



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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February 16, 2016

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

RE: Encompass Home Health & Hospice Of Idaho, Provider #131540

Dear Mr. Schellhous:

Based on the survey completed at Encompass Home Health & Hospice Of Idaho, on January 29, 2016, by our staff, we have determined Encompass Home Health & Hospice Of Idaho is out of compliance with the Medicare Hospice Condition of Participation of, **IDG, Care Planning, Coordination of Services (42 CFR 418.56)**. To participate as a provider of services in the Medicare Program, a hospice agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Encompass Home Health & Hospice Of Idaho, 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;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;

Randy Schellhous, Administrator
February 16, 2016
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 agency into compliance, and that the hospice agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before March 14, 2016. 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 March 6, 2016.

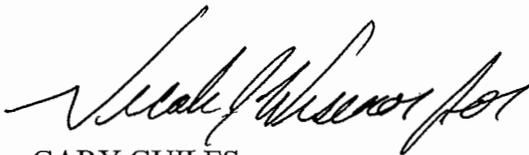
Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **February 29, 2016.**

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,



GARY GULES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/pmt

Enclosures

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

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

PRINTED: 02/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131540	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/29/2016
NAME OF PROVIDER OR SUPPLIER ENCOMPASS HOME HEALTH & HOSPICE OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 612 N KING ROAD NAMPA, ID 83687	
(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 complaint investigation survey of your hospice from 1/26/15 to 1/29/15. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Nancy Bax RN, HFS, Susan Costa, RN, HFS Acronyms used in this report include: ADLs - Activities of Daily Living ALF - Assisted Living Facility IDG - Interdisciplinary Group LMSW - Licensed Medical Social Worker LPN - Licensed Practical Nurse MAR - Medication Administration Record mg - milligram NP - Nurse Practitioner POA - Power of Attorney POC - Plan of Care prn - As needed pt. - Patient RN - Registered Nurse SN - Skilled Nursing SW - Social Worker	L 000		
L 533	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT 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	L 533		Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 Regional Administrator 2/26/16

