IDAHO DEPARTMENT OF HEALTH & WELFARE

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

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

January 26, 2016

Ashly Holaday-Copeland, Administrator
Heart N Home Hospice & Palliative Care
1100 Nw 12th Street
Fruitland, ID 83619

RE: Heart N Home Hospice & Palliative Care, Provider #131545

Dear Ms. Holaday-Copeland:

This is to advise you of the findings of the Medicare survey of Heart N Home Hospice & Palliative Care, which was conducted on January 8, 2016.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

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

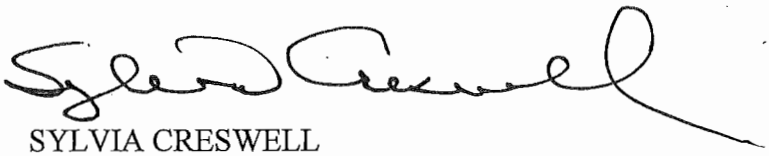
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the 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 the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **February 8, 2016,** and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

DENNIS KELLY
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

DK/pmt
Enclosures

Heart 'n Home
Hospice & Palliative Care, LLC
"Affirming life... every day, every time." SM

1100 NW 12th Street
Fruitland, ID 83619
PH: 208-452-2663
FX: 208-452-2665

February 19, 2016

Sylvia Creswell
Non-Long Term Care Section
Bureau of Facility Standards
P.O. Box 83720
3232 Elder Street
Boise, ID 83720-0009

Re: REVISED Plan of Correction Response – Survey 1/8/2016

Dear Reviewer,

Heart 'n Home Hospice & Palliative Care (Provider #: 131545) has included our Plan of Correction, addressing the following:

L 501 & L 502 Pages: 5 - 13
Supporting documentation: Communication for Persons with Limited English Proficiency (LEP) Procedure

L 511 Pages: 13 - 18
Supporting documentation: Abuse, Neglect, Exploitation and Immediate Jeopardy Procedure

L 530 Pages: 18 - 19
Supporting documentation: Medication Profile Form and Medication General Procedure

L 578 & L 579 Pages: 19 - 27
Supporting documentation:

- Infection Control information from Heart 'n Home Compliance Plan
- Recommendations for Environmental Services (CDC website)
- Guideline for Disinfection & Sterilization in Healthcare Facilities (CDC website)
- Hand Hygiene Procedure
- Infection Control Competency Form
- Infection Control Quiz

Please note, the additions to our correction plan are in red.

Also, your letter listed Ashley Holaday-Copeland as the Administrator and this is incorrect. Cineta (Cindy) Lee is the registered Administrator with CMS. Please update your records to reflect this information.

Please feel free to contact me if you should have any questions, I can be reached at 208-452-2662 x102.

Sincerely,

Cineta Lee RN, CHPN, CHPCA

Cineta Lee, RN, CHPN, CHPCA
CEO/Administrator

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

PRINTED: 01/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	131545		C 01/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART N HOME HOSPICE & PALLIATIVE CARE	1100 NW 12TH STREET FRUITLAND, ID 83619

(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	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification and complaint survey of your hospice conducted from 1/04/16 through 1/08/16. Surveyors conducting the recertification were: Dennis Kelly, RN-BC, CHPN, HFS, Team Leader Rebecca Lara, RN, BA, HFS Laura Thompson, RN, BSN, HFS Acronyms used in this report include: CDC - Center for Disease Control CNA - Certified Nursing Assistant DPOAHC - Durable Power of Attorney for Health-Care ED - Executive Director H&P - History and Physical IC - Infection Control IDT - Interdisciplinary Team LEP - Limited English Proficiency OPIM - Other Potentially Infectious Materials OSHA - Occupational Safety and Health Administration OTC - Over the Counter POA - Power of Attorney PRN - As Needed QAPI - Quality Assessment and Performance Improvement RN - Registered Nurse RNCM - Registered Nurse Case Manager SN - Skilled Nurse SSA - Social Security Administration	L 000	L 000 - RESPONSE:	L 000 COMPLETED DATE:
L 501	418.52 PATIENTS' RIGHTS The patient has the right to be informed of his or her rights, and the hospice must protect and	L 501	L 501 - RESPONSE:	L 501 COMPLETED DATE:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christa Rae RN, CHPN, CHPCA	CEO/Administrator	2/19/2016

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 501	Continued From page 1 promote the exercise of these rights. This STANDARD is not met as evidenced by: Based on record review, interview, and review of admission documents, it was determined the hospice agency failed to ensure patients were being informed of their rights and that rights were promoted for 1 of 1 patient (Patient #18) who had limited English proficiency. This failure resulted in the patient signing a revocation form without understanding its meaning. Findings include: An agency procedure "Communication for Persons with Limited English Proficiency (LEP) Procedure," revised 2/2014, stated staff were to document the language used to communicate with hospice patients or family members. Under the section Qualified Interpreters, the procedure stated to contact appropriate bilingual staff to interpret. If a translator was unavailable, staff could obtain an outside interpreter by calling a language line. The hospice agency maintained a list of bilingual staff, and the list was to be included in the patient binder from the agency. Additionally, the procedure stated staff were to ensure patients understood an interpreter was available and provided free of charge. The procedure also documented portions of admission paperwork were available in Spanish. The forms available included Waivers of Rights, Consent to Treatment, Financial Benefit forms, and Insurance Benefit forms. However, the revocation form (a signed statement from the patient that indicated they withdrew their election of the Medicare Hospice benefit), was not one of the forms available in Spanish. Patient #18 was an 88 year old female admitted	L 501	**L 501 - RESPONSE:** **Effective 2/1/2016, Heart 'n Home now has the following forms available in Spanish translated by a Qualified Interpreter:** **1. Revocation** **2. Notice of Election** **3. Receipt of Informed Consent** **4. Patient Rights and Responsibilities** **5. Notice of Privacy Practices** **Heart 'n Home has contracted with a Qualified Interpreter to translate the remaining admission forms by 4/15/16 into Spanish. We will also provide a "Spanish Admission" packet in one document to provide consistency in use of forms across the company. Heart 'n Home will educate all staff on forms when completed.** **Patients will more effectively understand their rights, consents and participate in their plan of care.** **Senior Vice President of Programs is responsible that all necessary paperwork will be translated, so that Spanish versions will be available for our Spanish speaking only patients.** **Executive Directors will use their Admission Monitor Tool - Effective 2/18/2016, they have been informed at the monthly All Leadership Meeting held on 2/18/2016—that they must check, that the proper translated forms have been used on Spanish speaking only patients.** **Upon further investigation, we have also found that CMS nor the Social Security Administration has the "Medicare Secondary Payer Screening" or "Appointment of Representative" forms available in Spanish, which are required documents from their website.**	**L 501 COMPLETED DATE:**

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L 501	Continued From page 2 to the agency on 10/23/12, with a diagnosis of Parkinson's disease. Her record, including two Physician's Orders/Plans of Care, dated 10/23/12 to 1/20/13, and 6/09/15 to 8/09/15, was reviewed. A nursing note dated 8/04/15, documented by an on-call RN from the agency, indicated she received a call from the answering service regarding Patient #18. The note stated that after several attempts, the RN was able to reach Patient #18's hired caregiver, from a personal care agency, by phone. The personal caregiver informed the on-call RN that when she arrived for her shift at 3:00 PM on 8/04/15, an ambulance was at Patient #18's residence. The on-call RN further documented that the caregiver stated Patient #18 had fallen at home and was being taken to the hospital. The note also indicated the personal caregiver told the on-call RN that Patient #18 wanted to go to the hospital instead of wait for hospice staff to assess her. The on-call RN further documented she called Patient #18's family member and informed her Patient #18 was at the hospital after falling at home. She informed the family member about the conversation with the caregiver and how Patient #18 did not want to wait for the hospice staff, but wanted to go to the hospital. The on-call RN documented "Pt [patient] chose to seek treatment and I was taking revoke paperwork for her." The on-call RN documented Patient #18's family member then became frustrated, and the RN offered to have the Executive Director (ED), for the branch office providing services, call the family member. The family member agreed to speak with the ED. In the nursing note dated 8/04/15, the on-call RN	L 501	L 501 - RESPONSE:	L 501 COMPLETED DATE:

