IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN– Director

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

August 4, 2020

Kelly Spiers, Administrator
Visions Home Health & Visions Home Care Llc
455 Park View Loop
Twin Falls, ID 83301

RE: Visions Home Health & Visions Home Care Llc, Provider #137107

Dear Mr. Spiers:

On July 16, 2020, a follow-up visit of your facility, Visions Home Health & Visions Home Care Llc, was conducted to verify corrections of deficiencies noted during the survey of February 20, 2020.

We were able to determine that the Condition of Participation of Care Planning, Coordination, Quality Of Care (42 CFR §484.60) is now met.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

DENNIS KELLY, Supervisor
Non-Long Term Care

DK/nw
Enclosures
ec: Julius Bunch, Certification & Enforcement Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH & VISIONS HOME CARE LLC	455 PARK VIEW LOOP TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS A second validation follow-up survey was conducted at your agency from 7/14/20 to 7/16/20. No deficient practices were identified. The surveyor conducting your survey was: Brian Osborn, RN, HFS, Team Lead	{G 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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August 4, 2020

Kelly Spiers, Administrator
Visions Home Health & Visions Home Care Llc
455 Park View Loop
Twin Falls, ID 83301

RE: Visions Home Health & Visions Home Care Llc, CCN #137107

Dear Mr. Spiers:

This is to advise you of the findings of the focused infection control survey of Visions Home Health & Visions Home Care Llc, which was concluded on July 16, 2020. Enclosed is your copy of the Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states no deficiencies were identified.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

DENNIS KELLY, Supervisor
Non-Long Term Care

DK/nw
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH & VISIONS HOME CARE LLC	455 PARK VIEW LOOP TWIN FALLS, ID 83301

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G 000	INITIAL COMMENTS A focused infection control survey was conducted at your agency from 7/14/20 to 7/16/20. No deficient practices were identified. The surveyor conducting your survey was: Brian Osborn, RN, HFS, Team Lead	G 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.