IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

May 19, 2015

Trevor Higby, Administrator
Horizon Home Health & Hospice
63 West Willowbrook Drive
Meridian, ID 83646-1656

RE: Horizon Home Health & Hospice, Provider #137065

Dear Mr. Higby:

On May 5, 2015, a follow-up visit of your facility, Horizon Home Health & Hospice, was conducted to verify corrections of deficiencies noted during the follow-up survey of February 5, 2015.

We were able to determine that the Condition of Participation of **Acceptance of Patients, POC, Med Super (42 CFR 484.18)** is now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Also enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Home Health Agency into compliance, and that the Home Health Agency remains in compliance with the regulatory requirements;

- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **June 1, 2015**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626, option 4.

Sincerely,

LAURA TOHMPSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LT/pmt
Enclosures
ec: Fe Yamada, CMS Region X Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
701 Fifth Avenue, Suite 1600, M/S RX-400
Seattle, WA 98104

CENTERS FOR MEDICARE & MEDICAID SERVICES

IMPORTANT NOTICE – PLEASE READ CAREFULLY

May 26, 2015

Trevor Higby, Administrator
Horizon Home Health and Hospice
63 W. Willowbrook Drive
Meridian, ID 83646

CMS Certification Number: 13-7065

Re: Conditions of Participation Met, Mandatory Termination Rescinded
Back in Substantial Compliance Effective March 15, 2015
SPNA Took Effect 03/07/2015 – 03/14/2015

Dear Mr. Higby:

On May 5, 2015 a revisit survey was conducted at Horizon Home Health and Hospice by the Idaho Bureau of Facility Standards (State survey agency) to determine compliance with the Conditions of Participation required for Home Health Agencies (HHA). Findings from that revisit indicate that Horizon Home Health and Hospice has now achieved substantial compliance with Federal requirements for HHAs participating in the Medicare and Medicaid programs. Based on the State survey agency's findings and recommendation, **CMS is rescinding the termination action effective March 15, 2015. However, the Suspension of Payment for New Admissions (SPNA) took effect on March 7, 2015 to March 14, 2015 with a total of 7 days. These dates will be reported to the Medicare contractor (NGS) and to the Idaho Medicaid.**

If you have any questions regarding this letter, please contact Fe Yamada of my staff at 206-615-2381 or by email at marie.yamada@cms.hhs.gov.

Sincerely,

Patrick Thrift
Manager, Seattle Regional Office
Division of Survey & Certification

Cc: Idaho Bureau of Facility Standards
ID Medicaid
NGS

HORIZON
HOME HEALTH & HOSPICE

Horizon Home Health & Hospice
Trevor Higby, Administrator
63 W. Willowbrook Dr.
Meridian, ID 83646
208-888-7877

May 28, 2015

Bureau of Facility Standards
Attn: Sylvia Creswell
3232 Elder Street
PO Box 83720
Boise, ID 83720-0009

Re: Credible Allegation of Compliance/Plan of Correction

Dear Ms. Creswell,

Pursuant to the follow-up visit at Horizon Home Health on May 5, 2015, please find attached the completed Statement of Deficiencies/Plan of Correction (CMS2567) along with attachments that give further evidence that Horizon Home Health complies with the Conditions of Participation.

As evidenced in the Plan of Correction and the enclosures, we have and will continue to conduct audits in-house, self-audits and one-on-one education of staff. The enclosures will speak to our compliance with the Conditions of Participation and include:

- Policies and Procedures:
  - Policy 2-018.1 Care Planning Process
- Attachment:
  - SOC Self-Audit Tool (copy)

In the event that you need additional information, please do not hesitate to contact me at 888-7877 or by email at thigby@horizonhh.com.

Sincerely,

Trevor Higby
Administrator
Horizon Home Health and Hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137065	A. BUILDING _____ B. WING _____	R 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HOME HEALTH & HOSPICE	63 WEST WILLOWBROOK DRIVE MERIDIAN, ID 83646

(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 The following deficiencies were cited during the follow up survey of your home health agency on 5/04/15 through 5/05/15. Surveyors conducting the follow up were: Laura Thompson, RN, BSN, HFS - Team Leader Susan Costa, RN, HFS Acronyms used in this report include: CHF - Congestive Heart Failure CKD - Chronic Kidney Disease DM - Diabetes Mellitus DME - Durable Medical Equipment DON - Director of Nursing ER - Emergency Room HHA - Home Health Aide HTN - Hypertension LPN - Licensed Practical Nurse OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy ROC - Resumption of Care RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	{G 000}	RECEIVED MAY 28 2015 FACILITY STANDARDS	
{G 158}	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	{G 158}	**G158 484.18 ACCEPTANC OF PATIENTS, POC, MEDICAL SUPERVISION** The RN Case Managers for patients #3 and #5 were counseled the week of 5/24/15. The counseling consisted of establishment of the patient's plan of care including frequencies, labs and add-on disciplines, following the plan of care, performing interventions as outlined on the POC and notifying the physician when changes to the plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	5/28/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137065	A. BUILDING _____ B. WING _____	R 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HOME HEALTH & HOSPICE	63 WEST WILLOWBROOK DRIVE MERIDIAN, ID 83646

