sugar levels and treat type 2 diabetes. The POC did not include directions to staff regarding monitoring Patient #7's blood glucose levels, nor did it indicate if he had a glucometer for the task. During a visit with the RN Case Manager to Patient #7's home on 3/12/14 beginning at 12:30 PM, the patient stated he did not have his own glucometer. He stated his wife checked his blood glucose level at times with her glucometer. His wife, who was present at the visit, stated the last time she checked his blood sugar was 2 weeks ago. The Patient Care Coordinator was interviewed on 3/11/14 beginning at 3:20 PM. She reviewed Patient #7's medical record. She stated Patient #7 did not have his own glucometer but she thought his wife checked his blood sugar daily with her, the wife's, glucometer. Patient #7's POC did not address his need for blood sugar monitoring and for a glucometer of his own, to avoid cross-contamination. 2. Patient #4 was a 66 year old male admitted to the agency on 12/31/13, with diagnoses of stage II pressure ulcer heel and buttock, and multiple sclerosis. His medical record and POC for the certification periods 12/31/13 through 4/29/14, were reviewed.	G 159		

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G 159	Continued From page 8 On 2/11/14, Patient #4's medical record documented an MSW evaluation was conducted. A physician's phone order signed by the MSW on 2/11/14, stated, "SW visits to assist in resource, referral and financial needs. Up to 5 visits face to face and consultation via phone as needed." The order did not include specific frequency and duration of visits. Further visits were completed on 2/12/14, 2/21/14, 3/04/14, and 3/11/14. The MSW was interviewed on 3/13/14 at 2:15 PM. He stated he worked for the hospice agency under the same ownership. He said since the prior MSW left, he helped out in the home health agency when requested to so. He said he had been told there are differences in the hospice and home health POC requirements, but was not familiar with what they were. Patient #4's POC did not include specific frequency and duration of MSW visits.	G 159	* * * PCC instructed MSW on proper way to write frequency and duration orders. PCC will review all MSW orders and documentation to ensure that the documentation meets all regulatory standards. MSW was instructed by PCC on Brightree software. All MSW documentation will now be on the Brightree Point of care system. Deficiency will be corrected 4/2/2014.	
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on staff interviews and medical record review, it was determined the agency failed to ensure the RN re-evaluated the nursing needs of 1 of 13 patients (#11) whose records were reviewed. This had the potential for delayed interventions and treatment if the patient's health	G 172		

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G 172	Continued From page 9 deteriorated. Findings include: Patient #11's medical record documented an 8 year old female who was admitted for home health services on 12/11/06 for the monitoring of a congenital heart defect. She was currently a patient as of 3/13/14. Patient #11's POCs, for the certification periods 1/03/14 to 3/03/14 and 3/04/14 to 5/02/14, both called for a nurse to visit 1 to 2 times a month for 3 months. One nursing visit was documented in January, on 1/31/14. A "Canceled/Missed Visit Report," dated 2/20/14 at 3:30 PM, stated a nursing visit was not made to Patient #11 because she was seeing a physician for chest pain and a respiratory infection. A nursing "PROGRESS NOTE," dated 2/20/14 at 8:00 PM, stated Patient #11 had been diagnosed with pneumonia. Another nursing "PROGRESS NOTE," dated 2/28/14 but not timed, stated Patient #11 had developed a UTI. No nursing visits to Patient #11 were documented in February 2014 or March 2014 in response to her deteriorating condition. Patient #11's RN Case Manager was interviewed on 3/13/14 beginning at 11:30 AM. She stated Patient #11 was medically fragile. She confirmed no nursing visits were made to Patient #11 after 1/31/14 to re-evaluate her nursing needs, including after she was diagnosed with pneumonia and a UTI. An RN did not re-evaluate Patient #11's nursing needs.	G 172	All patient's will receive care according to established POC reviewed by the physician. PCC will educate visit staff on the importance of following physician orders and to increase skilled nursing visits when the patient's condition is not stable. Monthly chart audits will be conducted to ensure that physician orders are being followed. This deficiency will also be monitored by our rehospitalization chart audits. Deficiency will be corrected 4/2/2014.	
G 236	484.48 CLINICAL RECORDS	G 236		

