



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
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November 27, 2013

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

RE: Avalon Home Health, Provider #137057

Dear Mr. Bryan:

Based on the survey completed at Avalon Home Health, on November 15, 2013, by our staff, we have determined Avalon Home Health is out of compliance with the Medicare Home Health Agency (HHA) **Conditions of Participation of Acceptance of Patients, POC, Med Super (42 CFR 484.18) and Home Health Aide Services (42 CFR 484.36)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;

Jake Bryan, Administrator
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- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health agency into compliance, and that the home health agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before December 30, 2013. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than December 22, 2013.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **December 9, 2013.**

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

We urge you to begin correction immediately.

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

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt

Enclosures

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

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

PRINTED: 11/25/2013
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 11/15/2013
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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 Medicare recertification survey of your home health agency on 11/12/13 through 11/15/13. The surveyors conducting the recertification were:</p> <p>Susan Costa RN, HFS, Team Lead Libby Doane BSN, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>abd - abdomen ADL - Activities of Daily Living BM - Bowel Movement COPD - Chronic Obstructive Pulmonary Disease CPR - Cardiopulmonary Resuscitation DME - Durable Medical Equipment DM II - Type 2 Diabetes Mellitus DON - Director of Nursing HHA - Home Health Aide HTN - Hypertension IM - Intramuscular IV - Intravenous LPN - Licensed Practical Nurse MD - Medical Doctor mg - milligram ml - milliliter OT - Occupational Therapy POC - Plan of Care prn - as needed pt - patient PT - Physical Therapy PTA - Physical Therapy Aide RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care x - times</p>	G 000	<p>Please refer to attached P.O.C. for details on how we have addressed these deficiencies.</p> <p>RECEIVED DEC 30 2013 FACILITY STANDARDS</p>	
G 141	484.14(e) PERSONNEL POLICIES	G 141		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Exec. Director	(X6) DATE 12/9/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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 141	<p>Continued From page 1</p> <p>Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of personnel files, it was determined the agency failed to ensure personnel files contained CPR certification in accordance with employee job descriptions for 5 of 13 staff (A, H, I, K and M) who were currently employed by the agency and whose personnel files were reviewed. This had the potential to result in services provided by unqualified staff. Findings include:</p> <p>1. The "JOB DESCRIPTION SUMMARY" for the home health aide stated the aide must "Possess and maintain current CPR certification." The following home health aide personnel files lacked current CPR certification:</p> <p>Staff H, CNA, hired 12/14/12 - CPR certification expired May of 2013. Staff I, CNA, hired 3/25/13 - personnel file did not contain evidence of CPR certification.</p> <p>The Administrator reviewed the personnel files and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed the home health aide personnel files lacked evidence of current CPR certification.</p> <p>Home health aides did not maintain current CPR certification in accordance with the home health</p>	G 141		
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G 141	<p>Continued From page 2 aide job description.</p> <p>2. The "JOB DESCRIPTION SUMMARY" for the RN stated the RN must have "Current...CPR certification." The following RN personnel file lacked current CPR certification:</p> <p>Staff A, RN, hired 8/12/13 - CPR certification expired 10/31/2013.</p> <p>The Administrator reviewed the personnel file and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed the RN's personnel file lacked evidence of current CPR certification.</p> <p>The RN personnel file did not contain current CPR certification in accordance with the RN job description.</p> <p>3. The "JOB DESCRIPTION SUMMARY" for the Physical Therapist stated the Physical Therapist must possess and maintain "current CPR certification." The following Physical Therapist personnel files lacked evidence of current CPR certification:</p> <p>Staff K, Physical Therapist, hired 9/11/13 - personnel file did not contain evidence of CPR certification.</p> <p>Staff M, Physical Therapist, a contract employee, hired 6/05/12 - personnel file did not contain evidence of CPR certification.</p> <p>The Administrator reviewed the personnel files and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed the Physical Therapist personnel files lacked evidence of current CPR certification.</p>	G 141		
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G 141 Continued From page 3
Physical therapist personnel files did not contain current CPR certification in accordance with the Physical Therapist job description.

CPR
G 141

G 143 484.14(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.

G 143

This STANDARD is not met as evidenced by:
Based on staff interview, review of medical records and agency policies, it was determined the agency failed to ensure care coordination between disciplines was documented for 3 of 12 patients (#1, #10, and #12) who received services from more than one discipline and whose records were reviewed. This interfered with quality and continuity of patient care. Findings include:

During an interview on 11/12/13 beginning at 2:00 PM, the Administrator stated coordination among staff was documented in visit notes, as well as, in "Care Coordination Notes," found in patient's records which would include the individual with whom the communication was made.
Coordination of patient care was not noted as follows:

1. Patient #12's medical record documented an 81 year old female admitted to the agency on 9/06/13, with diagnoses including abnormal gait, Alzheimers, weakness, and HTN. Her medical record and POCs for the certification periods of 9/06/13 through 11/04/13 and 11/05/13 through 1/03/14 were reviewed.

[Handwritten Signature] *Admiral*

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G 143	<p>Continued From page 4</p> <p>An HHA documented a visit to Patient #12 on 11/13/13 from 8:00 AM to 9:00 AM. She documented Patient #12's "Daughter said they believed that (Patient #12) suffered from a mini stroke over the weekend...." The HHA documented she reported this to the LPN.</p> <p>The LPN documented a visit to Patient #12 on 11/13/13 from 12:00 PM to 12:30 PM. There was no other documentation present on the note, other than the time of the visit. There was no documentation to indicate an assessment of Patient #12 had been performed or whether Patient #12's physician had been notified.</p> <p>The Administrator reviewed the record and was interviewed beginning at 1:30 PM on 11/14/13. He confirmed the visit note was not complete. He stated the LPN who documented the note still had until the end of the day to complete it.</p> <p>The medical record was reviewed again on 11/15/13 at 9:00 AM. The LPN visit note was still incomplete. The Administrator reviewed the record and confirmed the lack of documentation at 11:00 AM on 11/15/13. He stated he knew the LPN had made the visit to Patient #12's house and had assessed her condition, but confirmed this was not documented. He also confirmed there was no documentation to indicate the change in Patient #12's condition had been coordinated with the RN Case Manager or physician.</p> <p>Care was not coordinated regarding a change in Patient #12's condition.</p> <p>2. Patient #10 was an 81 year old female</p>	G 143		
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G 143 Continued From page 5
admitted to the agency on 8/07/13 for SN, HHA and PT services related to muscle weakness and DM II. The POC for the certification period 10/06/13 to 12/04/13 included orders for the following: SN 2 visits prn for falls, to assess vital signs and medical complications, HHA 3 times a week for 8 weeks, and PT 2 times a week for 7 weeks. The POC included orders to assess, perform and instruct Patient #10 and her caregivers in parameters for physician notification of changes in her vital signs.

The recertification and comprehensive assessment, dated 10/01/13, completed by an RN, noted Patient #10's blood pressure was 110/40. National Institute of Health (NIH) describes blood pressure lower than 90/60 as hypotension. According to the NIH, a person with hypotension is at risk for falls as a result of dizziness or fainting. Patient #10's assessment did not include an additional blood pressure reading or documentation that physician notification had occurred. The record did not include documentation of notification to the HHA or therapist of precautions related to Patient #10's low blood pressure.

During an interview on 11/15/13 beginning at 8:30 AM, the Administrator and DON reviewed Patient #10's record and each confirmed there was no documentation of communication between the physician, nursing, or therapy. The DON agreed the blood pressure of 110/40 should have been reported to Patient #10's physician and should have been repeated to ensure accuracy of the reading.

Patient #10 was documented as experiencing low blood pressure which could case dizziness and

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G 143 Continued From page 6
fainting. This information was not coordinated with the physician and other disciplines providing care, to promote safe practices.

3. Patient #1 was an 81 year old male admitted to the agency on 9/23/13, for nursing and therapy services related to muscle weakness following stroke, atrial fibrillation, and DM II. Patient #1's medical record included a written physician order, dated 9/23/13, for an OT evaluation.

A physical therapy evaluation, dated 9/27/13, noted "Discussed the role of OT in care, patient and wife interested in pursuing OT as well." A PT visit note, dated 10/09/13 at 9:00 AM, noted Patient #1's right wrist was massaged with carpal mobilization for decreased right hand numbness. Communication between the PT and RN Case Manager regarding the OT evaluation not yet being done was not found in Patient #1's medical record.

During an interview on 11/15/13 at 8:30 AM, the Administrator reviewed Patient #1's record and confirmed the order for an OT evaluation. He stated he was not aware of the order, as he was an Occupational Therapist and would have evaluated Patient #1. The DON was also present during the interview. She stated she wrote the order request for OT services based on the referral by Patient #1's physician. She stated she noted receipt of the signed physician order for OT, but the information was probably not relayed to the RN and Occupational Therapist. The DON stated she was currently the RN Case Manager for all agency and responsible for coordination with other staff providing patient care.

Patient #1's care was not effectively coordinated

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G 143	Continued From page 7 to ensure he received an OT evaluation as ordered by the physician.	G 143		
G 156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>This CONDITION is not met as evidenced by: Based on staff and patient interview, review of medical records and agency policies, and observation, it was determined the agency failed to ensure systems to plan for care and supervise the medical care of patients were implemented. These failures resulted in unmet patient needs and negatively impacted the continuity, safety, and quality of patient care. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with POCs. 2. Refer to G159 as it relates to the failure of the agency to ensure the POC included all pertinent diagnoses, types of services and equipment required. 3. Refer to G164 as it relates to the agency's failure to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter their POCs. <p>The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs.</p>	G 156		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 158		