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L 501	Continued From page 3 documented when she arrived at the hospital Emergency Department she talked with the personal caregiver and Patient #18. The on-call RN documented "When pt [patient] came back into room Educated [sic] her on choosing to come to the hospital to seek treatment and not wanting to wait for hospice to arrive. At this time she signed revoke paperwork." A nursing note, dated 8/05/15, documented by the on-call RN, indicated she called and spoke to a staff member at the personal care agency. The note indicated the staff member stated she did not believe Patient #18 understood that by going to the hospital for treatment, rather than having hospice staff assess her at home, she would lose her hospice services. The on-call RN further documented that the personal caregiver served as translator the previous night, 8/04/15, and she (the on-call RN) educated Patient #18 regarding her choice to receive emergency treatment, and Patient #18 understood she was revoking her status as a hospice patient. Patient #18's record included a note, dated 8/05/15 at 1:49 PM, signed by the ED of the branch providing services to the patient. The note indicated the ED spoke to the RNCM for Patient #18. According to the note, the RNCM stated Patient #18 was confused about why she was no longer receiving hospice services and wanted to have someone explain it to her. The ED documented telling the RNCM that Patient #18's personal caregiver served as a translator on 8/04/15, for the on-call RN and Patient #18. The caregiver told the on-call RN multiple times Patient #18 did not want the hospice agency to care for her injuries.	L 501	L 501 - RESPONSE:	L 501 COMPLETED DATE:

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L 501	Continued From page 4 In a subsequent note, dated 8/05/15 at 1:57 PM, the ED documented a phone conversation with Patient #18's family member, who was also the DPOAHC. The family member stated she felt because English was Patient #18's second language, and because the caregiver was new, the situation was not clearly translated. She also stated she did not believe Patient #18 intended to revoke her hospice benefit or service. In the same note, the ED further documented speaking with the IDT for Patient #18 regarding the situation. She stated "...because of patient's lack of understanding about why she is no longer on hospice, and because of variations in events which occurred leading up to patient electing to sign a revoke form, patient has chosen not to revoke from hospice services and therefore will remain an active patient." A request was made for additional records of LEP patients receiving services from the hospice agency. The Senior VP of Programs and the Senior VP of Clinical Operations stated there were no current patients who were LEP. During an interview on 1/07/16 at 1:00 PM, the ED reviewed Patient #18's record. She confirmed Patient #18 was Spanish speaking. The ED confirmed the agency procedure for LEP patients was not followed. She further confirmed the agency did not consistently utilize the language service when a patient need was identified. Patient #18's record did not include documentation that a formal interpreter, or interpreter service, was offered to her.	L 501	**L 501 - RESPONSE:** **During Heart 'n Home's Executive Director meeting on 2/4/16, re-education was provided to the team on use of our current LEP Procedure and use of the translation line.** **Director of Compliance and Senior Vice President of Programs - are responsible for annually checking our list of interpreters and verifying the translation line is in effect.** **Heart 'n Home's LEP Procedure was updated to include process for documenting patient and family preference of translation services. See attached "Communication for Persons with Limited English Proficiency (LEP) Procedure"** **Education was provided on 2/4/16 at our Executive Director Meeting that this will ensure the communication between patient and Heart 'n Home staff is better understood, ultimately resulting in better care for the patient.** **Execution will be monitored through our Executive Director Admission Monitor Tool, ensuring all involved are aware that the patient is Spanish speaking only.** **Care Plan Problem and Interventions were added to our EMR on 2/10/16 for any patient with LEP. This includes patient and family preferences for translation services. Executive Directors have been educated on the importance of following existing Heart 'n Home Procedures related to LEP. This addition to our EMR will ensure that everyone on the team knows the patient / family request to ensure communication and translation needs are met.**	L 501 COMPLETED DATE:

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L 502 L 502	Continued From page 5 418.52(a)(1) NOTICE OF RIGHTS AND RESPONSIBILITIES (1) During the initial assessment visit in advance of furnishing care the hospice must provide the patient or representative with verbal (meaning spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands. This STANDARD is not met as evidenced by: Based on record review, policy review and staff interview it was determined the agency failed to ensure patients were provided with a written notice of patients' rights in a language and manner the patient understands for 1 of 1 patient (Patient #18) who had limited English proficiency. This failure had the potential to result in the patient signing admission forms without understanding their meaning. Findings include: An agency procedure "Communication for Persons with Limited English Proficiency (LEP) Procedure," revised 2/2014, stated staff were to document the language used to communicate with hospice patients or family members. Under the section Qualified Interpreters, the procedure stated to contact appropriate bilingual staff to interpret. If a translator was unavailable, staff could obtain an outside interpreter by calling a language line. The hospice agency maintained a list of bilingual staff, and the list was to be included in the patient binder from the agency. Additionally, the procedure stated staff were to ensure patients understood an interpreter was available and provided free of charge. The procedure also documented portions of admission paperwork were available in Spanish.	L 502 L 502	**L 502 - RESPONSE:** **At the time of survey, Heart 'n Home had "Patient Rights and Responsibilities" available in Spanish. Education has been provided at the Executive Director meeting held on 2/4/16, to leaders on the use of LEP materials and we will continue to develop these as needed through our contracted Qualified Interpreter.** **Executive Directors will use the Admission Monitor Tool . They have been informed (2/18/2016 at the monthly All Leadership Meeting) that they must ensure the proper translated forms have been used with Spanish speaking only patients.** **Enhanced education was provided on 2/4/16 at our Executive Director Meeting to ensure the communication between patient and Heart 'n Home staff is better understood.** **Monitoring will occur through our Executive Director Admission Monitor Tool, ensuring all involved are aware that the patient is Spanish speaking only.** **Senior Vice President of Programs is responsible that all necessary paperwork will be translated, so that Spanish versions will be available for our Spanish speaking only patients.**	L 502 COMPLETED DATE:

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L 502	Continued From page 6 The forms available included Waivers of Rights, Consent to Treatment, Financial Benefit forms, and Insurance Benefit forms. The agency's "Patient Rights and Responsibilities" revised 4/14 stated "This written notice of Patient Rights and Responsibilities will be furnished and reviewed in a language and manner prior to initiation of treatment to ensure patient understanding." The rights and responsibilities listed on the form included, but were not limited to, the following: - Choose your attending physician - Receive information and be informed of services, products, and equipment provided by the agency and covered under the hospice benefit - Know in advance of agency charges, payment policies, and if you will be responsible for any payment - Be informed within 15 days of any change in charges and/or payment responsibilities to include the effect of changes in payment from Medicare, Medicaid, or any other federally funded or aided program - Confidentiality of all medical, financial, and other information related to your care - Be informed and receive written information, including agency policies and applicable state laws, regarding your right to accept or refuse medical treatment and the right to formulate advance directives	L 502	L 502 - RESPONSE:	L 502 COMPLETED DATE:

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L 502	Continued From page 7 The above rights and responsibilities were not consistently presented in a written format that a patient with LEP could understand. For example: Patient #18 was an 88 year old female admitted to the agency on 10/23/12, with a diagnosis of Parkinson's disease. Her record, including two Physician's Orders/Plans of Care, dated 10/23/12 to 1/20/13, and 6/09/15 to 8/09/15, was reviewed. In an initial nursing assessment, dated 10/23/12, the RN documented Patient #18 had a caregiver present during the visit. The RN documented both Patient #18 and her caregiver verbalized understanding of the hospice philosophy and the roles of different hospice staff. The nursing assessment did not include documentation that Patient #18 required a Spanish translator. A note by an agency Program Representative, dated 10/24/12, stated "Went to visit with patient and caregiver, [Name], to get new paperwork signed and deliver and go over new patient binder. Caregiver [Name] present to interpret since patient does not speak English." The caregiver was from a personal care agency, not a family member of Patient #18. Patient #18's record included admission paperwork and consents signed during her initial hospice visit by a Program Representative. The forms signed by Patient #18 were written in English and included, but were not limited to, the following: - Election of Medicare Hospice Benefit, dated 10/23/12 - Idaho Physician Orders for Scope of Treatment,	L 502	**L 502 - RESPONSE:** **As mentioned earlier, Heart 'n Home had available "Patient Rights and Responsibilities in Spanish at the time of survey. Education was provided to the Leadership Team 2/4/16 on use of these forms and where they are located for easier access to all staff.** **When the "Spanish Admission Packet" is completed by our contracted Qualified Interpreter (4/15/16), patients will be provided all admission forms in Spanish at time of admission.** **Care Plan Problem and Interventions were added to our EMR on 2/10/16 for any patient with LEP. This includes patient and family preferences for translation services. Executive Directors have been educated on the importance of following existing Heart 'n Home regarding LEP Procedures.** **Patients will more effectively understand their rights, consents and better participate in their plan of care.** **Senior Vice President of Programs is responsible that all necessary paperwork will be translated, so that Spanish versions will be available for our Spanish speaking only patients.**	**L 502 COMPLETED DATE:**

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L 502	Continued From page 8 dated 10/23/12 - Receipt and Understanding of Medicare Informed Consent, Patients Rights and Responsibilities, and Notice of Privacy Practices, dated 10/24/12 - Consent for Release of Medical Records or Health Information, dated 10/24/12 - Consent to Use and Disclose Health Information, dated 10/24/12 - Medicare Secondary Payer Screening Form, dated 10/24/12 - Social Security Administration form SSA-1696-U4, undated (the form assigns a representative who may request and receive information about a patient from the SSA) The admission and consent forms did not include documentation an interpreter or translator was present and utilized for the admission process. There was no documentation in Patient #18's record that she was provided with a Spanish version of the forms. During an interview on 1/07/16 at 1:00 PM, the ED reviewed the record. She confirmed Patient #18 was Spanish speaking. The ED confirmed Patient #18's admission forms were written in English and signed by Patient #18. She stated the staff provided forms which were available in Spanish for the patient to keep at home. The ED confirmed the agency procedure for LEP patients was not followed. She further confirmed the agency did not consistently utilize the language service when a patient need was identified.	L 502	**L 502 - RESPONSE:** **SSA –1696-U4 form is currently not available in Spanish through SSA.** **See attached "Communication for Persons with Limited English Proficiency (LEP)Procedure" which now includes required documentation in the EMR under the demographics screen for LEP patients, effective 2/10/16.** **Monitored through our Executive Director Admission Monitor Tool, ensuring all involved are aware that the patient is Spanish speaking only.** **Care Plan Problem and Interventions have been added in EMR 2/10/16 for any patient with LEP. This will include patient and family preferences for translation services. Executive Directors have been educated on the importance of following existing Heart 'n Home Policies and Procedures.** **Heart 'n Home has also added documentation requirements to our LEP Procedure and our EMR as of 2/18/16 to address LEP patient preferences on Program Representative visit.** **Patients will more effectively understand their rights, consents and better participate in their plan of care.** **Senior Vice President of Programs is responsible that all necessary paperwork will be translated, so that Spanish versions will be available for our Spanish speaking only patients.**	L 502 COMPLETED DATE:

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HEART N HOME HOSPICE & PALLIATIVE CARE	1100 NW 12TH STREET FRUITLAND, ID 83619

(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 502	Continued From page 9 The agency failed to provide Patient #18 with written notice of rights in a language and manner she understood.	L 502	L 502 - RESPONSE: Please see prior responses.	L 502 COMPLETED DATE:
L 511	418.52(b)(4)(iv) EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON [The hospice must:] (iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation. This STANDARD is not met as evidenced by: Based on record review, staff interview, and review of policies and agency incident reports, it was determined the hospice failed to ensure policies and procedures were sufficiently developed, implemented and monitored to ensure all allegations of abuse, neglect, mistreatment, or misappropriation of patient property, were reported in accordance with State Law. This failure directly impacted 1 of 19 patients (Patient #16) whose records were reviewed. This resulted in potential neglect not being reported to Idaho Adult Protective Services, as required by Idaho law. Findings include: 1. Patient #16 was an 84 year old female, who was admitted for hospice services on 8/22/12. Her primary terminal diagnosis was "Debility with a comorbidity of chronic phase of stroke." Patient #16 remained on service until 1/14/15, when services were revoked at the request of Patient #16's family member, who was the	L 511	L 511 - RESPONSE:	L 511 COMPLETED DATE:

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L 511	Continued From page 10 documented POA. According to the initial H&P, dated 4/20/12, Patient #16 had minimal use of her left leg and no use of her left arm. She required the assistance of 2 individuals to transfer from bed to chair and back. She also required assistance to reposition herself while in bed or in a chair. Patient #16 required assistance related to all activities of daily living, including but not limited to, eating, bathing and other personal hygiene activities. A Team Care Plan, dated 8/12/14, indicated Patient #16's condition had not improved over time. She was unable to care for herself and continued to require assistance with all activities of daily living. Skilled nursing visits were ordered every week, and CNA visits were ordered twice weekly and PRN. According to an IDT/HOSPICE PLAN OF CARE UPDATE, dated 1/14/15, an RN discovered the patient home alone and asleep before Patient #16's POA arrived home. A nursing DISCHARGE note, dated 1/14/15, included Patient #16 was found home alone on 1/14/15. The note also stated the RN attempted to speak with Patient #16's POA about the incident, when the POA became very upset and told the RN to leave the home. A note entered by the ED, dated 1/14/15, stated the RN contacted him to report the incident. The note stated the RN arrived for a home visit, found Patient #16 alone and telephoned the POA. The note indicated Patient #16 was found in a back room of the house, with the door closed "and without the ability to contact anyone if she needed	L 511	L 511 - RESPONSE:	L 511 COMPLETED DATE:

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L 511	Continued From page 11 help." The note stated Patient #16's POA arrived approximately 11 minutes later. After providing care, the RN attempted to discuss her concerns and educate the POA about the hospice's mandatory duty to report concerns of safety. The note said the POA then told the RN to leave the home. The same note also stated the ED contacted Patient #16's POA on the same date, 1/14/15, to discuss the safety concerns and educate her about the hospice's duty to report safety concerns. The note also stated an attempt to formulate a plan to prevent further safety concerns was attempted, but Patient #16's POA refused to discuss the incident or cooperate with a plan. According to the note, the POA later met with the ED, refused to allow the ED into Patient #16's home and signed the revocation document to discontinue hospice services. A document described as an incident report, but untitled, was reviewed. The report was completed on 1/14/15, by the RNCM, who was caring for Patient #16. Under the section, "Issue Summary," the following was documented: "Pt was discovered home by herself, in a bedroom, with no way to call for help" The section of the report titled, "Issue Details," included "...We walked to pt room, the door was closed, the shades were drawn, she was sleeping in bed, no phone was present for pt to be able to call for help." Also included by the RNCM in this section of the report was "She [the POA] became combative and argumentative and said she is always leaving the pt home, when she takes her kids to school, picks them up and to run errands...mom gets better care then 99% of the	L 511	**L 511 - RESPONSE:** **Heart 'n Home's Director of Compliance, Ethics representatives, QAPI Team and Administrator discussed and educated at our Leadership Team meeting held on 2/18/16 on Ethics in Hospice Care. This included examples of abuse, neglect, exploitation and imminent danger and action steps to take when in these situations. We also reviewed the procedure.** **This education is to ensure patients and families are safe from abuse, neglect, exploitation, and imminent danger.** **Heart 'n Home's "Abuse, Neglect, Exploitation and Imminent Danger" has been updated as of 2/10/16 to reflect the process of how and to whom reports will be made in the future.** **See attached "Abuse, Neglect, Exploitation and Imminent Danger Procedure"** **Imminent danger will be a 911 call.** **Administrator will monitor through the Ethics Committee all allegations related to abuse, neglect and exploitation. We will continue to educate and follow this procedure.** **Director of Compliance will conduct investigation of allegations under the direction of the Administrator.**	L 511 COMPLETED DATE:

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L 511	Continued From page 12 people out there and if she wants to leave her home alone then sobeit she will..." The section of the report titled, "Resolution Details," stated the RNCM followed up with the ED, who then contacted the POA of Patient #16, to discuss safety concerns and assist with a plan of action that would ensure Patient #16's safety. The POA insisted she no longer wanted the services of the hospice agency. The report stated the ED delivered the revocation paperwork on 1/14/15, Patient #16's POA signed the document, and services were terminated. The Director of Spiritual Care and Social Work, who was the ED at the time of the incident, was interviewed on 1/07/16, beginning at 10:05 AM. He reviewed all documentation related to Patient #16, and the incident of 1/14/15 was discussed. He confirmed Patient #16 should not have been left alone in the home without any method of calling for help. He also stated the incident and safety concerns related to Patient #16 were discussed during IDT, but were never reported to the appropriate State or local agency for follow up. Idaho law requires reporting abuse, exploitation, and neglect of vulnerable adults, as follows: Idaho statute 39-5303 states "Duty to report cases of abuse, neglect or exploitation of vulnerable adults. (1) Any physician, nurse, employee of a public or private health facility...social worker...pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such	L 511	L 511 - RESPONSE:	L 511 COMPLETED DATE:

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L 511	Continued From page 13 information to the commission [Idaho Commission on Aging]...When there is reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult, any person required to report under this section shall also report such information within four (4) hours to the appropriate law enforcement agency." The Idaho Commission on Aging is the agency having jurisdiction for adult protective services in Idaho. The hospice agency's "Abuse, Neglect, Exploitation And Immediate Jeopardy Procedure," last revised on 7/20/13, included the following: "Individuals must not be subjected to abuse by ANYONE including, but not limited to, Heart 'n Home employees/volunteers or the patient's family member or visitors." Additionally, the procedure provided the following definition: "Neglect is failure of caretaker to provide food, clothing, shelter or medical care reasonably necessary to sustain the life and health of a vulnerable adult, or the failure of a vulnerable adult to provide those services of his or herself." The procedure instructed staff to report all suspected and/or actual violations of mistreatment, neglect, verbal, mental, sexual or physical abuse to the ED. The policy did not include information or direction about when to report violations, or to whom to report violations (State and/or local bodies having appropriate jurisdiction.) Additionally, there was no procedure directing staff what to do if the ED was unavailable, for example after office hours or on a weekend, or the situation was emergent, the patient was at risk for harm.	L 511	L 511 - RESPONSE:	L 511 COMPLETED DATE:

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L 511	Continued From page 14	L 511	L 511 - RESPONSE:	L 511 COMPLETED DATE:
	The agency failed to ensure potential neglect was reported in accordance with Idaho State Law.			
L 530	418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. This STANDARD is not met as evidenced by: Based on review of medical records, observation, and staff interviews, it was determined the hospice failed to ensure a review of all medications was performed for 1 of 1 patient (#19), whose start of care was observed. This failure had the potential to result in adverse patient outcomes. Findings include: Patient #19 was a 75 year old female admitted to the hospice on 1/06/16, with a terminal diagnosis of unspecified encephalopathy. Her medical record, for the certification period beginning 1/06/16, was reviewed. On 1/06/16, beginning approximately 1:10 PM	L 530	L 530 - RESPONSE: Heart 'n Home would like to clarify that the observed visit was not a Comprehensive Assessment visit. We however recognize that best practice for nursing staff would be to visualize medication bottles anytime there is a discrepancy in a patient or families report of medications. What was not seen on the observation visit was that after the nurse returned to Heart 'n Home office, she sent a communication order to patient's primary physician requesting clarification on patients medications due to a reported discrepancy.	L 530 COMPLETED DATE:

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L 530	Continued From page 15 and ending at 2:00 PM, a SN visit was observed in the home where Patient #19 resided. The RNCM asked the caregiver if there were any medication needs. The caregiver stated she was confused on two medications. The RNCM compared the two medications with Patient #19's medication list and told the caregiver she would call the physician for clarifications. The RNCM did not visualize Patient #19's other medications to ensure type and dose of the medications taken by Patient #19 were consistent with those on her medication list in the medical record. During an interview with the RNCM on 1/06/16 at 2:10 PM, she stated Patient #19 and her caregiver were visited by a Program Representative on 1/05/16. She stated a medication reconciliation likely occurred during that visit but she could not confirm the representative looked at the medications. During an interview on 1/07/16 at 2:55 PM, the Senior Vice President of Clinical Operations and the Senior Vice President of Programs stated they expected an RN to visualize all prescribed medications, OTC medications and supplements, during a start of care visit. The agency did not perform a complete medication reconciliation for Patient #19 at her start of care.	L 530	**L 530 - RESPONSE:** **Heart 'n Home's "Medication Profile" has been revised as of 2/10/16 to reflect best practice of admit nurse comparing medication bottles to the medication list gathered during Program Representative visit. Heart 'n Home "Medication Profile" now includes a RN signature and check-off reminder for this process.** **See attached revised "Medication Profile"** **As of 2/18/16, the Medication General Procedure has been updated to include a Medication Discrepancy process. If at anytime a family, patient, caregiver or a nurse is not clear on any of the 5 Rights of medication, a RN will instruct the patient not to take the medication until clarification has been received from the Physician. All Leaders were educated at our Leadership meeting held on 2/18/16 of the new addition to the Medication General Procedure.** **Director of Compliance, Nurse Education Department, Executive Director and Clinical Director are responsible for monitoring and ensuring staff are following procedure.** **This change will decrease medication errors which will increase patient safety and confidence in regards to medications.**	L 530 COMPLETED DATE:
L 578	418.60 INFECTION CONTROL The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.	L 578	**L 578- RESPONSE:**	L 578 COMPLETED DATE:

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L 578	Continued From page 16 This STANDARD is not met as evidenced by: Based on staff interview and review of IC policies and documents, it was determined the hospice failed to ensure an effective infection control program was clearly defined, implemented, and sustained. This negative practice resulted in the inability of staff to effectively detect, monitor, and prevent infections. Findings include: 1. The hospice had not developed comprehensive IC policies. The infection control related policy that was provided by the agency was the INFECTION CONTROL/BLOODBORNE PATHOGEN POLICY, last revised in May of 2011. The policy identified the "Purpose...ensure that [The Agency] is in compliance with OSHA standard 29 CFR 1910.1030...to eliminate or minimize occupational exposure to bloodborne pathogens." In addition, the policy stated "[The Agency] will maintain and document an infection control program that protects patients, caregivers, families, visitors, employees, and Volunteers by preventing and controlling infections and communicable diseases..." Infections were not defined in the policies. Standards for disease prevention from nationally recognized organizations, such as the CDC or the World Health Organization, were not present. The Director of Compliance and the Director of Nursing Education were interviewed together on 1/16/16, beginning at approximately 2:00 PM. When asked which nationally recognized guidelines and acceptable standards of practice the agency used to develop their Infection Control	L 578	**L 578- RESPONSE:** **Heart 'n Home has updated its "Compliance and Quality Improvement Plan" as of 2/10/16 to clarify and specify parameters of its Infection Control Program including prevention, control, and education.** **Director of Compliance and the Compliance Department monitors the Infections and Communicable diseases. Both Infection Control and Blood Borne Pathogens are a required annual education by clinical staff.** **This will help establish best practices and ensure staff are consistent in these procedures which will therefore minimize staff and patient infections.** **Additionally, the following Policies and Procedure related to Infection Control have been updated as of 2/10/2016 to reflect best practices and standards of disease prevention from the CDC:** **See attached "Hand Hygiene Procedure"** **This will help establish best practices and ensure staff are consistent in these procedures which will therefore minimize staff and patient infections.** **Hand Hygiene Procedure is monitored by the Director of Nurse Education and Nurse Education Department through the Infection Control Competency which is conducted during initial and annual competencies.**	L 578 COMPLETED DATE:

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L 578	Continued From page 17 Program, both Directors indicated the Lippincott Nursing Manual was used as the basis for training employees about infection control. Although the Directors stated the Lippincott Nursing Manual referenced the CDC about certain aspects of infection control, they confirmed the agency had not actually chosen to follow CDC or any other nationally recognized infection control guidelines. During the same interview the Directors were asked about infection training provided for staff. They stated all staff received infection control training upon hire and annually. When asked for documentation of training during orientation related to infection control, the Director of Nursing Education provided a copy of an outline for OSHA training related to blood borne pathogens and a quiz related to the training. There was no other documentation related to infection prevention training provided. Additionally, the Directors stated they performed 1 on 1 visits with staff for observation of care and infection control practices in patients' homes monthly. They stated staff were chosen at random and the 1 on 1 visits were not scheduled, therefore, staff were unaware when the visits would occur. The Director of Nursing stated the 1 on 1 visits were part of their "Perfect Visit" format. She stated they had a form which outlined a perfect visit, and this was discussed in orientation. The form was included with the training information and included a section on proper hand sanitizing. However, the form did not include cleaning of equipment after patient use or cleaning of the nursing bag. The Director of Nursing confirmed this information was not included on the form for a perfect visit.	L 578	**L 578- RESPONSE:** **Attached is a copy of the Infection Control Quiz that all clinical staff are required to take during their initial orientation and annually on Infection Control. This was overlooked during survey as part of our established initial and annual education. Our apologies, as it was in effect at the time of the survey.** **See attached "Infection Control Quiz"** **Effective 2/10/16, Heart 'n Home has created an Infection Control Competency that all clinical staff will be required to complete during initial orientation and annually. This education reflects current CDC guidelines.** **See attached "Infection Control Competency"** **This will help establish best practices and ensure staff are consistent in these procedures which will therefore minimize staff and patient infections.** **Director of Nurse Education and Nurse Education Department will monitor the Infection Control by conducting initial and annual competencies.**	**L 578 COMPLETED DATE:**

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L 578	Continued From page 18	L 578	L 578	L 578 COMPLETED DATE:

2. The Directors were asked how the agency identified, tracked and monitored the occurrence of infections. They provided an "ADVERSE EVENT SUMMARY," with the date range 7/01/15-12/31/15. The summary included, but was not limited to, the following events/infections and corresponding number of infections that occurred during the documented date range for all branches:

a. Eye System Infection - 19

b. Ear System Infection - 6

c. Gastrointestinal System Infection - 18

d. Musculoskeletal System Infection - 6

e. Reproductive System Infection - 11

f. Respiratory System Infection - 129

g. Skin/Wound System Infection - 115

h. Urinary System Infection - 129

During the same interview the Director of Compliance and the Director of Nursing Education were asked how the infection related data was identified, tracked and analyzed to reduce and prevent the number of infections. The Directors stated the infection data was collected from the patient medical record monthly and reviewed annually. They stated the infection data was broken down by branches of the agency. When asked what was done with the information once it was collected, the Directors stated the information was presented to the QAPI

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L 578	Continued From page 19 committee and Senior Leadership annually. They confirmed the data was not analyzed or broken down further to prevent an increase in infection or decrease in the rate of infection for their patients. The Directors recalled one instance of education that was provided to the hospice nurses about proper sterile technique when inserting a Foley catheter, and proper technique for cleaning a Foley catheter. The Directors stated they were unable to determine whether the number of urinary tract infections had decreased as a result of the Foley catheter training. Additionally, they were unable to recall if the education was provided as a result of their collected infection data. The hospice did not maintain and document a comprehensive and effective infection control program.	L 578	L 578- RESPONSE: Heart 'n Home has updated its "Compliance and Quality Improvement Plan" as of 2/10/16 to clarify and specify parameters of its Infection Control Program including prevention, control and education. A component of the updated Infection Control Program includes a monthly review and trending of infection control data by the Compliance Department and QAPI Team. Performance Improvement Projects have started and will continue to occur as a result of this data analysis. This will help establish best practices and ensure staff are consistent in these procedures which will therefore minimize staff and patient infections.	L 578 COMPLETED DATE:
L 579	418.60(a) PREVENTION The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This STANDARD is not met as evidenced by: Based on observations, review of agency policies, infection control related documents, and staff interviews, it was determined the hospice failed to ensure staff followed acceptable standards of practice for infection control. This deficient practice directly affected 2 of 4 patients, (#3 and #19), whose care was observed and had the potential to affect all patients receiving services from the hospice. This had the potential to result in patients and/or family members	L 579	L 579- RESPONSE:	L 579 COMPLETED DATE:

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L 579	Continued From page 20 experiencing preventable infections. Findings include: 1. The agency's Policy and Procedure manual was reviewed. It did not include a policy and/or procedure to direct staff on maintaining cleanliness of their home visit nursing bag or the process for cleaning of supplies and equipment used in the assessment and treatment of patients in their residence. The one infection control policy provided by the agency was the INFECTION CONTROL/BLOODBORNE PATHOGEN POLICY, last revised in May of 2011. The policy included the following about Hand Hygiene: "...Hand Washing: Hands and other skin surfaces shall be washed immediately after contact with blood or OPIM. Hands shall be washed immediately, or as soon as feasible, after gloves or other personal protective equipment is removed." The policy did not identify nationally recognized infection control guidelines, or acceptable standards of practice, on which the agency's infection control program was based. The Director of Compliance and the Director of Nursing Education were interviewed together on 1/16/16, beginning at approximately 2:00 PM. The agency's Infection Control Program was discussed. When asked which nationally recognized guidelines and acceptable standards of practice the agency used to develop their Infection Control Program, both Directors indicated the Lippincott Nursing Manual was used as the basis for training employees about infection control. The Directors stated the Lippincott Nursing Manual referenced the CDC about certain aspects of infection control,	L 579	L 579- RESPONSE:	L 579 COMPLETED DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	131545		C 01/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART N HOME HOSPICE & PALLIATIVE CARE	1100 NW 12TH STREET FRUITLAND, ID 83619