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>Continued From page 1 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 2 of 8 patients (#2 and #3) whose records were reviewed. This failure resulted in the potential for patient and family needs to be unmet. Findings include:</p> <p>1. Patient #3 was a 66 year old female who resided in an ALF. She was admitted to the agency on 8/10/15 with a terminal diagnosis of Alzheimer's disease. She died on 11/23/15. Her record, including the POC, for the certification period 11/08/15 to 2/05/16, was reviewed.</p> <p>While receiving hospice services, Patient #3's record documented changes in her condition. However, her record did not reflect updates to her comprehensive assessment, as follows:</p> <p>Agency records included a client occurrence report dated 11/07/15. The report stated the agency received a call reporting Patient #3 had fallen out of bed and had a bruise on her hip. The report did not state who the caller was, or which hip was bruised. It stated "No visit being requested at this time. Encouraged the facility to notify hospice if any change in condition."</p> <p>a. The first SN visit following Patient #3's reported fall was documented on 11/10/15, and signed by</p>	L 533	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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L 533	<p>Continued From page 2</p> <p>her RN Case Manager. The note stated there were no new concerns at the time of the visit and stated an examination of her skin revealed no abnormal findings. The RN visit note did not include an assessment of Patient #3's hip. There was no documentation that additional information related to Patient #3's reported fall was gathered, or that measures were initiated to decrease her risk of another fall.</p> <p>During an interview on 1/28/16 beginning at 10:00 AM, the RN Case Manager reviewed Patient #3's SN visit note dated 11/10/15. She confirmed she did not complete an assessment of Patient #3's hip or leg, including presence of bruises, or range of motion. She stated Patient #3 was sleeping during the visit and the RN did not wake her.</p> <p>b. Patient #3's next SN visit was completed by an LPN on 11/12/15, beginning at 8:42 AM. The SN visit note stated her pain level was 7 on a scale of 0 to 10, with 10 being the worst pain. The note stated the staff reported Patient #3 had a fall 4 days prior, resulting in bruising on her left hip. The note stated she was in bed, moaning and crying, with fists clenched. Additionally, the note stated she had a large hematoma (collection of blood within the tissue) and swelling over her left trochanter (upper end of the femur) and buttock area. The LPN documented she spoke with Patient #3's husband and the possibility of a hip fracture was discussed. Patient #3's husband declined an x-ray. Therefore, it was not determined if Patient #3 suffered a hip fracture.</p> <p>During an interview on 1/29/16 beginning at 10:45 AM, the LPN stated she was scheduled to see Patient #3 on 11/12/15. She stated she read about Patient #3's reported fall in her record, but</p>	L 533	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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L 533	<p>Continued From page 3</p> <p>did not communicate with her RN Case Manager prior to her visit. She stated she knew Patient #3 from previous visits and noted a change in her condition on 11/12/15. She stated Patient #3 was incontinent, and she (the LPN) and 2 aides worked together to roll Patient #3 to her side to clean her and provide skin care. She stated the movement was painful for Patient #3. The LPN stated she was informed by the ALF staff that there was no Morphine available for Patient #3. The LPN stated she called the NP to obtain an order for pain medication. She stated she was concerned that her hip was fractured. However, she stated she did not talk to the ALF staff about precautions to prevent further injury to Patient #3's hip.</p> <p>c. Patient #3's record included a Physician Verbal Order dated 11/12/15. The order included Fentanyl transdermal patches to be applied every 72 hours, and Morphine to be given every 1 hour, as needed for pain. The order stated "Pt is declining." However, it did not include notification of her reported fall, the bruising and swelling of her left hip, or the change in her condition related to her fall.</p> <p>Patient #3's record included an SN visit note, dated 11/12/15 and signed by an RN. The note stated upon arrival, the RN applied a Fentanyl transdermal patch (long lasting opioid analgesic) and administered a dose of Morphine at approximately 12:30 PM. The note stated "Pt fell out of bed today and has a large hematoma on left hip causing nonverbal pain signs." It was unclear if Patient #3 suffered an additional fall on 11/12/15 or if her pain was related to her reported fall on 11/07/15. The note did not state the RN completed an assessment of Patient #3's left</p>	L 533	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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L 533	<p>Continued From page 4 lower extremity to determine the extent of injury.</p> <p>During an interview on 1/28/16 beginning at 9:05 AM, the RN who completed Patient #3's second visit on 11/12/15 stated the reason for her visit was to deliver and administer the Fentanyl patch and morphine. She stated she did not assess Patient #3's left leg. She stated it was her understanding Patient #3 fell on 11/12/15.</p> <p>During an interview on 1/28/16 at 9:22 AM, the Branch Director stated Patient #3 should have been assessed by an RN following her fall.</p> <p>The agency failed to ensure Patient #3's comprehensive assessment was updated in response to her falling and sustaining injuries which resulted in a significant change in Patient #3's status.</p> <p>2. Patient #2 was an 89 year old female who was admitted to hospice on 11/04/15. Her primary diagnosis was Alzheimers Disease. Additional diagnoses included HTN, Parkinson's Disease, and Constipation. Patient #2's record and POC for the certification period 11/04/15 to 2/01/16, was reviewed. Patient #2 remained on hospice services until her death on 11/16/15.</p> <p>Patient #2's record included a Visit Note Report dated 11/04/15, which was identified on the form as "Hospice RN Start of Care," and included a comprehensive nursing assessment. The nursing assessment noted that Patient #2 was unable to ambulate and required full assistance for repositioning and ADLs. The assessment included a section titled "Integumentary." The form included questions related to pressure ulcers and the RN stated "zero." The</p>	L 533	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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L 533	<p>Continued From page 5</p> <p>assessment did not include documentation of additional wounds or areas of disruption of skin integrity.</p> <p>The second nursing visit was completed on 11/09/15. The Visit Note Report did not include documentation related to assessment of skin integrity, but the narrative section stated "Dressed to open blisters to each foot, with assistance from facility staff [name of staff]. Applied Bacitracin gauze and secured with Tegaderm." The nursing visit note did not include further documentation of the wounds on Patient #2's feet. The RN did not document Patient #2's physician was alerted to the foot wounds, that wound care orders were obtained, or that updates to her comprehensive assessment and POC were made.