Form 3701
November 2012

Preliminary Findings Based on Survey, Inspection or Investigation

Facility/Agency Name	Entrance Date	Exit Date
Vibrant Home Health	09/17/18	09/19/18

Physical Street Address	Purpose of Visit
122 Lee St, Suite A	☒ Survey ☐ Complaint ☐ Other (describe)

City	ZIP Code	County
Sulphur Springs	75482	Hopkins

Facility Type	Facility ID/Vendor No.
☐ ADC ☐ ALF ☒ HCSSA ☐ SNF/NF ☐ ICF/IID	743171 / 011792

Administrator/Manager Name: Tanya Griffin

This list contains preliminary areas of potential noncompliance with federal and/or state requirements, based on findings from the entrance and exit dates listed above. Note: If the visit was to an assisted living facility, refer to the attached checklists.

State	Federal	Brief Description of Potential Noncompliance
☐	☐	
☐	☐	
☐	☐	Ø neg findings
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Signature – Administrator or Designee	Date
[signature]	9/19/18
Signature – Team Leader or Surveyor	**Date**
[signature] RN	09/19/18

TEXAS
Health and Human
Services

Texas Health and Human Services Commission

October 2, 2018

Administrator
Vibrant Home Health Care Inc
122 Lee Street Suite A
Sulphur Springs, TX 75482

Re: License number 011792
Provider number 743171

Dear Administrator:

Enclosed is:

____ The Centers for Medicare and Medicaid Services (CMS) Form CMS-2567, Statement of Deficiencies, for the **Health Survey** conducted on **September 19, 2018,** which states that your agency is in compliance with the Conditions of Participation for **Home Health.**

____ The Texas Health and Human Services Commission (HHSC) Form-3724, Statement of Licensing Violations, for the **Health Survey** conducted on **September 19, 2018,** which states that your agency meets the licensing standards in the Texas Administrative Code, Title 40, Part 1, Chapter 97, as a licensed **Home Health.**

Please keep a copy of the form(s) enclosed for your records.

Sincerely,

Brenda Hooker, RN
Brenda Hooker, R.N.
HCSSA Program Manager
Regulatory Services, Region 4 & 5

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Enclosures

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	743171	A. BUILDING ______ B. WING ______	09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRANT HOME HEALTH CARE INC	122 LEE STREET SUITE A SULPHUR SPRINGS, TX 75482

(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 recertification survey was initiated on 09/17/18 at 9:40 a.m. Census: L&C - 61 LHH - 0 Dialaysis - 11 The agency is in compliance with 42 CFR Part 484, Requirements for Home Health Agencies.	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.

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	743171	A. BUILDING ______ B. WING ______	09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRANT HOME HEALTH CARE INC	**122 LEE STREET SUITE A** **SULPHUR SPRINGS, TX 75482**

(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
E 000	Initial Comments A recertification survey was initiated on 09/17/18 at 9:40 a.m. Census: L&C - 61 LHH - 0 Dialaysis - 11 The agency is in compliance with 42 CFR Part 484.22, Emergency Preparedness Requirements For Home Health Agencies.	E 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.

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724

Date Printed: 10/02/2018 12:02:41PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011792	A. BUILDING: ______ B. WING ______	09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRANT HOME HEALTH CARE INC	122 LEE STREET SUITE A SULPHUR SPRINGS, TX 75482

(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
Z 000	Initial Comments A re-licensure survey was initiated on 09/17/18 at 9:40 a.m. Census: L&C - 61 LHH - 0 Dialaysis - 11 The agency is in compliance with 40 TAC Chapter 97, Licensing Standards for Home and Community Support Services Agencies.	Z 000		

SOD - State Form

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

September 20, 2018

Administrator
Vibrant Home Health Care Inc
122 Lee Street Suite A
Sulphur Springs, TX 75482

Re: License number 011792
Provider number 743171
Survey conducted September 19, 2018

Dear Administrator:

The purpose of this letter is to comply with Texas Health & Safety Code §142.009(g)(2), which requires that:

> "After a survey of an agency, HHSC will provide the chief executive officer of the agency:
> (2) information on the identity, including the signature, of each department representative conducting, reviewing, or approving the results of the survey and the date on which the HHSC representative acted on the matter...."

The following department representatives assisted in conducting, reviewing, or approving the survey:

Susan Coffelt, RN	09/20/18
Surveyor signature	Date
Surveyor signature	Date
Leartis Simmons	09/25/18
Technical Reviewer	Date
Brenda Hooker, RN	10/02/18
Program Manager	Date
Other	Date

THIS DOCUMENT IS TO BE RETAINED BY THE HOME HEALTH/HOSPICE AGENCY.