



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

CERTIFIED MAIL: 700 1670 0011 3315 1576

May 26, 2015

Trevor Higby, Administrator
Horizon Home Health & Hospice
1411 Falls Avenue East, Suite 615
Twin Falls, ID 83301

RE: Horizon Home Health & Hospice, Provider #131520

Dear Mr. Higby:

Based on the complaint survey completed at Horizon Home Health & Hospice, on May 8, 2015, by our staff, we have determined Horizon Home Health & Hospice is out of compliance with the Medicare Hospice Conditions of Participation of **Organizational Environment (42 CFR 418.100)** and **Medical Director (42 CFR 418.102)**. To participate as a provider of services in the Medicare Program, a Hospice 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 Horizon Home Health & Hospice, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

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;

Trevor Higby, Administrator
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Page 2 of 2

- 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 Hospice into compliance, and that the Hospice 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 June 22, 2015. 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 June 14, 2015.

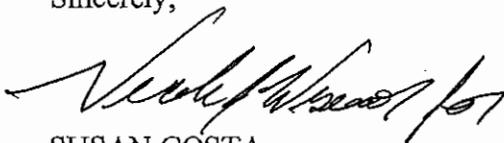
Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **June 8, 2015.**

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.

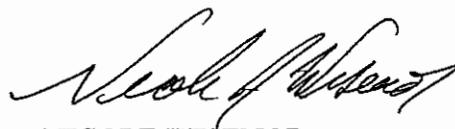
We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/pint

Enclosures

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Fe Yamada, CMS Region X

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

June 8, 2015

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

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JUN - 9 2015

FACILITY STANDARDS

Re: CREDIBLE ALLEGATION OF COMPLIANCE/PLAN OF CORRECTION

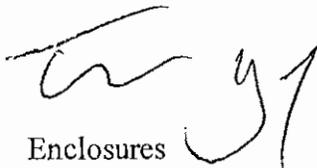
Dear Ms. Wisenor,

Pursuant to the complaint survey completed at Horizon Home Health and Hospice on May 8, 2015, please find attached the completed Statement of Deficiencies/Plan of Correction (CMS2567) along with attachments that give further evidence Horizon Home Health and Hospice complies with the Conditions of Participation.

As evidenced in the Plan of Correction and the enclosures, we have and will continue to conduct full staff education in each of the deficiencies cited and will continue to maintain evidence of compliance through chart audits and supervisory visits.

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,



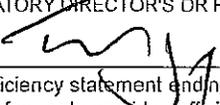
Enclosures
cc: files

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

PRINTED: 05/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2015
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(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	
L 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation of your hospice agency conducted from 5/05/15 through 5/08/15.</p> <p>The surveyors conducting the survey were:</p> <p>Susan Costa, RN, HFS, Team Lead Laura Thompson, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ALF - Assisted Living Facility ADL - Activity of Daily Living BG - Blood Glucose BM - Bowel Movement CHF - Congestive Heart Failure CMS - Centers for Medicaid and Medicare Services DME - Durable Medical Equipment DON - Director of Nursing EMS - Emergency Medical Services HA - Hospice Aide HTN - Hypertension IDG - Interdisciplinary Group LPN - Licensed Practical Nurse MAR - Medication Administration Record MD - Medical Doctor POC - Plan of Care PRN - As needed PT/INR - Prothrombin Time/International Normalized Ratio, a blood test to measure blood clotting times pt - patient RN - Registered Nurse SOC - Start of Care SN - Skilled Nurse SW - Social Worker</p>	L 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE ADMINISTRATOR (X6) DATE 6/8/15

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.

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L 533	<p>WOCN - Wound Ostomy and Continence Nurse</p> <p>418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT</p> <p>The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, policy review and review of medical records it was determined the hospice failed to ensure the comprehensive assessment was updated in response to patient and family changes and needs for 1 of 10 patients (#4) whose records were reviewed. This failure resulted in the potential for patient and family needs to be unmet. Findings include:</p> <p>1. Patient #4 was a 59 year old female who was admitted to hospice on 11/25/14, with a terminal diagnosis of liver cancer with a prognosis of less than 6 months. Additional diagnoses included Hepatitis C, cirrhosis of the liver, diabetes, and HTN.</p> <p>Patient #4 was on hospice services from 11/25/14 to 2/11/15, when she revoked her hospice benefit to pursue aggressive therapy. While receiving</p>	L 533	<p>L533 418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT</p> <p>Director of Nursing or designee will provide instruction to RN Case Managers the week of 6-8-15 on performing the on-going comprehensive assessment and updating the comprehensive assessment with any identified changes in condition or environment. Policy 2-031, Ongoing Comprehensive Assessment will be provided to RN Case Managers which also outlines the required elements that are to be assessed in the updated comprehensive assessment which includes: Full body system assessment including but not limited to respiratory, endocrine, nutritional, GI/GU and functional status, Patient/Family/Caregiver's response to care, Changes in patient's condition and/or level of deterioration, Changes in condition such as wounds or changes in skin integrity, Changes in patient's care environment or support systems,</p>		

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L 533	<p>Continued From page 2</p> <p>hospice services, Patient #4's record documented changes in her condition. However, her record did not reflect IDG activities and updates to her assessment with changes to her POC. Examples included, but were not limited to, the following:</p> <p>a. Patient #4's comprehensive assessment was not updated to meet her social, emotional, and pain management needs, as follows:</p> <p>i. Patient #4's SOC assessment dated 11/25/14, performed by the RN, documented Patient #4 lived alone, her home was in a remote location, and her living area was unclean and cluttered. The assessment identified her sister as her primary caregiver, who lived next door.</p> <p>The section of the assessment that identified her social support system included entries of "lives alone or without concerned relatives," "family /support sleep disturbed with patient's care," and "in need of respite care/sitter services." The section in which the RN was to indicate all abnormal social issues, she entered "other" and did not specify.</p> <p>On a form titled "Medical Review All Diagnoses," dated 11/25/14, the admitting RN wrote "Pt can no longer walk to her sister's house who lives next door. Is house bound unless extra measures are taken to lessen the burden of exertion."</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/04/14, included direct verbiage from Patient #4's POC. The report did not include discussion of the identified unclean and cluttered living area, the need for "respite care/sitter services," or "abnormal social issues."</p>	L 533	<p>and Changes in patient's or family/caregiver's actual or perceived needs such as additional disciplines needed such as Hospice Aides. Based on the assessments, the plan of care including problems, needs, goals, and interventions will be reviewed and updated by the interdisciplinary group members responsible for the patient. The physician will be notified of any identified changes in the areas noted above, as well as changes in any other areas such as medications, including over-the-counter medications, and treatment/interventions that require physician approval.</p> <p>Policy #2-050 Interdisciplinary Group Meeting will be provided to RN Case Managers and LPN's. Per Policy #2-050, the IDG will review the patient's Plan of Care and updated assessments at each IDG meeting, and updates will be made as necessary based on the updated comprehensive assessment.</p> <p>Based on the updated comprehensive assessment, the plan of care update/review will</p>		

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L 533	<p>Continued From page 3</p> <p>Further, the report did not include additional information or interventions related to Patient #4's inability to walk to her sister's house or what "extra measures...to lessen the burden of ' exertion" were considered and/or taken.</p> <p>ii. A visit note, dated 12/10/14, included documentation that Patient #4 required assistance with ADLs of bathing, dressing, and grooming. However, Patient #4's record did not indicate if a hospice aide was suggested for assistance.</p> <p>Additionally, a visit note dated 12/17/14, documented Patient #4 had an anxiety level of 8, which was an increase from her previous nursing visit (anxiety level of 6) and her admission assessment (anxiety level of 0). Further, her pain increased from 6/10 during her previous nursing visit to 8/10.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/18/14, included all medication and other physician orders from the previous IDG on 12/04/14. The report did not include specific condition changes or problems that were identified from the previous IDG. Additionally, information related to discussion or interventions related to Patient #4's increased need for assistance with ADLs or her increased anxiety and pain was not present in the report.</p> <p>iii. A visit note, dated 12/23/14, stated the "clutter has increased" in Patient #4's home. In the section "emotional status," the RN wrote "deteriorating." The RN did not include further assessment to describe how Patient #4 was deteriorating. However, the note included a detailed narrative entry in which the RN described</p>	L 533	<p>include identified changes, response to treatment and progress toward targeted outcomes, which may include: Pharmacological effectiveness for symptom management outcomes; Any increase or decrease in symptoms or acuity; Increases or decreases in frequency of visits by team members and reason for the change; Psychosocial needs identified and consultations/conferences with patient and family/caregiver; Ongoing spiritual support; Plan for changes in treatments or procedures; Problem solving for optimal care of the patient and family/caregiver will occur.</p> <p>All patient/family/caregiver changes will be documented in the clinical record as well documentation of physician contact and obtainment of specific orders based on these changes or needs.</p> <p>Director or Nursing will ensure mandatory training is completed for Licensed Nurses the week of 6/8/15, with a mandatory post-test to ensure that all required elements of the comprehensive assessments and ongoing comprehensive</p>	

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L 533	<p>Continued From page 4</p> <p>missing methadone. An empty bottle was found in the trash, which was labeled as 5 mg methadone, 60 tablets. The liquid morphine was diluted to a watery substance. Additionally, she described 5 boxes of wine, 1 in the refrigerator and 2 were empty. Patient #4's sister was documented as stating she would keep her medications for safety reasons since Patient #4 was found passed out. The RN did not document when the passing out incident occurred.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 1/02/15, included documentation that all Patient #4's medications were discontinued except her comfort medications. However, the IDG report included all medication and other physician orders from the previous IDG on 12/18/14. Information related to Patient #4's increased home clutter, deteriorating emotional status, and potential substance misuse was not present.</p> <p>iv. The RN documented, on 1/7/15, that Patient #4 needed assistance with ADLs of housekeeping, shopping, meal prep, feeding, toileting, bathing, dressing, and grooming.</p> <p>The IDG Comprehensive Assessment and POC Update Report, dated 1/15/15, included documentation and discussion regarding her current condition and plans for care.</p> <p>However, subsequent notes documented increased needs and escalating concerns which were not addressed, as follows:</p> <p>On 1/19/15, the RN documented Patient #4 had increased agitation, anxiety, and fear. Additionally, the RN wrote that Patient #4 required</p>	L 533	<p>assessments are completed and documented appropriately and that these elements are used to establish and update the patients' plans of care appropriately. Licensed Nurses who could not attend the trainings will be required to view the WebEx presentation of the training by 6-22-15. Inactive and part-time licensed nursing staff will be in-activated in the HR system and will be unable to provide patient care and will not be re-activated until they have viewed this WebEx. The WebEx will also be part of the orientation process with a post-test and attestation for new licensed nursing staff.</p> <p>REVIEW:</p> <p>The Director of Nursing or designee will review 100% of all new Starts of Care using an audit tool (see attached SOC/RCT/ONSITE Audit tool) to ensure that all required elements of the comprehensive assessment</p>		

Any clinicians who do not complete the training WebEx by 06/14/2015 will not be permitted to provide patient care after that date until training is complete.

STACY M. WILSON, DNP APRN

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L 533	<p>Continued From page 5</p> <p>assistance with bathing, dressing, grooming, and toileting. She required maximum assistance with transfers from her bed to her chair.</p> <p>Further, in a visit note dated 1/21/15, the RN documented Patient #4 had not slept for 2 days and was noted to refuse cares. The 1/21/15 visit note described her personal hygiene as deteriorating, and noted she needed assistance with bathing, dressing, and grooming and noted that Patient #4's caregiver was non-compliant or negligent with following the treatment plan, and indicated there was alcohol and marijuana abuse.</p> <p>The 1/26/15 RN note documented the family felt overwhelmed, their sleep was disturbed, care for Patient #4 caused extra stress, and the caregiver felt endangered by the patient. She also noted that there was abuse or history of abuse within the family system, and there was family discord. She noted there was a family feud.</p> <p>The 1/26/15 note stated nursing would be increased to twice weekly due to an increased need for wound care.</p> <p>In an IDG Comprehensive Assessment and POC Update Report, dated 1/29/15, the RN entered a detailed summary of the past two weeks. However, the IDG note did not include documentation of discussion regarding interventions related to Patient #4's alcohol consumption, marijuana abuse, safety concerns with the noted activities combined with her oxygen and narcotics, or interventions to address Patient #4's grooming needs. Further, information related to alleviating the stress of Patient #4's caregiver was not present.</p>	L 533	<p>are identified and that the Plan of Care is updated appropriately and is pertinent. 100% Audits will continue until an overall accuracy rating of 85% is reached. Upon 85% accuracy, the audit rate will decrease to 75%. Individual clinicians who fall below 85% accuracy will have one on one training, counseling, and follow-up to ensure compliance with initial and on-going comprehensive assessments and development of a pertinent and accurate Plan of Care.</p> <p>RESPONSIBLE: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>COMPLETION: 6/14/15 and on-going</p>		

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L 533	<p>Continued From page 6</p> <p>Additionally, on 2/3/15, the RN documented Patient #4's family felt overwhelmed, her illness was causing changes in the family lifestyle, her behavior was endangering the family, and the family had extreme feelings of anger. The RN documented there was discord between Patient #4 and her sister, who was her caregiver.</p> <p>Patient #4's record did not indicate nursing visits were increased to twice weekly as the RN noted would be done on the 1/26/15 visit.</p> <p>In a note dated 2/11/15, the RN Team Lead documented Patient #4 was found on the floor of her home, by an outside agency RN and Social Worker, and taken by EMS to the hospital. The duration of time she was on the floor was not specified. The RN Case Manager arrived at Patient #4's home shortly after EMS was contacted to take her to the hospital. While at the hospital, Patient #4 was diagnosed with pneumonia and rhabdomyolysis. She revoked her hospice benefit and was admitted for more aggressive treatment.</p> <p>During an interview on 5/06/15 at 10:15 AM, the RN Team Lead reviewed Patient #4's record. She stated the RN Case Manager for Patient #4 was no longer employed at the agency. She confirmed her record did not include updates to the comprehensive assessment as her needs changed. The RN Team Lead confirmed the record included documentation that Patient #4 required assistance with personal hygiene, grooming, and basic housekeeping, and she was unable to find documentation in the record that a hospice aide or other assistance was offered to Patient #4 or her family.</p>	L 533			

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L 533	<p>Continued From page 7</p> <p>The agency failed to ensure Patient #4's comprehensive assessment was updated to meet her needs.</p> <p>b. Patient #4's comprehensive assessment was not updated to meet her respiratory needs, as follows:</p> <p>i. The respiratory assessment documented Patient #4 had shortness of breath, and significant dyspnea with exertion. The RN documented treatment for dyspnea included oxygen that was initiated on 11/25/14. Additionally, the narrative section of a visit note, dated 11/26/14, included a note written by the RN which stated "supplies needed: O2 (oxygen)."</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/04/14, included direct verbiage from Patient #4's POC. The report did not include discussion of the initiation of oxygen.</p> <p>ii. In a visit note dated 12/10/14, the RN documented Patient #4's oxygen saturation was 85% on 2 liters of oxygen. The RN wrote that she set up Patient #4's oxygen concentrator during the visit. Patient #4's record did not include a method of oxygen delivery in the previous visit notes on 11/26/14 and 12/03/14.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/18/14, included all medication and other physician orders from the previous IDG on 12/04/14. The report did not include specific condition changes or problems that were identified from the previous IDG on 12/04/14 and information related to discussion or interventions related to Patient #4's oxygen use was not present in the report.</p>	L 533			

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L 533	<p>Continued From page 8</p> <p>iii. In a visit note dated 12/23/14, Patient #4's oxygen saturation was 86%. In the respiratory assessment section, the RN wrote "no change." The amount of oxygen delivery, if any, was not documented.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 1/02/15, did not include information related to Patient #4's oxygen use.</p> <p>During an interview on 5/06/15 at 10:15 AM, the RN Team Lead reviewed Patient #4's record. She stated the RN Case Manager for Patient #4 was no longer employed at the agency. She confirmed her record did not include updates to the comprehensive assessment as her needs changed.</p> <p>The agency failed to ensure Patient #4's comprehensive assessment was updated to meet her needs.</p> <p>c. Patient #4's comprehensive assessment was not updated to meet her diabetic and nutritional needs, as follows:</p> <p>i. The section of Patient #4's SOC assessment dated 11/25/14 that asked if endocrine/hematopoietic was assessed, the RN documented "yes." However, she did not include information that Patient #4 had diabetes, what medication she received, or if she monitored blood glucose levels.</p> <p>In a visit note dated 11/26/14, the section of the note to indicate if an endocrine assessment was performed, the RN wrote "no problems identified." However, in a visit note dated 12/03/14, the RN</p>	L 533			