(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 579	Continued From page 21 however they had not actually chosen to follow CDC or other nationally recognized infection control guidelines. The Lippincott Nursing Center website was accessed 1/10/16. It cited a study by Bakunas-Kenneley and Madigan (2009) that found that "43.7% of the patient-care equipment inside nursing bags was contaminated with human pathogens" and that "reusable equipment used after patient care should be cleaned before placing equipment back into the nursing bag and visiting another patient". Additionally, the Lippincott Nursing Center website included information specific to hand hygiene. The section titled, "Hand Hygiene" included "...The most important infection prevention activity that the staff can deploy is performing hand hygiene...It is required, based on the CDC Guideline for Hand Hygiene in Health-care Settings, that the staff perform hand hygiene..." The following CDC website, related to hand hygiene, was accessed on 1/13/16: http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf The "Guideline for Hand Hygiene in Health-Care Settings" was reviewed. The section titled "Recommendations" included, "...Decontaminate hands after contact with a patient's intact skin..." Agency staff did not follow the above referenced Lippincott and CDC practice standards. Examples include: a. Patient #3 was a 72 year old female admitted to the hospice on 10/29/13 with a terminal diagnosis of Alzheimer's disease.	L 579	**L 579- RESPONSE:** **Heart 'n Home will follow CDC Guidelines for Infection Control and Disease Prevention EFFECTIVE IMMEDIATELY 2/1/16.** **We will be very clear in education to staff that we follow ALL CDC guidelines for Infection Control and Disease Prevention.** **This will help establish best practices and ensure staff are consistent in these procedures which will therefore minimize staff and patient infections.** **Director of Nurse Education and Nurse Education Department monitor Infection Control by conducting initial and annual competencies.**	L 579 COMPLETED DATE:

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L 579	Continued From page 22 On 1/06/16, beginning at approximately 10:10 AM, an RN visit was observed in the home of Patient #3. The RN performed an evaluation of Patient #3. Prior to the evaluation, the RN performed hand hygiene using an alcohol-based hand sanitizer, and removed the necessary medical equipment from her bag, such as a stethoscope, blood pressure cuff, thermometer, and pulse oximeter to measure oxygen levels. She then began her examination of Patient #3, during which time she obtained vital signs, and listened to heart, lung and bowel sounds. The RN examined all exposed skin areas, including Patient #3's lower extremities. She palpated (touched) Patient #3's ankles and feet while assessing for edema. The RN then returned her equipment to her bag, opened her lap-top computer, and began entering notes related to her examination of Patient #3. The RN did not use hand sanitizer or wash her hands after examining the patient and before touching her computer. Additionally, the RN did not place a barrier between her bag and the floor. Appropriate infection control practices were not utilized during the care of Patient #3. b. Patient #19 was a 75 year old female admitted to the hospice on 1/06/16 with a terminal diagnosis of unspecified encephalopathy. On 1/06/16, beginning approximately 1:10 PM and ending at 2:00 PM, a SN start of care visit was observed in the home where Patient #19 resided. The RNCM cleansed her hands with hand sanitizer prior to removing equipment from her nursing bag. However, she did not clean the stethoscope or blood pressure equipment after	L 579	**L 579- RESPONSE:** **As stated before, as a result of these findings, Heart 'n Home has developed an Infection Control Competency 2/10/16 to ensure all staff are educated and re-educated on Infection Control best practices including but not limited to hand hygiene and proper cleansing of equipment. This will occur for all clinical staff upon initial orientation and annually.** **Heart 'n Home is currently evaluating an ongoing process for use of barriers under bags in patients homes. As of 3/1/16 Heart 'n Home will temporarily provide barriers for bags until a long term solution is decided, no later than 4/1/16. Research is being conducted to determine the most effective method in preventing infections and spread of disease. As we gather more information, we will determine next steps (i.e.: barriers required under all bags taken in by clinical staff, changing the type of bag taken in, etc.).** **If the state of Idaho is requiring that a barrier be placed under bags at EVERY patient visit, Heart 'n Home requests notification be sent so we can implement into our procedures. Otherwise Heart 'n Home will follow CDC guidelines.** **See attached CDC Guideline** **This will help establish best practices and ensure staff are consistent in procedures, minimizing staff and patient infections.** **Director of Nurse Education and Nurse Education Department will monitor Infection Control by conducting initial and annual competencies.**	**L 579 COMPLETED DATE:**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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L 579	Continued From page 23 they were used to assess Patient #19. Additionally, she did not perform hand hygiene or clean the equipment after performing patient care. The equipment was returned to her nursing bag without being cleaned. The agency did not ensure standards of infection control practice were followed during the care of Patient #19.	L 579	**L 579- RESPONSE:** **Heart 'n Home has updated the Infection Control Procedure as of 2/10/16 to include CDC standards on sanitizing equipment.** **Education has been provided at Leadership Meeting 2/18/16 by the Director of Nurse Education Department, that effective immediately we will be wiping down equipment with sanitation wipes and effective 3/1/16 barriers will be provided and implemented. A hands on Learning Lab will be scheduled no later than 5/31/16 to all clinical staff to complete competency on new procedure.** **Additionally, as mentioned above, the "Infection Control Competency" will also evaluate staff's adherence to the Heart 'n Home Infection Control Procedure.** **See attached "Infection Control Competency," "Infection Control Procedure," and the "Hand Hygiene Procedure".** **This will help establish best practices and ensure staff are consistent in these procedures which will therefore minimize staff and patient infections.** **Director of Nurse Education, Nurse Education Department, and Clinical Directors monitor this by making an onsite annual visit with every nurse, verifying infection control procedures are being followed.**	L 579 COMPLETED DATE:

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

August 17, 2016

Ashly Holaday-Copeland, Administrator
Heart N Home Hospice & Palliative Care
1107 Nw 11th Street
Fruitland, ID 83619

Provider #131545

Dear Ms. Holaday-Copeland:

An unannounced on-site complaint investigation was conducted from January 4, 2016 to January 8, 2016 at Heart N Home Hospice & Palliative Care. The complaint allegation, findings, and conclusions are as follows:

Complaint #ID00007127

Allegation: The agency insisted the patient revoke her hospice benefit because she had gone to the Emergency Room for treatment following a fall at home.

Findings: An unannounced visit was made to the hospice agency on 1/04/16 to 1/08/16. During the investigation, surveyors reviewed 19 medical records, observed 4 home visits, interviewed staff, interviewed patients and family members, and reviewed policies and procedures.

Two of the patient records reviewed included visits to the Emergency Room for treatment after a fall at home.

One record reviewed was an 88 year old female admitted to the agency on 10/23/12, for Parkinson's disease. The record documented the patient spoke Spanish and used her personal caregivers as interpreters.

A nursing note dated 8/04/15, documented the on call RN (Registered Nurse) from the agency received a call from the answering service regarding the patient. After several attempts, the RN was able to reach the patient's hired caregiver, from a personal care agency, by phone.

The personal caregiver stated when she arrived for her shift at 3:00 PM an ambulance was at the patient's residence after she had fallen at home and they were taking her to the hospital. The personal caregiver stated the patient did not want to wait for hospice and wanted to go to the hospital.

The on call RN documented she called the patient's daughter and informed her the patient was at the hospital after falling at home. She informed the daughter about the conversation with the caregiver and how the patient did not want to wait for the hospice staff but wanted to go to the hospital. The on call RN documented "Pt (patient) chose to seek treatment and I was taking revoke paperwork for her." The on call RN documented the patient's daughter then became frustrated and the RN offered to have the Executive Director, for the branch office providing services, call the daughter. The patient's daughter agreed to speak with the Executive Director.

The on call RN documented when she arrived at the hospital Emergency Department she talked with the personal caregiver and the patient. The on call RN documented "When pt (patient) came back into room Educated (sic) her on choosing to come to the hospital to seek treatment and not wanting to wait for hospice to arrive. At this time she signed revoke paperwork."

A nursing note dated 8/05/15, the day after the patient signed the revocation, documented the on call RN called and spoke to a staff member at the personal care agency. The staff member stated she believed the patient did not understand about going to the hospital rather than having the hospice come and assess her status. The RN stated the patient was educated the previous night and she understood per translation of their staff member, the personal caregiver.

