IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 18, 2015

Randy Schellhous, Administrator
Encompass Home Health & Hospice Of Idaho
16151 N Brinson St
Nampa, ID 83687

Provider #131540

Dear Mr. Schellhous:

An unannounced off-site complaint investigation was conducted from March 5, 2015 through March 16, 2015 at Encompass Home Health & Hospice Of Idaho. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006902

Allegation: The agency overmedicated patients and failed to adequately coordinate care for patients receiving respite services in a skilled nursing facility (SNF).

Findings: During the investigation hospice agency and SNF patient records were reviewed and interviews were conducted with the following results:

Hospice agency information documented from 1/1/15 - 3/5/15, 3 patients received respite services at SNFs. When asked, during a telephone interview on 3/16/15 at 11:30 a.m., if any coordination of service concerns had been expressed for patients receiving SNF respite services, the Hospice Administrator stated none had been expressed.

Facility records were reviewed and included a "Hospice Agreement," signed by a SNF Executive Director and Hospice Agency staff, dated 8/27/13. The Agreement included provisions of services for both general inpatient and respite care. The contract included a delineation of patient care responsibilities for the hospice agency, the SNF and joint responsibilities.

The Agreement stated "All physician orders communicated to {the skilled nursing} facility on behalf of Hospice in connection with the Hospice Plan of Care shall be in writing and signed by the applicable Attending Physician or Hospice Physician; provided, however, that in the case of urgent or emergency circumstances, such orders may be communicated by the Attending

Physician or the Hospice Physician orally and confirmed in writing thereafter. Hospice shall maintain adequate records of all physician orders communicated in connection with the Hospice Plan of Care."

Additionally, the Agreement stated "The Hospice primary nurse will provide nursing services and supervision to each Hospice Patient according to each Hospice Patient's needs as documented in the Hospice Plan of Care and required level of care. A Hospice nurse shall also provide twenty-four (24) hour availability for consultation and emergencies."

Patient medical records from the SNF and the hospice agency were reviewed. Both sets of records documented respite services were delivered in accordance with the Agreement. For example, one patient's hospice Comprehensive Assessment and Plan of Care Update Report, dated 1/14/15, documented the patient was diagnosed with malignant neoplasm (cancer) of the bronchus and lungs. The Update stated the patient had only one family member (the patient's son) available to assist him, and that neighbors and friends would "check in on" him, but he required additional assistance. The Update stated the agency was working with the family member to move the patient to an assisted living facility.

A 1/14/15 hospice Coordination Note, completed by the hospice Social Worker, documented she had spoken with the patient's son regarding the patient's confusion and moving the patient to an assist living facility. A subsequent 1/15/15 Coordination Note, completed by the hospice Social Worker, stated the patient's son was "...concerned about whether or not cancer could have spread to pt's {patient's} brain as he is still very confused at times..."

A corresponding hospice Registered Nurse (RN) visit note, dated 1/15/15 stated the visit was being conducted at the patient's home due to an unexpected status change. The note documented the patient's son had reported the patient was hallucinating, agitated and "having lots of involuntary movements." The note documented patient impairments including learning, communication, and immediate recall. The note stated the patient had physical limitations and was disoriented, experiencing hallucinations, confusion, agitation, restlessness, anxiety and fear. The note stated "Upon arrival {at the patient's home} found patient in his recliner with his son at his side, and nurse {name of assisted living facility nurse, who was visiting the patient at his home}. Patient is very jittery, arms and legs are moving involuntarily, patient will relax for a brief moment and then startled awake, reaching out and grabbing for things that he sees that are hallucinations. Patient also tries to get up on a recliner multiple times. Patient's son is going to spend the night with him, and is very attentive to the patient. Attempting to calm him and redirect him and keep him in recliner. Patient's son had given patient a Xanax around 5 o'clock. {Name of assisted living facility nurse} administered to {sic} milligrams of Haldol at 6 o'clock.

This nurse administered an additional 2 milligrams of Haldol at 7 o'clock, and son administered bedtime dose of Trazodone. Stayed at home with patient and his son for approximately 40 minutes waiting to see if patient would settle and be comfortable. Patient did seem a little less agitated, though it {sic} was still jittery, jumpy, restless, hallucinating, and attempting to get out of recliner. This nurse administered 5 milligrams of morphine before leaving. Patient was

resting more comfortably..." The "Plan" section of the note stated "Will continue to monitor neurological status and adjust medications appropriately to keep patient comfortable."

A hospice RN visit note, dated 1/15/15 at 8:50 a.m., stated the patient's mental and physical status was deteriorating. The note stated the patient was "...barely responsive, restless, able to help him get relief with Morphine." The RN documented she was unable to obtain the patient's blood pressure. Additionally, his oxygen, per nasal cannula was increased to 3 liters as his oxygen saturation level was 86% on 2 liters, with apneic episodes. The RN documented "...restlessness relieved by morphine. Pt was able to rest comfortably in his chair."