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L 533	<p>Continued From page 9</p> <p>documented Patient #4's blood glucose was between 200-500. The RN documented Patient #4 was non-compliant with BG, and she placed a reminder on the refrigerator for Patient #4 to take her Humalog.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/04/14, included direct verbiage from Patient #4's POC. The report did not include discussion of Patient #4's non-compliance related to diabetes management.</p> <p>ii. A visit note, dated 12/10/14, documented Patient #4 was taking insulin and checking her blood glucose 3-4 times daily with ranges of 160-300. The note also documented her nutritional risk score was 8+, an increase from her admission assessment score of 0-4.</p> <p>Further, in a visit note dated 12/17/14, the RN documented "no-change" in the nutritional assessment section and Patient #4's blood glucose was documented as 200-300.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/18/14, included all medication and other physician orders from the previous IDG on 12/04/14. The report did not include specific condition changes or problems that were identified from the previous IDG on 12/04/14. Additionally, information related to discussion or interventions related to Patient #4's elevated blood sugar levels, non-compliance with diabetes management, or increased nutritional risk was not present.</p> <p>iii. The RN documented, on 12/23/14, that Patient #4 was not compliant with insulin administration and blood glucose monitoring.</p>	L 533		

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L 533	<p>Continued From page 10</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 1/02/15, included documentation that all Patient #4's medications were discontinued except her comfort medications. However, the IDG report included all medication and other physician orders from the previous IDG on 12/18/14, and information related to Patient #4's non-compliance with with diabetes management was not present.</p> <p>During an interview on 5/06/15 at 10:15 AM, the RN Team Lead reviewed Patient #4's record. She stated the RN Case Manager for Patient #4 was no longer employed at the agency. She confirmed her record did not include updates to the comprehensive assessment as her needs changed.</p> <p>The agency failed to ensure Patient #4's comprehensive assessment was updated to meet her needs.</p> <p>d. Patient #4's comprehensive assessment was not updated to meet her skin and wound care needs, as follows:</p> <p>i. Patient #4's SOC assessment, dated 11/25/14, did not include documentation that the RN had performed a skin assessment. However, a 12/10/14 skin assessment included "poor turgor, and rash" and her 12/17/14 skin assessment notes documented "no change."</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/18/14, included all medication and other physician orders from the previous IDG on 12/04/14. The report did not include specific condition changes or problems</p>	L 533		

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L 533	<p>Continued From page 11 that were identified from the previous IDG on 12/04/14, and information related to discussion or interventions related to Patient #4's "poor turgor, and rash" was not present.</p> <p>ii. The skin assessment section on Patient #4's 12/23/14 visit note stated "no problems identified." Further, in the skin assessment section of her 12/30/14 note, the RN documented that a skin assessment was not performed and wrote "Not appropriate at the time of evaluation."</p> <p>However, Patient #4's record included wound care instructions for 2 terminal ulcers on her coccyx and left heel. The order for the wound care was received on 12/27/14, and signed by the Medical Director on 12/29/14.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 1/02/15, did not include additional information related to discussion or interventions related to Patient #4's skin concerns other than the wound care orders.</p> <p>iii. In a visit note report dated 1/07/15, the RN documented Patient #4 had a wound on her head, an injury that resulted from a fall on 12/31/14. Patient #4 also had sternal and rib pain from falling and the note documented Patient #4 "falls far forward while sleeping until she lands on her head." The RN further documented Patient #4's blood pressure was 96/44, she was having bloody noses and vomiting of blood.</p> <p>In the skin assessment section, the RN documented Patient #4 had bruising to her left elbow and no pressure ulcers. No other wounds were identified on the assessment for that date.</p>	L 533			

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L 533	<p>Continued From page 12</p> <p>However, in a visit note dated 1/14/15, the RN documented Patient #4 had a Stage 3 pressure ulcer to her left heel. It did not include documentation of a coccyx wound. The RN further documented in the narrative section "Intact blister, pressure ulcer of 5 X 4 cm covered with Tegaderm." The location of the wound she described in the narrative section was not identified as the heel wound or the coccyx wound. It was unclear which foot had the heel wound, or if both feet had wounds.</p> <p>The IDG Comprehensive Assessment and POC Update Report, dated 1/15/15, included documentation and discussion regarding her current condition and plans for care. However, in a visit note dated 1/19/15, the RN documented Patient #4 had a pressure wound on her right heel. The coccyx and left heel wound were not addressed.</p> <p>Further, a skin assessment on 1/21/15 included documentation of a blister on her left thigh, and a right heel wound. A visit note dated 1/26/15, documented Patient #4 had vesicles on her inferior heel. However, the note did not identify if it was her right or her left heel. The narrative section of the 1/26/15 note included an entry by the RN describing the "diabetic ulcer on her left thigh." She noted Patient #4's right heel pressure ulcer had a new blister distally, with purple discoloration. The RN wrote that she suspected a DTI, or Deep Tissue Injury. The RN documented that dressing changes by nursing would be increased to twice weekly.</p> <p>In an IDG Comprehensive Assessment and POC Update Report, dated 1/29/15, the RN entered a detailed summary of the past two weeks.</p>	L 533		

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L 533	Continued From page 13 However, the IDG note did not include documentation of discussion regarding interventions related to the wounds and did not indicate that dressing changes would be increased to twice weekly. During an interview on 5/06/15 at 10:15 AM, the RN Team Lead reviewed Patient #4's record. She stated the RN Case Manager for Patient #4 was no longer employed at the agency. She confirmed her record did not include updates to the comprehensive assessment as her needs changed. The agency failed to ensure Patient #4's comprehensive assessment was updated to meet her needs.	L 533	L543 418.56 (b) PLAN OF CARE Director of Nursing or designee will provide instruction to RN Case Managers regarding Policy #2-044 The Plan of Care , and Policy #2-050 Interdisciplinary Group Meeting the week of 6-8-15.		
L 543	418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure an individualized written plan of care developed by the hospice IDG in collaboration with the attending physician was followed for 2 of 10 patients (#1 and #6) whose records were reviewed. Failure to follow the individualized plan of care had the potential to interfere with hospice	L 543	Instruction will include formulation of the patient's plan of care in conjunction with the patient, caregiver/family with each plan of care to be individualized with specific interventions/measurable goals to meet the overall needs of the patient and family unit including all medical equipment/supplies required to meet the needs of the patient and documentation of education provided. Medical equipment and supplies will be identified on the initial plan of care and ongoing changes identified will be added to the updated POC. Instruction will also include documentation of oxygen delivery, wound care, and laboratory monitoring and specimen handling.		

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L 543	<p>Continued From page 14 staff meeting the medical needs of the patient. Findings include:</p> <p>1. Patient #6 was an 89 year old female admitted to the agency on 11/26/14, with a diagnosis of Ovarian Cancer. She received SN, SW, and HA services. Her record, including the POC, was reviewed for the certification period of 2/24/15 to 5/24/15.</p> <p>Patient #6's record included a POC with wound care orders. The physician orders for wounds stated for Stage I pressure ulcers a moisture barrier cream or a Tegaderm dressing (a transparent film dressing) were to be used. For a Stage II pressure ulcer an antibiotic cream and foam dressing were to be used. The physician order stated for Stage III or Stage IV pressure ulcers there was to be a consultation with the WOCN or physician for treatment, equipment, and supplies that are needed to promote patient safety and comfort.</p> <p>Wounds other than pressure wounds were not addressed in Patient #6's physician orders.</p> <p>The recertification visit note, dated 2/24/15 and completed by the RN, documented Patient #6's skin was assessed and no problems were identified. A subsequent SN visit, dated 2/27/15 and completed by the LPN, documented the same.</p> <p>An SN visit note, dated 2/28/15 and completed by the LPN, documented she was contacted by Patient #6's caregiver for a new open wound that was bleeding. The LPN documented Patient #6 had a new wound, which was weeping but not open, to her left lower abdominal area. The</p>	L 543	<p>This instruction will include documenting the rate of Oxygen flow in liters/min, how often; continuous or intermittent, and the education provided. Oxygen will be documented and included on the patient's medication profile and supply list; instruction on wound care assessment and documentation on the Wound Assessment Tool and obtaining physician orders for all wound care; and instruction on obtaining orders for all treatments/interventions including laboratory such as PT/INR and ascertaining that orders are present for all treatments/interventions and how to document all provided interventions and education.</p> <p>Additionally, instruction will include that the plan of care will be updated/reviewed at each IDG meeting and will include documentation of identified changes, response to treatment and progress toward targeted outcomes, which may include: Pharmacological effectiveness for symptom management outcomes; Any increase or decrease in symptoms or acuity; Increases or decreases in frequency of visits by</p>		

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L 543	<p>Continued From page 15</p> <p>wound was documented as " ...quarter sized top white with possible puss under the skin and bottom black with skin covering entire wound bed that had serosanguinous fluid weeping from it. Area surrounding wound area 4-6 inches in diameter warm red raised with signs of possible infection."</p> <p>The LPN documented Patient #6's physician was contacted and antibiotics were ordered. The wound was cleansed and covered with a Tegaderm dressing by the LPN. There was no documentation the RN was notified of the wound or of the order for the antibiotic.</p> <p>Additionally, physician orders for cleaning the wound or applying the Tegaderm dressing were not present.</p> <p>An SN visit note, dated 3/01/15 at 1:12 PM and completed by the LPN, documented Patient #6's wound was open and draining a pustulent yellow fluid. The LPN documented the surrounding area was red, warm, and raised. The LPN stated while cleaning the wound the skin on the wound had opened.</p> <p>There was no documentation the physician or RN was notified of the wound or changes in its appearance.</p> <p>A subsequent SN visit was conducted on 3/01/15 at 9:46 PM by the LPN. Patient #6's caregiver had contacted the LPN because the wound dressing had fallen off due to excessive draining from the wound. The LPN documented the wound was cleansed and a new dressing was applied.</p>	L 543	<p>team members and reason for the change; Psychosocial needs identified and consultations/conferences with patient and family/caregiver; Ongoing spiritual support; Plan for changes in treatments or procedures; and Problem solving for optimal care of the patient and family/caregiver.</p> <p>Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audit (see attached SOC/RCT/ONSITE Audit tool) to ensure that medications, DME and supplies, wound care, and the patient's developed Plan of Care are pertinent and appropriate.</p> <p>Director or Nursing will ensure mandatory training is completed for RN's the week of 6/8/15, with a mandatory post-test to ensure that all required elements of the development of a pertinent and accurate Plan of Care are completed and documented appropriately and that these elements are used to update the patients'</p>	

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L 543	<p>Continued From page 16</p> <p>There was no documentation the RN or physician was notified of the excessive draining from the wound.</p> <p>An SN visit note, dated 3/02/15 and completed by the RN, did not include documentation of an assessment, description, or dressing change of Patient #6's wound. Patient #6's record included an order request, dated 3/02/15, for wound care. The order for wound care stated "Cleanse with wound cleaner. Pat dry. Skin prep around borders [sic]. Cover with absorbent dressing of choice. Change 3x weekly and as needed to control exudate."</p> <p>An SN visit note, dated 3/03/15 and completed by the RN, documented Patient #6's wound to the left lower abdomen was draining copious amounts of brown tinged fluid. The RN stated a colostomy bag was placed over the wound to contain the draining fluid.</p> <p>There was no documentation Patient #6's physician was contacted regarding the placement of the colostomy bag to contain the draining fluid instead of using an absorbent dressing.</p> <p>An SN visit note, dated 3/04/15 and completed by the RN, documented Patient #6's wound drainage was increasing. The RN documented an ostomy bag was placed on the wound to contain the drainage.</p> <p>There was no documentation Patient #6's physician was contacted for consultation regarding the increased drainage and changing status of Patient #6's wound or the appropriateness of the use of the ostomy bag.</p>	L 543	<p>plans of care appropriately. RN's who could not attend the trainings will be required to view the WebEx presentation of the training by 6-22-15. Inactive and part-time licensed nursing staff will be in-activated in the HR system and will be unable to provide patient care and will not be re-activated until they have viewed this WebEx. The WebEx will also be part of the orientation process with a post-test and attestation for new licensed nursing staff.</p> <p>Beginning the week of 6-14-15, Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audits (see attached SOC/RCT/ONSITE Audit tool) to ensure that medications, DME and supplies, wound care, and the patient's developed Plan of Care are pertinent and appropriate.</p> <p>REVIEW:</p> <p>The Director of Nursing or designee will review 100% of all</p>		

ANY CLINICIANS who do not complete the training WebEx by 06/14/2015 will not be permitted to provide patient care after that date until training is complete.

*Sharon M. RN, CARN
DOW - Hospice 6/15*

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L 543	<p>Continued From page 17</p> <p>An SN visit note, dated 3/09/15 and completed by the RN, documented Patient #6's wound had created its own stoma (a mouth-like opening in the skin) and was draining a dark, milky color fluid with a foul odor.</p> <p>There was no documentation Patient #6's physician was notified of the wound changes.</p> <p>SN visits were documented on 3/11/15, 3/12/15, 3/13/15, 3/14/15, 3/15/15, 3/16/15, 3/17/15, 3/18/15, 3/19/15, and 2 visits on 3/20/15. There was no documentation in the visit notes indicating Patient #6's physician was notified or consulted with for wound care.</p> <p>During an interview on 5/07/15 at 10:05 AM, the RN who completed the recertification visit reviewed the record. The RN stated she was coordinating Patient #6's wound care with the physician and other staff members. She stated the physician was in agreement with the wound care she was providing. The RN confirmed there were no wound care orders or discussions with the physician documented in the record.</p> <p>The agency failed to ensure wound care was provided to Patient #6 in accordance with physician's orders.</p> <p>2. Patient #1 was a 94 year old male admitted to hospice services on 12/19/14, related to a terminal diagnosis of CHF. Patient #1 received SN, HA, SW, and Chaplain services. His POC and record for the certification period 3/19/15 until his death on 4/05/15, was reviewed.</p> <p>Patient #1's record noted he was taking Coumadin (warfarin), a blood thinner. However</p>	L 543	<p>new Starts of Care using an audit tool (see attached SOC/RCT/ONSITE Audit tool) to ensure that all required elements of the comprehensive assessment are identified and that the Plan of Care is updated appropriately and is pertinent. 100% Audits will continue until an overall accuracy rating of 85% is reached. Upon 85% accuracy, the audit rate will decrease to 75%. Individual clinicians who fall below 85% accuracy will have one on one training, counseling, and follow-up to ensure compliance with development of a pertinent and accurate Plan of Care.</p> <p>RESPONSIBLE: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>COMPLETION: 6/14/15 and on-going</p>	
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L 543	<p>Continued From page 18</p> <p>the POC did not include routine blood tests for PT/INR to monitor his ability to clot.</p> <p>Further, in a visit note report dated 3/24/15 from 4:07 PM to 4:40 PM, the RN documented Patient #1's last BM was on 3/22/15.</p> <p>Later that evening, in a "Client Coordination Note Report," an RN documented a phone call was received from the ALF at 7:52 AM. The ALF was calling to report that Patient #1 was having a moderate amount of lower abdominal pain, and had frank blood in his stool. The RN documented she instructed the ALF staff to administer Miralax (a laxative), and to hold the Coumadin until further notice. Patient #1's record did not include documentation the RN obtained an order for the Coumadin to be held. Additionally, the record did not include documentation Patient #1's physician was notified of the bloody stools.</p> <p>The MAR from the ALF documented Patient #1 received Coumadin 5 mg orally at 5:00 PM each day in March 2015 except 3/31/15. The MAR did not indicate his Coumadin doses were to be held from 3/24/15 until further notice.</p> <p>b. In a PRN visit note on 3/29/15 from 9:45 AM to 10:23 AM, the LPN documented Patient #1 fell on 3/28/15. The LPN noted Patient #1 had a skin tear to his left elbow that he cleansed, and applied medicated ointment, steri-strips, and a dressing to. The visit note report did not document Patient #1's physician or case manager was notified of his fall. Additionally, the LPN did not obtain wound care orders.</p> <p>During an interview on 5/07/15 beginning at 10:30 AM, an RN that identified herself as "Branch</p>	L 543		
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L 543	Continued From page 19 Office Team Lead," reviewed Patient #1's record. The RN Team Lead reviewed the documentation indicating Patient #1 had bloody stools, and the documentation of instructing the ALF to hold the Coumadin on 3/24/15. She confirmed the ALF MAR indicated Coumadin was continued daily until 3/31/15. The RN Team Lead also confirmed documentation of wound care.	L 543			
L 545	The agency failed to ensure Patient #1's care was provided in accordance with physician's orders. 418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure a comprehensive individualized POC was developed and updated by the IDG to ensure patient needs were met for 1 of 10 patients (#4) whose records were reviewed. Failure to develop individualized plans of care had the potential to interfere with the ability of hospice staff to meet each patient's current needs. Findings include: 1. Patient #4 was a 59 year old female who was admitted to hospice on 11/25/14, with a terminal	L 545	L545 418.56 (c) CONTENT OF PLAN OF CARE Director of Nursing or designee will provide instruction to RN Case Managers regarding Policy #2-044 The Plan of Care, and #2-046 Verification of Physician's Orders the week of 6-8-15. Instruction will include formulation of the patient's plan of care in conjunction with the patient, caregiver/family with each plan of		