 Admin

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G 158	<p>Continued From page 8</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on review of agency policies, patient record review, and staff interview, it was determined the agency failed to ensure care followed a physician's written POC for 7 of 12 patients (#1, #3, #4, #6, #8, #10, and #11) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and had the potential to result in negative patient outcomes. Findings include:</p> <p>1. Patient #10 was an 81 year old female admitted to the agency on 8/07/13, for SN and PT services related to muscle weakness and DM II. The POC's for the certification periods of 8/07/13 to 10/05 and 10/06/13 to 12/04/13, included orders for SN visits prn for falls and to assess vital signs and medical complications. The POC's both included orders to assess, perform and instruct Patient #10 and her caregivers in parameters for physician notification of changes in her vital signs. The record contained verbal orders for the SN visits. There were no physician orders for PT and HHA evaluation and visits.</p> <p>a. The recertification and comprehensive assessment, dated 10/01/13, completed by an RN, noted Patient #10's blood pressure was 110/40. The National Institute of Health (NIH) described blood pressure lower than 90/60 as hypotension. According to the NIH, a person with hypotension is at risk for falls as a result of dizziness or fainting. Patient #10's assessment</p>	G 158		
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G 158	<p>Continued From page 9</p> <p>did not include an additional blood pressure reading or documentation that physician notification had occurred. The record did not indicate Patient #10 or her caregivers were instructed on vital sign reporting or parameters.</p> <p>During an interview on 11/15/13 beginning at 8:30 AM, the Administrator and DON reviewed Patient #10's record. Each confirmed there was no documentation of communication with the physician. The DON agreed the blood pressure of 110/40 should have been reported to Patient #10's physician and should have been repeated to ensure accuracy of the reading.</p> <p>b. The certification period of 8/07/13 to 10/05/13 included 16 PT visits, and 25 HHA visits. A PT evaluation dated 8/20/13, noted discussing the POC with Patient #10 and her family, however, there was no communication noted with the physician to discuss the POC and receive orders.</p> <p>c. The POC for the certification period of 10/06/13 to 12/04/13 was not signed by a physician until 10/20/13. Patient #10 was received 4 PT visits and 6 HHA visits that were completed before they were ordered by her physician.</p> <p>There was no documentation the RN or therapist had communicated with the physician to receive verbal orders for both of the POCs before they had been signed.</p> <p>The Administrator was interviewed on 11/15/13 beginning at 8:30 AM. He reviewed Patient #10's record and confirmed the PT and HHA visits had been made without a physician order.</p> <p>Patient #10's POC was not established by a</p>	G 158		
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G 158	<p>Continued From page 10 physician prior to HHA and therapy visits.</p> <p>2. Patient #11 was an 87 year old male admitted to the agency on 9/27/12, for nursing and therapy services related to generalized muscle weakness and pain. The POC for the certification period 11/02/13 to 12/31/13 included orders for skilled nursing 1 time the first week and 2 times a week for the second week; and for PT 2 times a week for 1 week, 3 times a week for 5 weeks, and 1 time a week for 1 week.</p> <p>a. Patient #11's POC for the certification period 11/02/13 to 12/31/13 was unsigned as of 11/15/13. There was no documentation the RN or therapist had communicated with the physician and received orders for SN or PT services.</p> <p>b. A "PHYSICIAN'S ORDER," dated 11/02/13, and signed by the physician on 11/05/13, was to admit Patient #11 to home health services for SN, PT and OT to evaluate and treat. It was electronically signed by the RN on 11/02/13. The orders did not specify the frequency for the PT visits.</p> <p>c. An evaluation by the physical therapist was completed on 11/05/13. PT visits were completed on 11/07/13, 11/12/13 and 11/13/13. There were no written or verbal orders for on-going PT services after the evaluation visit.</p> <p>PT visits were completed without a physician order.</p> <p>d. There was no OT evaluation documented in Patient #11's record as of 11/15/13.</p> <p>The Administrator was interviewed on 11/15/13</p>	G 158		
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G 158	<p>Continued From page 11</p> <p>beginning at 8:30 AM. He reviewed Patient #11's record and confirmed the POC had not yet been reviewed and signed by the physician. He confirmed the written order for OT and PT evaluation and stated he, as the occupational therapist, had not been notified of the OT referral. He confirmed 3 PT visits were completed after the evaluation visit and there were no physician orders for the visits.</p> <p>3. Patient #1 was an 81 year old male admitted to the agency on 9/23/13, for nursing and therapy services related to muscle weakness following a stroke, atrial fibrillation and DM II. A written order, dated 9/23/13, included OT for evaluation of Patient #1's right hand coordination and ROM loss, however, the order was not included on the POC.</p> <p>A "Physical Therapy Evaluation," dated 9/27/13, noted "Discussed role of OT in care, patient and wife interested in pursuing OT as well." A PT visit, dated 10/09/13 at 9:00 AM, noted Patient #1's right wrist was massaged with carpal mobilization to decrease right hand numbness.</p> <p>A visit to Patient #1's home was conducted on 11/13/13 at 9:00 AM, to observe PT services. After the therapist left, Patient #1 and his wife discussed his care provided by the agency. Patient #1 stated he understood he was to receive OT services, as well as, PT services. He stated he was weak on his left side as a result of a stroke, and needed surgery on his right wrist. He stated he understood OT was going to work with him in strengthening his left hand. Patient #1 stated he was concerned he would not be able to use his walker if he could not use his right or left</p>
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Continued From page 12 hand effectively.

During an interview on 11/15/13 at 8:30 AM, the Administrator reviewed Patient #1's record and confirmed the order for OT evaluation. He stated he had not been informed of that order, as he was an Occupational Therapist and would have evaluated Patient #1. The DON was also present during the interview and stated she had written the order request for OT services based on the referral by Patient #1's physician. She stated she had noted the receipt of the signed physician order for OT, but the information was probably not relayed to the RN and Occupational Therapist. The DON stated she was the RN Case Manager for all of the patients for the agency, and took responsibility for the missed order for OT.

The POC for Patient #1 was not followed.

4. Patient #3 was an 82 year old male admitted to the agency on 4/01/13, for nursing and therapy services related to muscle weakness, dementia, and failure to thrive. The POC for the certification period 4/01/13 to 5/30/13 included orders for SN 2 times a week for 1 week, once a week for 2 weeks and 2 prn visits. Orders for therapy included PT and OT twice weekly for 8 weeks.

Visit notes for Patient #3 from 4/01/13 to 5/30/13 were reviewed. The OT evaluation was not performed until 5/30/13, 59 days after the order. Patient #3's record did not indicate his physician had been notified regarding the delay of OT services.

In an interview on 11/15/13 at 9:50 AM, the Administrator reviewed Patient #3's medical

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G 158	<p>Continued From page 13</p> <p>record and confirmed there was no documentation of an OT visit until 5/30/13. He stated the therapist who had provided care to Patient #3 was dually licensed as a Physical Therapist and Occupational Therapist. He stated it was possible that a PT reassessment may have been completed by mistake instead of an OT evaluation, but he was uncertain if that was the case. The Administrator stated the therapist no longer worked for the agency, and was not able to explain why OT services were delayed.</p> <p>The POC for Patient #3 was not followed.</p> <p>6. Patient #4's medical record documented a 75 year old male admitted to the agency on 1/05/13 with diagnoses including prostate cancer, COPD and edema. His medical record was reviewed from the date of admission on 1/05/13 to the date of his discharge on 6/10/13. Care of Patient #4 did not follow a written POC as follows:</p> <p>a. An order request, written by agency staff on 1/02/13, requested to admit Patient #4 to home health services for SN and for PT to evaluate and treat for weakness, decreased mobility, respiratory issues and edema. The order was never signed by a physician. There was no other referral documented for Patient #4.</p> <p>A POC for the certification period 1/05/13 through 3/05/13 included SN visits once a week for 5 weeks, to assess respiratory status, skin integrity and side effects of chemotherapy. The physician signed the POC on 1/28/13. Patient #4 received visits from skilled nursing on 1/05/13, 1/11/13, 1/17/13, and 1/25/13, prior to the physician signing the POC on 1/28/13.</p>	G 158		
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G 158	<p>Continued From page 14</p> <p>An order request, written by agency staff on 1/31/13, requested PT to evaluate and treat due to increasing numbness and "difficult movements" in the left leg and foot. The request stated the initial PT evaluation would be done the week of 2/03/13-2/09/13. In addition, the order request asked for additional SN visits with a frequency of twice a week for one week then once a week for 2 weeks. The order was not signed by the physician as of 11/15/13.</p> <p>A "PHYSICAL THERAPY EVALUATION," documented by the Physical Therapist on 2/06/13, documented PT treatments for the rest of the certification period and frequencies of once a week for one week, then twice a week for three weeks. There was no indication the treatments and frequencies were reviewed and ordered by the physician. Patient #4's medical record documented he received 7 PT visits, on 2/06/13, 2/12/13, 2/15/13, 2/19/13, 2/20/13, 2/26/13, and 3/01/13, during the certification period of 1/05/13 through 3/05/13.</p> <p>The Administrator reviewed the record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed the initial order for home health services was not signed by a physician. He stated it was a community referral and a verbal order for home health services would have been obtained prior to SOC. He confirmed there was no documentation of this in the medical record. In addition, he confirmed there was no documentation to explain why a PT evaluation had not been done after the initial request for services, or why a second order was requested. He confirmed there was no documentation to indicate an order had been obtained for the PT evaluation, or the treatments and frequencies</p>	G 158		
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G 158	<p>Continued From page 15 described in the "PHYSICAL THERAPY EVALUATION."</p> <p>b. A "PHYSICAL THERAPY EVALUATION," documented by the Physical Therapist on 5/03/13, documented treatments to be provided during the new certification period of 5/05/13 through 7/03/13 and visit frequencies of twice a week for nine weeks. There was no documentation to indicate the frequencies and treatments were reviewed and ordered by Patient #4's physician.</p> <p>An order request, written by agency staff on 4/29/13, requested Patient #4 continue with PT during the new certification period starting 5/05/13. The physician did not sign the order until 10/08/13, almost 4 months after Patient #4 was discharged from the agency.</p> <p>The POC for the certification period of 05/05/13 through 07/03/13 stated "SN visit frequency none, PT to consult, evaluate and treat." The medical record documented Patient #4 received PT visits on 5/09/13, 5/10/13, 5/17/13, 5/18/13, 5/22/13, 5/24/13, 5/29/13, and 5/31/13 during the certification period. The POC was signed by the physician 6/18/13, 8 days after Patient #4 was discharged from the agency.</p> <p>The Administrator reviewed the record and was interviewed on 11/14/13 at 1:30 PM. He confirmed the PT evaluation done on 5/03/13 was in preparation to recertify Patient #4 for PT services and did not constitute an order. He confirmed Patient #4's POC for the certification period of 5/05/13 through 7/03/13 did not contain PT frequencies or treatments. He confirmed the documentation found in Patient #4's medical</p>	G 158		
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G 158	<p>Continued From page 16</p> <p>record indicated PT services had been provided without an order during the certification period beginning 5/05/13.</p> <p>SN and PT services were provided without orders.</p> <p>7. Patient #6's medical record documented a 92 year old female admitted to the agency on 8/07/12 with diagnoses including regional enteritis (a type of inflammatory bowel disease causing chronic inflammation of the lining of the bowel tract), dehydration, and vascular catheter care. Her medical record for the certification period of 10/01/13 through 11/29/13 was reviewed.</p> <p>Patient #6's medical record contained an order request dated 10/02/13, and signed by the RN on 10/03/13. It stated "10/2/13; Pt without BM for 1 week, give enema today and PRN, abd discomfort, start stool softeners 1-2 tabs daily and healthy colon 2 tabs daily. 10/4/13; saw [name of physician] yesterday, he wants her to have Miralax 6x today (10/3) and tomorrow (10/4) then daily, extra SN [visits] to assist pt with the miralax, assess bowels, teach bowel obstruction prevention and when to notify MD or RN. Give 2 doses IV fluids next week. May give flu vaccine 0.5 mg IM x1 next week when feeling better." It was unclear as to when the order request was actually sent to the physician. The physician signed the order on 10/09/13. There was no documentation to indicate a verbal order had been obtained for the orders listed above.</p> <p>An RN visit note, dated 10/02/13 at 9:30 AM, documented Patient #6 was experiencing abdominal discomfort due to not having a BM for 1 week. The RN documented Patient #6 wanted</p>	G 158		
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G 158	<p>Continued From page 17</p> <p>to have an enema, and the RN gave Patient #6 an enema three times. The RN also documented she instructed Patient #6 to start taking stool softeners. There was no documentation to indicate an order was obtained prior to giving the enemas.</p> <p>The Administrator reviewed the record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed there was no documentation to indicate an order had been received prior to giving the enemas on 10/02/13. In addition, he confirmed the order request lacked clarity as to when it was actually written. However, he confirmed the orders were not valid until the physician signed the request on 10/09/13.</p> <p>Patient #6 was given multiple enemas without an order.</p> <p>8. Patient #8 was an 81 year old female admitted to the agency on 11/07/13. Her POC did not contain diagnoses at the time of the survey. Her medical record for the certification period of 11/07/13 through 1/05/14 was reviewed.</p> <p>An order request, written by agency staff on 11/07/13, contained a request to admit Patient #8 to home health services, including SN once a week for 4 weeks and PT to evaluate and treat. The order was not signed by a physician as of 11/15/13. There was no documentation on the order to indicate a verbal order for home health services had been received.</p> <p>Patient #8's medical record documented RN visits on 11/07/13, 11/11/13 and 11/13/13.</p> <p>The Administrator reviewed the record and was</p>	G 158		

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interviewed on 11/14/13 beginning at 1:30 PM. He stated Patient #8 had been a community referral and that verbal orders had been received from her physician to start home health services. He confirmed there was no documentation to indicate a verbal order was received to begin home health services.

SN services were provided without an order.

9. An undated agency policy, titled "Physician Orders/Plan of Care," stated: "To ensure that each patient's care is under the direction of the physician. The physician establishes and reviews a plan of treatment for the patient." In addition, "The Plan of Care is based upon the physician's orders and encompasses the equipment, supplies, disciplines, and services required to meet the patient/client's needs." The agency policy was not followed by agency staff in the above examples.