A hospice Physician Verbal Order dated 1/16/15 at 12:54 p.m., stated "Change Level of Care to Respite." A corresponding fax cover sheet, dated 1/16/15 from the hospice agency to the SNF stated the patient was being admitted to the SNF for a 5 night respite stay.

SNF "Admission Physicians Orders," dated 1/16/15, but not timed, documented the patient's diagnoses as "End Stage Lung Cancer {and} Renal Failure." He was to receive routine medications which included Morphine 20 mg/ml: .5 ml/10 mg every 4 hours for pain and shortness of breath and Lorazepam 2 mg/ml: 1 ml/2 mg every 4 hours for anxiety and agitation. The routine Morphine and Lorazepam were to be given at alternating times. The order also included as needed (prn) medications, which included Morphine Solution 20 mg/ml: 0.25 ml/5 mg by mouth every hour as needed for pain and Lorazepam 1 mg tabs: 1 tab (1 mg) by mouth every 4 hours as needed for anxiety.

The patient's SNF "Interdisciplinary Progress Notes," documented on 1/16/15 at 1:45 p.m., the patient was admitted to the facility in a lethargic state, but was responding to verbal and tactile stimuli. The note stated the patient's family and hospice RN reported the patient had "...eaten very little in the past week but had 'sips of 'Boost'...actively dying per Hospice RN. Bed bound. {oxygen at} 2-4 liters..." Additionally his SNF "Interim Care Plan," dated 1/16/15, stated in the "Behaviors/Special Information" section that the patient was "Actively Dying {with} terminal agitation, pain." (Terminal agitation or restlessness can be defined as agitated delirium with cognitive impairment. It tends to occur frequently at the end stage of cancer. The main symptoms are agitation, sudden involuntary jerking of muscles or twitching, irritability and impaired consciousness. Other symptoms include hallucinations, paranoia, confusion and disorientation).

The patient's SNF Medication Administration Record (MAR) documented he received routine Morphine .5 ml/10 mg at 2:00 p.m.

The Hospice RN's Coordination notes documented on 1/16/15 at 2:10 p.m., the hospice RN "...checked in and out with {name of SNF RN} RN. He requested some changes in comfort meds. Will fax order shortly {sic}. No further needs at this time." The note documented the patient was "...relaxed, eyes closed."

A SNF "Physician's Order" form dated 1/16/15 at 2:49 p.m., documented the patient was to receive routine medications which included Morphine 20 mg/mL: 10 mg/.5 every 4 hours and Ativan (Lorazepam) Intensol 2 mg/ml: 2 mg every 4 hours. The physician's order documented the patient was to continue receiving the prn Morphine and Lorazepam between scheduled doses as previously ordered. A corresponding Hospice "Physician Verbal Order" form dated 1/16/15 at 2:50 p.m., also documented the medication changes, noting "Patient with increased discomfort."

The patient's SNF MAR documented he received prn Morphine .25 ml at 3:45 p.m.

On 1/16/15 at 3:48 p.m. a Hospice "Physician Verbal Order" form stated the patient was having difficulty swallowing pills. The physician changed the prn Lorazepam order to Lorazepam "Intensol 2 MG/MLK"{sic}: 1 MG/.5ML every 4 hours as needed for anxiety and/or nausea/vomiting. The order stated it was to include 60 prefilled syringes that were to be delivered.

The patient's SNF MAR documented he received routine Lorazepam 1 ml/2 mg at 4:00 p.m. and prn Morphine 20 mg/ml: 10 mg (.5 cc) at 5:10 p.m. Additionally, the patient's MAR documented he received routine Morphine .5 ml/10 mg at 6:00 p.m. and prn Lorazepam Intensol 1 MG/.5ML at 6:15 p.m.

A 1/16/15 hospice RN note from 5:00 - 8:00 p.m. stated "Came in to deliver meds & assess Pt. (Delivered Morphine & Ativan)." The note documented the patient was unable to get comfortable, the hospice physician was contacted at 6:05 p.m. and medication orders were changed. A corresponding hospice "Physician Verbal Order" form dated 1/16/15 at 6:17 p.m. documented additional medications which included Morphine concentrate .25/5 MG every 15 minutes until relief and a Fentanyl 25 MCG patch was to be applied and changed every 72 hours. A supplemental SNF "Physician's Progress Note " completed by the Hospice RN at 6:20 p.m., stated the patient was "...very restless, stating he's in pain ..." The note documented the patient was to receive Morphine every 15 minutes until his pain was relieved and a Fentanyl transdermal patch was to be applied "...to give more constant pain relief. PT. still restless...hallucinating."

The patient's SNF MAR documented the Fentanyl patch was applied. However, a specific time of the application was not noted. His MAR further documented he received prn Morphine concentrate .25/5 MG at 6:15 p.m., 6:35 p.m., 6:55 p.m., 7:20 p.m., 7:40 p.m. and 8:00 p.m. and he received routine Lorazepam 1 ml/2 mg at 8:00 p.m.