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L 545	<p>Continued From page 20</p> <p>diagnosis of liver cancer with a prognosis of less than 6 months. Additional diagnoses included Hepatitis C, cirrhosis of the liver, diabetes, and HTN.</p> <p>Patient #4 was on hospice services from 11/25/14 to 2/11/15, when she revoked her hospice benefit to pursue aggressive therapy. While receiving hospice services, Patient #4's record documented changes in her condition. However, her record did not reflect IDG activities and updates to her assessment with changes to her POC. Examples included, but were not limited to, the following:</p> <p>a. Patient #4's POC was not updated to meet her social, emotional, and pain management needs, as follows:</p> <p>i. Patient #4's SOC assessment dated 11/25/14, performed by the RN, documented Patient #4 lived alone, her home was in a remote location, and her living area was unclean and cluttered. The assessment identified her sister as her primary caregiver, who lived next door.</p> <p>The section of the assessment that identified her social support system included entries of "lives alone or without concerned relatives," "family /support sleep disturbed with patient's care," and "in need of respite care/sitter services." In the section which the RN was to indicate all abnormal social issues, she entered "other," and did not specify.</p> <p>On a form titled "Medical Review All Diagnoses," dated 11/25/14, the admitting RN wrote "Pt can no longer walk to her sisters house who lives next door. Is house bound unless extra measures are taken to lessen the burden of exertion."</p>	L 545	<p>care to be individualized with specific interventions/measurable goals to meet the overall needs of the patient and family unit.</p> <p>Education provided will also include obtaining specific MD orders for required interventions at the Start of Care and ongoing to meet the needs of the patient such as wound care, laboratory orders, missed visit notifications, and updating the visit frequency when adding PRN visits to the schedule.</p> <p>Beginning the week of 6-14-15, Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audits (see attached SOC/RCT/ONSITE Audit tool) to ensure that medications, DME and supplies, wound care, and the patient's developed Plan of Care are pertinent and appropriate.</p> <p>Director or Nursing will ensure mandatory training is completed</p>	
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L 545	Continued From page 21 An IDG Comprehensive Assessment and POC Update Report, dated 12/04/14, included direct verbiage from Patient #4's POC. The report did not include discussion of the identified unclean and cluttered living area, the need for "respite care/sitter services," or "abnormal social issues." Further, the report did not include additional information or interventions related to Patient #4's inability to walk to her sister's house or what "extra measures...to lessen the burden of exertion" were considered and/or taken. ii. A visit note, dated 12/10/14, included documentation that Patient #4 required assistance with ADLs of bathing, dressing, and grooming. However, Patient #4's record did not indicate if a hospice aide was suggested for assistance. Additionally, a visit note dated 12/17/14, documented Patient #4 had an anxiety level of 8 which was an increase from her previous nursing visit (anxiety level of 6) and her admission assessment (anxiety level of 0). Further, her pain increased from 6/10 during her previous nursing visit to 8/10. An IDG Comprehensive Assessment and POC Update Report, dated 12/18/14, included all medication and other physician orders from the previous IDG on 12/04/14. The report did not include specific condition changes or problems that were identified from the previous IDG. Additionally, information related to discussion or interventions related to Patient #4's increased need for assistance with ADLs or her increased anxiety and pain was not present in the report.	L 545	for RN's the week of 6/8/15, with a mandatory post-test to ensure that all required elements of the development of a pertinent and accurate Plan of Care are completed and documented appropriately and that these elements are used to update the patients' plans of care appropriately. RN's who could not attend the trainings will be required to view the WebEx presentation of the training by 6-22-15. Inactive and part-time licensed nursing staff will be in-activated in the HR system and will be unable to provide patient care and will not be re-activated until they have viewed this WebEx. The WebEx will also be part of the orientation process with a post-test and attestation for new licensed nursing staff. Beginning the week of 6-14-15, Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audits (see attached SOC/RCT/ONSITE Audit tool) to		

Any clinician who do not complete the training WebEx by 06/14/2015 will not be permitted to provide patient care after that date until training is completed.

Standing Order for MR, CHPN Done Hospice 6/15

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L 545	<p>Continued From page 22</p> <p>iii. A visit note, dated 12/23/14, stated the "clutter has increased" in Patient #4's home. In the section "emotional status," the RN wrote "deteriorating." The RN did not include further assessment to describe how Patient #4 was deteriorating. However, the note included a detailed narrative entry in which the RN described missing methadone. An empty bottle was found in the trash, which was labeled as 5 mg methadone, 60 tablets. The liquid morphine was diluted to a watery substance. Additionally, she described 5 boxes of wine, 1 in the refrigerator and 2 were empty. Patient #4's sister was documented as stating she would keep her medications for safety reasons since Patient #4 was found passed out. The RN did not document when the passing out incident occurred.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 1/02/15, included documentation that all Patient #4's medications were discontinued except her comfort medications. However, the IDG report included all medication and other physician orders from the previous IDG on 12/18/14. Information related to Patient #4's increased home clutter, deteriorating emotional status, and potential substance misuse was not present.</p> <p>iv. The RN documented, on 1/7/15, that Patient #4 needed assistance with ADLs of housekeeping, shopping, meal prep, feeding, toileting, bathing, dressing, and grooming.</p> <p>The IDG Comprehensive Assessment and POC Update Report, dated 1/15/15, included documentation and discussion regarding her current condition and plans for care.</p>	L 545	<p>ensure that medications, DME and supplies, wound care, and the patient's developed Plan of Care are pertinent and appropriate.</p> <p>REVIEW:</p> <p>The Director of Nursing or designee will review 100% of all new Starts of Care using an audit tool (see attached SOC/RCT/ONSITE Audit tool) to ensure that all required elements of the comprehensive assessment are identified and that the Plan of Care is updated appropriately and is pertinent. 100% Audits will continue until an overall accuracy rating of 85% is reached. Upon 85% accuracy, the audit rate will decrease to 75%. Individual clinicians who fall below 85% accuracy will have one on one training, counseling, and follow-up to ensure compliance with development of a pertinent and accurate Plan of Care.</p> <p>RESPONSIBLE: Director of Nursing has overall responsibility for the corrective</p>		

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L 545	<p>Continued From page 23</p> <p>However, subsequent notes documented increased needs and escalating concerns which were not addressed, as follows:</p> <p>On 1/19/15, the RN documented Patient #4 had increased agitation, anxiety, and fear. Additionally, the RN wrote that Patient #4 required assistance with bathing, dressing, grooming, and toileting. She required maximum assistance with transfers from her bed to her chair.</p> <p>Further, in a visit note dated 1/21/15, the RN documented Patient #4 had not slept for 2 days and was noted to refuse cares. The 1/21/15 visit note described her personal hygiene as deteriorating, and noted she needed assistance with bathing, dressing, and grooming and noted that Patient #4's caregiver was non-compliant or negligent with following the treatment plan, and indicated there was alcohol and marijuana abuse.</p> <p>The 1/26/15 RN note documented the family felt overwhelmed, their sleep was disturbed, care for Patient #4 caused extra stress, and the caregiver felt endangered by the patient. She also noted that there was abuse or history of abuse within the family system, and there was family discord. She noted there was a family feud.</p> <p>The 1/26/15 note stated nursing would be increased to twice weekly due to an increased need for wound care.</p> <p>In an IDG Comprehensive Assessment and POC Update Report, dated 1/29/15, the RN entered a detailed summary of the past two weeks. However, the IDG note did not include documentation of discussion regarding interventions related to Patient #4's alcohol</p>	L 545	<p>action and ongoing completion of this standard.</p> <p>COMPLETION: 6/14/15 and on-going</p>	

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L 545	<p>Continued From page 24</p> <p>consumption, marijuana abuse, safety concerns with the noted activities combined with her oxygen and narcotics, or interventions to address Patient #4's grooming needs. Further, information related to alleviating the stress of Patient #4's caregiver was not present.</p> <p>Additionally, on 2/3/15, the RN documented Patient #4's family felt overwhelmed, her illness was causing changes in the family lifestyle, her behavior was endangering the family, and the family had extreme feelings of anger. The RN documented there was discord between Patient #4 and her sister, who was her caregiver.</p> <p>Patient #4's record did not indicate nursing visits were increased to twice weekly as the RN noted would be done on the 1/26/15 visit.</p> <p>In a note dated 2/11/15, the RN Team Lead documented Patient #4 was found on the floor of her home, by an outside agency RN and Social Worker, and taken by EMS to the hospital. The duration of time she was on the floor was not specified. The RN Case Manager arrived at Patient #4's home shortly after EMS was contacted to take her to the hospital. While at the hospital, Patient #4 was diagnosed with pneumonia and rhabdomyolysis. She revoked her hospice benefit and was admitted for more aggressive treatment.</p> <p>During an interview on 5/06/15 at 10:15 AM, the RN Team Lead reviewed Patient #4's record. She stated the RN Case Manager for Patient #4 was no longer employed at the agency. She confirmed her record did not include updates to the POC as her needs changed. The RN Team Lead confirmed the record included</p>	L 545		

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L 545	<p>Continued From page 25</p> <p>documentation that Patient #4 required assistance with personal hygiene, grooming, and basic housekeeping, and she was unable to find documentation in the record that a hospice aide or other assistance was offered to Patient #4 or her family.</p> <p>The agency failed to ensure Patient #4's POC was updated to meet her needs.</p> <p>b. Patient #4's POC was not updated to meet her respiratory needs, as follows:</p> <p>i. The respiratory assessment documented Patient #4 had shortness of breath, and significant dyspnea with exertion. The RN documented treatment for dyspnea included oxygen that was initiated on 11/25/14. Additionally, the narrative section of a visit note, dated 11/26/14, included a note written by the RN which stated "supplies needed: O2 (oxygen)."</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/04/14, included direct verbiage from Patient #4's POC. The report did not include discussion of the initiation of oxygen.</p> <p>ii. In a visit note dated 12/10/14, the RN documented Patient #4's oxygen saturation was 85% on 2 liters of oxygen. The RN wrote that she set up Patient #4's oxygen concentrator during the visit. Patient #4's record did not include a method of oxygen delivery in the previous visit notes on 11/26/14 and 12/03/14.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/18/14, included all medication and other physician orders from the previous IDG on 12/04/14. The report did not</p>	L 545		

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L 545	<p>Continued From page 26</p> <p>include specific condition changes or problems that were identified from the previous IDG on 12/04/14 and information related to discussion or interventions related to Patient #4's oxygen use was not present in the report.</p> <p>iii. In a visit note dated 12/23/14, Patient #4's oxygen saturation was 86%. In the respiratory assessment section, the RN wrote "no change." The amount of oxygen delivery, if any, was not documented.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 1/02/15, did not include information related to Patient #4's oxygen use.</p> <p>During an interview on 5/06/15 at 10:15 AM, the RN Team Lead reviewed Patient #4's record. She stated the RN Case Manager for Patient #4 was no longer employed at the agency. She confirmed her record did not include updates to the POC as her needs changed.</p> <p>The agency failed to ensure Patient #4's POC was updated to meet her needs.</p> <p>c. Patient #4's POC was not updated to meet her djabetic and nutritional needs.</p> <p>i. The section of the SOC assessment dated 11/25/14, that asked if endocrine/hematopoietic was assessed, the RN documented "yes." However, she did not include information that Patient #4 had diabetes, what medication she received, or if she monitored blood glucose levels.</p> <p>In a visit note dated 11/26/14, the section of the note to indicate if an endocrine assessment was</p>	L 545		
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L 545	<p>Continued From page 27</p> <p>performed, the RN wrote "no problems identified." However, in a visit note dated 12/03/14, the RN documented Patient #4's blood glucose was between 200-500. The RN documented Patient #4 was non-compliant with BG, and she placed a reminder on the refrigerator for Patient #4 to take her Humalog.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/04/15, included direct verbiage from Patient #4's POC. The report did not include discussion of Patient #4's non-compliance related to diabetes management.</p> <p>ii. A visit note, dated 12/10/14, documented Patient #4 was taking insulin and checking her blood glucose 3-4 times daily with ranges of 160-300. The note also documented her nutritional risk score was 8+, an increase from her admission assessment score of 0-4.</p> <p>Further, in a visit note dated 12/17/14, the RN documented "no-change" in the nutritional assessment section and Patient #4's blood glucose was documented as 200-300.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/18/14, included all medication and other physician orders from the previous IDG on 12/04/14. The report did not include specific condition changes or problems that were identified from the previous IDG on 12/04/14. Additionally, information related to discussion or interventions related to Patient #4's elevated blood sugar levels, non-compliance with diabetes management, or increased nutritional risk was not present.</p> <p>iii. The RN documented, on 12/23/14, that Patient</p>	L 545		

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L 545	<p>Continued From page 28</p> <p>#4 was not compliant with insulin administration and blood glucose monitoring.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 1/02/15, included documentation that all Patient #4's medications were discontinued except her comfort medications. However, the IDG report included all medication and other physician orders from the previous IDG on 12/18/14, and information related to Patient #4's non-compliance with with diabetes management was not present.</p> <p>During an interview on 5/06/15 at 10:15 AM, the RN Team Lead reviewed Patient #4's record. She stated the RN Case Manager for Patient #4 was no longer employed at the agency. She confirmed her record did not include updates to the POC as her needs changed.</p> <p>The agency failed to ensure Patient #4's POC was updated to meet her needs.</p> <p>d. Patient #4's POC was not updated to meet her skin and wound care needs.</p> <p>i. Patient #4's SOC assessment, dated 11/25/14, did not include documentation that the RN had performed a skin assessment. However, a 12/10/14 skin assessment included "poor turgor, and rash" and her 12/17/14 skin assessment notes documented "no change."</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 12/18/14, included all medication and other physician orders from the previous IDG on 12/04/14. The report did not include specific condition changes or problems that were identified from the previous IDG on</p>	L 545		
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L 545	<p>Continued From page 29</p> <p>12/04/14, and information related to discussion or interventions related to Patient #4's "poor turgor, and rash" was not present.</p> <p>ii. The skin assessment section on Patient #4's 12/23/14 visit note stated "no problems identified." Further, in the skin assessment section of her 12/30/14 note, the RN documented that a skin assessment was not performed and wrote "Not appropriate at the time of evaluation."</p> <p>However, Patient #4's record included wound care instructions for 2 terminal ulcers on her coccyx and left heel. The order for the wound care was received on 12/27/14, and signed by the Medical Director on 12/29/14.</p> <p>An IDG Comprehensive Assessment and POC Update Report, dated 1/02/15, did not include additional information related to discussion or interventions related to Patient #4's skin concerns other than the wound care orders.</p> <p>iii. In a visit note report dated 1/07/15, the RN documented Patient #4 had a wound on her head, an injury that resulted from a fall on 12/31/14. Patient #4 also had sternal and rib pain from falling and the note documented Patient #4 "falls far forward while sleeping until she lands on her head." The RN further documented Patient #4's blood pressure was 96/44, she was having bloody noses and vomiting of blood.</p> <p>In the skin assessment section, the RN documented Patient #4 had bruising to her left elbow and no pressure ulcers. No other wounds were identified on the assessment for that date.</p> <p>However, in a visit note dated 1/14/15, the RN</p>	L 545			