</p> <p>The third nursing visit was completed on 11/11/15, by a different RN. The Visit Note Report included documentation in the narrative section by the RN which stated "Noted ruptured blister to left instep and another to right heel. Removed old dressing cleansed wounds, applied antibiotic ointment, replaced dressing. Wounds are consistent with walking with ill fitting shoes." Patient #2's record did not include documentation her physician was notified of her wounds, that wound care orders were obtained, or that updates to her comprehensive assessment and POC were made.</p> <p>During an interview on 1/28/16 beginning at 9:55 AM, the RN Branch Director reviewed Patient #2's record and confirmed the SOC nursing assessment did not include documentation of blisters on her feet. She confirmed Patient #2's record included multiple entries of wound care that was provided to her feet, without</p>	L 533	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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L 533	Continued From page 6 documentation of physician notification, wound care orders, or updates to her comprehensive assessment and POC.	L 533	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	
L 536	The agency failed to ensure Patient #2's comprehensive assessment was updated to reflect her wounds. 418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES This CONDITION is not met as evidenced by: Based on record review, review of agency policies, and staff interview, it was determined the agency failed to ensure communications systems were developed and maintained, necessary to ensure patient care was sufficiently coordinated with patients' family, non-hospice healthcare workers and all hospice disciplines. These failures resulted in a lack of comprehensive information being available necessary to ensure the needs of patients and their family members were being met. Findings include: 1. Refer to L540 as it relates to the agency's failure to ensure an RN was designated to provide continuous assessment of patient needs. 2. Refer to L554 as it relates to the agency's failure to ensure the IDG was provided with comprehensive information on which to base intervention decisions. 3. Refer to L556 as it relates to the agency's failure to ensure communication was maintained with patients and their family members. 4. Refer to L557 as it relates to the agency's	L 536	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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L 536	Continued From page 7 failure to ensure communication and integration of patient services between all hospice disciplines was maintained.	L 536	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016
L 540	5. Refer to L558 as it relates to the agency's failure to ensure communication and integration of patient services all non-hospice healthcare providers was maintained. 418.56(a)(1) APPROACH TO SERVICE DELIVERY The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure an RN was designated to provide continuous assessment of patient needs. This directly impacted 1 of 8 patients (#3), whose records were reviewed and had the potential to impact all patients receiving services at the agency. This failure resulted in a lack of RN oversight being provided to patients. Findings include: Patient #3 was a 66 year old female who resided in an ALF. She was admitted to the agency on 8/10/15 with a terminal diagnosis of Alzheimer's disease. She died on 11/23/15. Patient #3's record included documentation of a SN visit by an LPN on 11/12/15, beginning at 8:42 AM. The SN visit note stated her pain level was 7	L 540	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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L 540	<p>Continued From page 8</p> <p>on a scale of 0 to 10, with 10 being the worst pain. The note stated the staff reported Patient #3 had a fall 4 days prior, (on 11/07/15) resulting in bruising on her left hip. The note stated she was in bed, moaning and crying, with fists clenched. Additionally, the note stated she was had a large hematoma and swelling over her left trochanter and buttock area. The LPN documented she spoke with Patient #3's husband and the possibility of a hip fracture was discussed. Patient #3's husband declined an x-ray. Therefore, it was not determined if Patient #3 suffered a hip fracture.</p> <p>A visit note by an RN was dated 11/12/15 at 9:57 AM. The note stated the RN administered Morphine and Fentanyl (both narcotic pain medication) to Patient #3. The note did not document an assessment or care planning for Patient #3.</p> <p>A third visit note to Patient #3 was documented by the LPN on 11/12/15 at 5:29 PM for follow-up to the new pain medications ordered earlier that day. The note stated Patient #3 was becoming agitated and restless. The LPN called an on-call RN who was different from the RN on the earlier visit. This RN instructed the LPN to give Patient #3 Haldol, an anti-psychotic medication.</p> <p>The next nursing visit was not conducted until 11/17/15, 5 days later.</p> <p>An assessment by an RN of Patient #3's change in condition and living situation was not documented on 11/12/15. An assessment to determine if Patient #3's hip was fractured was not performed. A change to Patient #3's POC was not completed. Patient #3's care was driven</p>	L 540	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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L 540	<p>Continued From page 9</p> <p>by an LPN. An RN was not involved in determining Patient #3's course of treatment.</p> <p>During an interview on 1/29/16 beginning at 10:45 AM, the LPN stated she was scheduled to see Patient #3 on 11/12/15. She stated she read about Patient #3's reported fall in her record, but did not communicate with her RN Case Manager prior to her visit. She stated she knew Patient #3 from previous visits and noted a change in her condition on 11/12/15. She stated Patient #3 was incontinent, and she (the LPN) and 2 aides worked together to roll Patient #3 to her side to clean her and provide skin care. She stated the movement was painful for Patient #3. The LPN stated she called the NP to obtain an order for pain medication.</p> <p>During an interview on 1/28/16 beginning at 9:05 AM, the RN who completed Patient #3's second visit on 11/12/15 stated the reason for her visit was to deliver and administer the Fentanyl patch and morphine. She stated she did not assess Patient #3's left leg.</p> <p>During an interview on 1/28/16 at 9:22 AM, the Branch Director reviewed Patient #3's record and confirmed Patient #3's POC was not updated to include interventions related to her fall and injury. She confirmed an RN did not assess Patient #3 for a fracture or coordinate the patient's care.</p> <p>During an interview on 1/28/16 beginning at 10:00 AM, the RN Case Manager stated she was on vacation on 11/12/15. She stated different RNs were not assigned as Case Managers for patients when the original Case Manager was not available. She stated Patient #3 did not have another Case Manager assigned.</p>	L 540	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