(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 158}	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 2 of 6 patients (#3 and #5) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include: 1. Patient #5 was a 42 year old male admitted on 1/19/15, for ST services related to Cerebral Palsy. Additional diagnoses included quadriplegia, DM, voice and resonance problems, muscle weakness, and tracheostomy. His record, including the POC, was reviewed for the certification period 3/20/15 to 5/18/15. a. Patient #5 was transferred to an acute care hospital on 3/31/15, for hyponatremia (low sodium level in the blood). Patient #5 was placed on hold for home health services until he was discharged from the acute care hospital on 4/09/15. Home health services were resumed by the agency beginning on 4/10/15. Patient #5's record included a POC dated 4/10/15, and signed by the attending physician on 4/23/15. The POC included orders for an evaluation by a physical therapist. However, Patient #5's record did not include an evaluation visit by a physical therapist. During an interview on 5/04/15 at 2:40 PM, the DON reviewed the record and confirmed the order on the POC for a physical therapy evaluation. She confirmed an evaluation visit was not completed by a physical therapist. Patient #5's POC was not followed for a physical	{G 158}	care are required in order to avoid unauthorized treatments, as well as, omissions of care and unmet patient needs. Plans of Care will be followed as developed with the patient and attending physician. Upon SOC, the admitting clinician will call the primary care physician to obtain verbal orders for frequencies, additional needs/services identified at initial evaluation and authorization for ongoing home health services. This will be documented in the initial note with the name of the physician, the name of the physician's representative, date and comments related to the verbal authorization. The 485/POC, including all services, interventions and goals, will be sent to the physician for signature. Supplemental physician orders will be documented in the patient's record by documentation of a verbal order. Staff will adhere to frequencies of visits/services provided as established in the plan of care and/or supplemental orders. No deviation will be permitted without consent from the primary physician who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137065	A. BUILDING _____ B. WING _____	R 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HOME HEALTH & HOSPICE	63 WEST WILLOWBROOK DRIVE MERIDIAN, ID 83646

(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 158}	Continued From page 2 therapy evaluation. b. Patient #5 was transferred to an acute care hospital and readmitted on 4/14/15 for continued hyponatremia. Patient #5 was placed on hold for home health services until he was discharged from the acute care hospital on 4/17/15. Home health services were resumed by the agency beginning on 4/18/15. Patient #5's record included a POC dated 4/18/15. The POC included orders for SN visits 4 times a week for 1 week, 5 times a week for 1 week, and 1 time a week for 3 weeks. The POC was unsigned by a physician as of 5/05/15. A ROC visit note, dated 4/18/15, signed by the RN, documented the RN was unable to speak with the physician because the office was closed on weekends, but would fax the physician orders the next business day. There was no documentation in the record the orders were faxed. A physician order request was documented on 4/24/15, by an intake LPN, to add SN visits for daily blood draws to measure Patient #5's sodium level. The order request was for SN visits to be changed to 6 times a week for 1 week, 7 times a week for 2 weeks, and 1 time a week for 1 week. The change in frequency of SN visits was to be effective 4/19/15, 5 days before the order request. The physician order request was unsigned by a physician as of 5/05/15. The order request form had a section titled "Send to the Physician" which was marked no. Additionally, at the bottom of the order request on the physician signature line it	{G 158}	oversees the plan of care. Any changes in the visit frequency/services provided will be documented in the patient's medical record via a physician order. **REVIEW:** A SOC Self-Audit form (attached) will be included all Admission Packets for use by the Case Managers of patients #3 and #5. Additionally, Case Managers for patients #3 and #5 will be provided a copy of Policy # 2-018.1 "Care Planning Process" which will be reviewed with the employees by their supervisor by June 15, 2015. The Director of Nursing or designee will continue to review 100% of the SOC/ROC performed by the Case Mangers of patient's #3 and #5 for compliance to the plan of care through the SOC audit process identified at the State Re-Survey on 5/4/2015. This process will continue until their error rate reaches 10% or less. By June 30, 2015, if their 10% or less error rates have not been achieved, these clinicians will be placed on a Performance Improvement Plan with the DON, Staff Development Coordinator and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137065	A. BUILDING _____ B. WING _____	R 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HOME HEALTH & HOSPICE	63 WEST WILLOWBROOK DRIVE MERIDIAN, ID 83646