The 1/16/15 hospice RN note from 5:00 - 8:00 p.m. stated the hospice RN "...worked with {name}, RN from {SNF} to deliver q {every} 15 min morph{ine}..." The note documented the Chaplain "...here & stayed with patient." A subsequent hospice RN note from 1/16/15 at 9:30 p.m. to 1/17/15 at 1:00 a.m. stated "Assessed patient still very agitated. Relieved Chap. {name} & Family..."

The patient's MAR documented he received prn Lorazepam Intensol 1 MG/.5ML at 9:20 p.m. and .25 ml of prn Morphine at 9:25 p.m. and 9:45 p.m., and routine Morphine .5 ml/10 mg at

10:00 p.m.

A SNF "Interdisciplinary Progress Note" completed by the SNF RN documented on 1/16/15 at 10:00 p.m., the patient was "Very restless {with} Lorazepam and MS {morphine}, but continues to be restless." His vitals were documented as "180/100, 97.3, 88, 24, 90% {oxygen} per N/C."

The patient's MAR documented he received .25 ml of prn Morphine at 10:10 p.m.

A SNF "Interdisciplinary Progress Note" completed by the SNF RN documented on 1/16/15 at 10:15 p.m. "Call to {hospice agency name} for requested assistance...clients {sic} current condition - very restless {and} anxious - son in room." His vitals were documented as "180/100, 97.3, 73, 22, 91% 3 L per NCO2."

The patient's MAR documented he received .25 ml of Morphine at 10:30 p.m. and 11:00 p.m.

The hospice RN note from 1/16/17 at 9:30 p.m. to 1/17/15 at 1:00 a.m., stated at 11:05 p.m., the hospice physician was contacted and medication orders were changed. A corresponding hospice "Physician Verbal Orders" form documented on 1/16/15 at 11:10 p.m., the patient's Fentanyl Patch was to be increased to 50 MCG (change every 72 hours) and Haloperidol 5 MG IM every 4 hours as needed for agitation, Lorazepam 2 MG IM every 2 hours as needed for anxiety, and Benadryl 50 MG IM every 4 hours as needed for insomnia and anxiety was ordered. Morphine was to be discontinued and a hold was placed on the oral Lorazepam orders.

The patient's MAR also documented at 11:30 p.m. he received 5 mg Haloperidol, 2 mg Lorazepam, 50 mg Benadryl IM, and the Fentanyl 25 mg patch was removed and replaced with a Fentanyl 50 mg patch.

The hospice RN's note from 1/16/17 at 9:30 p.m. to 1/17/15 at 1:00 a.m., stated "I gave 5 mg Haloperidol, 2 mg Lorazepam, 50 mg Benadryl IM @ {at} 2330 {11:30 p.m.}. 30 min later, PT relaxed + Breathing easier. This RN left @ 0100 {1:00 a.m.} after making sure PT was {cross-out and error} comfortable." A corresponding SNF "Interdisciplinary Progress Notes," completed by the SNF RN and dated 1/17/15 at midnight documented "Calmer - Now - Required .25 - .5 ml of 20 mg/ml MSO x 16 dosed for pm shift. Hospice RN onsite - Report Given..." The note documented the patient's blood pressure as 165/85.

A subsequent SNF "Interdisciplinary Progress Notes, "completed by the SNF RN and dated 1/17/15 at 1:00 a.m. documented "Client more rested {less} restless - son & {hospice name} RN leave {with} report to call {hospice name} RN if any needs."

A SNF "Interdisciplinary Progress Notes," completed by the SNF RN and dated 1/17/15 at 3:11 a.m. documented the patient was not showing signs of life and the hospice RN was contacted. A corresponding hospice RN "Client Coordination Note Report" completed by the hospice RN on 1/17/15, but not timed, documented the patient "...passed peacefully at 0311 {3:11 a.m.} as reported by {name of SNF RN}..." Final SNF "Interdisciplinary Progress Notes," completed by

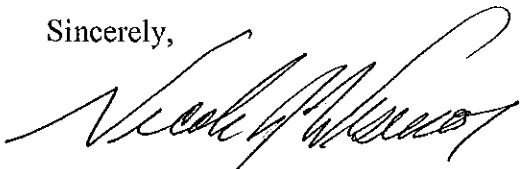
the SNF RN and dated 1/17/15 at 3:30 a.m., documented the hospice RN was at the SNF and "...will make relevant calls..."

It could not be established that the hospice agency failed to follow physician medication orders or that the hospice agency failed to coordinate care for patients receiving respite services in SNFs. Therefore, the allegation was unsubstantiated and no deficient practice was identified. Further, the Bureau of Facility Standards has no regulatory authority over physician prescribing practices. Physician practices are under the jurisdiction of the Idaho Board of Medicine.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As the allegation was unsubstantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during this investigation.

Sincerely,



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