PRINTED: 02/16/2016
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131540	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2016
NAME OF PROVIDER OR SUPPLIER ENCOMPASS HOME HEALTH & HOSPICE OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 612 N KING ROAD NAMPA, ID 83687		
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L 540	Continued From page 10	L 540	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	
L 554	<p>418.56(e)(1) COORDINATION OF SERVICES</p> <p>The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-</p> <p>(1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the hospice failed to ensure the IDG was provided with comprehensive information for 2 of 8 patients (#3 and #8) whose records were reviewed. This failure impeded the IDG's ability to direct, coordinate, and supervise patient care and services. Findings include:</p> <p>1. Patient #3 was a 66 year old female who resided in an ALF. She was admitted to the agency on 8/10/15 with a terminal diagnosis of Alzheimer's disease. She died on 11/23/15. Her record, including the POC, for the certification period 11/08/15 to 2/05/16, was reviewed.</p> <p>Patient #3's record included documentation of a SN visit by an LPN on 11/12/15, beginning at 8:42 AM. The SN visit note stated her pain level was 7 on a scale of 0 to 10, with 10 being the worst pain. The note stated the staff reported Patient #3 had a fall 4 days prior, (on 11/07/15) resulting in bruising on her left hip. The note stated she</p>	L 554	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

PRINTED: 02/16/2016
FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER ENCOMPASS HOME HEALTH & HOSPICE OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 512 N KING ROAD NAMPA, ID 83687	
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L 554	<p>Continued From page 11</p> <p>was in bed, moaning and crying, with fists clenched. Additionally, the note stated she was had a large hematoma (collection of blood within the tissue) and swelling over her left trochanter (upper end of the femur) and buttock area. The LPN documented she spoke with Patient #3's husband and the possibility of a hip fracture was discussed. Patient #3's husband declined an x-ray. Therefore, it was not determined if Patient #3 suffered a hip fracture.</p> <p>During an interview on 1/29/16 beginning at 10:45 AM, the LPN stated she was scheduled to see Patient #3 on 11/12/15. She stated she read about Patient #3's reported fall in her record, but did not communicate with her RN Case Manager prior to her visit. She stated she knew Patient #3 from previous visits and noted a change in her condition on 11/12/15. She stated Patient #3 was incontinent, and she (the LPN) and 2 aides worked together to roll Patient #3 to her side to clean her and provide skin care. She stated the movement was painful for Patient #3. The LPN stated she was informed by the ALF staff that there was no Morphine available for Patient #3. The LPN stated she called the NP to obtain an order for pain medication.</p> <p>Patient #3's record included documents titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report," which were completed every 2 weeks in conjunction with Hospice IDG meetings. The report dated 11/18/15 did not include documentation that her fall, her injury, the new onset of pain or of her change in condition were discussed during the IDG meeting. The document stated there were no changes in her POC.</p>	L 554	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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