The patient's record included a note, dated 8/05/15 at 1:49 PM, signed by the Executive Director of the branch providing services to the patient. The Executive Director documented she spoke to the RN Case Manager for the patient. The RN Case Manager stated the patient was confused why she was no longer on hospice services and wanted to have someone explain it to her. The Executive Director stated the patient's caregiver was translating for the on call RN and told her multiple times the patient did not want the hospice agency to care for her injuries.

A subsequent note included in the record, dated 8/05/15 at 1:57 PM, signed by the Executive Director, documented a phone conversation with the patient's daughter who was also the Durable Power of Attorney for Healthcare (DPOAHC). The daughter stated she felt because English was the patient's second language, and because the caregiver was new to the patient, the situation was not clearly translated. She also stated she did not believe the patient intended to revoke her hospice benefit or service.

The Executive Director further documented speaking with the Interdisciplinary Team for the patient regarding the situation. She stated " ...because of patient's lack of understanding about why she is no longer on hospice, and because of variations in events which occurred leading up to patient electing to sign a revoke form, patient has chosen not to revoke from hospice services and therefore will remain an active patient."

A procedure "Communication for Persons with Limited English Proficiency (LEP) Procedure," revised 2/14, stated staff were to document the language used to communicate with patients or family members. Under the section Qualified Interpreters, the procedure stated to contact appropriate bilingual staff to interpret. If a translator was unavailable staff could obtain an outside interpreter by calling a language line. The hospice agency maintained a list of bilingual staff, and the list was to be included in the patient binder from the agency.

Additionally, the procedure stated staff were to ensure patients understood an interpreter was available and provided free of charge. The procedure also documented portions of admission paperwork were available in Spanish. However, the revocation form was not one of the forms available in Spanish.

The patient record did not include documentation an interpreter or interpreter service was offered to the patient while on hospice.

The agency's policy and procedure for LEP patients was not followed and resulted in miscommunication and misunderstanding between the patient and the agency staff. This resulted in unnecessary duress of the patient and her family and had the potential to result in premature discharge from needed hospice services.

The allegation was substantiated and deficiencies were cited at 42 CFR 418.52 (a)(1) and 42 CFR 418.52 (c)(2) as it related to the failure of the hospice agency to promote and protect patients rights and to provide information in a language and manner the patient could understand.

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

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.

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

Sincerely,

DENNIS KELLY, RN
Co-Supervisor
Non-Long Term Care

DK/pmt

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 17, 2016

Ashly Holaday-Copeland, Administrator
Heart N Home Hospice & Palliative Care
1107 Nw 11th Street
Fruitland, ID 83619

Provider #131545

Dear Ms. Holaday-Copeland:

An unannounced on-site complaint investigation was conducted from January 4, 2016 to January 8, 2016 at Heart N Home Hospice & Palliative Care. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007183

Allegation #1: Hospice staff did not allow the patient to receive treatment in the Emergency Department for injuries related to his fall.

Findings #1: An unannounced complaint survey was made to the hospice agency on 1/04/16 to 1/08/16. During the investigation, surveyors reviewed 19 medical records, observed 4 home visits, interviewed staff, interviewed patients and family members, and reviewed policies and procedures.

Review of the agency's policies and procedures was also completed during the unannounced visit. One of the agency's procedures was related to the admission process of the patient. A section of the procedure stated a surrogate decision maker may make health care decisions for a patient that is unable to do so. It further stated if the patient did not have a Power of Attorney the order for the surrogate decision maker would be as follows:

- Spouse
- Adult child
- Parent
- Any relative

Two of the patient records reviewed included visits to the Emergency Room for treatment after a fall at home.

One patient record was that of an 89 year old male admitted to the agency on 9/12/15, for bladder cancer.

A note dated 10/14/15, signed by the social worker, documented she received a phone call from the RN Case Manager that the patient was on his way to the Emergency Department and was requesting the social worker meet her there.

A nursing note dated 10/14/15, signed by the RN Case Manager, documented a phone call to the patient's son. The son reported the patient fell and hit his head going unconscious. Emergency medical personnel were contacted for assistance by the son. Upon arrival of the medical response unit the patient was awake and refused to be transported to the hospital for further evaluation. The son stated he signed a declination form for the emergency response team. The patient was assisted into his home and the response team left.

Less than 5 minutes later the patient's son called for the emergency response team to return to the home. The patient had fallen inside the home again and was unconscious. Upon arrival of the medical response unit it was recommended the patient be transported for further evaluation at the hospital. The patient's son stated he decided to have the patient transported per their recommendation.

The RN Case Manager documented she asked the son if the patient was requesting transport to the hospital. The son stated the patient was unconscious and unable to make the decision. The RN Case Manager asked the son if the patient's wife was contacted and the son stated she was not answering her cell phone. The RN Case Manager stated she discussed with the son the patient's desire to remain in his home earlier that day and on admission to hospice. She informed the son she was on her way to the patient's home to assess the situation and patient's injuries, and to speak with emergency personnel and requested they wait for her arrival. The son declined to wait and stated the patient was ready to be transported.

The RN Case Manager documented the patient's son transferred the phone over to an EMT (Emergency Medical Technician). The RN Case Manager stated to the EMT as a hospice patient the staff liked to educate the patient and family on the patient's options prior to transport.

She stated she wanted to review medical treatment versus comfort interventions since the patient was declining related to his terminal diagnosis. The RN Case Manager also documented she informed the EMT the patient had requested earlier not to seek treatment at the hospital and she was on her way to the home. She also informed him the patient's wife, who was the Power of Attorney (POA), had not been contacted at this point. The EMT stated the son informed them he was the POA and requested the patient be transported. The EMT stated they were not going to wait and were transporting the patient per the son's request.

The RN Case Manager documented upon her arrival to the Emergency Department the patient was awake and lying in the hospital bed. He was having some difficulty speaking but stated he did not remember exactly how he fell, but remembered falling once outside and once inside the home.

The RN Case Manager documented she spoke with the patient's son. The patient's son stated after the second fall the patient was not conscious and was unable to make a decision regarding transport for further medical treatment and evaluation. He did not feel the patient was able to wait for the RN Case Manager's arrival at the home for an assessment. The son also informed the RN Case Manager he was the patient's POA.

The RN Case Manager documented when the Social Worker arrived at the hospital they both entered the patient's room to discuss his current status and medical options. She documented the patient stated he wanted to go home and was not sure why he was in the hospital. The patient's wife then arrived in the patient's room. The RN Case Manager stated the wife wanted to take the patient home at that time. The patient agreed with his wife and stated he wanted to go home.

The RN Case Manager documented the Emergency Department physician entered the room at that point and examined the patient. The physician reported to the patient and his wife his possible injuries, potential complications and recommended further testing. The patient's wife informed the physician the patient has terminal bladder cancer and was on hospice. She stated the patient desired comfort care only. The patient agreed with the wife's statement to the physician and he declined further testing. The physician canceled further testing and discharged the patient home with his wife, per the patient's request.

The patient and his spouse were informed of their choices regarding seeking emergency treatment while under hospice services. The choice to return home and not seek further treatment was an informed decision made by the patient and the spouse after discussion with the Emergency Room physician and hospice staff.

The allegation could not be verified through the investigative process.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The hospice failed to recognize the patient's right to personal integrity and quality of life during the dying process.

Findings #2: Patient records reviewed included current and discharged patients. Additionally, the records chosen included involvement by more than 1 discipline providing services to the patient.

The record of an 89 year old male admitted to the agency on 9/17/15, was reviewed. The patient's wife was his primary caregiver and he had several family members, including children and grandchildren, who lived locally and would visit frequently.

An assessment by the Social Worker on 10/15/15, documented a discussion regarding visitation of family members and the patient's need for rest. She documented the patient stated he had several family members visit throughout the weekend and he did not want to take his pain medications while visitors were present because they would make him sleepy. The patient's wife stated they had as many as 20 family members come to visit over the weekend and she felt overwhelmed. The Social Worker stated she facilitated a discussion about setting boundaries for family and their current family problems, and how to involve the family in the patient's hospice care and needs. The Social Worker documented the patient, his wife, and the family members present understood the education provided.