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L 545	<p>Continued From page 30</p> <p>documented Patient #4 had a Stage 3 pressure ulcer to her left heel. It did not include documentation of a coccyx wound. The RN further documented in the narrative section "Intact blister, pressure ulcer of 5 X 4 cm covered with Tegaderm." The location of the wound she described in the narrative section was not identified as the heel wound or the coccyx wound. It was unclear which foot had the heel wound, or if both feet had wounds.</p> <p>The IDG Comprehensive Assessment and POC Update Report, dated 1/15/15, included documentation and discussion regarding her current condition and plans for care. However, in a visit note dated 1/19/15, the RN documented Patient #4 had a pressure wound on her right heel. The coccyx and left heel wound were not addressed.</p> <p>Further, a skin assessment on 1/21/15 included documentation of a blister on her left thigh, and a right heel wound. A visit note dated 1/26/15, documented Patient #4 had vesicles on her inferior heel. However, the note did not identify if it was her right or her left heel. The narrative section of the 1/26/15 note included an entry by the RN describing the "diabetic ulcer on her left thigh." She noted Patient #4's right heel pressure ulcer had a new blister distally, with purple discoloration. The RN wrote that she suspected a DTI, or Deep Tissue Injury. The RN documented that dressing changes by nursing would be increased to twice weekly.</p> <p>In an IDG Comprehensive Assessment and POC Update Report, dated 1/29/15, the RN entered a detailed summary of the past two weeks. However, the IDG note did not include</p>	L 545		

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L 545	Continued From page 31 documentation of discussion regarding interventions related to the wounds and did not indicate that dressing changes would be increased to twice weekly. During an interview on 5/06/15 at 10:15 AM, the RN Team Lead reviewed Patient #4's record. She stated the RN Case Manager for Patient #4 was no longer employed at the agency. She confirmed her record did not include updates to the POC as her needs changed.	L 545			
L 546	The agency failed to ensure Patient #4's POC was updated to meet her needs. 418.56(c)(1) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (1) Interventions to manage pain and symptoms. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to provide patients with palliative treatment for symptom management related to the terminal diagnosis for 1 of 5 active patients (#8), whose records were reviewed. This resulted in unnecessary, unrelieved pain and distress for the patient and caregiver. The findings include: 1. Patient #8 was a 57 year old female who was admitted to hospice on 2/28/15 with a diagnosis of end stage renal disease with a prognosis of less than 6 months. Additional diagnoses	L 546	L546 418.56 (c) (1) CONTENT OF PLAN OF CARE Director of Nursing or designee will provide instruction to RN Case Managers and LPN's regarding Policy #2-044 The Plan of Care and Policy #2-032 Pain Assessment the week of 6-8-15. A written individualized patient and family/caregiver plan of care will be established and maintained for each individual admitted to the hospice program. Provided instruction includes that the plan of care will identify the patient's needs and services required to meet those needs, including the management of pain and discomfort and symptom relief. Instruction will include provision of pain management including		

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L 546	<p>Continued From page 32</p> <p>included cirrhosis, morbid obesity, decubitus ulcers on right heel, coccyx, and left lower leg, chronic pain, and diabetes. A note dictated by her physician and signed on 2/27/15, documented Patient #8 was non-ambulatory. The dictated note by her hospice physician included a plan to "maintain excellent pain control."</p> <p>The agency did not ensure Patient #8 received pain medications as ordered by her physician as follows:</p> <p>Patient #8's record documented she transferred from another state where she was on hospice. The transfer documents, dated 2/25/15, included a medication list that indicated Patient #8 was receiving fentanyl transdermal patch, 37.5 mcg every 72 hours for pain.</p> <p>The POC for Patient #8 for the certification period 2/28/15 to 5/28/15, included fentanyl transdermal 37 mcg/hr, 1 patch every 72 hours. The POC noted the medication was for pain.</p> <p>Patient #8's record documented repeated delays in securing the fentanyl patches as follows:</p> <p>In a "Client Coordination Note Report," noted as a late entry for 3/02/15, the RN documented she dropped off a prescription for fentanyl patches and Norco at a pharmacy, and Patient #8's sister would pick it up.</p> <p>In a "Client Coordination Note Report," the Social Worker documented on 3/03/15 that Patient #8 was unable to get relief from the pain, and "Patient still does not have the fentanyl patch."</p>	L 546	<p>techniques and modalities as well as obtaining of needed</p> <p>Medication's in a timely manner for all patients who suffer from pain.</p> <p>Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audits (see attached SOC/RCT/ONSITE Audit tool) to ensure that medications, DME and supplies, wound care, pain management, visit frequencies, and the patient's developed Plan of Care are pertinent and appropriate.</p> <p>Director or Nursing will ensure mandatory training is completed for licensed nurses the week of 6/8/15, with a mandatory post-test to ensure that all required elements of the development of a pertinent and accurate Plan of Care are completed and documented appropriately and that these elements are used to update the patients' plans of care appropriately. Licensed Nurses who could not attend the trainings will</p>	

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L 546	Continued From page 33 In a "Client Coordination Note Report," dated 3/04/15, the LPN documented Patient #8 "Still does not have fentanyl patch." In a "Client Coordination Note Report," dated 3/09/15, the Branch Manager documented Patient #8 "still has not received fentanyl patches from the pharmacy." In an additional entry on the same report, the Branch Manager noted she stopped by the pharmacy, and the pharmacist stated an authorization form for the fentanyl patches was sent to the physician. The Branch Manager noted she left a message at the physician's office to have the authorization form signed and faxed to the pharmacy. In a "Client Coordination Note Report," the Social Worker documented on 3/10/15, that Patient #8 was experiencing significant pain and was still waiting for the fentanyl patches. In a "Client Coordination Note Report," dated 3/11/15, the LPN documented Patient #8 continued to have pain, and noted "Has not gotten a pprox al [sic] for fentanyl patch from Medicaid." Patient #8's record did not include further indication of follow-up regarding obtaining the fentanyl patches. Patient #8's record included a verbal order, dated 3/24/15, to discontinue the fentanyl patches. However, Patient #8's record did not include documentation of why the medication was discontinued. In an interview on 5/07/15 at 10:40 AM, Patient #8's RN Case Manager stated she never got the	L 546	be required to view the WebEx presentation of the training by 6-22-15. Inactive and part-time licensed nursing staff will be in-activated in the HR system and will be unable to provide patient care and will not be re-activated until they have viewed this WebEx. The WebEx will also be part of the orientation process with a post-test and attestation for new licensed nursing staff. Beginning the week of 6-14-15, Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audits (see attached SOC/RCT/ONSITE Audit tool) to ensure that medications, DME and supplies, wound care, and the patient's developed Plan of Care are pertinent and appropriate. REVIEW: The Director of Nursing or designee will review 100% of all new Starts of Care and Recertification Visits using an audit tool (see attached SOC/RCT Audit tool) to ensure that all required elements of the comprehensive assessment are identified and that the Plan of Care is updated appropriately and is pertinent. 100% Audits will continue until an overall accuracy rating of 85% is reached. Upon 85% accuracy, the audit rate will		

Any clinicians who do not complete the training by 06/19/2015 will not be permitted to provide patient care after that date until training is completed.
Stanley, RN, CHRN
Don Hospice 6/19/15

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L 546	Continued From page 34 fentanyl patches as it was not related to her terminal diagnosis, and therefore was not authorized. She further stated that Patient #8 was using fentanyl patches at her previous hospice location because there were concerns regarding drug diversion of her oral pain medications by family members.	L 546	decrease to 75%. Individual clinicians who fall below 85% accuracy will have one on one training, counseling, and follow-up to ensure compliance with development of a pertinent and accurate Plan of Care.		
L 547	The agency failed to ensure effective pain management was provided to Patient #8. 418.56(c)(2) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the POC contained a detailed statement of the frequency of services necessary to meet patient needs for 1 of 10 patients (#6) whose records were reviewed. This had the potential to result in unmet patient and family needs. Findings include: 1. Patient #6 was an 89 year old female admitted to the agency on 11/26/14, with a diagnosis of Ovarian Cancer. She received SN, SW, and HA services. Her record, including the POC, was reviewed for the certification period of 2/24/15 to 5/24/15.	L 547	RESPONSIBLE: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard. COMPLETION: 6/14/15 and on-going L547 418.56 (c) (2) CONTENT OF PLAN OF CARE A written individualized patient and family/caregiver plan of care will be established and maintained for each individual admitted to the hospice program. Instruction to the RN Case Managers will include that the plan of care will identify the patient's needs and services required to meet those needs, including the management of pain and discomfort and symptom relief. It must state, in detail, the scope and frequency of services needed to meet the patient's and family/caregiver's needs. Beginning the week of 6-14-15, Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audits (see attached SOC/RCT/ONSITE Audit tool) to ensure that medications, DME and supplies, wound care, pain management, visit frequencies, and		

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L 547	Continued From page 35 Patient #6's record included an order request by the RN, dated 3/02/15, for wound care and increasing SN visits. The order for wound care stated "Cleanse with wound cleaner. Pat dry. Skin prep around boarders [sic]. Cover with absorbent dressing of choice. Change 3 x weekly and as needed to control exudate." The request also included a change in frequency for SN visits. The frequency request did not correlate with the wound care request for changing the wound dressing 3 times weekly. The request for the frequency change stated the SN was to visit 5 times a week for 1 week, 2 times a week for 9 weeks, and 2 times a week for 1 week. The physician order request was signed by Patient #6's physician on 3/03/15. During an interview on 5/07/15 at 10:05 AM, the RN reviewed the record and confirmed she had written the order request. She confirmed the visit frequency did not correlate with changing the wound dressing 3 times weekly. She stated it was incorrect because she was still learning her position and responsibilities.	L 547	the patient's developed Plan of Care are pertinent and appropriate. Director or Nursing will ensure mandatory training is completed for licensed nurses the week of 6/8/15, with a mandatory post-test to ensure that all required elements of the development of a pertinent and accurate Plan of Care are completed and documented appropriately and that these elements are used to update the patients' plans of care appropriately. Licensed Nurses who could not attend the trainings will be required to view the WebEx presentation of the training by 6-22-15. Inactive and part-time licensed nursing staff will be in-activated in the HR system and will be unable to provide patient care and will not be re-activated until they have viewed this WebEx. The WebEx will also be part of the orientation process with a post-test and attestation for new licensed nursing staff. Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audits (see attached	
L 550	418.56(c)(5) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (5) Medical supplies and appliances necessary to	L 550	SOC/RCT/ONSITE Audit tool) to ensure that medications, DME and supplies, wound care, and the patient's developed Plan of Care are pertinent and appropriate. REVIEW:	

Any clinicians who do not complete the training by 6/8/15 will not be permitted to provide patient care after that date until training is completed.

*Stacy R. MS, CAPA
DOR - Hospice 6/8/15*

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L 550	<p>Continued From page 36 meet the needs of the patient.</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 patient specific supplies were included on each POC for 2 of 10 patients (#1 and #9) whose records were reviewed. This failure had the potential to result in patients not receiving adequate care based on their needs. Findings include:</p> <p>1. Patient #9 was a 66 year old male admitted to the agency on 1/16/15, with a diagnosis of cardiac dysrhythmia. His POC for the certification period of 1/16/15 to 4/15/15 was reviewed.</p> <p>Patient #9's record included a brief narrative statement by the Medical Director which documented he needed gastrostomy feedings upon his admission to the agency. The narrative statement was signed by the Medical Director on 1/28/15.</p> <p>Patient #9's record included a Hospice Certification and Plan of Care dated 1/16/15. The orders on the POC stated the SN was to provide instructions for performing enteral feedings and instruction on the care of Patient #9's equipment and preparation of his feedings. However, Patient #9's POC did not include enteral/tube feeding supplies under the section DME.</p> <p>Additionally, the Hospice Certification and Plan of Care documented under "Activities Permitted," that Patient #9 was using a wheelchair. The POC did not include Patient #9 had a wheelchair.</p>	L 550	<p>The Director of Nursing or designee will review 100% of all new Starts of Care and Recertification Visits using an audit tool (see attached SOC/RCT Audit tool) to ensure that all required elements of the comprehensive assessment are identified and that the Plan of Care is updated appropriately and is pertinent. 100% Audits will continue until an overall accuracy rating of 85% is reached. Upon 85% accuracy, the audit rate will decrease to 75%. Individual clinicians who fall below 85% accuracy will have one on one training, counseling, and follow-up to ensure compliance with development of a pertinent and accurate Plan of Care.</p> <p>RESPONSIBLE: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>COMPLETION: 6/14/15 and on-going</p> <p>L550 418.56 (c) (5) CONTENT OF PLAN OF CARE Director of Nursing or designee will provide instruction to RN Case Managers regarding <i>Policy #2-044 The Plan of Care</i> the week of 6-8-15. Instruction to the RN Case Managers will include that the plan of care will identify the and document patient's needs and services required to meet those needs, including the management of all supplies and medical equipment that the patient/family/caregiver require for all cares and safety needs, and updating of</p>		

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L 550	<p>Continued From page 37</p> <p>Further, Patient #9's records included a "Physician Verbal Order," signed by the physician on 4/8/15 for the recertification period of 4/16/15 to 7/14/15. The order stated "Continue with current hospice plan of care." The order did not include information related to enteral/tube feeding supplies or assistive devices for ambulation.</p> <p>An SN visit note, dated 4/17/15 and signed by the RN, documented Patient #9 received enteral support for nutrition. The RN documented Patient #9 had a jejunostomy tube for feeding. The visit note included documentation Patient #9 used an assistive device for ambulation.</p> <p>During an interview on 5/07/15 at 9:20 AM, the DON reviewed the record and confirmed the DME did not include assistive devices for ambulation or feeding supplies for Patient #9's enteral feedings. She stated she would look for documentation for the missing DME.</p> <p>On 5/07/15 at 4:32 PM, a fax was received from the DON which included new DME on the Client Supplies Report for Patient #9. The new DME listed were a scooter, rolling walker, wheelchair, and enteral/tube feeding supplies. The section titled "Date Entered" documented these items were added by an LPN on 5/07/15.</p> <p>The agency failed to ensure Patient #9's POC included medical supplies and appliances necessary to meet his needs.</p> <p>2. Patient #1 was a 94 year old male admitted to hospice services on 12/19/14, related to a terminal diagnosis of CHF. Patient #1 received SN, HA, SW, and Chaplain services. His POC and record for the certification period 3/19/15 until</p>	L 550	<p>the plan of care to reflect supplies/medical equipment. Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audits (see attached SOC/RCT/ONSITE Audit tool) to ensure that medications, DME and supplies, wound care, pain management, visit frequencies, and the patient's developed Plan of Care are pertinent and appropriate. Director or Nursing will ensure mandatory training is completed for licensed nurses the week of 6/8/15, with a mandatory post-test. Licensed Nurses who could not attend the trainings will be required to view the WebEx presentation of the training by 6-22-15. Inactive and part-time licensed nursing staff will be in-activated in the HR system and will be unable to provide patient care and will not be re-activated until they have viewed this WebEx. Beginning the week of 6-14-15, Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audits (see attached SOC/RCT/ONSITE Audit tool) to ensure that medications, DME and supplies, wound care, and the patient's developed Plan of Care are pertinent and appropriate.</p> <p>REVIEW:</p>		