PRINTED: 02/16/2016
FORM APPROVED
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L 554	<p>Continued From page 12</p> <p>During an interview on 1/28/16 at 9:22 AM, the Branch Director reviewed Patient #3's record and confirmed her IDG notes did not include information related to her fall and new onset of pain. The Branch Director confirmed Patient #3's POC was not updated to include interventions related to her fall and injury.</p> <p>The agency failed to ensure comprehensive information was provided to the IDG necessary to ensure Patient #3's needs were being met.</p> <p>2. Patient #8 was a 98 year old male admitted to the agency on 5/06/15 with a terminal diagnosis of coronary atherosclerosis. He died on 8/25/15. His record, including the POC, for the certification period 7/05/15 to 9/02/15, was reviewed.</p> <p>Patient #8's medication profile included ABHR cream to be applied every 4 hours as needed for anxiety or restlessness. The start date of the medication was 6/23/15. ABHR cream included Ativan, Benadryl, Haldol and Reglan.</p> <p>Patient #8's record included a physician's verbal order dated 7/13/15, stating his family wanted to hold the ABHR cream.</p> <p>Patient #8's record included an RN visit note, dated 7/14/15 and signed by the RN Case Manager. The note stated the RN spoke with Patient #8's daughter, who was his POA. The note stated his daughter requested Patient #8's prn medications administered for anxiety be discontinued. Patient #8's daughter requested the ALF staff call her when Patient #8 was restless or anxious so she (Patient #8's daughter) could come to the facility and attempt to relieve his anxiety without medications. The note stated</p>	L 554	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

PRINTED: 02/16/2016
FORM APPROVED
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L 554	<p>Continued From page 13 the ALF staff was informed of the daughter's request.</p> <p>Patient #8's record included documents titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report," completed every 2 weeks in conjunction with Hospice IDG meetings. The IDG note dated 7/15/15 did not include information related to Patient #8's family's request to hold his prn anxiety medication or the family's request to be called when he displayed symptoms of anxiety. There was no documentation of communication with the IDG team regarding his anxiety or methods to relieve his anxiety.</p> <p>Additionally, Patient #8's record included a Physician's Verbal Order, dated 7/16/15, for ABHR cream to be applied to his forearm 3 times a day. The order stated he was having increased agitation. Patient #8's record did not include documentation of communication with his family regarding the new order for ABHR cream.</p> <p>Patient #8's record included an RN visit note dated 7/17/15, and signed by the RN Case Manager. The note stated the ALF staff administered ABHR cream for agitation.</p> <p>Patient #8's "Hospice IDG Comprehensive Assessment and Plan of Care Update Report," dated 7/29/15, stated ABHR cream was resumed. However, the report did not state whether Patient #8's family was able to assist in relieving his anxiety or document communication with his family regarding the resumption of anxiety medications.</p> <p>During an interview on 1/28/15 at 8:20 AM, the RN Case Manager stated Patient #8's family</p>	L 554	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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