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G 159 484.18(a) PLAN OF CARE

The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

This STANDARD is not met as evidenced by:
Based on review of patient records, patient and staff interview, and observation, it was

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determined the agency failed to ensure the plan of care included all pertinent information, including types of services and frequency of visits, for 5 of 12 patients (#2, #4, #5, #6, and #12) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include:

1. Patient #12's medical record documented an 81 year old female admitted to the agency on 9/06/13, with diagnoses including abnormal gait, Alzheimers, weakness and HTN. Her medical record for the certification periods of 9/06/13 through 11/04/13 and 11/05/13 through 1/03/14 were reviewed.

A "PHYSICAL THERAPY EVALUATION," documented by the Physical Therapist on 11/04/13, documented "PHYSICAL THERAPY ORDERS," which included the treatments that would be provided to Patient #12 in the new certification period and the frequency of visits: once a week for one week, twice a week for six weeks, and once a week for two weeks. There was no documentation to indicate the orders had been reviewed and signed by Patient #12's physician, or that a verbal order was obtained.

The POC for the certification period of 11/05/13 through 1/03/14 did not contain PT visit frequencies identified on the "PHYSICAL THERAPY EVALUATION." The POC only documented for PT to evaluate and treat Patient #12, though she had already been evaluated by PT and received 20 PT visits during the first certification period of 9/06/13 through 11/04/13. In addition, Patient #12 had received 4 PT visits during the current certification period.

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G 159	<p>Continued From page 20</p> <p>The Administrator reviewed the record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed the PT evaluation done on 11/04/13 was in preparation to recertify Patient #12 for PT services and did not constitute an order. He confirmed PT treatments and frequencies were not present on the POC for 11/05/13 through 1/03/13. He confirmed the order for PT to evaluate and treat was inappropriate, as Patient #12 had already been evaluated and treated during the first certification period. He stated the electronic medical record was supposed to allow the treatments and frequencies identified on the "PHYSICAL THERAPY EVALUATION" to populate the POC, but that had not happened in this case.</p> <p>Patient #12's POC did not contain PT treatments and frequencies.</p> <p>2. Patient #6's medical record documented a 92 year old female admitted to the agency on 8/07/12, with diagnoses of regional enteritis, dehydration, and care of a vascular catheter. Her medical record for the certification period of 10/01/13 through 11/29/13 was reviewed.</p> <p>A "PHYSICAL THERAPY EVALUATION," documented by the Physical Therapist on 09/27/13, documented "PHYSICAL THERAPY ORDERS," which included the treatments that would be provided to Patient #6 in the new certification period and the frequency of visits: twice a week for six weeks. There was no documentation to indicate the treatments and frequencies had been reviewed and ordered by Patient #6's physician.</p> <p>The POC for the certification period of 10/01/13</p>	G 159		
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G 159	<p>Continued From page 21</p> <p>through 11/29/13 included a report of the PT goals Patient #6 had achieved during the prior certification period. The POC did not include PT treatments or visit frequencies. Patient #6's medical record documented PT visits were made on 10/01/13, 10/07/13, 10/09/13, 10/16/13, 10/18/13, 10/25/13, 10/29/13, 11/01/13, 11/05/13, 11/08/13, and 11/12/13 during the certification period.</p> <p>The Administrator reviewed the record and was interviewed on 11/14/13 at 1:30 PM. He confirmed the PT evaluation done on 9/27/13 was in preparation to recertify Patient #6 for PT services and did not constitute an order. He confirmed Patient #6's POC for the certification period of 10/01/13 through 11/29/13 did not contain PT frequencies or treatments. He stated the electronic medical record was supposed to allow the treatments and frequencies identified on the "PHYSICAL THERAPY EVALUATION" to populate the POC, but that had not happened in this case.</p> <p>Patient #6's POC did not contain PT treatments or frequencies.</p> <p>3. Patient #4's medical record documented a 75 year old male admitted to the agency on 1/05/13, with diagnoses including prostate cancer, COPD and edema. His medical record was reviewed from the date of admission on 1/05/13 to the date of his discharge on 6/10/13.</p> <p>A "PHYSICAL THERAPY EVALUATION," documented by the Physical Therapist on 5/03/13, documented treatments to be provided during the new certification period and visit frequencies of twice a week for nine weeks.</p>	G 159		
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G 159	<p>Continued From page 22</p> <p>There was no documentation to indicate the frequencies and treatments had been reviewed and signed by Patient #4's physician as an order.</p> <p>The POC for the certification period of 05/05/13 through 07/03/13 stated " SN visit frequency none, PT to consult, evaluate and treat." Patient #4's medical record documented he had been receiving PT services since 2/06/13. In addition, the medical record documented Patient #4 received PT visits on 5/09/13, 5/10/13, 5/17/13, 5/18/13, 5/22/13, 5/24/13, 5/29/13, and 5/31/13 during the certification period.</p> <p>The Administrator reviewed the record and was interviewed on 11/14/13 at 1:30 PM. He confirmed the PT evaluation done on 5/03/13 was in preparation to recertify Patient #4 for PT services and did not constitute an order. He confirmed Patient #4's POC for the certification period of 5/05/13 through 7/03/13 did not contain PT frequencies or treatments. He stated the electronic medical record was supposed to allow the treatments and frequencies identified on the "PHYSICAL THERAPY EVALUATION" to populate the POC, but that had not happened in this case.</p> <p>Patient #4's POC did not contain PT treatments or frequencies.</p> <p>4. Patient #2 was an 83 year old female admitted to the agency on 5/01/13, with diagnoses including physical therapy for quadriplegia, edema and incontinence. Her medial record for the certification period of 10/28/13 through 12/26/13 was reviewed.</p> <p>A "PHYSICAL THERAPY EVALUATION,"</p>	G 159		
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G 159 Continued From page 23
documented by the Physical Therapist on 10/25/13, documented treatments to be provided during the new certification period and visit frequencies of 3 times a week for 7 weeks and once a week for one week. There was no documentation to indicate Patient #2's physician had reviewed and signed for the frequencies and treatments listed on the "PHYSICAL THERAPY EVALUATION."

The POC for the certification period of 10/28/13 through 12/26/13 was reviewed. There was no documentation of PT frequencies or treatments on the POC. Patient #2's medical record documented she received visits on 10/28/13, 10/30/13, 11/01/13, 11/04/13, 11/07/13, 11/08/13, 11/11/13 and 11/13/13 during the certification period.

The Administrator reviewed the record and was interviewed on 11/14/13 at 1:30 PM. He confirmed the PT evaluation done on 10/25/13 was in preparation to recertify Patient #2 for PT services and did not constitute an order. He confirmed Patient #2's POC for the certification period of 10/28/13 through 12/26/13 did not contain PT frequencies or treatments. He stated the electronic medical record was supposed to allow the treatments and frequencies identified on the "PHYSICAL THERAPY EVALUATION" to populate the POC, but that had not happened in this case.

Patient #2's POC did not contain PT treatments or frequencies.

5. Patient #5 was a 22 year old male admitted to the agency on 10/08/13 for wound care and antibiotic therapy. A referral dated and signed by

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G 159	<p>Continued From page 24</p> <p>Patient #5's physician on 10/07/13 included orders for SN, OT and PT.</p> <p>Visit notes for Patient #5 from 10/08/13 to 11/14/13 were reviewed. The OT evaluation was not performed until 11/07/13. Patient #5's record did not indicate his physician had been notified regarding the delay of OT services.</p> <p>An order requesting Patient #5 have an OT evaluation was written by the Physical Therapist dated 10/10/13 and signed by the physician on 11/06/13. Patient #5 was seen by the Occupational Therapist on 11/07/13.</p> <p>In an interview on 11/15/13 beginning at 8:30 AM, the Administrator reviewed Patient #5's medical record and confirmed there was no documentation of an OT visit until 11/07/13. He stated the original order and referral which included the OT orders had been missed. The Administrator confirmed the second order written by the Physical Therapist to the physician on 10/10/13 requesting an OT evaluation was not signed until 11/06/13.</p> <p>Patient #5's POC did not include an OT evaluation.</p>	G 159		
G 164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records and staff and</p>	G 164		

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G 164	<p>Continued From page 25</p> <p>patient interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 2 of 12 patients (#10 and #12) whose records were reviewed. This resulted in missed opportunity for the physician to alter the POC to meet patient needs. Findings include:</p> <p>1. Patient #10 was an 81 year old female admitted to the agency on 8/07/13 for SN, HHA and PT services related to muscle weakness and DM II. The POC's for the certification periods of 8/07/13 to 10/05 and 10/06/13 to 12/04/13 included orders for SN visits prn for falls and to assess vital signs and medical complications. The POC's both included orders to assess, perform and instruct Patient #10 and her caregivers in parameters for physician notification of changes in her vital signs.</p> <p>a. The recertification and comprehensive assessment, dated 10/01/13, completed by an RN, noted Patient #10's blood pressure was 110/40. The assessment did not include an additional blood pressure reading or documentation that physician notification had occurred. Patient #10's Medicare plan (Traditional Fee-for-Service) required confirmation of homebound status. The recertification confirmed that at the time of the recertification, Patient #10 was homebound.</p> <p>b. During a home visit to observe care provided by the HHA, Patient #10 conversed with the HHA, and spoke of working as a foster grandparent. Upon further discussion, she stated she worked as a volunteer at a local elementary school 15 hours a week. She stated she independently</p>	G 164		
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G 164	<p>Continued From page 26</p> <p>boarded public transportation, used her walker, and was at the school 3 days a week to assist children in their reading activities. Patient #10's record did not contain documentation the physician was notified that she no longer appeared homebound.</p> <p>During an interview on 11/15/13 beginning at 8:30 AM, the Administrator and DON reviewed Patient #10's record and confirmed the RN had not notified the physician about the low blood pressure. The DON stated the agency did not have a policy which included vital sign parameters for the staff to reference. She stated the staff knew vital sign norms and they should know to report abnormal values, either to the RN, or to the physician. She stated the RN should have notified Patient #10's physician about the low blood pressure. The DON also stated she was not aware that Patient #10 was not homebound. She stated she would confirm the activities with Patient #10 and her family, then obtain physician orders to discharge her from home health if she was determined to not be homebound.</p> <p>Patient #10's physician was not notified of changes that required an alteration of her POC.</p> <p>2. Patient #12's medical record documented an 81 year old female admitted to the agency on 9/06/13 with diagnoses including abnormal gait, Alzheimers, weakness and HTN. Her medical record for the certification period of 9/06/13 through 11/04/13 and 11/05/13 through 1/03/14 were reviewed.</p> <p>An HHA documented a visit to Patient #12 on 11/13/13 from 8:00 AM to 9:00 AM. She</p>	G 164		
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G 164 Continued From page 27
documented Patient #12's "Daughter said they believed that (Patient #12) suffered from a mini stroke over the weekend...." The HHA documented she reported this to the LPN.

The LPN documented a visit to Patient #12 on 11/13/13 from 12:00 PM to 12:30 PM. There was no other documentation present on the note, other than the date and time of the visit. There was no documentation to indicate an assessment of Patient #12 had been performed or whether Patient #12's physician had been notified.

The Administrator reviewed the record and was interviewed beginning at 1:30 PM on 11/14/13. He confirmed the visit note had not been completed. He stated the LPN who documented the note still had until the end of the day to complete it.

The medical record was reviewed again on 11/15/13 at 9:00 AM. The LPN visit note was still not documented. The Administrator reviewed the record and confirmed the lack of documentation at 11:00 AM on 11/15/13. He confirmed there was no documentation to indicate Patient #12's physician had been notified

Patient #12's physician was not updated about a change in her condition.