The record of an 86 year old female on hospice services was reviewed. The start of care assessment stated the patient was sleeping 22 out of 24 hours a day. The record included a note from the Social Worker which documented a discussion between her, the patient and the patient's family member/caregiver. Included in the discussion were patient preferences for her care, the patient and patient's caregiver understanding of her end-of-life wishes, including advance directives, the patient and families expectations from the hospice care team visits and the hospice philosophy of care. Additionally, the Social Worker documented she did a life review with the patient and provided a supportive presence.

The record of a 95 year old male on hospice services with a diagnosis of Alzheimer's disease was also reviewed. The record included a note by the Social Worker which documented a care conference with a son, three daughters and multiple other family members present. Included in the care conference were discussions related to the patient's spiritual beliefs (Buddhist) and making arrangements with community resources for appropriate spiritual care. She also documented discussing coping methods for the patient and family members and advance directives including the DPOAHC. Additionally, time was provided for the patient and family to discuss family dynamics, fond memories, coping skills, patient hobbies and likes, and patient accomplishments. The note documented the Social Worker's efforts for family collaboration in the patient's plan of care.

As part of the unannounced survey to the agency, 4 home visits were completed to observe care of the patients at their residence, as well as, interview patients and their family members or caregivers about the care and services of the hospice. Two of the observations were in the patient's home and 2 were in Assisted Living Facilities.

The staff observed included 3 RNs and 2 Aides. The interaction of the staff observed during the visits was appropriate. Each of the staff members greeted the patients and asked how they were on that day.

At one of the visits with an RN, the patient was sitting upright in a recliner in her living room and the RN sat on the floor right next to the patient and held her hand while assessing her pain and symptoms. The RN requested the patient's permission prior to placing her stethoscope under her blouse to listen. After examining both of the patient's feet, the RN placed her socks back on.

At another visit with 2 Aides, the patient was non-verbal but both of the Aides greeted her and inquired how she was feeling. Additionally, they informed the patient prior to performing any cares or moving her. The patient was placed in a bath chair, a chair which is made of plastic and intended for use in showers. The Aides then removed her clothing and placed sheets over her to maintain her privacy as they moved the patient from her room to the walk in shower down the hall.

A start of care visit for a 75 year old female was also observed. The patient had a long history of mental delay and was unable to express her own needs or concerns. The RN performing the start of care visit demonstrated concern for the family member/caregiver asking about her concerns, asking about the patient's habits and preferences and verifying schedules for visits. The RN was observed speaking softly to the patient with engaging non-threatening body language as she performed an assessment of the patient. The RN verified the family member/caregiver was, in fact, not the Durable Power of Attorney for Health Care (DPOAHC) and clarified the name and contact information of the DPOAHC.

It could not be verified that patient's quality of life and personal integrity were not respected by the agency and their staff.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Hospice staff treated patients and family with disrespect and failed to include family members in the decision making process.

Findings #3: As part of the unannounced visit to the agency 4 home visits were completed to observe care of the patients at their residence, as well as, interview patients and their family members or caregivers about the care and services of the hospice.

Two of the observations were in the patient's home and 2 were in Assisted Living Facilities.

The staff observed included 3 RNs and 2 Aides. The interaction of the staff observed during the visits was appropriate. Each of the staff members greeted the patients and asked how they were on that day. At one of the visits with an RN, the patient was sitting upright in a recliner in her living room and the RN sat on the floor right next to the patient and held her hand while assessing her pain and symptoms. At another visit with the Aides, the patient was non-verbal but both of the Aides greeted her and inquired how she was feeling. Additionally, they informed the patient prior to performing any cares or moving her.

During the observations patients, family members, and caregivers were interviewed regarding care provided by the hospice and their staff. One of the family members interviewed stated the patient and her family were very pleased with the care and services by the agency. She stated this was the third family member who had been on hospice services with this agency and the care was "excellent" with each one. A caregiver at one of the Assisted Living Facilities stated the agency staff were good at communicating with her about the patient. She stated whenever she needed to speak with them or needed supplies the staff would respond quickly.

The record of an 89 year old male admitted to the agency on 9/17/15, for bladder cancer was reviewed. The patient's wife was his primary caregiver and he had several family members, including children and grandchildren, who lived locally and would visit frequently.

The record included documentation by different clinicians and staff of the hospice agency regarding visits and phone calls with the patient, his wife and other family members. The documentation included discussions about the patient's plan of care, hospice services and philosophy, and availability of services for the patient and his family members.

Examples include, but are not limited to, the following:

An initial nursing assessment was documented on 9/17/15. The RN documented during this visit the patient's wife and 2 daughters were present. The patient and family members were educated on hospice services and the patient's plan of care. The RN stated the patient was complaining of a high level of pain to his lower abdomen and she instructed the patient and his family on the use of Morphine and Oxycodone to help control the pain. The RN also documented she provided education to the patient and his family members to call the hospice at any time for urgent needs or if the patient's pain was not controlled with medications.

On 9/21/15, the patient received a joint visit from the Social Worker and a Spiritual Care Provider (SCP). The patient was accompanied by his wife, daughter, and stepdaughter during the visits. The SCP went to the patient's home for a spiritual care assessment of the patient's and family's needs.

The patient shared with the SCP he was satisfied with his life and his wife of 10 years was his great friend. The SCP documented she educated the patient and family about her plan of care, length and frequency of visits, and to call the hospice any time there were questions or concerns. She documented the patient and family understood the education provided.

The assessment by the Social Worker on the same day documented she provided education on her role, the availability of hospice staff, and discussed her plan of care. The Social Worker documented there was a discussion regarding visitation of family members and the patient's need for rest. She stated she facilitated a discussion about setting boundaries for family and their current family problems, and how to involve the family in the patient's hospice care and needs. The Social Worker documented the patient, his wife, and the family members present understood the education provided.

The RN documented a visit on 9/21/15 in an Interdisciplinary Team meeting note. The RN stated during her visit the patient's wife, sister, daughter, and daughter-in-law were present. She documented the patient stated he had several family members visit throughout the weekend and he did not want to take his pain medications while visitors were present because they would make him sleepy. The patient's wife stated they had as many as 20 family members come to visit over the weekend and she felt overwhelmed. The RN documented she discussed and educated the patient and family members, who were present, about allowing time for the patient to rest. She suggested to them visitors should call prior to visits and keep the visits short to allow for quality and to prevent exhaustion of the patient.

Additionally, the record included communication notes between different disciplines who were in the patient's home and involved with his care.

A communication note dated 10/15/15, and written by the Clinical Director, documented she had spoken with the Social Worker regarding family dynamics keeping the patient's son updated on any changes in his status. A communication note by the Social Worker, dated the same day, documented she had spoken with the Executive Director regarding family coping and a plan for communicating with the family. The Social Worker stated she had spoken with the Clinical Director also to discuss and review the patient's POC and a communication plan for the family.

The patient's record included documentation of a visit by the Social Worker to the son's home on 10/15/15. The Social Worker documented she discussed the hospice philosophy with the patient's son due to his concerns about the patient's quality of life and his participation in decisions. She stated she discussed a communication plan with the son to contact him for any significant changes in his father's condition or if he had a fall or injury. The Social Worker documented the son understood the plan for communication and the hospice philosophy.

Throughout the patient's record there was documentation of communication with the patient, his wife, and family members regarding his care.

It could not be verified the hospice staff were disrespectful to patients or their family members and family were not included in the decision process.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

DENNIS KELLY, RN
Co-Supervisor
Non-Long Term Care

DK/pmt