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FORM APPROVED
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L 554	<p>Continued From page 14</p> <p>expressed concern about his drowsiness and requested the ABHR cream be held, and his daughter be called to calm him down when he was anxious. She stated this was communicated to her on 7/13/15. She was unable to remember whether it was communicated to her by Patient #8's family or the ALF staff. She confirmed there was no documentation regarding Patient #8's response when the medication was held or whether his family was called to come to the ALF. She stated that was between the ALF and the family, and did not have anything to do with his hospice care. The RN Case Manager confirmed she did not communicate with Patient #8's family regarding the resumption of ABHR cream on 7/16/15. She confirmed there was no documentation of communication with his family between 7/13/15 and 8/12/15 and that there was no documentation of coordination with the IDG to ensure Patient #8's needs and the needs of his family were met.</p> <p>The agency failed to ensure comprehensive information was provided to the IDG necessary to ensure Patient #8's needs and the needs of his family were met.</p> <p>3. Refer to L556 as it relates to the agency's failure to ensure communication was maintained with patients and their family members.</p> <p>4. Refer to L557 as it relates to the agency's failure to ensure communication and integration of patient services between all hospice disciplines was maintained.</p> <p>5. Refer to L558 as it relates to the agency's failure to ensure communication and integration of patient services with all non-hospice healthcare</p>	L 554	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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L 554	Continued From page 15 providers was maintained.	L 554	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	
L 556	418.56(e)(3) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (3) Ensure that the care and services provided are based on all assessments of the patient and family needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the hospice failed to ensure communication was maintained with patients and their family for 1 of 8 patients (#8) whose records were reviewed. This resulted in a lack of information being available to the IDG on which to base intervention decisions. Findings include: 1. Patient #8 was a 98 year old male admitted to the agency on 5/06/15 with a terminal diagnosis of coronary atherosclerosis. He died on 8/25/15. His record, including the POC, for the certification period 7/05/15 to 9/02/15, was reviewed. Patient #8's medication profile included ABHR cream to be applied every 4 hours as needed for anxiety or restlessness. The start date of the medication was 6/23/15. ABHR cream included Ativan, Benadryl, Haldol and Reglan. Patient #8's record included a physician's verbal order, dated 7/13/15, stating his family wanted to hold the ABHR cream. Patient #8's record included an RN visit note,	L 556	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

PRINTED: 02/16/2016
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L 556	<p>Continued From page 16</p> <p>dated 7/14/15 and signed by the RN Case Manager. The note stated the RN spoke with Patient #8's daughter, who was his POA. The note stated his daughter requested Patient #8's prn medications administered for anxiety be discontinued. Patient #8's daughter requested the ALF staff call her when Patient #8 was restless or anxious so she (Patient #8's daughter) could come to the facility and attempt to relieve his anxiety without medications. The note stated the ALF staff was informed of the daughter's request.</p> <p>Patient #8's record did not include an SN visit note on 7/15/15 or 7/16/15. There was no documentation of communication with Patient #8's family after 7/14/15. Information regarding Patient #8's episodes of anxiety or whether his daughter was able to assist in relieving his anxiety could not be found.</p> <p>Patient #8's record included documents titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report," completed every 2 weeks in conjunction with Hospice IDG meetings. The IDG note dated 7/15/15 did not include information related to Patient #8's family's request to hold his prn anxiety medication or the family's request to be called when he displayed symptoms of anxiety. There was no documentation of communication with the IDG team regarding his anxiety or methods to relieve his anxiety.</p> <p>Additionally, Patient #8's record included a physician's verbal order, dated 7/16/15, for ABHR cream to be applied to his forearm 3 times a day. The order stated he was having increased agitation. Patient #8's record did not include documentation of communication with his family</p>	L 556	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