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G 236	Continued From page 10 A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to ensure medical records of 4 of 13 patients (#7, #8, #12, and #13) whose records were reviewed, were complete. This resulted in a lack of information available to other staff providing patient care. Findings include: The policy "STANDARDS/VISIONS HOME HEALTH VISIT STAFF," dated 1/01/13, stated "Staff visit notes will be closed within 24 hours of the visit." The Patient Care Coordinator was interviewed on 3/18/14 beginning at 1:30 PM. She confirmed the policy required staff to complete visit notes within 24 hours. She stated the electronic medical record allowed staff to start a visit note and then leave it open indefinitely without completing the note. She stated staff members had not followed the policy to complete visit notes within 24 hours and said it was an ongoing problem. Examples of staff members not completing visit	G 236	Home Health Director will in-service all staff that documentation must be done in the home and closed by the end of that business day. See policy 3000. PCC will run the Brightree custom report weekly that will itemize each staffs visits and when they were completed. If visits are out of compliance the report will be ran more than once a week. Deficiency will be corrected 4/2/2014.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 11 notes in a timely manner include: 1. Patient #8 was an 88 year old male, admitted to the agency on 2/21/14, with diagnoses pressure ulcer stage IV, fatigue, fitting urinary device, history of UTI, DVT, and spinal stenosis. His medical record and POC for the certification period 2/21/14 through 4/21/14, were reviewed. The RN did not complete the SN visit note, dated 2/24/14, until 3/12/14, 16 days after visit. The RN did not complete the SN visit note, dated 3/05/14, until 3/12/14, 7 days after visit. The RN who wrote the visit notes was interviewed on 3/13/14 beginning at 2:10 PM. She stated, visit notes were to be completed and dated within 24 hours of the visit. She also stated she sometimes did not get her visit notes completed on time. She confirmed Patient #8's visit notes were not completed on time. Patient #8's medical record did not consistently include current nursing visit notes. 2. Patient #12 was a 90 year old male, admitted to the agency on 2/18/14, with diagnoses DM II, malaise and fatigue, hypertension, and chronic airway obstruction. His medical record and POC for the certification period 2/18/14 through 4/18/14, were reviewed. The RN did not complete the SN visit note, dated 2/19/14, until 2/23/14, 4 days after visit. The RN did not complete the SN visit note, dated 2/20/14, until 3/11/14, 15 days after visit.	G 236		

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	137107	A. BUILDING _____ B. WING _____	03/14/2014

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G 236	Continued From page 12 The RN who wrote the visit notes was interviewed on 3/13/14 beginning at 2:10 PM. She stated, visit notes would be signed and dated within 24 hours of the visit. She also stated she sometimes did not get her visit notes completed on time. She confirmed Patient #12's visit notes were not completed on time. Patient #12's medical record did not consistently include current nursing visit notes. 3. Patient #7's medical record documented a 74 year old male who was admitted for home health services on 10/21/09 with diagnoses of pulmonary hypertension and blindness. He was currently a patient as of 3/14/14. A "Skilled Nursing Visit Note" stated the RN Case Manager visited Patient #7 on 2/05/14. The note was completed by the RN on 2/17/14, 12 days after the visit. Another "Skilled Nursing Visit Note" stated the RN Case Manager visited Patient #7 on 1/08/14. The note was completed by the RN on 1/14/14, 6 days after the visit. Another "Skilled Nursing Visit Note" stated the RN Case Manager visited Patient #7 on 12/24/13. The note was completed by the RN on 12/29/13, 5 days after the visit. The Patient Care Coordinator was interviewed on 3/14/14 beginning at 8:45 AM. She reviewed Patient #7's medical record. She confirmed the late notes. Visit notes were not documented in a timely manner in accordance with agency policy.	G 236		

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G 236	Continued From page 13 4. Patient #13's medical record documented a 68 year old female who was admitted for home health services on 3/16/13 for the treatment of a pressure ulcer and other wounds. She was currently a patient as of 3/12/14. A "Skilled Nursing Visit Note" stated the LPN visited Patient #13 on 11/27/13. The note was completed by the LPN on 12/02/12, 5 days after the visit. A "Skilled Nursing Visit Note" stated the LPN visited Patient #13 on 12/06/13. The note was completed by the LPN on 12/09/12, 3 days after the visit. The Patient Care Coordinator was interviewed on 3/13/14 beginning at 11:40 AM. She reviewed Patient #13's medical record. She confirmed the late notes. Visit notes were not documented in a timely manner in accordance with agency policy.	G 236		
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure the SOC assessment included an examination of assistance available to patients for	G 331		