G 169 484.30 SKILLED NURSING SERVICES

The HHA furnishes skilled nursing services by or under the supervision of a registered nurse.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it

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G 169

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G 169	<p>Continued From page 28</p> <p>was determined the facility failed to ensure that skilled nursing services were provided under the supervision of a registered nurse for 1 of 4 patients (#6) who received nursing services from an LPN and whose records were reviewed. This had the potential to result in inappropriate clinical decisions being made without the RN's knowledge. Findings include:</p> <p>1. Patient #6's medical record documented a 92 year old female admitted to the agency on 8/07/12 with diagnoses including regional enteritis, dehydration, and care of a vascular catheter. Her medical record for the certification period of 10/1/13 through 11/29/13 was reviewed.</p> <p>The POC ordered SN visits once a week for 9 weeks plus 3 prn visits for exacerbation of rash, hypertension, or hypotension. Patient #6's medical record documented an LPN made visits to the home on 10/25/13, 10/30/13, 11/08/13, and 11/11/13. RN visits were documented on 10/31/13 and 11/07/13. Neither visit contained documentation to indicate the LPN had been supervised by the RN.</p> <p>The Administrator reviewed the record and was interviewed on 11/14/13 beginning at 1:30 PM. He stated LPN supervision was to be performed by the RN every 14 days and documented on the RN visit note. He confirmed there was no documentation to indicate the LPN had been supervised by the RN.</p> <p>SN services were not provided under the supervision of an RN.</p>	G 169		
G 180	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE	G 180		

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G 180	<p>Continued From page 29</p> <p>The licensed practical nurse prepares clinical and progress notes.</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 LPN notes included complete and consistent information regarding the health status of 2 of 4 patients (#6 and #12) who received nursing care from an LPN and whose records were reviewed. This had the potential to compromise continuity of care and assessment of patients' progress. Findings include:</p> <p>During an interview on 11/14/13 at 1:30 PM, the Administrator stated visit notes were to be completed by staff within 48 hours of the visit. For example, a visit occurring on 11/01/13 should be completed by 11/03/13. The agency failed to ensure visit notes were completed in 48 hours as follows:</p> <p>1. Patient #12's medical record documented an 81 year old female admitted to the agency on 9/06/13 with diagnoses including abnormal gait, Alzheimers, weakness and HTN. Her medical record for the certification period of 9/06/13 through 11/04/13 and 11/05/13 through 1/03/14 were reviewed.</p> <p>An HHA documented a visit to Patient #12 on 11/13/13 from 8:00 AM to 9:00 AM. She documented Patient #12's "Daughter said they believed that (Patient #12) suffered from a mini stroke over the weekend.... " The HHA documented she reported this to the LPN.</p>	G 180		
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G 180	<p>Continued From page 30</p> <p>The LPN documented a visit to Patient #12 on 11/13/13 from 12:00 PM to 12:30 PM. There was no other documentation present on the note to indicate an assessment of Patient #12 had been performed or whether Patient #12's physician had been notified.</p> <p>The Administrator reviewed the record and was interviewed beginning at 1:30 PM on 11/14/13. He confirmed the visit note had not been completed. He stated the LPN who documented the note still had until the end of the day to complete it.</p> <p>The medical record was reviewed again on 11/15/13 at 9:00 AM. The LPN visit note was still not documented. The Administrator reviewed the record and confirmed the lack of documentation at 11:00 AM on 11/15/13. He stated he knew the LPN had made the visit to Patient #12's home and had assessed her condition, but confirmed this was not documented.</p> <p>LPN visits were not documented timely.</p> <p>2. Patient #6's medical record documented a 92 year old female admitted to the agency on 8/07/12, with diagnoses of regional enteritis, dehydration, and care of a vascular catheter. Her medical record for the certification period of 10/01/13 through 11/29/13 was reviewed and contained the following incomplete documentation:</p> <p>A nursing visit note, dated 11/11/13, documented the LPN made a visit to Patient #6 from 4:30 PM to 6:00 PM. There was no other documentation on the note. The note was unsigned.</p>	G 180		
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G 180	Continued From page 31 The Administrator reviewed the record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed the LPN made a visit to Patient #6 on 11/11/13 from 4:30 PM to 6:00 PM, but had not documented an assessment, vitals signs, interventions, or teaching done during the visit.	G 180		
G 202	LPN visits were not documented timely. 484.36 HOME HEALTH AIDE SERVICES This CONDITION is not met as evidenced by: Based on record review, personnel record review, review of the in-service training log, and staff interview it was determined the agency failed to ensure initial competency requirements were observed and at least 12 hours of in-service training was provided annually for home health aides. In addition, the agency failed to ensure a written aide plan of care was provided and home health aide supervisory visits were conducted by an RN and/or other licensed personnel. This had the potential to result in inadequate home health aide care being provided. Findings include: 1. Refer to G212 as it relates to the failure of the agency to perform initial competency assessments for home health aides. 2. Refer to G214 as it relates to the failure of the agency to provide annual performance review of competencies for home health aides. 3. Refer to G224 as it relates to the failure of the agency to ensure ensure the RN provided written instructions for the home health aide.	G 202		

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G 202	Continued From page 32 4. Refer to G229 as it relates to the failure of the agency to provide required RN supervisory visits for home health aides.	G 202		
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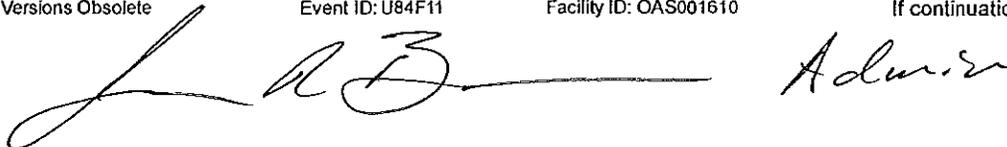
G 212	484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.	G 212		
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This STANDARD is not met as evidenced by:
Based on review of personnel records and staff interview, it was determined the agency failed to ensure 3 of 5 home health aides (H, I and J), whose records were reviewed, met competency evaluation requirements. This had the potential to allow home health aides who had not met competency requirements to provide services on behalf of the agency. Findings include:

Employee files were reviewed. The following files did not include evidence of competency evaluations:

Staff H, CNA, hired 12/14/12
Staff I, CNA, hired 3/25/13
Staff J, CNA, hired 8/05/13

The Administrator was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed the personnel files of the home health aides listed



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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 11/15/2013
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NAME OF PROVIDER OR SUPPLIER AVALON HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 403 1ST ST IDAHO FALLS, ID 83401
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G 212	Continued From page 33 above did not contain evidence of competency evaluations.	G 212		
G 224	<p>The agency did not ensure home health aides met competency evaluation requirements prior to providing care.</p> <p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p> <p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</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 RN provided written instructions for the home health aide for 4 of 4 patients (#6, #9, #10 and #12) who received aide services and whose records were reviewed. This had the potential to negatively impact quality, completeness, and coordination of patient care. Findings include:</p> <p>1. Patient #6's medical record documented a 92 year old female admitted to the agency on 8/07/12 with diagnoses of regional enteritis, dehydration, and care of a vascular catheter. Her medical record and POC for the certification period of 10/01/13 through 11/29/13 was reviewed.</p> <p>Her POC documented HHA visits were to be made 3 times a week for 9 weeks to assist with personal care, ADL's, and light house keeping as needed. However, there was no aide care plan</p>	G 224		

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G 224	<p>Continued From page 34 documented for this certification period.</p> <p>Home health aide visits were documented on 10/01/13, 10/04/13, 10/07/13, 10/08/13, 10/11/13, 10/14/13, and 10/18/13, during which the aide documented performing services including, but not limited to, vital signs, bathing, hair care, foot care, perineal care, skin care and ambulation.</p> <p>The Administrator reviewed Patient #6's record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed there was no documentation to indicate an aide care plan had been developed by an RN for this certification period. He confirmed that without an aide care plan, the aide did not have RN direction as to what care should be provided to Patient #6.</p> <p>Written instructions were not provided to the HHA.</p> <p>2. Patient #12's medical record documented an 81 year old female admitted to the agency on 9/06/13 with diagnoses of abnormal gait, Alzheimers, weakness, HTN, and abnormal weight loss. Her medical record for the certification periods of 9/06/13 through 11/04/13 and 11/05/13 through 1/03/14 were reviewed.</p> <p>Her POC for the certification period of 9/06/13 through 11/04/13 documented HHA visits were to occur twice a week for 4 weeks then once a week for one week. The aide care plan included taking vital signs, bathing assistance, hair care, mouth care, dressing, nail care, perineal care, skin care and ambulation and transfer assistance.</p> <p>Patient #12's POC for the following certification period of 11/05/13 through 01/03/13, documented</p>	G 224		
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G 224	<p>Continued From page 35</p> <p>HHA visits were to occur twice a week for 8 weeks. There was no aide care plan documented for this certification period. HHA visits were documented on 11/05/13, 11/07/13, and 11/13/13.</p> <p>The Administrator reviewed Patient #12's record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed there was no documentation to indicate an aide care plan had been developed by the RN for the certification period of 11/05/13 through 01/03/13. He confirmed that without an aide care plan, the aide did not have RN direction as to what care should be provided to Patient #12.</p> <p>Written instructions were not provided to the HHA.</p> <p>3. Patient #9's medical record documented a 79 year old female admitted to the agency on 11/13/12 with diagnoses including amputation, pressure ulcer, HTN, chronic pain, peripheral neuropathy and depression. Her medical record for the certification periods of 9/09/13 through 11/07/13 and 11/08/13 through 1/06/13 were reviewed.</p> <p>a. Her POC for the certification period 9/09/13 through 11/07/13 documented HHA visits were to occur three times a week for nine weeks to assist with personal care, ADL's and light house keeping. There was no aide care plan documented for this certification period. HHA visits were documented on 9/09/13, 9/13/13, 09/19/13, 9/24/13, 10/01/13, 10/05/13, 10/08/13, 10/10/13, 10/15/13, 10/19/13, 10/22/13, 10/24/13, 10/26/13, 10/30/13, 11/01/13, and 11/06/13. During the HHA visits, the HHA performed cares</p>	G 224		
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G 224 Continued From page 36 including, but not limited to bathing, skin care, nail care, dressing and assistance with ambulation.

b. Patient #9's POC for the following certification period of 11/08/13 through 1/06/14, documented HHA visits were to occur once a week for one week, then three times a week for eight weeks. There was no aide care plan documented for this certification period. HHA visits were documented on 11/08/13, 11/11/13, and 11/13/13. During the HHA visits, the HHA performed cares including, but not limited to, bathing, skin care, nail care, dressing and assistance with ambulation.

The Administrator reviewed Patient #9's record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed there was no documentation to indicate aide care plans had been developed by the RN for the certification periods of 9/09/13 through 11/07/13 and 11/08/13 through 1/06/14. He confirmed that without an aide care plan, the aide did not have RN direction as to what care should be provided to Patient #9.

Written instructions were not provided to the HHA.

4. Patient #10's medical record documented an 82 year old female admitted to the agency on 9/06/13 with diagnoses of muscle weakness and DM II. Her medical record for the certification periods of 9/06/13 through 11/04/13 and 11/05/13 through 1/03/14 were reviewed.

Patient #10's POC for the certification period of 8/07/13 to 10/05/13 did not include HHA visits. The aide care plan dated 8/07/13 included bathing assistance, hair care, dressing, skin care and assistance when using her walker.

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G 224 Continued From page 37

Patient #10's POC for the certification period of 10/06/13 to 12/04/13 documented HHA visits were to occur 3 times a week for 8 weeks. There was no aide care plan documented for this certification period. HHA visits were documented on 10/07/13, 10/09/13, 10/11/13, 10/14/13, 10/15/13, 10/18/13, 10/21/13, 10/22/13, 10/25/13, 10/28/13, 10/30/13, 11/01/13, 11/04/13, 11/06/13, 11/08/13, 11/11/13 and 11/13/13.

G 224

During an interview on 11/15/13 beginning at 8:30 AM, the Administrator reviewed Patient #10's record and confirmed there was no documentation to indicate an aide care plan had been developed by the RN for the certification period of 10/06/13 to 12/04/13. He confirmed that without an aide care plan, the aide did not have RN direction as to what care should be provided to Patient #10.

Written instructions were not provided to the HHA.

G 229 484.36(d)(2) SUPERVISION

G 229

The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.