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L 556	<p>Continued From page 17 regarding the new order for ABHR cream.</p> <p>Patient #8's record included an RN visit note, dated 7/17/15 and signed by the RN Case Manager. The note stated the ALF staff administered ABHR cream for agitation. The note also stated the ALF staff wanted to arrange a conference with Patient #8's family regarding interventions for his agitation. However, the note did not include documentation of communication with his family. There was no documentation stating Patient #8's family was consulted and approved the resumption of the anxiety medication.</p> <p>Patient #8's record included an SN visit note, dated 7/20/15 and signed by another RN. The RN documented she would coordinate with the RN Case Manager to schedule a conference with Patient #8's family.</p> <p>Patient #8's record included an RN visit note, dated 7/23/15 and signed by the RN Case Manager. The note stated a conference with Patient #8's family would be scheduled for the following week.</p> <p>Patient #8's record included a SW visit note, dated 7/30/15 and signed by the LMSW. The note did not include documentation of communication with Patient #8's family or scheduling of a conference with his family.</p> <p>Patient #8's record included an RN visit note, dated 8/12/15 and signed by the RN Case Manager. The note stated a conference was scheduled with the family and ALF staff. The note documented a phone conversation with Patient #8's daughter. However, Patient #8's</p>	L 556	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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L 556	Continued From page 18 record did not include documentation of communication with his family between 7/14/15 and 8/12/15. During an interview on 1/28/15 at 8:20 AM, the RN Case Manager stated Patient #8's family expressed concern about his drowsiness and requested the ABHR cream be held, and his daughter be called to calm him down when he was anxious. She stated this was communicated to her on 7/13/15. She was unable to remember whether it was communicated to her by Patient #8's family or the ALF staff. She confirmed there was no documentation regarding Patient #8's response when the medication was held or whether his family was called to come to the ALF. She stated that was between the ALF and the family, and did not have anything to do with his hospice care. The RN Case Manager confirmed she did not communicate with Patient #8's family regarding the resumption of ABHR cream on 7/16/15. She confirmed there was no documentation of communication with his family between 7/13/15 and 8/12/15 and that there was no documentation of coordination with the IDG to ensure Patient #8's needs and the needs of his family were met.	L 556	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	
L 557	418.56(e)(4) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-]	L 557	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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L 557	<p>Continued From page 19</p> <p>(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the hospice failed to maintain a system of communication and integration to ensure information was shared between all disciplines providing care for 3 of 8 patients (#2, #3, and #8) whose records were reviewed. This failure resulted in a lack of coordination of care and a potential lack of appropriate precautions being taken to prevent patient injury. Findings include:</p> <p>1. Patient #3 was a 66 year old female who resided in an ALF. She was admitted to the agency on 8/10/15 with a terminal diagnosis of Alzheimer's disease. She died on 11/23/15. Her record, including the POC, for the certification period 11/08/15 to 2/05/16, was reviewed.</p> <p>Patient #3's record included documentation of a SN visit by an LPN on 11/12/15, beginning at 8:42 AM. The SN visit note stated her pain level was 7 on a scale of 0 to 10, with 10 being the worst pain. The note stated the staff reported Patient #3 had a fall 4 days prior, (on 11/07/15) resulting in bruising on her left hip. The note stated she was in bed, moaning and crying, with fists clenched. Additionally, the note stated she had a large hematoma (collection of blood within the tissue) and swelling over her left trochanter (upper end of the femur) and buttock area. The LPN documented she spoke with Patient #3's</p>	L 557	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