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G 331	Continued From page 14 1 of 13 patients, (#1), whose records were reviewed. This had the potential to result in unmet patient needs. Findings include: 1. Patient #1's medical record documented a 77 year old female who was admitted for home health services on 2/19/14 following back surgery. She was currently a patient as of 3/14/14. Her SOC assessment, dated 2/19/14 at 1:30 PM, did not describe her living situation. The assessment did not state where she lived or describe her environment. The assessment stated Patient #1 had "Occasional/short-term assistance" but did not describe her access to help more specifically. The Patient Care Coordinator was interviewed on 3/13/14 beginning at 3:05 PM. She reviewed Patient #1's medical record. She stated Patient #1 lived alone. She confirmed Patient #1's living situation and her access to assistance was not documented on her comprehensive assessment. Patient #1's assessment was not complete.	G 331	* * Visit staff were in-serviced on more thorough documentation of patients living situation. This documentation will need to include who the primary caregiver is(name and relation to patient), what their role is in the patient's care, and if they are independent in this role. PCC will monitor this with all new SOC. Monthly chart audits will be conducted to ensure this documentation is complete. Deficiency will be corrected 4/2/2014. * * * * * * * * * * * * *	
G 338	484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status. This STANDARD is not met as evidenced by: Based on home visit observation, medical record	G 338	See Tag G331	

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G 338	Continued From page 15 review, staff and patient interviews, and interaction with individuals present in a patient's home, it was determined the agency failed to ensure recertification assessments included information necessary for the care of 2 of 13 patients, (#4 and #7), whose records were reviewed. This resulted in a lack of information available to staff providing care. Findings include: 1. Patient #4 was a 66 year old male admitted to the agency on 12/31/13, with diagnoses pressure ulcer heel and buttock stage II, and multiple sclerosis. His medical record, including POC for the certification period 3/01/14 through 4/29/14, was reviewed. A visit was conducted on 3/12/14 at 4:00 PM, to observe Home Health Aide services at Patient #4's home. Immediately upon entering the house, two adults angrily informed surveyors and the aide that Patient #4 would not be having a bath that day. Both individuals expressed intense anger that the aide and surveyors were late for the visit. An aide visit was not completed. The verbal barrage continued for approximately 10-15 minutes, while one surveyor spoke privately with Patient #4. Patient #4's recertification assessment, completed by the RN on 3/11/14, was reviewed prior to the home visit. It did not include specific information regarding his living arrangements. A 2/11/14 MSW assessment, reviewed after the visit, documented Patient #4 lived with his ex-wife and her husband. The Patient Care Coordinator was interviewed on 3/14/14 beginning at 8:20 AM. She confirmed	G 338		

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G 338	Continued From page 16 Patient #4's medical record did not include a specific assessment of his living situation. Patient #4's recertification assessment did not include a complete assessment of his living situation. 2. Patient #7's medical record documented a 74 year old male who was admitted for home health services on 10/21/09, with diagnoses of pulmonary hypertension and blindness. He was currently a patient as of 3/14/14. Patient #7's "HOME HEALTH CARE RECERTIFICATION AND PLAN OF CARE," for the certification period 1/28/14 to 3/28/14, stated he took Flolan, an intravenous medication. The manufacturer's package insert for the medication, dated 2011, stated "Important Note: FLOLAN must be reconstituted only with STERILE DILUENT for FLOLAN." The insert also stated "Abrupt withdrawal (including interruptions in drug delivery) or sudden large reductions in dosage of FLOLAN may result in symptoms associated with rebound pulmonary hypertension, including dyspnea, dizziness, and asthenia [weakness]. In clinical trials, one Class III patient's death was judged attributable to the interruption of FLOLAN. Avoid abrupt withdrawal." During a visit with the RN Case Manager to Patient #7's home on 3/12/14 beginning at 12:30 PM, it appeared the patient was not able to see where other people were in the room. Patient #7 was not able to manage his Flolan because of his blindness. During the home visit, the patient stated his	G 338		