This STANDARD is not met as evidenced by:
Based on record review, policy review, home visit observation, and staff interview, it was determined the agency failed to ensure home health aide supervisory visits were conducted every 14 days for 4 of 4 patients (#6, #9, #10 and

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G 229	<p>Continued From page 38</p> <p>#12) who received home health aide services and whose records were reviewed. This had the potential to interfere with the quality and safety of patient care. Findings include:</p> <p>During the entrance conference on 11/12/13 at 12:40 PM, the Administrator stated the RN was to document supervision of the HHA at least every 14 days on the RN visit note. The agency policy "Nurse Supervision," undated, stated "Home care aides will be supervised every 14 days or more often by an RN." The agency failed to adhere to this policy as follows:</p> <ol style="list-style-type: none"> 1. Patient #6's medical record documented a 92 year old female admitted to the agency on 8/07/12, with diagnoses of regional enteritis, dehydration, and care of a vascular catheter. Her medical record for the certification period of 10/01/13 through 11/29/13 was reviewed. <p>Her POC for the above certification period documented HHA visits were to be made 3 times a week for 9 weeks to assist with personal care, ADL's, and light house keeping as needed. There was no aide care plan documented for this certification period. An order dated 10/21/13, and signed by the physician 11/13/13, documented that due to Patient #6's preference not to have a male aide, aide services could no longer be offered and SN staff would be providing baths during SN visits and prn.</p> <p>Home health aide visits were documented on 10/01/13, 10/04/13, 10/07/13, 10/08/13, 10/11/13, 10/14/13, and 10/18/13, during which the aide documented performing vital signs, bathing, hair care, foot care, perineal care, skin care and ambulation. RN visits were documented on</p>	G 229		
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10/02/13, 10/04/13, 10/07/13, 10/09/13, 10/10/13, 10/17/13, 10/21/13, 10/24/13, 10/31/13, and 11/07/13. None of the RN visit notes contained documentation of HHA supervision.

The Administrator reviewed Patient #6's record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed there was no documentation to indicate aide supervision had occurred by the RN every 14 days.

2. Patient #12's medical record documented an 81 year old female admitted to the agency on 9/06/13, with diagnoses of abnormal gait, Alzheimers, weakness, HTN, and abnormal weight loss. Her medical record for the certification periods of 9/06/13 through 11/04/13 and 11/05/13 through 1/03/14 were reviewed. Patient #12 was receiving SN, PT, and HHA services.

Her POC for the certification period of 9/06/13 through 11/04/13 documented HHA visits were to occur twice a week for 4 weeks then once a week for one week. The aide care plan included taking vital signs, bathing assistance, hair care, mouth care, dressing, nail care, perineal care, skin care and ambulation and transfer assistance. The HHA documented visits on 9/09/13, 9/13/13, 9/16/13, 9/20/13, 9/23/13, 9/27/13, 9/30/13, 10/04/13, 10/07/13, 10/11/13, 10/14/13, 10/17/13, 10/21/13, 10/25/13, 10/28/13, and 11/01/13.

Patient #12's POC for the certification period of 11/05/13 through 01/03/13 documented HHA visits were to occur twice a week for 8 weeks. There was no aide care plan documented for this certification period. HHA visits were documented on 11/05/13, 11/07/13, and 11/13/13.

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G 229	<p>Continued From page 40</p> <p>RN visits were made to Patient #12 on 9/06/13, 9/12/13, 9/16/13, 9/24/13, 10/04/13, 10/11/13, 10/21/13, and 11/04/13. None of the RN visit notes contained documentation of HHA supervision.</p> <p>The Administrator reviewed Patient #12's record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed there was no documentation to indicate aide supervision had occurred by the RN every 14 days.</p> <p>3. Patient #9's medical record documented a 79 year old female admitted to the agency on 11/13/12, with diagnoses including amputation, pressure ulcer, HTN, chronic pain, peripheral neuropathy and depression. Her medical record for the certification periods of 9/09/13 through 11/07/13 and 11/08/13 through 1/06/13 were reviewed.</p> <p>a. Her POC for the certification period 9/09/13 through 11/07/13 documented HHA visits were to occur three times a week for nine weeks to assist with personal care, ADL's and light house keeping. There was no aide care plan for this certification period. HHA visits were documented on 9/09/13, 9/13/13, 09/19/13, 9/24/13, 10/01/13, 10/05/13, 10/08/13, 10/10/13, 10/15/13, 10/19/13, 10/22/13, 10/24/13, 10/26/13, 10/30/13, 11/01/13, and 11/06/13.</p> <p>During this certification period, RN visits were documented on 9/09/13, 9/11/13, 9/13/13, 9/16/13, 9/18/13, 9/20/13, 9/23/13, 9/25/13, 10/01/13, 10/03/13, 10/05/13, 10/08/13, 10/10/13, 10/12/13, 10/15/13, 10/17/13, 10/19/13, 10/22/13, 10/24/13, 10/26/13, 10/29/13, 10/30/13, 11/01/13,</p>	G 229		
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G 229	<p>Continued From page 41</p> <p>11/04/13, and 11/06/13. None of the RN visit notes contained documentation of HHA supervision.</p> <p>b. Patient #9's POC for the certification period of 11/08/13 through 1/06/14 documented HHA visits were to occur once a week for one week, then three times a week for eight weeks. HHA visits were documented on 11/08/13, 11/11/13, and 11/13/13.</p> <p>RN visits were documented on 11/08/13 and 11/11/13. None of the visit notes documented HHA supervision. In addition, an RN visit was observed by a surveyor on 11/13/13 beginning at 2:00 PM. The RN did not ask questions about the HHA during the visit.</p> <p>The Administrator reviewed Patient #9's record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed there was no documentation to indicate aide supervision had occurred by the RN every 14 days.</p> <p>4. Patient #10's medical record documented an 82 year old female admitted to the agency on 8/07/13, with diagnoses of muscle weakness and DM II. Her medical record for the certification periods of 8/07/13 through 10/05/13 and 10/06/13 to 12/04/13 were reviewed.</p> <p>a. The POC for the certification period of 8/07/13 to 10/05/13 did not include orders for HHA visits. There was an "AIDE/HOMEMAKER CARE PLAN," dated 8/07/13, which included bathing assistance, hair care, dressing, skin care, and assistance when using her walker.</p> <p>- Patient #10's record documented HHA visits on</p>	G 229		

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Continued From page 42
8/09/13, 8/12/13, 8/14/13, 8/16/13, 8/19/13, 8/21/13, 8/23/13, 8/26/13, 8/28/13, 8/30/13, 9/02/13, 9/04/13, 9/06/13, 9/09/13, 9/11/13, 9/13/13, 9/16/13, 9/18/13, 9/20/13, 9/22/13, 9/25/13, 9/27/13, 9/30/13, 10/02/13 and 10/04/13. RN visits were documented on 8/12/13 and 10/01/13. There was no documentation of supervision by the RN.

b. The POC for the certification period from 10/06/13 to 12/04/13 included orders for one skilled nursing visit to admit Patient #10 to services and 2 prn visits, as well as, physical therapy to evaluate and treat, and home health aide visits 3 times a week for 8 weeks.

- Patient #10's POC for the certification period of 10/06/13 to 12/04/13 documented HHA visits were to occur 3 times a week for 8 weeks. There was no aide care plan documented for this certification period. HHA visits were documented on 10/07/13, 10/09/13, 10/11/13, 10/14/13, 10/15/13, 10/18/13, 10/21/13, 10/22/13, 10/25/13, 10/28/13, 10/30/13, 11/01/13, 11/04/13, 11/06/13, 11/08/13, 11/11/13 and 11/13/13. There was no documentation of supervision by the RN.

The medical record contained documentation of home health aide and physical therapy visits throughout the admission. However, the medical record did not contain documentation that the Physical Therapist had completed home health aide supervision at any point during Patient #10's admission.

During an interview on 11/15/13 beginning at 8:30 AM, the Administrator reviewed Patient #10's record and confirmed there was no documentation that HHA supervision had

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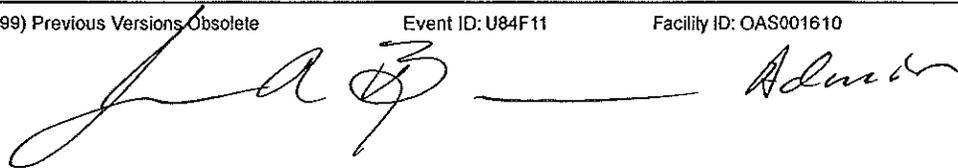
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G 229	Continued From page 43 occurred. He stated that as physical therapy was the only skilled service providing care to Patient #10, it was the Physical Therapist's responsibility to provide home health aide supervision. He confirmed that there was no documentation in the medical record to indicate the home health aide had been supervised by the Physical Therapist.	G 229		
G 331	The agency failed to ensure home health aide supervisory visits were completed when the only skilled service provided was physical therapy. 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 record review and staff and patient interview, it was determined the facility failed to ensure initial SOC comprehensive assessments were complete and included a thorough assessment to determine eligibility for the Medicare home health benefit for 2 of 12 patients, (#8 and #10) whose records were reviewed. This failure resulted in a lack of clarity regarding diagnoses and need and appropriateness of home health services. Findings include: 1. Patient #10 was an 81 year old female admitted to the agency on 8/07/13, for SN, HHA and PT services related to muscle weakness and DM II. A "Home Health Face-to-Face Encounter," was signed by Patient #10's physician on 9/17/13. The form certified that Patient #10 was	G 331		



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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 331	<p>Continued From page 44</p> <p>homebound because of a fall risk and her inability to leave her home without assistance.</p> <p>The recertification comprehensive assessment, dated 10/01/13, noted Patient #10 was homebound. The assessment included functional limitations as bowel/bladder incontinence, hearing, endurance, and ambulation. The "Safety Measures" section of the assessment stated Patient #10 required support during transfer and ambulation. The "Ambulation/Locomotion" section of the assessment stated Patient #10 was able to walk only with the supervision or assistance of another person at all times.</p> <p>During a home visit to observe care provided by the HHA, Patient #10 conversed with the HHA, and spoke of working as a foster grandparent. Upon further discussion, she stated she worked as a volunteer at a local elementary school 15 hours a week. She stated she independently boarded public transportation, used her walker, and was at the school 3 days a week to assist children in their reading activities.</p> <p>During an interview on 11/15/13 beginning at 8:30 AM, the Administrator and DON reviewed Patient #10's record. The DON stated she was not aware that Patient #11 was not homebound. She stated she would confirm the activities with Patient #11 and her family, then obtain physician orders to discharge her from home health if she was determined to not be homebound.</p> <p>Patient #10's described activities were inconsistent with the 10/01/13 assessment, and raised questions regarding whether she met homebound criteria.</p>
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G 331

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G 331 Continued From page 45

2. Patient #8 was an 81 year old female admitted to the agency on 11/07/13. Her POC did not contain diagnoses as of 11/15/13. Her medical record for the certification period of 11/07/13 through 1/05/14 was reviewed.

An order request, written by agency staff on 11/07/13, contained a request to admit Patient #8 to home health services, including SN once a week for 4 weeks and PT to evaluate and treat. There was no documentation on the request to indicate the reason for home health admission. The order request was not signed by a physician. There was no documentation on the order to indicate a verbal order for home health services had been received.

The comprehensive assessment, documented by the RN on 11/07/13, did not contain diagnoses for which Patient #8 was receiving home care.

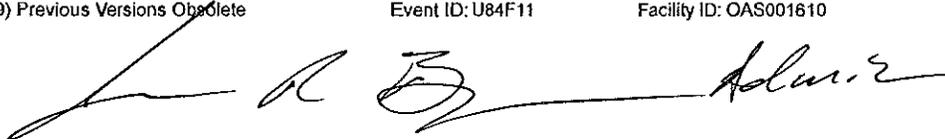
The Administrator reviewed the record and was interviewed on 11/14/13 beginning at 1:30 PM. He confirmed the assessment was not complete. He confirmed it was difficult to determine the reason Patient #8 was receiving home health services. He stated Patient #8 had been a community referral and was admitted to home health for generalized weakness, but confirmed there was no documentation to indicate this.