(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 158}	Continued From page 3 read "Do Not Send." SN visits were made daily beginning on 4/18/15 through 5/03/15. During an interview on 5/04/15 at 2:40 PM, the DON reviewed the record and confirmed the ROC orders and physician order request were unsigned by the physician. The DON confirmed daily visits were made to Patient #5's home by the SN beginning on 4/18/15. She confirmed a physician verbal order of approval for the updated POC was not received after the ROC visit. Patient #5's orders for SN visits were provided without a physician order. 2. Patient #3 was a 75 year old female admitted on 4/18/15, for SN and PT services related to pulmonary embolism. Additional diagnoses included CHF, peripheral vascular disease, unspecified thrombosis and embolism, and general weakness. Her record, including the POC, was reviewed for the certification period 4/18/15 to 5/16/15. Patient #3's record included an order for the SN to obtain her weight at every visit. The order stated the physician was to be notified of a weight gain or loss of 3 pounds within 1 day. The SOC visit, dated 4/18/15, completed by the RN, did not document a weight for Patient #3. Additionally, the RN documented Patient #3 did not own a scale. There was no documentation by the RN how a weight was going to be obtained for Patient #3 while she was on service. The visit note did not have documentation of a discussion	{G 158}	Clinical Resource providing one-on-one education of the Care Planning Process. There will be weekly "spot checks" of all clinical documentation (2 notes from the beginning or current episode to date compared to the POC) by Team Leads, Coder, Branch Directors, Clinical Support Team and/or DON, of 10% of case managers who are responsible for entering notes in patient records to ensure a 10% or lower error rate is maintained. A plan of correction will be developed for any Case Manager who does not achieve and/or maintain a 10% or lower error rate. Results of these audits will be reported at the next quarterly Quality Improvement Committee Meeting on June 25, 2015. **RESPONSIBLE:** Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard. **COMPLETION:** June 30, 2015 and ongoing. lace text here...	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137065	A. BUILDING _____ B. WING _____	R 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HOME HEALTH & HOSPICE	83 WEST WILLOWBROOK DRIVE MERIDIAN, ID 83646

(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 158}	Continued From page 4 with Patient #3 or her family regarding purchasing a scale. An SN visit note, dated 4/20/15, did not include documentation of a weight for Patient #3. The visit was completed by an LPN. There was no documentation by the LPN of how a weight was going to be obtained for Patient #3 at her next visit. An SN visit note, dated 4/27/15, did not include documentation of a weight for Patient #3. There was no documentation by the LPN of how a weight was going to be obtained for Patient #3 at her next visit. The SN visit notes dated 4/18/15, 4/20/15, and 4/27/15, did not include documentation Patient #3 received education or training on how to monitor her weight and the importance of doing so. During an interview on 5/04/15 at 4:00 PM, the DON reviewed Patient #3's record and confirmed the order for obtaining a weight at each SN visit. She confirmed the RN documented Patient #3 did not own a scale. The DON further confirmed there was no documentation about obtaining a scale or education for monitoring Patient #3's weight. Patient #3's POC was not followed for monitoring her weight as ordered by her physician.	{G 158}		
{G 164}	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.	{G 164}	**G164 484.18(b) PERIODIC REVIEW OF PLAN OF CARE** The case manager for patient #6 was counseled the week of 5/24/15. The counseling consisted of review of Case Manager's responsibilities in periodic review of the Plan of Care. The Case Manager was instructed that the home health plan of care is reviewed by the primary physician who oversees the plan of care and the home health personnel as often as the severity of the patient's condition requires. When there is a condition that suggests a need to alter the plan of care to avoid the potential for patients to experience adverse outcomes due to delayed medical interventions, the home health clinician is required to call, promptly notify the physician of the decline or significant change in condition and document such notification within the patient's clinical record in a coordination note. Revisions or updates in the POC are documented	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137065	A. BUILDING _____ B. WING _____	R 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HOME HEALTH & HOSPICE	63 WEST WILLOWBROOK DRIVE MERIDIAN, ID 83646