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G 338	Continued From page 17 daughter mixed and administered his Flolan. He stated she lived with him and his wife. Patient #7's comprehensive assessment, dated 1/23/14, did not document who was responsible for mixing and administering his Flolan nor did it assess that person's ability to do so. The Patient Care Coordinator was interviewed on 3/11/14 beginning at 3:20 PM. She confirmed the assessment did not describe Patient #7's living situation or who provided his intravenous medication. Patient #7's assessment was not complete.	G 338		

Bureau of Facility Standards

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	OAS001650	A. BUILDING: _____ B. WING _____	03/14/2014

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey of your home health agency on 3/10/14 through 3/14/14. The surveyors conducting the survey were: Don Sylvester, BSN, RN, HFS - Team Leader Gary Guiles, RN, HFS Sylvia Creswell, LSW, Non-Long Term Care Supervisor	N 000	*	
N 048	03.07021. ADMINISTRATOR N048 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: b. Providing staff orientation, continuing education, information on applicable laws, rules and policies, resource materials, and staff development to effectively implement and continue the program. This Rule is not met as evidenced by: Based on staff personnel files and staff interview, it was determined the agency failed to ensure completion of orientation for 1 of 11 direct patient care staff (MSW) whose personnel files were reviewed. This had the potential to allow an employee who was not orientated to the agency provide direct patient care. The findings include: Personnel records were reviewed with the Director on 3/06/14 at 9:45 AM. The following personnel file did not contain orientation to the agency.	N 048	* Visions Home Health will add "Orientation to Agency" to new hire checklist to ensure that orientation is completed prior to any direct patient care. Human Resource Manager will be responsible to monitor that all new hires for adequate orientation. Deficiency will be completed 4/2/2014.	

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N 048	Continued From page 1 Masters of Social Work hired 7/13. The Director reviewed the personnel file and was interviewed on 3/06/14 at 9:45 AM. She confirmed the MSW had direct access to patients. She also confirmed the personnel file for the MSW, lacked evidence of orientation to the agency. The agency did not ensure all staff had completed orientation to the agency.	N 048	*	
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to G159	N 093	* See G159	
N 095	03.07024. SK. NSG. SERV. N095 01.Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:	N 095	* See G159	

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N 095	Continued From page 2 c. Provides those services requiring substantial and specialized nursing skill; This Rule is not met as evidenced by: Refer to G144	N 095	See G144	
N 153	03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: a. All pertinent diagnoses; This Rule is not met as evidenced by: Refer to G159	N 153	See G159	
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 G158	N 156	See G158	

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N 174	Continued From page 3	N 174	* * * * See G236 * * * * * * * * * * *	
N 174	03.07031.01 CLINICAL RECORDS N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services. This Rule is not met as evidenced by: Refer to G236	N 174		
N 199	Criminal History and Background Check 009.CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS. 01. Compliance with Department ' s Criminal History and Background Check. A home health agency must comply with IDAPA 16.05.06, " Criminal History and Background Checks. " (3-26-08) 02. Direct Patient Access Individuals. These rules apply to employees and contractors hired or contracted with after October 1, 2007, who have direct patient access. (3-26-08) 03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must complete an application before having access to patients. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any patient without a clearance by the Department. Once the notarized application is completed the individual can only work under supervision until the individual has been fingerprinted. The individual	N 199	* * * * Human Resource manager will ensure that all new hires have a criminal history and back-ground check completed prior to any direct patient care. The record that was out of compliance is corrected at this time. Criminal History and background check was added to new hire orientation checklist. Deficiency will be corrected 4/2/2014	

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N 199	Continued From page 4 must have his fingerprints submitted to the Department within twenty-one (21) days of completion of the notarized application. (3-26-08) This Rule is not met as evidenced by: Based on review of personnel records and staff interview, it was determined the agency failed to ensure completion of criminal background checks for 1 of 11 direct patient care staff (MSW) whose personnel files were reviewed. This had the potential to allow an employee who may have had disqualifying crimes access to patients. Findings include: Personnel records were reviewed with the Director on 3/06/14 at 9:45 AM. The following personnel file did not contain a criminal history background check. Masters of Social Work hired 7/13. The Director reviewed the personnel file and was interviewed on 3/06/14 at 9:45 AM. She confirmed the MSW had direct access to patients. She also confirmed the personnel file for the MSW, lacked evidence of criminal history background check. The agency did not ensure all staff had completed a qualifying criminal history background check.	N 199		