*Any clinician who does not complete the mandatory WebEx by 06/14/2015 will not be permitted to provide patient care after that date until training is completed. Sandra M. RN, CHRN
DON - Hospice 6/9/15*

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L 550	Continued From page 38 his death on 4/05/15, was reviewed. The narrative section of a 3/26/15 visit note included documentation Patient #1 was not able to tell the RN about his procedure for CPAP at night. However, his POC did not include CPAP. During an interview on 5/07/15 beginning at 10:30 AM, an RN that identified herself as "Branch Office Team Lead," reviewed Patient #1's record. She confirmed the POC did not include the CPAP. The agency failed to ensure Patient #1's POC included medical supplies and appliances necessary to meet his needs.	L 550	The Director of Nursing or designee will review 100% of all new Starts of Care and Recertification Visits using an audit tool (see attached SOC/RCT Audit tool) to ensure that all required elements of the comprehensive assessment are identified and that the Plan of Care is updated appropriately and is pertinent. 100% Audits will continue until an overall accuracy rating of 85% is reached. Upon 85% accuracy, the audit rate will decrease to 75%. Individual clinicians who fall below 85% accuracy will have one on one training, counseling, and follow-up to ensure compliance with development of a pertinent and accurate Plan of Care.		
L 648	418.100 ORGANIZATIONAL ENVIRONMENT This CONDITION is not met as evidenced by: Based on review of the agency's compliance history, agency policies, contracts and staff interview, it was determined the hospice failed to ensure organization and administration of services were conducted in a manner which provided direction and oversight of the agency's operations. This resulted in the inability of the agency to achieve and sustain regulatory compliance and provide the necessary services and systems to meet patient needs. Findings include: 1. Refer to L651 as it relates to the governing body's failure to ensure responsibility was assumed for implementing programs and providing direction to the agency.	L 648	RESPONSIBLE: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard. COMPLETION: 6/14/15 and on-going		
L 651	418.100(b) GOVERNING BODY AND ADMINISTRATOR	L 651			

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L 651	<p>Continued From page 39</p> <p>A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.</p> <p>This STANDARD is not met as evidenced by: Based on review of the organization chart, personnel documentation, policies and procedures, patient records, and staff interview, it was determined the hospice failed to ensure the Governing Body assumed responsibility for the management and operational direction of the hospice agency for all patients receiving services at the agency. This prevented the hospice from being organized along clear lines of authority which impeded the agency's ability to meet the patients' health and safety needs and achieve and sustain compliance with regulatory requirements. The findings include:</p> <p>1. CMS correspondence dated 6/10/13, documented the agency's primary location was in Meridian, Idaho and multiple locations associated with the primary location were in Twin Falls, Mountain Home, Burley, Caldwell, Weiser, and Emmett, Idaho.</p> <p>The top of the agency's undated organizational chart included a box with the title "Administrator." To the right of the Administrator's box and</p>	L 651	<p>L648 ORGANIZATIONAL ENVIRONMENT</p> <p>The agency recognizes oversight in contract verbiage that caused ambiguity in the role of the Medical Director as well as the opportunity to create a more detailed org chart, which has been rectified as of 6/8/15.</p> <p><i>RESPONSIBILITY: ADMINISTRATION HAS OVERALL RESPONSIBILITY. FOR CORRECTION</i></p> <p>L651 418.100 (b) GOVERNING BODY AND ADMINISTRATOR</p> <p>The agency's org chart was updated 6/5/15 to include the effective date as well as a more clear delineation of the Medical Director and Associate Medical Directors. The org chart was also redrawn in a clearer manner that indicated the relationship between the Medical Director, Associate Medical Directors and agency staff with the multiple locations.</p> <p>L651 1(a) the typo indicating that the Associate Medical Director for Twin Falls and Burley has been corrected and updated to reflect</p>	<p><i>Wmj</i> <i>6/9/15</i></p>
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L 651	<p>Continued From page 40</p> <p>connected by a solid line, was a box labeled "Hospice Medical Director." Below the Hospice Medical Director box was a box labeled "Hospice Director of Nursing." The Hospice Medical Director box and the Hospice Director of Nursing boxes were connected by a dotted line. The organizational chart did not demonstrate other Medical Director connections to the hospice agency or other staff.</p> <p>However, a separate undated organizational chart included a box at the top of the chart titled "Chief Medical Director [Physician A] Meridian Branch." Under the box and connected by a solid line, were the names of 5 physicians (Physicians B - F) and the locations they were responsible for.</p> <p>The relationship between the 2 organizational charts was not evident.</p> <p>When asked, during an interview on 5/06/15 at 10:15 AM, the DON stated each branch office had 2 Medical Directors. On 5/07/15 at 9:00 AM, the DON approached this surveyor to clarify the statement she made the day before. She stated each branch office had 2 physicians, and the term Medical Director was an "industry" term. She stated that although the branch physicians were called Medical Directors, there was only 1 Chief Medical Director, which was Physician A.</p> <p>The agency's organization chart for physicians and the physician's contracts were reviewed. The top box of the organizational chart included a box which stated "Chief Medical Director [Physician A] Meridian Branch" and included Physician A's name.</p> <p>The organizational chart did not list Meridian as</p>	L 651	<p>Idaho as the state in which said Associate Medical Director practices within.</p> <p>L651 1(b) the contract for the Associate Medical Director for Mountain Home has been recreated and executed.</p> <p>The Medical Director and all Associate Medical Directors contracts will be reviewed, updated and signed by each responsible party. The contracts will specify designated coverage area and Idaho Licensure by Associate Medical Director and Medical Director. The Associate Medical Director Contract verbiage that stated additional responsibilities that the overall Medical Director would typically assume have been removed.</p> <p>The overall Medical Director has accepted the role and the responsibilities to oversee the total medical component of the hospice's patient care program. The agency has removed verbiage from and altered the Associate Medical Director Contracts so as to</p>	

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L 651	<p>Continued From page 41 the agency's primary location.</p> <p>Directly under the "Chief Medical Director" box was a horizontal row of 5 boxes, which were connected to the "Chief Medical Director" box by a solid line. The horizontal row of boxes included a location, "Hospice Physician," and a physician's name, as follows:</p> <p>a. The organizational chart stated "Burley and Twin Falls Hospice Physician [Physician B]." The contract for Physician B, effective 9/1/14, was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for its Agency Branches located in Burley, Idaho and Twin Falls, Idaho..." However, the contract also stated "the Medical Director is a doctor of medicine or osteopathy licensed to practice medicine in the state of Colorado."</p> <p>The contract did not reflect Idaho licensure.</p> <p>b. The organizational chart stated "Mountain Home Hospice Physician [Physician D]." A contract for Physician D could not be located by the agency.</p> <p>c. The organizational chart stated "Caldwell Hospice Physician [Physician E]." The contract for Physician E, effective 11/1/14, was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for its Hospice Agency located at [agency address], Meridian, Idaho..."</p>	L 651	<p>remove any ambiguity of the Medical Director role.</p> <p>COMPLETION 6/8/15</p> <p>RESPONSIBLE: ADMINISTRATOR HAS MEDICAL RESPONSIBILITY FOR CORRECTION</p> <p><i>[Signature]</i> 6/8/15</p>		

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L 651	<p>Continued From page 42</p> <p>The contract did not include information specific to the Caldwell location as listed on the organizational chart. Further, the "Compensation" section of the contract, outlined additional compensation for "...Service performed for branches other than Meridian branch..."</p> <p>Additionally, the contract for Physician A, who was listed as the "Chief Medical Director" on the organizational chart, was reviewed. The contract stated it was a "Medical Director Service Agreement," effective 11/1/14. The contract stated the same information as Physician E's contract, including additional compensation for "...Service performed for branches other than Meridian branch..."</p> <p>The contract did not identify Meridian as the agency's primary location and the contracts did not specify which physician assumed the agency's full Medical Director responsibilities and obligations.</p> <p>When asked about the contracts, during a telephone interview on 5/13/15 at 12:38 PM, the Administrator stated in January 2015, the Caldwell and Meridian multiple locations were placed under the leadership of one Branch Director and Physician E and Physician A covered both areas.</p> <p>d. The organizational chart stated "Emmett Hospice Physician [Physician C]." The contract for Physician C, effective 12/1/14, was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for a branch of its Hospice Agency located in</p>	L 651		

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L 651	<p>Continued From page 43 Emmett, Idaho..."</p> <p>The organizational chart stated "Weiser Hospice Physician [Physician F]." The contract for Physician F, effective 6/16/14, was reviewed. The contract stated it was an "Associate Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for its Hospice Agency located at [agency address], Meridian, Idaho..." However, item 1, under the "Terms and Conditions" section stated "The Medical Director agrees to serve as a Medical Director for the Branch..."</p> <p>Physician F's "Associate Medical Director Service Agreement" included a section titled "Terms and Conditions." The section outlined responsibilities which were consistent with the "Terms and Conditions" found in Physician A - E's "Medical Director Service Agreement." However, the "Medical Director Service Agreements" listed additional responsibilities which included the following:</p> <ul style="list-style-type: none"> - "Serves as a member of the Agency's Quality Assurance Committee, and attends and participates in both Quality Assurance Committee meetings." - "Participates in the development of formal patient care policies..." - "Participates in the design, conduct, review and periodic evaluation of the Agency's staff development and in-service programs.." <p>The "Medical Director Service Agreements" for Physicians A, B, C, and E all included the same</p>	L 651		
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L 651	<p>Continued From page 44</p> <p>information. The contracts did not clearly identify a single physician who filled the role of the Medical Director and assumed overall responsibility for the medical component of the hospice's patient care program, including care delivered at all of the agency's multiple locations.</p> <p>The agency Administrator stated, via email received on 5/11/15 at 1:47 PM, that all of the physician contracts had been reviewed and it was determined the agency had not delineated the Medical Director from the associates except in the case of Physician F. The Administrator stated the agency did not ensure associates received the appropriate associate contracts as they were updated due to an oversight.</p> <p>The Governing Body failed to ensure physician contracts were accurate and appropriately executed.</p> <p>2. Refer to L664 Condition of Participation: Medical Director and related standard level deficiencies as they relate to the Governing Body's failure to ensure a single Medical Director assumed full responsibility and oversight of the total medical component of the hospice's patient care program, including the agency's primary site and multiple locations.</p> <p>a. Refer to L669 as it relates to the Governing Body's failure to ensure the Medical Director provided sufficient oversight to meet each patient's needs. The agency was previously cited at L669 during an annual recertification survey dated 9/10/14. The Governing Body failed to ensure sustained compliance was achieved.</p> <p>3. Refer to L533 as it relates to the Governing</p>	L 651			

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L 651	Continued From page 45 Body's failure to ensure comprehensive assessments were updated in response to patient and family changes and needs. The agency was previously cited at L533 during an annual recertification survey dated 9/10/14. The Governing Body failed to ensure sustained compliance was achieved. 4. Refer to L545 as it relates to the Governing Body's failure to ensure a comprehensive individualized POC was developed and updated by the IDG to ensure patient needs were met. The agency was previously cited at L545 during an annual recertification survey dated 9/10/14. The Governing Body failed to ensure sustained compliance was achieved.	L 651		
L 664	418.102 MEDICAL DIRECTOR This CONDITION is not met as evidenced by: Based on review of agency CMS documentation, agency organization and personnel information, physician contracts, patient medical records and staff interview, it was determined the agency failed to ensure a single Medical Director assumed full responsibility and oversight of the total medical component of the hospice's patient care program, including the agency's primary site and multiple locations. This resulted in a lack of clear lines of authority, a lack of accountability, and a lack of sufficient oversight and supervision of patient care. Findings include: 1. Refer to L665 as it relates to the agency's failure to ensure hospice physicians functioned under the supervision of a designated Medical Director and that a physician was designated to assume the responsibilities of the Medical	L 664	L664 418.102 MEDICAL DIRECTOR The agency's org chart was updated 6/5/15 to include the effective date as well as a more clear delineation of the Medical Director and Associate Medical Directors. The org chart was also redrawn in a clearer manner that indicated the relationship between the Medical Director, Associate Medical Directors and agency staff with the multiple locations. The org chart also now indicates a backup MD in the event the Medical Director is not available. COMPLETION 6/8/15 RESPONSIBLE: ADMINISTRATOR ASSUMES OVERALL RESPONSIBILITY FOR CORRECTION <i>[Signature]</i> 6/9/15	

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L 664	Continued From page 46 Director when the Medical Director was unavailable. 2. Refer to L666 as it relates to the agency's failure to ensure contracts specified the physician who assumed the overall Medical Director responsibilities and obligations including the agency's primary site and multiple locations. 3. Refer to L669 as it relates to the agency's failure to ensure the Medical Director's role and responsibilities for the total medical component of the hospice's patient care program, including care delivered at the agency's primary site and all multiple locations, was assumed by a single physician.	L 664		
L 665	418.102 MEDICAL DIRECTOR The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with, the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director. This STANDARD is not met as evidenced by: Based on review of CMS documentation, agency organization and personnel information, and staff interview, it was determined the agency failed to ensure hospice physicians functioned under the supervision of a designated Medical Director and that a physician was designated to assume the responsibilities of the Medical Director when the Medical Director was unavailable. This resulted in a lack of clear lines of authority and responsibility for the medical component of the	L 665	L665 418.102 MEDICAL DIRECTOR The agency's org chart was updated 6/5/15 to include the effective date as well as a more clear delineation of the Medical Director and Associate Medical Directors. The org chart was also redrawn in a clearer manner that indicated the relationship between the Medical Director, Associate Medical Directors and agency staff with the multiple locations. The Medical Director assumes overall responsibility for the medical component of the hospice's patient care program. This responsibility,	

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L 665	<p>Continued From page 47 hospice's patient care program. The findings include:</p> <p>1. CMS correspondence dated 6/10/13, documented the agency's primary location was in Meridian, Idaho and multiple locations associated with the primary location were in Twin Falls, Mountain Home, Burley, Caldwell, Weiser, and Emmett, Idaho.</p> <p>The agency's records included a 2/25/15 letter from the agency's Medical Director (Physician G) stating he was resigning his position effective 3/25/15.</p> <p>When asked, during an interview on 5/06/15 at 10:15 AM, the DON stated each branch office had 2 Medical Directors. On 5/07/15 at 9:00 AM, the DON approached this surveyor to clarify the statement she made the day before. She stated each branch office had 2 physicians, and the term Medical Director was an "industry" term. She stated that although the branch physicians were called Medical Directors, there was only 1 Chief Medical Director, which was Physician A.</p> <p>The agency's undated physician's organizational chart included a box at the top of the chart titled "Chief Medical Director [Physician A] Meridian Branch." Under the box and connected by a solid line, were the names of 5 physicians (Physicians B - F) and the locations they were responsible for.</p> <p>During an interview on 5/7/15 beginning at 1:00 PM, Physician A was introduced as the Medical Director. He stated for approximately one and a half months he had been transitioning into the "Chief Medical Director" position, but it was informal. He stated there were discussions</p>	L 665	<p>which extends to all hospice multiple locations, includes overseeing the implementation of the entire physician, nursing, social work, therapy, and counseling areas within the hospice to ensure that these areas consistently meet patient and family needs. The oversight occurs via a sample of chart reviews, attending QAPI and participating in the QAPI committee, assisting in development of policies and the annual agency evaluation.</p> <p>COMPLETION 6/17/15</p> <p>RESPONSIBLE: ADMINISTRATOR ASSUMES OVERALL RESPONSIBILITY FOR CORRECTION</p> <p><i>[Signature]</i> 6/9/15</p>	
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L 665	<p>Continued From page 48</p> <p>regarding evaluating and defining his role, but he had not yet been officially designated or signed a contract for the Chief Medical Director position. Physician A stated he was contracted and not an employee of the agency. Physician A stated he did not have oversight of the agency's other locations. He stated he was responsible for oversight of the agency's Meridian location and that other locations had their own Medical Directors. He stated each branch had their own Medical Directors. He stated he had no contact with the other branches and did not communicate with the agency's other physicians on a frequent basis.</p> <p>On 5/11/15 at 11:27 AM, the agency's Administrator stated he was still in the process of making final decisions regarding the Medical Director position. He stated when the agency received the previous Medical Director's resignation, the Governing Body had designated Physician A to serve as the Medical Director. However, he did not believe the designation had been documented.</p> <p>The agency failed to ensure the hospice physicians, including those assigned to multiple locations, functioned under the supervision of a designated Medical Director.</p> <p>2. The agency's physician's organizational chart included a hand-written note which stated "[Physician E's name]" at the bottom of the "Chief Medical Director" box. Beyond the note, the chart did not include information related to which physician had been designated to assume the Medical Director responsibilities when the Medical Director was unavailable.</p>	L 665		
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L 665	<p>Continued From page 49</p> <p>The organizational chart stated "Caldwell Hospice Physician [Physician E]." The contract for Physician E, effective 11/1/14, was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for its Hospice Agency located at [agency address], Meridian, Idaho..."</p> <p>The contract did not include information specific to the Caldwell location as listed on the organizational chart. Further, the "Compensation" section of the contract, outlined additional compensation for "...Service performed for branches other than Meridian branch..." which was identical to the information found in Physician A's contract. The section stated "...services of the Medical Director may be needed at other branches of Horizon (outside of the Meridian branch) and the Medical Director is willing to provide said services if his schedule permits..."</p> <p>Physician E's contract did not include information related to assuming the responsibilities and obligations for the complete agency, including the primary site and the 6 multiple locations when the Medical Director was unavailable.</p> <p>The agency failed to ensure a physician was designated to assume the responsibilities of the Medical Director when the Medical Director was unavailable.</p>	L 665		
L 666	<p>418.102(a) MEDICAL DIRECTOR CONTRACT</p> <p>(1) A hospice may contract with either of the following-</p> <p>(i) A self-employed physician; or</p>	L 666	<p>L666 418.102 (a) MEDICAL DIRECTOR CONTRACT</p>	