G 331

G 337 484.55(c) DRUG REGIMEN REVIEW

The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse

G 337



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NAME OF PROVIDER OR SUPPLIER AVALON HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 403 1ST ST IDAHO FALLS, ID 83401
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G 337	<p>Continued From page 46</p> <p>effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>This STANDARD is not met as evidenced by: Based on record review, policy review, observations during home visits, staff interview and patient interview, it was determined the agency failed to ensure the drug review was comprehensive for 1 of 6 patients (#10) who were visited in their homes. Failure to obtain an accurate patient medication list or to evaluate the list for duplicative therapy, drug interactions, or significant side effects had the potential to place patients at risk for adverse events or negative drug interactions. Findings include:</p> <p>A policy, titled "Medication Profile," undated, noted "It is the responsibility of the admitting therapist/nurse to record all medications that the patient is currently taking on a routine or PRN basis. Documentation will include upon admission, the medication, route, amount and frequency." The policy did not include questioning the patient or caregiver regarding medication changes or updates during visits.</p> <p>1. Patient #10 was an 81 year old female admitted to the agency on 8/07/13 for SN, HHA and PT services related to muscle weakness and DM II.</p> <p>A home visit was conducted on 11/13/13, at 4:00 PM to observe care provided by the HHA. Patient #10's granddaughter brought out two trays of medications and stated they were current as ordered by her physician. The following discrepancies were noted with the home</p>	G 337		
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NAME OF PROVIDER OR SUPPLIER AVALON HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 403 1ST ST IDAHO FALLS, ID 83401		
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G 337	<p>Continued From page 47</p> <p>medication regime for Patient #10 compared to the POC for the certification period 10/06/13 to 12/04/13.</p> <p>Patient #10 was currently taking:</p> <ul style="list-style-type: none"> a. Trazodone 150 mg, 1 daily. The POC indicated 50 mg, 1 daily. b. Cinnamon, 1000 mg, 2 daily. The POC indicated 500 mg, 2 daily. c. Flaxseed Oil, 1300 mg, 1 daily. The POC indicated 5 mg, twice daily. d. Lower Bowel Stimulant II, 2 daily. The POC indicated 1 daily. e. Oxycodone 5 mg, 1 tablet daily. The POC indicated 5 mg/ml liquid, twice daily. f. Vitamin C 500 mg, 1 daily, however, it was not included on the POC. g. Atenelol 25 mg, 1 daily, however, it was not included on the POC. h. Chlortalidone 25 mg, 1 daily, however, it was not included on the POC. i. Simvastatin 10 mg, 1 daily, however, it was not included on the POC. j. Gabapentin 300 mg, 1 daily, however, it was not included on the POC. k. Omeprazole 20 mg, 1 daily, however, it was not included on the POC. 	G 337		

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G 337	<p>Continued From page 48</p> <p>l. Bactrim DS 800-160, 1 daily, however, it was not included on the POC.</p> <p>m. Multivitamin with Iron, 1 daily was on the POC, but Patient #10's family member stated the medication was not included in her regime.</p> <p>In an interview on 11/15/13 beginning at 8:30 AM, the Administrator reviewed Patient #10's record, as well as, the list of medications her family member had provided that she was currently taking. He confirmed the discrepancies with what was included on the POC.</p> <p>Medications were not reviewed and updated to reflect Patient #10's current medication routine.</p>	G 337		
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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	<p>16.03.07 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the licensure survey of your home health agency completed 11/12/13 through 11/15/13.</p> <p>The surveyors conducting the survey were:</p> <p>Susan Costa RN, HFS, Team Lead Libby Doane BSN, RN, HFS</p>	N 000		
N 051	<p>03.07021. ADMINISTRATOR</p> <p>N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:</p> <p>e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations.</p> <p>This Rule is not met as evidenced by: Refer to G-141 as it related to the agency's failure to ensure personnel records contained current CPR certification.</p>	N 051	<p><i>Please refer to Plan of Correction for G-141 on the attached worksheet</i></p> <p>RECEIVED</p> <p>DEC 30 2013</p> <p>FACILITY STANDARDS</p>	
N 156	<p>03.07030.PLAN OF CARE.</p> <p>N156 01. Written Plan of Care. A</p>	N 156	<p><i>Refer to Attached POC section G-159</i></p>	

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

TITLE
Exec. Director

(X6) DATE
12/9/13

JRB
12/9/13

Bureau of Facility Standards

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N 156	Continued From page 1 written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: d. Frequency of visits; This Rule is not met as evidenced by: Refer to G 159 as it relates to the failure of the agency to ensure the plan of care included included all pertinent information, including types of services and frequency of visits for PT and the HHA.	N 156		
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 as it relates to the failure of the agency to ensure care followed a physician's written POC.	N 170	<i>Refer to Attached POC Section G-158 for our response to 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 as it relates to notification of a physician to any changes that suggest a need to	N 172	<i>Refer to attached POC Section G-164 for our response to this area.</i>	

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STATE FORM

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If continuation sheet 2 of 5

[Signature]
12/9/13

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AVALON HOME HEALTH

403 1ST ST
IDAHO FALLS, ID 83401

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N 172	Continued From page 2 alter the plan of care.	N 172		
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G337 as it relates to the agency's failure to ensure comprehensive medication reviews during initial or recertification assessments.	N 173	<i>Please refer to attached POC in sect. G-337</i>	
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)	N 199	<i>Please refer to POC section G-141 attached to this document.</i>	


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N 199	<p>Continued From page 3</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must complete an application before having access to patients. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any patient without a clearance by the Department. Once the notarized application is completed the individual can only work under supervision until the individual has been fingerprinted. The individual must have his fingerprints submitted to the Department within twenty-one (21) days of completion of the notarized application. (3-26-08)</p> <p>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 13 direct patient care staff (Staff E) whose personnel files were reviewed. This had the potential to allow an employee who may have had disqualifying crimes access to patients. Findings include:</p> <p>Personnel records were reviewed with the Administrator on 11/14/13 at 1:30 PM. The following personnel file did not contain a criminal history background check:</p> <p>Staff E, LPN, hired 5/13/13</p> <p>The Administrator reviewed the personnel file and was interviewed on 11/14/13 at 1:30 PM. He confirmed Staff E provided direct patient care. He also confirmed the personnel file for Staff E lacked evidence of a criminal history background check.</p>	N 199		
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N 199	Continued From page 4 The agency did not ensure all direct care staff had completed a qualifying criminal history background check.	N 199		

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12/9/13



G 141, N 051, N 199 - Personnel Policies

The findings of the state survey indicated that 5 out of 13 staff did not have documentation of CPR in their personnel files and 1 Staff LPN did not have a current background check in place. What led to the deficiency in this area was a lack of attention and review of the personnel files.

1. Corrective Action

- a. A complete review of personnel files has determined which personnel do not have adequate documentation in their file for CPR certification or federal background check. Regardless of the reason for the lack of documentation, all personnel who are found not to have CPR certification will renew or recertify by December 22. All Personnel who are found to not have a current background check will schedule one immediately and cease patient care until scheduling has taken place.
- b. The process will be corrected by allocating time and personnel to the review and implementation of correct documentation for all personnel files. The required personnel prerequisites will be collected and documented before the employee can start seeing patients.
- c. A tracking form has been modified to show all of the potentially required personnel documents that must be in place before patient care and employee duties can begin as well as expiration dates of documentation where applicable. A job description for each role in the company will be signed by the respective employee and will also dictate which documents must be collected in order for that personnel chart to be complete.
- d. These tracking forms will be reviewed often (at least quarterly) to ensure correctness and compliance. Though this deficiency reflects a lack of proper CPR documentation, this revised procedure will ensure that all required documentation will be maintained in compliance with policy and procedure as well as federal regulation.

2. Company Policy

- a. It is the current policy of this company that the home health program will recruit and retain qualified personnel. Documentation of these efforts will be evidenced in the home health personnel and health record for each employee hired by the organization. Staff will be selected based on education, experience, specialized training, communication, and interpersonal skills in accordance with job description requirements. Policy # HH:3-001.1

3. Company Procedure

- a. Prior to higher, the organization will secure multiple reference checks, health reports as required by the state or policy, criminal record

checks when required by law, proof of citizenship or documentation of resident status, and any other prerequisite as outlined by the official job description listed in section 6 of this policy and procedure manual. Professional personnel will submit copies of their diplomas or transcripts showing successful completion of the approved/accredited program. These copies will be retained in the individuals personnel file. Clinical personnel will maintain active licensure or verification. Verification of current licensure or certification will be filed in the personnel record. (Procedure # HH:3-001.1.3-5)

4. Responsible Parties and Compliance Dates

The administrator, or designee under the direction of the administrator, will be responsible to review the charts often for compliance and correctness. The corrective procedure as well as the completed corrective actions will be fully implemented and in compliance by December 22, 2013.

G 143 - Coordination of Patient Services



The findings of the recent state survey indicated that 3 out of 12 patients had issues of care coordination between the various disciplines involved in the PoC. These inconsistencies interfered with the quality and continuity of patient care.

1. Corrective Action

- a. All employees will document within 48 hours every visit provided to a patient, any communication regarding that patient's plan of care, and/or any change of condition.
- b. Avalon Home Health has published parameters for vital signs that indicate the thresholds for safety. Education will also be given on the parameters as well as the procedure that needs to be followed if any readings are outside of normal.
- c. The RN that provides the admitting assessment will also thoroughly review the original service orders and ensure that all prescribed services initiate care within 48 hours unless otherwise dictated by a doctor's order. This will be added as a focus area in our QA/OBQI program and will not be cleared as a focus area until 100% of care plans demonstrate compliance to the federal standard for any given quarter (3 consecutive months).

2. Company Policy

- a. It is currently the policy of this company to provide complete and accurate documentation within 48 hours of every visit or communication regarding the patient's plan of care. (Policy # HH:2-013.1) In response to the failure to follow this policy, the administrator and director of nursing will be conducting education opportunities for all staff to reinforce this policy as well as the procedure to ensure that the policy is met. Employees that fail to comply to the standard will go through disciplinary action, and if necessary, terminated.
- b. Avalon has added Vital Sign Safety Parameters to our policy and procedures. It is now the policy of this company that if any vital sign readings fall outside the published safety parameters that the director of nursing, or case manager designee, will be contacted and physician notified for guidance on how to address the issue. (Policy # HH:2-015.1) The vital sign parameters that are now published within our Policy and Procedures that have been suggested and endorsed by our Medical Director are as follows:
 - i. Blood pressure: Systolic range must be between 80 - 180 and Diastolic must be between 50 - 90
 - ii. SPO2%: 88-100%
 - iii. Pulse: 60 - 120 beats per minute
 - iv. Temperature: 96 - 100.5 degrees Fahrenheit

- c. It is the policy of this company that a clinical supervisor will assign clinical personnel to conduct initial assessments of eligibility for services within 48 hours of acceptance of a referral information and or discharge information from her referring facility. (Policy # HH:2-003.2)

3. Company Procedure

- a. Employees Will complete the necessary documentation at point of care when ever possible or will come back to the computers made available to them at the office to finish their documentation as quickly as possible, never to exceed 48 hours for visits, communications, or changes in condition, or 72 hours for admissions. Any communication between disciplines, physicians, or family members as it pertains to the plan of care of any patient, will also be documented thoroughly within 48 hours of it occurring. (Policy # HH:2-013.1)
- b. This company's official procedure indicates that the patient's physician will be contacted on the same day one any of the following occur: (Policy # HH:2-015.1.3.A-C)
 - i. Significant changes in the patient's condition
 - ii. Vital sign readings that fall outside of the published safety parameters.
 - iii. Significant changes in the patient's psychosocial status, family/caregiver support, home environment.
This Communication will be required (as stated above) to be documented within 48 hours and made aware to all appropriate caregivers participating in that patient's plan of care via a care coordination note within that patients' medical record.
- c. When an initial or recertification order from a doctor is received, the admitting nurse will go through the orders thoroughly and circle all disciplines ordered in the care of that patient. All disciplines ordered will then be dispatched to provide their initial evaluations. The director of nursing, or designee operating under the authority of the director of nursing, will audit initial doctor orders until 100% of the orders and Plans of care are fulfilled within that calendar month. At that point, the initial doctor order will remain a focal point in all subsequent chart audits performed in accordance to Federal guidelines and Avalon home health's OBQI program.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.