(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 164}	Continued From page 5 This STANDARD is not met as evidenced by: Based on staff interview and review of patient records, 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 1 of 6 patients (#6) whose records were reviewed. This resulted in the potential for patients to experience adverse outcomes due to delayed medical interventions. Findings include: 1. Patient #6 was an 86 year old male admitted on 4/15/15, for SN services related to cellulitis of the scrotum. Additional diagnoses included fungal infection of the groin and perianal area, CKD, cardiac pacemaker, incomplete bladder emptying, and fitting/adjustment of a urinary device. The SOC visit dated 4/15/15, completed by the RN Case Manager documented Patient #6 had an indwelling catheter for urine drainage. The RN Case Manager documented there were no abnormal genitourinary findings during the visit. - An SN visit note, dated 5/02/15, documented Patient #6 had hematuria (blood in the urine). Additionally, the RN documented Patient #6 had "cola-colored urine" which was a new symptom. The RN documented Patient #6 was unsure if he aggravated his catheter. Patient #6 was not complaining of pain or burning to the area according to the documentation by the RN. Patient #6 was instructed by the RN to notify his physician if it did not improve. There was no documentation Patient #6's	{G 164}	in a verbal order, if supplemental orders are received at the time of the call. **REVIEW:** A SOC Self-Audit form (attached) will be included in all Admission Packets of the Case Manager for patient #6. Additionally, the Case Manager for patient #6 will be provided a copy of Policy # 2-018.1 "Care Planning Process" which will be reviewed with the clinician by his/her supervisor by June 15, 2015. The Director of Nursing or designee will continue to review 100% of the SOC/ROC performed by the Case Manager for patient #6 for compliance to the plan of care through the SOC audit process identified at the State Re-Survey on 5/4/2015. This process will continue until his/her error rate reaches 10% or less. By June 30, 2015, if his/her 10% or less error rate has not been achieved, this clinician will be placed on a Performance Improvement Plan with the DON, Staff Development Coordinator and/or Clinical Resource providing one-on-one education of the Care Planning Process. There will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137065	A. BUILDING _____ B. WING _____	R 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HOME HEALTH & HOSPICE	63 WEST WILLOWBROOK DRIVE MERIDIAN, ID 83646

(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 164}	Continued From page 6 physician was notified of his urinary changes. - An SN visit note, dated 5/03/15, documented Patient #6 continued to have hematuria present. The RN documented Patient #6's urine was dark amber in color, but lighter in color than it was at the previous visit. Patient #6 denied pain to the area. Patient #6 was instructed by the RN to notify his physician if it did not improve. There was no documentation Patient #6's physician was notified of the abnormal color or blood in his urine. The Mayo Clinic website, accessed 5/08/15, stated normal urine color varies. Depending on how much fluid is consumed, it should be clear or pale yellow to amber. Severe dehydration may cause urine to become a deep amber color. It further stated blood in the urine may be related to a urinary tract infection or kidney stones, which would cause pain. Painless bleeding may be a sign of a more serious condition, such as cancer. During an interview on 5/04/15 at 4:20 PM, the DON reviewed Patient #6's record and confirmed the RN documented changes in his urine color, which included blood. She confirmed there was no documentation Patient #6's physician was notified of the blood in his urine or the darkening color. Patient #6's physician was not notified of the abnormal color change or presence of blood in his urine.	{G 164}	weekly "spot checks" (notes from the beginning or the current episode to date compared to the POC) by Team Leads, Coder, Branch Directors, Clinical Support Team and/or DON of 10% of all case managers who are responsible for entering notes in patient records to ensure a 10% or lower error rate is maintained. A plan of correction will be developed for any Case Manager who does not achieve and/or maintain a 10% or lower error rate. Results of these audits will be reported at the Quarterly Quality Improvement Committee Meeting on June 25, 2015. **RESPONSIBLE:** Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard. **COMPLETION:** June 30, 2015 and ongoing	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001260	A. BUILDING: _____ B. WING _____	R 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HOME HEALTH & HOSPICE	63 WEST WILLOWBROOK DRIVE MERIDIAN, ID 83646

(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}	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the follow up survey of your home health agency on 5/04/15 through 5/05/15. Surveyors conducting the follow up were: Laura Thompson, RN, BSN, HFS - Team Leader Susan Costa, RN, HFS Acronyms used in this report include: CHF - Congestive Heart Failure CKD - Chronic Kidney Disease DM - Diabetes Mellitus DME - Durable Medical Equipment DON - Director of Nursing ER - Emergency Room HHA - Home Health Aide HTN - Hypertension LPN - Licensed Practical Nurse OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy ROC - Resumption of Care RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	{N 000}	RECEIVED MAY 28 2015 FACILITY STANDARDS	
{N 152}	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:	{N 152}	**N152 03.07030.01 PLAN OF CARE (See G158 484.18 Acceptance of Patients, POC, Medical Supervision)**	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 5/28/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001260	A. BUILDING: _____ B. WING _____	R 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HOME HEALTH & HOSPICE	63 WEST WILLOWBROOK DRIVE MERIDIAN, ID 83646

(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 152}	Continued From page 1 This Rule is not met as evidenced by: Refer to G 158	{N 152}		
{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 G 164	{N 172}	**N172 03.07030.06 PLAN OF CARE (See G164 484.18(b) Periodic Review of Plan of Care)**	