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L 666	<p>Continued From page 50</p> <p>(ii) A physician employed by a professional entity or physicians group. When contracting for medical director services, the contract must specify the physician who assumes the medical director responsibilities and obligations.</p> <p>This STANDARD is not met as evidenced by: Based on review of CMS documentation, agency organization and personnel information, physician contracts and staff interview, it was determined the agency failed to ensure Medical Director responsibilities were specifically delineated for a single physician in 4 of 5 current physician contracts (Physicians A, B, C, and E) reviewed. This resulted in a lack of accountability for the overall medical component of the hospice's patient care program, including the primary site and the 6 multiple locations. The findings include:</p> <p>1. CMS correspondence dated 6/10/13, documented the agency's primary location was in Meridian, Idaho and multiple locations associated with the primary location were in Twin Falls, Mountain Home, Burley, Caldwell, Weiser, and Emmett, Idaho.</p> <p>The agency's records included a 2/25/15 letter from the agency's Medical Director (Physician G) stating he was resigning his position effective 3/25/15.</p> <p>During an interview on 5/7/15 beginning at 1:00 PM, Physician A was introduced as the Medical Director. He stated for approximately one and a half months he had been transitioning into the "Chief Medical Director" position, but it was informal. He stated there were discussions</p>	L 666	<p>The agency's org chart was updated 6/5/15 to include the effective date as well as a more clear delineation of the Medical Director and Associate Medical Directors. The org chart was also redrawn in a clearer manner that indicated the relationship between the Medical Director, Associate Medical Directors and agency staff with the multiple locations. The overall Medical Director is aware of the responsibilities of his role. The Associate Medical Directors have signed new contracts that remove verbiage that caused ambiguity.</p> <p>COMPLETION 6/18/15</p> <p>RESPONSIBLE: ADMINISTRATOR ASSUMED OVERALL RESPONSIBILITY FOR ACTION</p> <p><i>[Signature]</i> 6/19/15</p>		

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L 666	<p>Continued From page 51</p> <p>regarding evaluating and defining his role, but he had not yet been officially designated or signed a contract for the Chief Medical Director position. Physician A stated he was contracted and not an employee of the agency. Physician A stated he did not have oversight of the agency's other locations. He stated he was responsible for oversight of the agency's Meridian location and that other locations had their own Medical Directors. He stated each branch had their own Medical Directors. He stated he had no contact with the other branches and did not communicate with the agency's other physicians on a frequent basis.</p> <p>On 5/11/15 at 11:27 AM, the agency's Administrator stated he was still in the process of making final decisions regarding the Medical Director position. He stated when the agency received the previous Medical Director's resignation, the Governing Body had designated Physician A to serve as the Medical Director. However, he did not believe the designation had been documented.</p> <p>However, the agency's undated physician's organizational chart included a box at the top titled "Chief Medical Director" and listed Physician A's name. The box also included the words "Meridian Branch."</p> <p>The contract for Physician A, effective 11/1/14 was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for its Hospice Agency located at [agency address], Meridian, Idaho..." The "Compensation" section of the contract, outlined</p>	L 666			

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L 666	<p>Continued From page 52</p> <p>additional compensation for "...Service performed for branches other than Meridian branch..." The section stated "...services of the Medical Director may be needed at other branches of Horizon (outside of the Meridian branch) and the Medical Director is willing to provide said services if his schedule permits..."</p> <p>Physician A's contract was signed prior to the resignation of the previous Medical Director (Physician G) and did not include information related to responsibilities and obligations for the complete agency, including the primary site and the 6 multiple locations.</p> <p>Additionally, directly under the "Chief Medical Director" box was a horizontal row of 5 boxes, which were connected to the "Chief Medical Director" box by a solid line. The horizontal row of boxes included a location, "Hospice Physician," and a physician's name. The organizational chart and physician contracts included the following physician information:</p> <ul style="list-style-type: none"> - The organizational chart stated "Burley and Twin Falls Hospice Physician [Physician B]." The contract for Physician B, effective 9/1/14, was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for its Agency Branches located in Burley, Idaho and Twin Falls, Idaho..." - The organizational chart stated "Emmett Hospice Physician [Physician C]." The contract for Physician C, effective 12/1/14, was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the 	L 666		

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L 666	<p>Continued From page 53</p> <p>"...Agency desires to engage the services of Medical Director to serve as Medical Director for a branch of its Hospice Agency located in Emmett, Idaho..."</p> <p>- The organizational chart stated "Caldwell Hospice Physician [Physician E]." The contract for Physician E, effective 11/1/14, was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for its Hospice Agency located at [agency address], Meridian, Idaho..."</p> <p>The contract did not include information specific to the Caldwell location as listed on the organizational chart. Further, the "Compensation" section of the contract, outlined additional compensation for "...Service performed for branches other than Meridian branch..." which was identical to the information found in Physician A's contract.</p> <p>The "Medical Director Service Agreements" listed the "Medical Director's Duties" and responsibilities in the "Terms and Conditions" section of the agreements. The agreements for Physicians A, B, C, and E all included the same information. The contracts did not clearly identify a single physician who filled the role of the Medical Director and assumed overall responsibility for the medical component of the hospice's patient care program, including care delivered at all of the agency's multiple locations.</p> <p>The agency Administrator stated, via email received on 5/11/15 at 1:47 P.M., that all of the physician contracts had been reviewed and it was</p>	L 666			

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L 666	Continued From page 54 determined the agency had not delineated the Medical Director from the associates. The Administrator stated the agency did not ensure associates received the appropriate associate contracts as they were updated due to an oversight. The agency failed to ensure physician contracts clearly identified a Medical Director who assumed overall responsibility for the medical component of the hospice's patient care program, including care delivered at all of the agency's 6 multiple locations.	L 666			
L 669	418.102(d) MEDICAL DIRECTOR RESPONSIBILITY The medical director or physician designee has responsibility for the medical component of the hospice's patient care program. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the Medical Director failed to ensure sufficient oversight was provided to meet the needs of each patient. This failure directly impacted 5 of 10 patients (#1, #4, #6, #8, and #9) whose records were reviewed and had the potential to impact all patients receiving services from the agency. This failure resulted in assessments and plans of care that were not comprehensive, not updated, and not being followed. Findings include: 1. CMS correspondence dated 6/10/13, documented the agency's primary location was in Meridian, Idaho and multiple locations associated with the primary location were in Twin Falls,	L 669	L669 418.102 (d) MEDICAL DIRECTOR RESPONSIBILITY The Medical Director will review one chart per Associate Medical Director per month to ensure comprehensive individualized plans of care, updated assessments, effective pain management interventions and overall patient care are evident. On the occasion in which these and other areas pertaining to patient and family needs are not met the Medical Director will assist in creating corrective actions. COMPLETION 6/18/15 RESPONSIBLE: ADMINISTRATOR ASSUMES RESPONSIBILITY FOR CORRECTION <i>[Signature]</i> 6/9/15		

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L 669	<p>Continued From page 55</p> <p>Mountain Home, Burley, Caldwell, Weiser, and Emmett, Idaho.</p> <p>The top of the agency's undated organizational chart included a box with the title "Administrator." To the right of the Administrator's box and connected by a solid line, was a box labeled "Hospice Medical Director." Below the Hospice Medical Director box was a box labeled "Hospice Director of Nursing." The Hospice Medical Director box and the Hospice Director of Nursing boxes were connected by a dotted line. The organizational chart did not demonstrate other Medical Director connections to the hospice agency or other staff.</p> <p>However, a separate undated organizational chart included a box at the top of the chart titled "Chief Medical Director [Physician A] Meridian Branch." Under the box and connected by a solid line, were the names of 5 physicians (Physicians B - F) and the locations they were responsible for.</p> <p>The agency's organization chart for physicians and the physician's contracts were reviewed. The top box of the organizational chart included a box which stated "Chief Medical Director [Physician A] Meridian Branch" and included Physician A's name.</p> <p>Directly under the "Chief Medical Director" box was a horizontal row of 5 boxes, which were connected to the "Chief Medical Director" box by a solid line. The horizontal row of boxes included a location, "Hospice Physician," and a physician's name, as follows:</p> <p>- The organizational chart stated "Burley and Twin Falls Hospice Physician [Physician B]." The</p>	L 669		

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L 669	<p>Continued From page 56</p> <p>contract for Physician B, effective 9/1/14, was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for its Agency Branches located in Burley, Idaho and Twin Falls, Idaho..."</p> <p>- The organizational chart stated "Emmett Hospice Physician [Physician C]." The contract for Physician C, effective 12/1/14, was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for a branch of its Hospice Agency located in Emmett, Idaho..."</p> <p>- The organizational chart stated "Caldwell Hospice Physician [Physician E]." The contract for Physician E, effective 11/1/14, was reviewed. The contract stated it was a "Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for its Hospice Agency located at [agency address], Meridian, Idaho..."</p> <p>The contract did not include information specific to the Caldwell location as listed on the organizational chart. Further, the "Compensation" section of the contract, outlined additional compensation for "...Service performed for branches other than Meridian branch..."</p> <p>Additionally, the contract for Physician A, who was listed as the "Chief Medical Director" on the organizational chart, was reviewed. The contract stated it was a "Medical Director Service</p>	L 669			

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L 669	<p>Continued From page 57</p> <p>Agreement," effective 11/1/14. The contract stated the same information as Physician E's contract, including additional compensation for "...Service performed for branches other than Meridian branch..."</p> <p>The contracts did not identify which physician assumed the agency's full Medical Director responsibilities and obligations.</p> <p>Further, the organizational chart stated "Weiser Hospice Physician [Physician F]." The contract for Physician F, effective 6/16/14, was reviewed. The contract stated it was an "Associate Medical Director Service Agreement." The contract stated the "...Agency desires to engage the services of Medical Director to serve as Medical Director for its Hospice Agency located at [agency address], Meridian, Idaho..." However, item 1, under the "Terms and Conditions" section stated "The Medical Director agrees to serve as a Medical Director for the Branch..."</p> <p>Physician F's "Associate Medical Director Service Agreement" included a section titled "Terms and Conditions." The section outlined responsibilities which were consistent with the "Terms and Conditions" found in Physician A - E's "Medical Director Service Agreement." However, the "Medical Director Service Agreements" listed additional responsibilities which included the following:</p> <ul style="list-style-type: none"> - "Serves as a member of the Agency's Quality Assurance Committee, and attends and participates in both Quality Assurance Committee meetings." - "Participates in the development of formal 	L 669			

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L 669	<p>Continued From page 58 patient care policies..."</p> <p>- "Participates in the design, conduct, review and periodic evaluation of the Agency's staff development and in-service programs.."</p> <p>The "Medical Director Service Agreements" for Physicians A, B, C, and E all included the same information. The contracts did not clearly identify a single physician who filled the role of the Medical Director and assumed overall responsibility for the medical component of the hospice's patient care program, including care delivered at all of the agency's multiple locations.</p> <p>The agency Administrator stated, via email received on 5/11/15 at 1:47 PM, that all of the physician contracts had been reviewed and it was determined the agency had not delineated the Medical Director from the associates except in the case of Physician F. The Administrator stated the agency did not ensure associates received the appropriate associate contracts as they were updated due to an oversight.</p> <p>The agency failed to ensure the Medical Director's role and responsibilities for the total medical component of the hospice's patient care program, including care delivered at all of the agency's 6 multiple locations, was assumed by a single physician.</p> <p>2. Refer to L533 as it relates to the Medical Director's failure to ensure comprehensive assessments were updated in response to patient and family changes and needs.</p> <p>3. Refer to L543 as it relates to the Medical Director's failure to ensure individualized written</p>	L 669		

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L 669	Continued From page 59 plans of care were followed.	L 669			
L 672	<p>4. Refer to L545 as it relates to the Medical Director's failure to ensure a comprehensive individualized POC was developed and updated by the IDG to ensure patient needs were met.</p> <p>5. Refer to L546 as it relates to the Medical Director's failure to ensure patients were provided with effective pain management interventions.</p> <p>6. Refer to L547 as it relates to the Medical Director's failure to ensure POCs contained a detailed statement of the frequency of services necessary to meet patient needs.</p> <p>7. Refer to L550 as it relates to the Medical Director's failure to ensure patient specific supplies were included on each patient's POC.</p> <p>418.104(a)(1) CONTENT</p> <p>Each patient's record must include the following: (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.</p> <p>This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview it was determined the hospice failed to ensure patient records included complete clinical notes for 4 of 10 patients (#1, #4, #6, and #8) whose records were reviewed. Failure to complete clinical notes had the potential to interfere with clarity regarding the course and coordination of patient care. Findings include:</p>	L 672	<p>L672 418.104 (a) (1) CONTENT</p> <p>Director of Nursing or designee will provide instruction to RN Case Managers regarding Policy #2-044 The Plan of Care, and Policy #2-050 Interdisciplinary Group Meeting the week of 6-8-15.</p> <p>Instruction will include formulation of the patient's plan of care in conjunction with the patient, caregiver/family with each plan of care to be individualized with specific interventions/measurable goals to meet the overall needs of the patient and family unit including all medical equipment/supplies required to meet the needs of the patient and documentation of education provided. Medical equipment and supplies will be identified on the initial plan of care and ongoing changes</p>		

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L 672	<p>Continued From page 60</p> <p>1. Patient #6 was an 89 year old female admitted to the agency on 11/26/14, with a diagnosis of Ovarian Cancer. She received SN, SW, and HA services. Her record, including the POC, was reviewed for the certification period of 2/24/15 to 5/24/15.</p> <p>Patient #6's record included a Hospice Recertification order for the frequency of visits by disciplines needed in her home. SN services were ordered twice weekly for 13 weeks.</p> <p>An SN visit note, dated 2/28/15 and completed by the LPN, documented she was contacted by Patient #6's caregiver for a new open wound that was bleeding. The LPN documented Patient #6 had a new wound which was weeping but not open on her left lower abdominal area.</p> <p>A Wound Assessment Tool Report was included in Patient #6's record. The wound to Patient #6's left lower abdomen was documented on 3 dates. The report included the following:</p> <ul style="list-style-type: none"> - On 3/03/15 there was no measurement documented. A section titled "Surface Area Score" was documented as 1. - On 3/09/15 the measurement of the wound was 1.5 cm by 1.5 cm with a "Surface Area Score" of 1. - On 3/12/15 the measurement of the wound was 1 cm by 1 cm with a "Surface Area Score" of 1. <p>A policy, "Skin Care: Wound-Assessment" revised 1/15, stated "Reassess wounds weekly, according to the initial assessment guidelines. Document the progress by noting an</p>	L 672	<p>identified will be added to the updated POC.</p> <p>Instruction will also include documentation of oxygen delivery, wound care, and laboratory monitoring and specimen handling. This instruction will include documenting the rate of Oxygen flow in liters/min, how often; continuous or intermittent, and the education provided. Oxygen will be documented and included on the patient's medication profile and supply list; instruction on wound care assessment and documentation on the Wound Assessment Tool and obtaining physician orders for all wound care; and instruction on obtaining orders for all treatments/interventions including laboratory such as PT/INR and ascertaining that orders are present for all treatments/interventions and how to document all provided interventions and education.</p> <p>Additionally, instruction will include that the plan of care will be updated/reviewed at each IDG meeting and will include documentation of identified changes, response to treatment and progress toward targeted</p>	