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

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

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

1. Action Taken

- a. Avalon Home Health has published parameters for vital signs that indicate the thresholds for safety. If at any time patient readings fall outside these parameters, employees will report the findings to the DON (or designated case manager under the direction of the DON) and nursing will notify the physician and follow the physician's subsequent direction. This Communication will be required (as stated above) to be documented within 48 hours and made aware to all appropriate caregivers participating in that patient's plan of care via a care coordination note within that patients' medical record.
- b. The RN that provides the admitting assessment will also thoroughly review the original service orders and ensure that all prescribed services initiate care within 48 hours unless otherwise dictated by a doctor's order.
- c. The written and verbal orders have been added as a focus area in our OBQI program and will not be cleared as a focus area until 100% of care plans demonstrate compliance to the federal standard for any given quarter (3 consecutive months).

2. Company Policy

- a. Avalon has added Vital Sign Safety Parameters to our policy and procedures. It is now the policy of this company that if any vital sign readings fall outside the published safety parameters that the director of nursing, or case manager designee, will be contacted and physician notified for guidance on how to address the issue. (Policy # HH:2-015.1)
- b. It is currently the policy of this company to provide complete and accurate documentation within 48 hours of every visit or communication regarding the patient's plan of care. In response to the failure to follow this policy, the administrator and director of nursing will be conducting education opportunities for all staff to reinforce this policy as well as the procedure to ensure that the

policy is met. Employees that fail to comply to the standard will go through disciplinary action, and if necessary, termination. (Policy # HH:2-013.1)

- c. It is currently the policy of this company that all aspects of patient care are directed and signed off by a physician. Orders to clarify initial orders, frequency, disciplines, etc. all fall under this policy that a physician directs and signs off on all aspects of the plans of care. It is the policy of this company to call and received orders verbally before documenting it on a verbal order or modifying the plan of care in any way or wait until a physician signature is applied to proceed with what was ordered. (Policy # HH:2-005.1)

3. Company Procedure

- a. Nurses and CNA's will know and follow safety parameters for vital signs. This company's official procedure indicates that the patient's physician will be contacted on the same day any of the following occur: (Policy # HH:2-015.1.3.A-C)
 - i. Significant changes in the patient's condition
 - ii. Vital sign readings that fall outside of the published safety parameters.
 - iii. Significant changes in the patient's psychosocial status, family/caregiver support, home environment.This Communication will be required (as stated above) to be documented within 48 hours and made aware to all appropriate caregivers participating in that patient's plan of care via a care coordination note within that patients' medical record.
- b. It is the official procedure of this company that employees will complete the necessary documentation at point of care when ever possible or will come back to the computers made available to them at the office to finish their documentation as quickly as possible, never to exceed 48 hours for visits, communications, or changes in condition, or 72 hours for admissions. Any communication between disciplines, physicians, or family members as it pertains to the plan of care of any patient, will also be documented thoroughly within 48 hours of it occurring. (Policy # HH:2-013.1)
- c. It is the official procedure this company that physician orders will be individualized and based on patient needs. The attending physician's verbal orders will be obtained at the time the plan of care is established. The attending physician will sign the plan of care/treatment within 30 days of the start of care. The attending physician's recertification will be obtained in intervals of at least every 60 days, when the patient's plan of care is reviewed, the patient recertified, and more often if warranted. (Policy # HH:2-005.1)

5. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.

G 159, N 156 - Plan of Care



The findings of the state survey that triggered these deficiencies were based on three areas. The orders received from the physician were not identified as Verbal, and therefore physician oversight could not be verified. The Recertification therapy evaluations were not auto-populating to the POC, resulting in POC's not including therapy goals and frequencies. Lastly, an original OT order was missed on the initial admit documentation. The actions listed below addresses these three issues.

1. Action taken

- a. All orders written for physician signature will be clearly marked whether the order is intended to be a written request for signature or a verbal order clarified over the phone with the physician. The EMR system used by Avalon Home Health has been altered to cue the writer of the order to mark it as written or verbal before the software will let the user save and exit out of the form. This ensures all orders will be correctly marked to their actual purpose. This also ensures that discipline, frequency, and in some cases, initial orders will demonstrate physician involvement, as they will be designated as written orders or as verbal clarifications. All care requiring immediate execution will be (per policy) clarified by the physician over the phone for his/her consent and any further direction the physician wants to impart. All other orders will be submitted to the physician as a written request for signature.
- b. Action has been taken with the EMR used by Avalon Home Health that addresses the issue of recertification evaluations performed by therapy not auto-populating to the recertification POC. The EMR update has fixed this issue so therapy evaluations done for the recertification will now auto-populate to the POC.
- c. The RN that provides the admitting assessment will also thoroughly review the original service orders and ensure that all prescribed services initiate care within 48 hours unless otherwise dictated by a doctor's order. This will be added as a focus area in our QA/OBQI program and will not be cleared as a focus area until 100% of care plans demonstrate compliance to the federal standard for any given quarter (3 consecutive months).

2. Company Policy

- a. It is currently the policy of this company 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) The EMR update allows us to be compliant with our existing company policy to ensure that all patient care is being directed and overseen by a physician.

- b. It is the policy of this company to address a physician order within 48 hours of the order being given. The initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patients return home, or on the start of care date ordered by the physician. (Policy # HH:2-003.2)

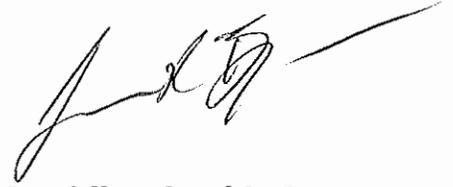
3. Correcting Procedure

- a. The following procedure will be part of our education to our clinical staff to realign them to our policy and procedure regarding this matter. All disciplines will receive verbal direction from a physician or a signed order from a physician prior to initiating care or modifying care from an existing plan of care. Direction and orders received over the phone will be indicated on the order as being received verbally. Any orders not indicated as verbal will not be valid until signed by a physician. (Policy # HH:2-005.1)
- b. The procedure for Therapy frequency and goals populating to the POC is largely a function of the EMR. However, as previously listed, the modification of our system of having the DON (or designee) audit all initial and recertification orders and POCs will also double check the EMR function of ensuring all ordered disciplines are part of the Plan of Care. When an initial order or recertification order from a doctor is received, the admitting nurse will go through the orders thoroughly and circle all disciplines ordered in the care of that patient. All disciplines ordered will then be dispatched to provide their initial evaluations. (Policy # HH:2-003.2) The director of nursing, or designee operating under the authority of the director of nursing, will audit initial doctor orders and Plans of care until 100% of the orders are fulfilled within that calendar month. At that point, the initial doctor order will remain a focal point in all subsequent chart audits performed in accordance to Federal guidelines and Avalon home health's OBQI program.
- c. The procedure listed directly above in subset b. of this section will address the missing discipline as well as verifying that the POCs are correct.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines outlined in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.

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



The recent state survey indicates 2 primary issues that fall under this G tag/ N Tag that necessitate the deficiency being cited. The first is the previously identified issue of the RN not communicating or clarifying to the physician a blood pressure that fell outside safe parameters. The second issue was the lack of documentation completed within a timely matter that would explain the actions of an LPN in response to the CNA relaying family concerns of a mini Stroke. The following plan is in place to correct the issues that led to this citation:

1. Action Taken

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

2. Correcting the Policy

- a. Avalon has added Vital Sign Safety Parameters to our policy and procedures. It is now the policy of this company that if any vital sign readings fall outside the published safety parameters that the director of nursing, or case manager designee, will be contacted and physician notified for guidance on how to address the issue. (Policy # HH:2-015.1) The vital sign parameters that are now published within our Policy and Procedures that have been suggested and endorsed by our Medical Director are as follows:
 - i. Blood pressure: Systolic range must be between 80 - 180 and Diastolic must be between 50 - 90
 - ii. SPO2%: 88-100%
 - iii. Pulse: 60 - 120 beats per minute
 - iv. Temperature: 96 - 100.5 degrees Fahrenheit
- b. It is currently the policy of this company to provide complete and accurate documentation within 48 hours of every visit or

communication regarding the patient's plan of care. (Policy # HH:2-013.1)

3. Correcting the Procedure

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

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

- b. As outlined above, education will take place regarding timeliness of documentation as well as corrective action or punitive action as necessary. Employees Will complete the necessary documentation at point of care when ever possible or will come back to the computers made available to them at the office to finish their documentation as quickly as possible, never to exceed 48 hours for visits or 72 hours for admissions. Any communication between disciplines, physicians, or family members as it pertains to the plan of care of any patient, will also be documented thoroughly within 48 hours of it occurring.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines outlined in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.

G 169 – Skilled Nursing Services

State survey findings indicate that 1 of 4 patients being seen by an LPN did not have the appropriate documentation demonstrating supervision by an RN. The following action has been taken to rectify the deficiency cited.

1. Action Taken
 - a. Education has taken place on November 20th and 21st outlining the necessity of RN supervision at least every 14 days. RN oversight visits will take place at least every 14 days or punitive action will occur and potentially termination of employment.
 - b. LPNs have also been tasked to inform Case Manager/DON on upcoming needs for supervisory visits a week prior to them being due.
 - c.

2. Correcting the Policy
 - a. It is already the policy of this company to follow the federal standard and provide LPN oversight visits at least every 14 days for patients receiving care from an LPN.

3. Correcting the Procedure
 - a. It is currently the Procedure of this company to ensure that any LPN seeing patients for a Home Health POC is over sighted at least every 14 days. The paperwork system/EMR that we currently use has a section on every visit note set aside to address supervisory visits for both LPN and CNA. The procedure that is currently in place is that the RN marks the appropriate boxes on the visit note as well as makes the appropriate free form commentary on the LPN's performance as per the patient report. The RN also ensures that the LPN is following the Physician signed Plan of Care without deviating from the goals outlined on that document. They are to ensure that this section of the note is filled out no more than 13 days between LPN visits. Education has already taken place on this subject on November 20th and 21st and will be reinforced on December 17th and 18th. RNs will also verify receipt and understanding of this information by signing the in-service forms provided to them.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines outlined in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.

G 180 – Duties of a Licensed Practical Nurse

The recent state survey findings indicate a deficiency in this area due to documentation not being completed on the appropriate forms in a timely manner. The following actions have been taken to rectify the deficiency:

1. Action Taken

- a. Policies and procedures on timeliness of documentation guidelines of been reviewed and found to be in compliance with state and federal guidelines.
- b. Education has been provided on November 20th and 21st reinforcing our current policy and procedure stating that all documentation of services and communications will take place within 48 hours. This re-education for our clinical staff involved all disciplines, including LPN's.
- c. Tracking of the timeliness of documentation will be a focus area for our QA/OBQI program. Checking timeliness of documentation can be measured by comparing form dates/visit dates to the electronic signature date on the bottom of each form. This focus area will remain as part of the QA/OBQI program until 90% of documentation meets timeliness guidelines for any given quarter (3 consecutive months).

2. Company Policy

- a. It is the Policy of this company to have documentation entered in the EMR within 72 hours for Admission paperwork, and 48 hours of any other kind of visit or communication. (Policy # HH:2-013.1) The LPN in question for this deficiency did not adhere to this policy, but also other staff members were found by this survey to have similar timeliness issues that contributed to other deficiencies. Since the Policy is current and covers state and federal rules in this matter, the response to this deficiency will be to educate and realign clinical staff the adherence of said policy.