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L 672	<p>Continued From page 61</p> <p>improvement in the characteristics (size, depth, etc.) or identify the wound as a healing stage 3 or a healed stage 3 wound. Contact the physician for any changes or deterioration in wound status."</p> <p>There was no documentation included in the report for 2/28/15, the date the wound was identified. Additionally, the RN documented in Patient #6's record the wound was worsening at each SN visit with increasing and changing drainage. On 3/09/15, the RN documented the wound had created its own opening and was emanating a foul odor.</p> <p>During an interview on 5/07/15 at 10:05 AM, the RN reviewed the record and confirmed the documentation in the wound report. She confirmed it was incomplete and the wound was not documented on a weekly basis. The RN stated she was discussing the wound with the physician but confirmed the conversations were not documented in the record.</p> <p>Patient #6's wound was not properly assessed and documented in the record according to agency policy.</p> <p>2. Patient #4 was a 59 year old female who was admitted to hospice on 11/25/14, with a terminal diagnosis of liver cancer with a prognosis of less than 6 months. Additional diagnoses included Hepatitis C, cirrhosis of the liver, diabetes, and HTN.</p> <p>Patient #4 was on hospice services from 11/25/14 to 2/11/15, when she revoked her hospice benefit to pursue aggressive therapy. Patient #4's record included inaccuracies, incomplete documentation, and incomplete assessments.</p>	L 672	<p>outcomes, which may include: Pharmacological effectiveness for symptom management outcomes; Any increase or decrease in symptoms or acuity; Increases or decreases in frequency of visits by management, visit frequencies, and the patient's developed Plan of Care are pertinent and appropriate. Director or Nursing will ensure mandatory training is completed for licensed nurses the week of 6/8/15, with a mandatory post-test to ensure that all required elements of the development of a pertinent and accurate Plan of Care are completed and documented appropriately and that these elements are used to update the patients' plans of care appropriately. Licensed Nurses who could not attend the trainings will be required to view the WebEx presentation of the training by 6-22-15. Inactive and part-time licensed nursing staff will be in-activated in the HR system and will be unable to provide patient care and will not be re-activated until they have viewed this WebEx. The</p>		

Any clinicians who do not complete the training WebEx by 06/14/2015 will not be permitted to provide patient care after that date until training is completed.

*Sandra L. Paul, RN, LHN
DON - Hospice 6/15/15*

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L 672	<p>Continued From page 62</p> <p>Examples included, but were not limited to, the following:</p> <p>a. The SOC assessment dated 11/25/14, performed by the RN, documented Patient #4 lived alone, her home was in a remote location, and her living area was unclean and cluttered. The assessment identified her sister as her primary caregiver, who lived next door.</p> <p>i. The section of the assessment that identified her social support system, included entries of "lives alone or without concerned relatives," "family /support sleep disturbed with patient's care," and "in need of respite care/sitter services." The section which the RN was to indicate all abnormal social issues, she entered "other," and did not specify.</p> <p>ii. In the section of the assessment that asked if endocrine/hematopoietic systems were assessed, the RN documented "yes." However, she did not include information that Patient #4 had diabetes, and what medication she received, or if she monitored BG levels.</p> <p>iii. The RN did not perform a skin assessment at the time of the assessment, and documented that a skin assessment was "not appropriate at time of evaluation."</p> <p>iv. The respiratory assessment documented Patient #4 had shortness of breath, and significant dyspnea with exertion. The RN documented treatment for dyspnea included oxygen that was initiated on 11/25/14.</p> <p>The section of the assessment which included physician notification, with review and approval of</p>	L 672	<p>WebEx will also be part of the orientation</p> <p>process with a post-test and attestation for new licensed nursing staff.</p> <p>Director of Nursing or designee will perform two (2) on-site visits per identified clinician to perform an audits (see attached SOC/RCT/ONSITE Audit tool) to ensure that medications, DME and supplies, wound care, and the patient's developed Plan of Care are pertinent and appropriate.</p> <p>REVIEW:</p> <p>The Director of Nursing or designee will review 100% of all new Starts of Care and Recertification Visits using an audit tool (see attached SOC/RCT Audit tool) to ensure that all required elements of the comprehensive assessment are identified and that the Plan of Care is updated appropriately and is pertinent. 100% Audits will continue until an overall accuracy rating of 85% is reached. Upon 85% accuracy, the</p>		

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L 672	<p>Continued From page 63</p> <p>the POC, the RN wrote "yes." However, the section where the date and time the physician was notified, the RN entered "to be called tomorrow AM."</p> <p>The record did not indicate the physician was notified the following day to approve the POC. Additionally, the RN wrote that she would request an order for oxygen, which then made it unclear if Patient #4 actually had oxygen as she noted in the respiratory assessment.</p> <p>b. In a visit note dated 11/26/14, the RN documented the following:</p> <p>i. The RN documented oxygen was initiated at 2 liters/minute on 11/26/14. However, the same visit note, in the section equipment/supplies, the RN wrote "N/A- no equipment available." In the section which asked if the oxygen was safely stored, the RN wrote "N/A not applicable." Further, the narrative section of the visit note included a note written by the RN which stated "supplies needed: O2 (oxygen)."</p> <p>It was unclear if Patient #4 was started on oxygen based on the conflicting documentation.</p> <p>ii. In the section of the note to indicate if an endocrine assessment was performed, the RN wrote "no problems identified." However, Patient #4's diagnosis included diabetes.</p> <p>c. In a visit note dated 12/10/14, the RN documented Patient #4's oxygen saturation was 85% on 2 liters of oxygen.</p> <p>The RN wrote that she set up Patient #4's oxygen concentrator during the visit. Patient #4's record</p>	L 672	<p>audit rate will decrease to 75%. Individual clinicians who fall below 85% accuracy will have one on one training, counseling, and follow-up to ensure compliance with development of a pertinent and accurate Plan of Care.</p> <p>RESPONSIBLE: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>COMPLETION: 6/14/15 and on-going</p>		

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L 672	<p>Continued From page 64</p> <p>did not include a method of oxygen delivery in the previous visit notes on 11/26/14 and 12/03/14.</p> <p>Further, in a visit note dated 12/23/14, Patient #4's oxygen saturation was 86%. In the respiratory assessment section, the RN wrote "no change." The amount of oxygen delivery, if any, was not documented.</p> <p>d. In a visit note dated 12/23/14, in the section "emotional status," the RN wrote "deteriorating." The RN did not include further details of how Patient #4 was deteriorating.</p> <p>Additionally, the visit note included a detailed narrative entry in which the RN described missing methadone and an empty bottle which was found in the trash, which was labled as 5 mg methadone, 60 tablets. The liquid morphine was diluted to a watery substance. Additionally, she described 5 boxes of wine, 1 in the refrigerator, and 2 were empty. Patient #4's sister was documented as stating she would keep the medications for safety reasons since Patient #4 was found passed out. The RN did not document when the passing out incident occurred.</p> <p>e. In a visit note report dated 12/30/14, in the section of the report for skin assessment, the RN documented that a skin assessment was not performed and wrote "Not appropriate at the time of evaluation." Additional information regarding why the evaluation was not appropriate was not present.</p> <p>Further, an IDG POC Update Report, dated 1/02/15, were orders were wound care instructions for 2 terminal ulcers - one on her coccyx, and one on her left heel.</p>	L 672		

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L 672	Continued From page 65 The nurse visit notes from 11/25/14 through 12/30/14 did not include documentation that Patient #4 had wounds on her coccyx or her left heel. f. In a visit note report dated 1/07/15, the RN documented Patient #4 had a wound on her head, an injury that resulted from a fall on 12/31/14. In the skin assessment section, the RN documented Patient #4 had bruising to her left elbow, and no pressure ulcers. No other wounds were identified on the assessment for that date. In the visit note, the RN documented Patient #4 "falls far forward while sleeping until she lands on her head." In the narrative section of the visit note, the RN described another fall that Patient #4 had the week before, and she had sternal and rib pain. The RN further documented Patient #4's blood pressure was 96/44, she was having bloody noses and vomiting of blood. The RN documented she would call Patient #4 on Friday (1/09/15), to evaluate. However, Patient #4's record did not include documentation that a phone call was made by the RN to evaluate Patient #4 on 1/09/15 as she noted would occur. g. In a visit note dated 1/14/15, the RN documented Patient #4 had a Stage 3 pressure ulcer to her left heel. It did not include documentation of a coccyx wound. The RN further documented in the narrative section "Intact blister, pressure ulcer of 5 X 4 cm covered	L 672			

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L 672	<p>Continued From page 66 with Tegaderm." The location of the wound she described in the narrative section was not identified as the heel wound or the coccyx wound.</p> <p>h. In a visit note dated 1/19/15, the RN documented Patient #4 had a pressure wound on her right heel. The coccyx and left heel wound were not addressed. Previously the record indicated Patient #4 had a wound on her left heel, this was not clarified.</p> <p>f. In a visit note dated 1/26/15, the RN documented that Patient #4 had vesicles on her inferior heel, the note did not identify if it was her right or her left heel.</p> <p>The narrative section of the note included an entry by the RN describing the "diabetic ulcer on her left thigh." She noted Patient #4's right heel pressure ulcer had a new blister distally, with purple discoloration. The RN wrote that she suspected a DTI, or Deep Tissue Injury. The RN documented that dressing changes by nursing would be increased to twice weekly.</p> <p>Her record did not include an order for dressing changes to be increased to twice weekly.</p> <p>g. The RN Team Lead documented in a Coordination Note Report dated 2/11/15, that Patient #4 was found on the floor of her house by an outside agency RN and Social Worker and Patient #4's RN Case Manager arrived at her home shortly after EMS was contacted to take her to the hospital.</p> <p>However, her record did not include documentation of the on site visit by the RN Case Manager.</p>	L 672		

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L 672	<p>Continued From page 67</p> <p>During an interview on 5/06/15 at 10:15 AM, the RN Team Lead reviewed Patient #4's record. She stated the RN Case Manager for Patient #4 was no longer employed at the agency. She confirmed the POC did not include the additional diagnoses of diabetes. She confirmed the conflicting documentation related to the presence of wounds, and on which foot. The RN Team Lead confirmed that Patient #4 was found on the floor of her home and confirmed the record did not include documentation of the visit by the RN Case Manager.</p> <p>The agency failed to ensure Patient #4's record included comprehensive information.</p> <p>3. Patient #1 was a 94 year old male admitted to hospice services on 12/19/14, related to a terminal diagnosis of CHF. Patient #1 received SN, HA, SW, and Chaplain services. His POC and record for the certification period 3/19/15 until his death on 4/05/15, was reviewed.</p> <p>Patient #1's record included incomplete documentation, procedures were performed without physician orders, lack of follow up for reported conditions, and inaccurate entries, as follows:</p> <p>a. Patient #1's record noted he was taking Coumadin (warfarin), a blood thinner. However the POC did not include routine blood tests for PT/INR to monitor his ability to clot.</p> <p>In a visit note report dated 3/24/15 from 4:07 PM to 4:40 PM, the RN documented Patient #1's last BM was on 3/22/15.</p>	L 672		

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L 672	<p>Continued From page 68</p> <p>Later that evening, in a "Client Coordination Note Report," an RN documented a phone call was received from the ALF at 7:52 AM. The ALF was calling to report that Patient #1 was having a moderate amount of lower abdominal pain, and had frank blood in his stool. The RN documented she instructed the ALF staff to administer Miralax (a laxative), and to hold the Coumadin until further notice. Patient #1's record did not include documentation the RN obtained an order for the Coumadin to be held. Additionally, the record did not include documentation Patient #1's physician was notified of the bloody stools.</p> <p>The MAR from the ALF documented Patient #1 received Coumadin 5 mg orally at 5:00 PM each day in March 2015 except 3/31/15. The MAR did not indicate his Coumadin doses were to be held from 3/24/15 until further notice.</p> <p>In a visit note on 3/26/15 from 4:04 PM to 4:43 PM, the RN documented "No Change," under the section for gastrointestinal status. The RN did not document a follow up assessment related to the reported bloody stools, or the Coumadin being held.</p> <p>b. In a visit note report dated 3/30/15 from 12:45 PM to 1:52 PM, the RN documented the dressing to Patient #1's left elbow was clean, dry, and intact. The RN did not directly visualize the wound. The RN did not document a gastrointestinal assessment, and the date of his last BM was not documented.</p> <p>c. The narrative section of Patient #1's 3/30/15 visit note included the following entry "...hospice diagnosis is unspecified cerebrovascular disease." However, Patient #1's admitting</p>	L 672		

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L 672	<p>Continued From page 69</p> <p>diagnosis and the recertification diagnosis was noted to be CHF. There were no additional diagnoses included in his admission and recertification documents.</p> <p>d. In a visit note report dated 3/31/15 from 12:27 PM to 1:18 PM, the RN documented the dressing to Patient #1's left elbow dressing was in place. The RN did not indicate the wound was assessed. The narrative section of the visit note included documentation a PT/INR was performed. The RN documented Patient #1's physician was notified, and she instructed the ALF staff to not give Coumadin that day.</p> <p>The results were above therapeutic range, PT - 91.3, and INR - 7.1.</p> <p>According to the National Library of Medicine website: "Prothrombin time is measured in seconds. Most of the time, results are given as what is called INR (or international normalized ratio). If taking blood thinning medicines such as warfarin, the normal range for PT results is 11 - 13.5 seconds, or INR of 0.8 - 1.1. If taking warfarin to prevent blood clots, the doctor will most likely choose to keep the INR between 2.0 and 3.0. The risks of bleeding and hematoma in these patients are greater than for people without bleeding problems."</p> <p>In a PRN visit note report that evening, from 7:57 PM to 9:43 PM, the LPN documented he was called by the ALF to evaluate Patient #1 due to a bloody nose for 2 hours. The LPN documented he contacted Patient #1's physician and received an order for Vitamin K. Additionally, the LPN noted Coumadin was to be held until 4/04/15, when it was to be restarted at a dose on 1 mg</p>	L 672			

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L 672	<p>Continued From page 70 daily.</p> <p>Patient #1's record included an order for Mephyton (Vitamin K) 5 mg tablets, 2 tablets "now" and 2 tablets as needed for increased bleeding.</p> <p>A physician order, dated 4/01/15 at 12:16 PM, included the following "Please provide for a pm visit today. Patient has had a fall. Please discontinue order for vitamin K pills/IM. SN to visit tonight for dinner date with terminally ill patient. SN is bringing collard greens to provide some natural vitamin K. Patient is terminally ill and will benefit more from social contact than from pharmaceutical." However, Patient #1's record did not include documentation of a nursing visit on 4/01/15, or of a nursing assessment after his fall.</p> <p>e. In a hospice aide visit note dated 4/02/15 from 7:45 AM to 10:00 AM, the HA documented Patient #1 had a "couple" of falls the day before. The HA also documented Patient #1 was assisted with his breakfast as his right arm was very sore from the falls and he was unable to lift it.</p> <p>In a visit note report dated 4/02/15 from 12:46 PM to 1:58 PM, the RN documented Patient #1 had an intact dressing to his right elbow. The RN did not indicate why he had a bandage on his right elbow, or further assessment of what the HA described as a "sore right elbow." Additionally, the injury to Patient #1's left elbow, after a fall on 3/28/15, which resulted in a skin tear, was not assessed.</p> <p>f. In a visit note dated 4/03/15 from 12:15 PM to 1:19 PM, the RN documented Patient #1 had</p>	L 672		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2015
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
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L 672	<p>Continued From page 71</p> <p>bruising to his back. The visit note also documented Patient #1 fell on 3/29/15, however, his record did not include documentation of a fall on 3/29/15.</p> <p>During an interview on 5/07/15 beginning at 10:30 AM, an RN that identified herself as "Branch Office Team Lead," reviewed Patient #1's record. She confirmed the POC did not include the CPAP. The RN Team Lead also reviewed the documentation indicating Patient #1 had bloody stools, and the documentation of instructing the ALF to hold the Coumadin on 3/24/15. She confirmed the ALF MAR indicated Coumadin was continued daily until 3/31/15. The RN Team Lead also confirmed the visit notes did not include documentation of further wound assessments of his elbows after the initial dressings were applied. The RN confirmed Patient #1's PT/INR levels were not monitored on a routine basis, and confirmed the levels noted on 3/31/15 were significantly elevated.</p> <p>The agency failed to ensure Patient #1's record included accurate, comprehensive information.</p> <p>4. Patient #8 was a 57 year old female who was admitted to hospice on 2/28/15 with a diagnosis of end stage renal disease with a prognosis of less than 6 months. Additional diagnoses included cirrhosis, morbid obesity, decubitus ulcers on right heel, coccyx, and left lower leg, chronic pain, and diabetes. Patient #8's record was reviewed for the certification period 2/28/15 through 5/28/15.</p> <p>Patient #8's record included inaccuracies, incomplete documentation and assessments, as follows:</p>	L 672			

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L 672	<p>Continued From page 72</p> <p>a. Lab work was performed without orders, and labs that were not ordered were performed, as follows:</p> <p>i. A blood test to determine Patient #8's average glucose range, (Hgb A1C), was ordered on 3/10/15. The order specified the results would be faxed to her physician. Her record did not include results of the lab, or that it was faxed to her physician.</p> <p>ii. Patient #8's record included a narrative note for an RN visit on 3/13/15, that noted a PT/PTT was performed without difficulty. However, her record did not include a physician order for that blood test, nor did it include the results of the blood test.</p> <p>iii. On 3/24/15, an order to draw the following labs was received: "Labs to be drawn on 3/25/15: PT/PTT, CBC, Chem 14, and A1C." Her record did not include documentation the tests were performed, or the results of the tests.</p> <p>During a phone interview on 5/07/15 at 10:40 AM, Patient #8's RN Case Manager stated she did not recall what lab tests were performed, as her tablet device was also the phone she was talking on at that time. She was unable to recall if she had received an order for the PT/PTT that was drawn on 3/13/15.</p> <p>On 5/07/15 at 4:29 PM, the agency provided results of the above labs that were drawn. However, the A1C ordered for 3/10/15 and 3/25/15 were not included in the results.</p> <p>b. Patient #8's record documented she had wounds. However the staging of the wounds, as</p>	L 672		

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L 672	<p>Continued From page 73</p> <p>well as location and description of status of the wounds was unclear from visit to visit. The nursing visit notes for Patient #8 included documentation of her wounds as follows:</p> <ul style="list-style-type: none"> - 2/28/15: the RN documented three pressure ulcers, two Stage 1 and one Stage 2. Stasis ulcers were noted on both legs. Large Stage 2 ulcer to right heel. Stage 1 pressure ulcer noted on coccyx. - 3/04/15: the LPN documented one Stage 1 and one Stage 2 pressure ulcer. - 3/06/15: the RN documented open wound to buttocks. Wound to right heel. Stasis ulcers to right and left leg were not addressed by the RN. - 3/09/15: the LPN documented two Stage 2 pressure ulcers, "Wounds documented on wound assessment tool present at SOC. Wound care done to coccyx and RT heel." - 3/11/15: the LPN documented two Stage 2 pressure ulcers. - 3/13/15: the RN documented two pressure ulcers, both Stage 2. The RN documented the coccyx wound dressing change, but did not document her other wounds were assessed or cared for. - 3/14/15: the RN documented two pressure ulcers, one Stage 1 and one Stage 2. The RN did not identify the sites of the wounds. - 3/16/15: the LPN documented two Stage 2 pressure ulcers, "Barrier cream applied to coccyx and peri area. Wound care done per MD order 	L 672			

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L 672	<p>Continued From page 74 without difficulty to coccyx and Rt heel."</p> <p>- 3/18/15: the LPN documented two Stage 2 pressure ulcers, "Wound care done to Rt heel. Area near coccyx cleansed with wound cleanser."</p> <p>- 3/20/15: the LPN documented two Stage 2 pressure ulcers, "Coccyx dressing secured with Tegaderm. Foot dressing secured with Kerlix."</p> <p>- 3/23/15: the RN documented two pressure ulcers, one Stage 2. The other pressure ulcer was not identified. Stage 2 ulcer was noted on buttocks. Wound to heel dressing was changed, no further identification of wounds, or staging.</p> <p>- 3/25/15: the RN documented two pressure ulcers, one Stage 2. The other pressure ulcer was not identified. Wound care and dressing change performed on right heel. Additional wounds were not addressed by the RN.</p> <p>- 3/26/15: the LPN documented integumentary was not assessed, that it was not appropriate at the time of the evaluation.</p> <p>- 3/27/15: the RN documented two pressure ulcers, one Stage 2. The other pressure ulcer was not identified or staged. The RN documented wound care and dressing changes to the right heel and coccyx.</p> <p>- 3/30/15: the LPN documented Patient #8 had wounds, the section for stages was noted as "zero." The narrative section included her coccyx area was dry and flakey, but closed. The heel wound was cleansed and dressed.</p> <p>- 4/01/15: the RN documented two pressure</p>	L 672			

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L 672	<p>Continued From page 75</p> <p>ulcers, one Stage 1. The other pressure ulcer was not identified. In the narrative section of the visit note, the RN documented the right heel was noted to have foul odor and moderate amount of bloody drainage. She also noted that Patient #8's heel had thick black eschar attached. The buttocks wound was noted to have redness and a healing Stage 2 ulcer. A new wound was identified on Patient #4's right leg, with a blister.</p> <p>- 4/03/15: the RN documented one pressure ulcer, unstaged. The heel wound was noted to have foul odor which remained after cleansing. Black eschar was noted on the heel. The buttocks wound was red, barrier cream was applied, and no further wound descriptions were noted.</p> <p>- 4/06/15: the RN documented one pressure ulcer, unstaged. The RN documented that multiple scabs to both lower extremities were starting to separate. The heel wound was noted to have a strong odor, black eschar, and stringy yellow slough. The RN documented wound care and dressing change to the heel wound.</p> <p>- 4/08/15: the RN documented one pressure ulcer, unstaged. Patient #8's heel was noted to have moderate amount of bloody drainage, foul odor, and necrotic black eschar. No other wounds were addressed.</p> <p>- 4/10/15: the LPN documented the number of pressure ulcers was "zero." She noted that a piece of eschar came off from the heel during cleansing.</p> <p>- 4/13/15: the RN documented two pressure ulcers, one Stage 2 and one Stage 4. The RN</p>	L 672			

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L 672	<p>Continued From page 76</p> <p>documented Patient #8 picked the scab off her left leg wounds, and was noted to have yellow slough. She noted that she packed the wound with gauze, and wound cleanser.</p> <p>- 4/15/15: the RN documented two pressure ulcers, one Stage 2 and one Stage 4. The RN documented the left lower extremity had a small amount of purulent drainage. The left heel was noted to have a moderate amount of bloody drainage. The wounds to the heel and left leg were cleansed and dressed.</p> <p>- 4/16/15: the LPN documented one Stage 2 pressure ulcer, one Stage 4 pressure ulcer. Wound care not documented.</p> <p>- 4/17/15: the LPN documented one Stage 2 and one Stage 3 pressure ulcer. Only the wound care to Patient #8's right heel was documented.</p> <p>- 4/18/15: the RN documented four or more pressure ulcers, one Stage 2, two Stage 3, and one Stage 4. The RN did not identify where the wounds were, and there was no documentation in the narrative section of wound care.</p> <p>- 4/20/15: the RN documented four or more pressure ulcers, one Stage 2, two Stage 3, and one Stage 4. The RN documented 2 wounds on the left lower leg. The heel wound was cleansed and dressed, and Patient #8 was noted to have an open wound on her buttocks.</p> <p>- 4/22/15: the RN documented four or more pressure ulcers, one Stage 1, two Stage 2, and one Stage 4. The RN documented 2 wounds on the left lower leg. The heel wound was cleansed and dressed, and Patient #8 was noted to have</p>	L 672		

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L 672	<p>Continued From page 77 an open wound on her buttocks.</p> <p>- 4/24/15: the RN documented four or more pressure ulcers, one Stage 1, two Stage 2, and one Stage 4. The RN documented 2 wounds on the left lower leg. The heel wound was cleansed and dressed, and Patient #8 was noted to have an open wound on her buttocks.</p> <p>- 4/27/15: the LPN documented one Stage 2 and three Stage 3 pressure ulcers. She documented wound care to Patient #8's leg wounds and right heel wound.</p> <p>- 4/29/15: the RN documented three pressure ulcers, two Stage 2, and one Stage 4. The RN documented wound care to the lower left leg and right heel.</p> <p>- 5/01/15: the RN documented three pressure ulcers, two Stage 2, and one Stage 4. The RN documented wound care to the lower left leg and right heel.</p> <p>- 5/04/15: the RN documented three pressure ulcers, two Stage 2, and one Stage 4. The RN documented wound care to the lower left leg and right heel.</p> <p>A home visit was conducted on 5/06/15 beginning at 1:30 PM, to observe nursing care provided by the LPN. Wound care was performed on two leg wounds on Patient #8's lower left leg. The wounds were noted to be deep with tunneling, which was not identified or measured by the LPN. The right heel wound was cleansed and dressed. Patient #8 was noted to have a wound to her right lower leg, the outer aspect of the calf. It was approximately 5 cm long by 2 cm wide, and</p>	L 672			

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L 672	<p>Continued From page 78</p> <p>appeared as a blood blister that was purple. Patient #8's coccyx wound was healed, and barrier cream was applied.</p> <p>During a phone interview on 5/07/15 beginning at 10:40 AM, the RN Case Manager for Patient #8 stated she did not routinely measure and record hospice patients' wounds. She stated she did not know it was required for hospice patients. The RN confirmed the documentation of the staging of the wounds was conflicting and unclear. She stated she contacted her manager to have Patient #8's wounds evaluated by a wound care nurse, and took pictures of the wounds. She stated she sent pictures of the wounds to the DON for review.</p> <p>The agency failed to ensure Patient #8's record included complete and accurate documentation.</p>	L 672			



IDAHO DEPARTMENT OF
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June 1, 2015

Trevor Higby, Administrator
Horizon Home Health & Hospice
1411 Falls Avenue East, Suite 615
Twin Falls, ID 83301

Provider #131520

Dear Mr. Higby:

An unannounced on-site complaint investigation was conducted from May 5, 2015 to May 8, 2015 at Horizon Home Health & Hospice. The complaint allegation, findings, and conclusion are as follows:

Complaint #ID00006874

Allegation: The agency did not ensure that patients were provided with adequate care.

Findings: During the investigation, patient records were reviewed and staff were interviewed.

Ten patient records were reviewed. Five of the 10 patient records did not demonstrate patient needs were being comprehensively addressed by the agency. For example, one patient's records did not include documentation that her comprehensive assessment and plan of care were updated to meet her changing needs. Her record documented she was admitted to hospice services on 11/25/14 and nursing visits were ordered for 3 times weekly for 1 week, twice weekly for 1 week, and once a week thereafter.

The patient's admission assessment documented her living area was unclean and cluttered and that a family member, who lived close by served as her caregiver. The support system assessment which was performed at the start of care documented the patient lived alone without concerned relatives, the family was sleep disturbed related to the patient's care, and she was in need of respite care/sitter services.

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Subsequent nursing documentation from the patient's start of care through 1/26/15, described staff concerns with the patient's health and safety. Documentation of concerns included increased clutter, and safety hazards in the patient's home, the patient's non-compliance in monitoring her diabetes and taking her medication, resulting in on-going blood glucose levels which were out of normal range, the patient smoking while receiving oxygen therapy, alcohol and drug abuse, patient falls with injury, the patient's increased need of assistance in housekeeping, shopping, meal preparation, feeding, toileting, bathing, dressing, and grooming, and the development of skin wounds.

However, despite the patient's increasing needs, updates to her comprehensive assessment and related updates to her plan of care and interventions were not documented or implemented.

Further, in a visit note dated 1/26/15, the Registered Nurse (RN) documented the patient had not slept in 2 days, her personal hygiene was deteriorating, and she needed assistance with personal cares. The visit note included documentation by the RN that the patient's caregiver was non-compliant or negligent with following the treatment plan, the family felt overwhelmed and felt caring for the patient caused extra stress, and the caregiver felt endangered by the patient. She also noted there was abuse within the family system, there was family discord, and a "family feud."

The 1/26/15 note also documented the patient's skin wounds would require dressing changes and that nursing visits would be increased to twice weekly. The patient's record did not include documentation that other interventions were discussed or implemented based on the patient's deteriorating status.

However, the patient's record did not demonstrate nursing visits were increased. The RN saw the patient again on 2/03/15 and no further visits were provided until 2/11/15, after the patient had been found on the floor by another care agency.

A report from the other care agency, dated 2/13/15, stated the patient's sister who was identified by the hospice as the primary caregiver, was also a paid caregiver by the other care agency. The report included documentation that the patient's sister was very overwhelmed with the patient's behavior, was thrown out of the patient's house on 2/06/15, and not allowed back in. The report stated the patient's sister reported the patient to be drinking alcohol "again" which contributed to her behavior. The report documented the other care agency's RN and Social Worker went to the patient's home on 2/11/15 at 11:00 AM.

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The report documented the patient was yelling for help and the RN and Social Worker entered the unlocked house. The patient was laying on the floor, moaning, crying, and asking for help. She was wearing a shirt and incontinent brief, and was noted to have been incontinent of urine and feces. Her home was noted to be cluttered with garbage all around, dirty dishes with mold, urine on the floor, blood on the floor, and medication bottles laying in various places. The patient told the RN she did not know how long she had been on the floor. She was disoriented and her leg had an open ulcer that had bled on the floor.

The patient's record documented she was taken to the hospital on 2/11/15 and was admitted with diagnoses of pneumonia and rhabdomyolysis (a breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood, which can cause kidney damage). Her hospice benefit was revoked at that time.

The patient's record was reviewed with the hospice agency's RN Team Lead and Director of Nursing (DON) during an interview on 5/06/15 beginning at 10:15 AM. They confirmed the patient lived in a cluttered and unclean environment and was non-compliant with medications and diabetic management. The DON stated the patient was competent, and had the right to choose her lifestyle. The DON further stated the RN that provided care for the patient was no longer employed by the agency.

The patient's records described increased patient needs and documented that an increase in the frequency of nursing visits was necessary to meet those needs. However, the RN weekly visits continued, resulting in the patient not receiving hospice visits/assessments for a span of 8 days. The agency did not ensure care was provided necessary to meet the patient's needs.

Further, a second patient's records did not demonstrate that the patient's pain had been adequately addressed and a third patient's records did not include the equipment and supplies necessary to meet the patient's needs. A fourth patient's records did not include the equipment and supplies necessary to meet the patient's needs or demonstrate that the patient's individualized plan of care had been followed. A fifth patient's records did not include a detailed statement of the frequency of services necessary to meet the patient's needs or demonstrate that the patient's individualized plan of care had been followed. When asked about the patients' records, during interviews conducted on 5/6/15 and 5/7/15, agency staff confirmed that the information was not present in the patient records.

The agency did not ensure comprehensive assessments and patient care plans were sufficiently developed, implemented, and monitored. Therefore, the allegation was substantiated and federal deficiencies were cited.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Trevor Higby, Administrator
June 1, 2015
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Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/pmt