3. Company Procedure

- a. As outlined above, education will take place regarding timeliness of documentation as well as corrective action or punitive action as necessary. Employees Will complete the necessary documentation at point of care when ever possible or will come back to the computers made available to them at the office to finish their documentation as quickly as possible, never to exceed 48 hours for visits, communications, or changes in condition, or 72 hours for admissions. Any communication between disciplines, physicians, or family members as it pertains to the plan of care of any patient,

will also be documented thoroughly within 48 hours of it occurring.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines outlined in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.

**Condition Of Participation – G 212 - Competency Assessments for CNA's, G 214
- Annual Performance review for CNA, G 224 – CNA RN Written Instruction**

G 212 – Competency Assessments for CNA

Findings of the recent survey indicate that CNA competencies were not completed in 3 out of 5 CNA personnel files. The following action has been taken to ensure compliance is regained as it pertains to this deficiency.

1. Action Taken

- a. All current CNA staff will have full competencies completed by December 22nd, 2013 and all new staff will have mandatory competencies signed off on prior to doing any unsupervised client care. Ongoing compliance to this standard will be tracked via a spreadsheet that includes mandatory items, tasks, and completion dates to ensure that we are maintaining compliance across all personnel throughout the year.

2. Correcting the Policy

- a. It is the current policy of this company to provide every employee with a job description and competency checklist upon hire and annually that needs to be filled out as part of the employee's orientation process and annual review. Although not all items on the list are required before client care begins, there are specially marked items on the competency form that must be checked off before the CNA can work with patients without the nurse present. Policy # HH:3-011.1.

3. Correcting the Procedure

- a. As part of the orientation process, a preceptor/clinical supervisor will be assigned each person. Using a competency skills performance checklist, and orientation checklist, the preceptor/clinical supervisor will observe the new personnel performing the required skills and activities. Upon completion of the checklists, the new personnel will end the orientation/probationary period. Procedure # HH:3-0111.1. This procedure meets the federal and state guidelines for home health. Therefore, education needs to be provided to staff to ensure re-alignment of there compliance to this procedure.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines outlined in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.

G 224 - Assignment of Duties to a Home Health Aid

The recent state survey findings indicate that written instructions from an RN for home health aid care plans were not found in patient charts. The certification periods cited are all subsequent certification periods and both clinician and EMR issues have been identified as to why this was a problem. The actions listed below indicate what we have done to rectify the situation and prevent it from occurring in the future:

1. Action Taken

- a. It was identified that the EMR documentation did not populate the HHA care plan into subsequent certification periods and RN oversight was not in all cases updating the HHA care plan since it was not present in the EMR's current certification period. The form used has the ability to be updated for up to 4 certification periods but was not able to be moved out of the EMR's 1st certification period for any given patient. The action taken to fix this issue was threefold:
 - i. EMR software was modified to auto-populate the prior certification periods HHA care plan to the current certification period, thereby making it available to update with current needs and necessary changes (if any are needed).
 - ii. RNs have been re-educated on November 20th and 21st on the policy and procedure of timely updates for the HHA care plan and ensuring HHA compliance to that plan through supervisory visits. Reinforcement of this policy and procedure are also scheduled to happen on December 17th and 18th of this year
 - iii. HHA care plans have been added as a focus area in our QA/OBQI program and will not be cleared as a focus area until 100% of care plans demonstrate compliance to the federal standard for any given quarter (3 consecutive months).

2. Company Policy

- a. It is the current policy of this company that each patient receiving home health aide services will have an individualized plan developed by an appropriate professional and utilized to direct the care performed by the assigned aide. Policy # HH:2-009.1. Since the policy is current and addresses all necessary state and federal standards, the action plans consisted of software modification, staff education, and tracking in our quality assurance program.

3. Company Procedure

- a. The patient's case manager, upon initialization of aide services, will develop the home health aide plan of care, consistent with the comprehensive plan of care and physician orders.

- b. The home health aide plan of care will be individualized to be specific to the needs of the patient
- c. The case manager will review the home health aide plan of care with the aid assigned to the case. The case manager and assigned aide will sign the home health aide plan of care.
- d. The home health aide plan of care will be revised at least every 60 days based upon a professional reassessment of the patient and it any time the patients change of condition warrants revision.
- e. The case manager will review changes to the home health aide plan of care with the assigned aide the case manager and aid will initial the plan to indicate this review has occurred.
- f. The home health aide care plan will be reviewed with the patient to ensure understanding of the AIDS role in the home.
- g. A current copy of the home health aide plan of care will be maintained in the patient's home.
- h. The case manager or other appropriate clinician, will supervise the home health aide at least every two weeks to ensure care is provided according to plan.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines outlined in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.

G 229 - Home Health Aid Supervision

The recent state survey indicated that the appropriate professionals were not supervising home health aides every 14 days as per the federal standard. It is been identified that clinicians are not filling out the appropriate part of our visit forms to indicate that supervision of a CNA has happened. Both RN as well as therapy professionals have been educated to the standard. The following are the actions taken to rectify this deficiency:

1. Action Taken

- a. RN's have been re-educated to the standard of supervision of a CNA at least every 14 days. They have also received education on the appropriate policy and procedure to ensure that all aspects of the home health aide care plan are fulfilled and supervised correctly by the appropriate professional.
- b. Therapy professionals, our staff therapists as well as contract therapists, have been re-educated to the Standard of supervision of a home health a plan of care that must take place every 14 days. Our therapy professionals have been educated that when nursing is no longer part of the plan of care, the therapy professional must be the supervisory discipline for they home health aide care plan at least every 14 days.
- c. As indicated under G224, the HHA care plans have been added as a focus area in our OBQI program and will not be cleared as a focus area until 100% of care plans demonstrate compliance to the federal standard for any given quarter (3 consecutive months).

2. Company Policy

- a. It is the current policy of this company that each patient receiving home health aide services will have an individualized plan developed by an appropriate professional and utilized to direct the care performed by the assigned aide. Policy # HH:2-009.1. Since the policy is current and addresses all necessary state and federal standards, the action plans consisted of software modification, staff education, and tracking in our quality assurance program.

3. Company Procedure

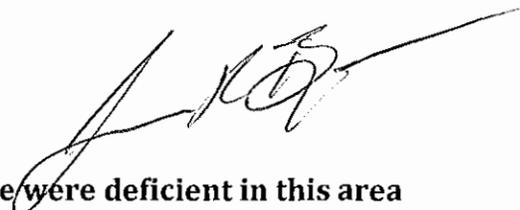
- a. The patient's case manager, upon initialization of aide services, will develop the home health aide plan of care, consistent with the comprehensive plan of care and physician orders.
- b. The home health aide plan of care will be individualized to be specific to the needs of the patient
- c. The case manager will review the home health aide plan of care with the aid assigned to the case. The case manager and assigned aide will sign the home health aide plan of care.

- d. The home health aide plan of care will be revised at least every 60 days based upon a professional reassessment of the patient and at any time the patient's change of condition warrants revision.
- e. The case manager will review changes to the home health aide plan of care with the assigned aide. The case manager and aide will initial the plan to indicate this review has occurred.
- f. The home health aide care plan will be reviewed with the patient to ensure understanding of the aide's role in the home.
- g. A current copy of the home health aide plan of care will be maintained in the patient's home.
- h. The case manager or other appropriate clinician, will supervise the home health aide at least every two weeks to ensure care is provided according to plan.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines outlined in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.

G 331 – Initial Assessment Visit



The recent state surveys findings concluded that we were deficient in this area because of two different issues. The first issue was the appropriate assessment of homebound status, and the second issue was the appropriate verbal order or signed physician order to initiate care. These issues are addressed by two different policies and procedures within our policy and procedure manual. The following are the actions that this company has taken to ensure that the deficiencies are rectified and ongoing compliance can be achieved.

1. Action Taken

- a. Reeducation as been provided to all of our nurses and physical therapists that are responsible to do an initial assessments for home health as well as ongoing assessments for homebound status. Education as to what homebound status means was based on our policy (HH:2-003.2) listed below, which is also compliant with the definition of homebound status as found in CMS operations manual chapter 7.
- b. As indicated under sections G 158 and G 159, All orders written for physician signature will be clearly marked whether the order is intended to be a written request for signature or a verbal order clarified over the phone with the physician. The EMR system used by Avalon Home Health has been altered to cue the writer of the order to mark it as written or verbal before the software will let the user save and exit out of the form. This ensures all orders will be correctly marked to their actual purpose. This also ensures that discipline, frequency, and in some cases even initial orders will demonstrate physician involvement, as they will be designated as written orders or as verbal orders/clarifications. All care requiring immediate execution will be (per policy) clarified by the physician over the phone for his/her consent and any further direction the physician wants to impart. All other orders will be submitted to the physician as a written request for signature.
- c. Also as indicated under G 158 and G 159, the written and verbal orders have been added as a focus area in our OBQI program and will not be cleared as a focus area until 100% of care plans demonstrate compliance to the federal standard for any given quarter (3 consecutive months).

2. Company Policy

- a. It is our current company policy that services may be provided to a patient insured by Medicare who has a primary need for skilled nursing, physical and/or speech therapy on an intermittent basis and is homebound. (A patient is considered to be homebound if he/she has a condition that restricts his/her ability to leave his/her place of

residence except with the aid of supportive devices, the use of special transportation, the assistance of another person, or if he/she has a condition which is such that leaving his/her home is medically contraindicated.) Policy # HH:2-003.2:6

- b. It is also the policy of this company that a physician will direct the care of every home health care patient admitted for service. The attending physician will certify that Medical, skilled, rehabilitative, and social services provided by the organization are medically required for the patient. The attending physician will participate in the care planning process by initiating, reviewing, and revising therapeutic and diagnostic orders. The care will be provided in compliance with the therapeutic and diagnostic orders and excepted standards and practice. Policy # HH:2-005.1

3. Company Procedure

- a. Our current company procedures outline that upon initial assessment, the patient must be assessed for homebound status if participating in the Medicare program. It is also part of our procedure that in every visit, Medicare patients are assessed for ongoing homebound status. If this procedure was followed thoroughly, there would not have been a deficiency cited on this topic. The complete policy and procedure has been attached for further review if necessary.
- b. Our current company procedures for Dr. orders indicate that the attending physician's verbal orders will be obtained at the time the plan of care is established. The attending physician will also sign the plan of care within 30 days of the start of care. (Procedure # HH:2-005.1). Verbal orders are further clarified in procedure # HH:2-006.1 by stating that "all telephone orders will be received and processed in accordance with state and federal laws and regulations. All telephone orders or verbal orders will be read back to the physician (or other authorized licensed independent practitioner) or designee to assure accuracy. Orders will be documented on a form provided by Avalon Home Health, dated and signed by the professional receiving the order. A copy of the physicians order will be kept in the clinical record and the original order form will be delivered to the physician for signature.

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines outlined in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.

G 337, N 173 – Drug Regimen Review

The recent state survey indicates a deficiency in this area due to a medication profile that was not complete. This was found during a patient interview that the surveyor conducted, where the patient expressed having more medications or nutritional supplements than were indicated on the comprehensive medication profile. The following actions have been taken to ensure this deficiency will not be repeated and ongoing compliance will be maintained.

1. Action Taken

- a. Our company policies and procedures regarding the medication profile and medication review have been reviewed and found to be compliant to state and federal standards.
- b. Education has been administered to our nurses performing initial and ongoing assessments to be compliant with our policy procedure on developing and maintaining a medication profile. This education has already taken place on November 20th and 21st of 2013 and will be reinforced on December 17th and 18th.
- a. Medication profiles have been added to our OBQI program and will not be cleared as a focus area until 100% of care plans demonstrate compliance to the federal standard for any given quarter (3 consecutive months).

2. Company Policy

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

3. Company Procedure

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

4. Responsible Parties and Compliance Dates

The director of nursing will be the responsible party for these corrections as well as maintaining the timelines outlined in this plan of correction. All of the education needed to inform our personnel of the corrections made and reinforce policy and procedure will take place no later than Dec 18th. Our documentation will prove to be compliant to the corrective actions identified in this section by December 22, 2013.