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L 557	<p>Continued From page 20</p> <p>husband and the possibility of a hip fracture was discussed. Patient #3's husband declined an x-ray. Therefore, it was not determined if Patient #3 suffered a hip fracture.</p> <p>During an interview on 1/29/16 beginning at 10:45 AM, the LPN stated she was scheduled to see Patient #3 on 11/12/15. She stated she read about Patient #3's reported fall in her record, but did not communicate with her RN Case Manager prior to her visit. She stated she knew Patient #3 from previous visits and noted a change in her condition on 11/12/15. She stated Patient #3 was incontinent, and she (the LPN) and 2 aides worked together to roll Patient #3 to her side to clean her and provide skin care. She stated the movement was painful for Patient #3. The LPN stated she was informed by the ALF staff that there was no Morphine available for Patient #3. The LPN stated she called the NP to obtain an order for pain medication.</p> <p>a. Patient #3's record included a Physician Verbal Order, dated 11/12/15. The order, obtained from the NP, included Fentanyl transdermal patches to be applied every 72 hours and Morphine to be given every 1 hour as needed for pain. The order stated "Pt is declining." However, it did not include notification of her reported fall, or the change in her condition related to her fall. Documentation that the NP or the physician had been notified of Patient #3's fall or of the bruising and swelling of her left hip was not present in her record.</p> <p>The agency failed to ensure communication occurred with the NP or the physician regarding Patient #3's fall and possible hip fracture.</p>	L 557	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131540	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/29/2016
NAME OF PROVIDER OR SUPPLIER ENCOMPASS HOME HEALTH & HOSPICE OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 612 N KING ROAD NAMPA, ID 83687	
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L 557	<p>Continued From page 21</p> <p>b. Patient #3's record included an SN visit note, dated 11/12/15 and signed by an RN. The note stated upon arrival, the RN applied a Fentanyl transdermal patch (long lasting opioid analgesic) and administered a dose of Morphine at approximately 12:30 PM. The note stated "Pt fell out of bed today and has a large hematoma on left hip causing nonverbal pain signs." It was unclear if Patient #3 suffered an additional fall on 11/12/15 or if her pain was related to her reported fall on 11/07/15. The note did not state the RN completed an assessment of Patient #3's left lower extremity to determine the extent of injury.</p> <p>During an interview on 1/28/16 beginning at 9:05 AM, the RN who completed Patient #3's second visit on 11/12/15 stated the reason for her visit was to deliver and administer the Fentanyl patch and morphine. She stated she did not assess Patient #3's left leg. She stated it was her understanding Patient #3 fell on 11/12/15.</p> <p>The agency failed to ensure Patient #3's injury was assessed and that complete information regarding her fall was clearly communicated to the RN.</p> <p>c. Patient #3's record included documentation of a SN visit by an LPN, on 11/12/15 beginning at 5:29 PM. The SN visit note stated the LPN was following up on her earlier visit. The note stated ALF staff reported Patient #3 was starting to become agitated and restless. The note stated the on-call RN was contacted and ordered Haldol to be given. The note stated if after 49 minutes, Patient #3 was still restless and crying then Morphine could be given. The note did not include documentation that the on-call RN was notified of Patient #3's fall or of the bruising and</p>	L 557	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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L 557	<p>Continued From page 22 swelling of her left hip.</p> <p>d. Patient #3's record included a care plan for the Hospice Aide who provided personal care, including bathing. The most recent update to the care plan was dated 9/17/15. The Hospice Aide care plan was not updated following her fall and injury. Patient #3's record did not include documentation stating the Hospice Aide was informed of Patient #3's change in condition or instructed in precautions necessary to prevent further injury to her hip.</p> <p>Patient #3 record included a Hospice Aide visit note, dated 11/13/15, one day after her hip injury was documented in SN visit notes. The visit note stated the Hospice Aide provided a shower to Patient #3. There was no documentation stating precautions were taken related to her hip injury.</p> <p>During an interview on 1/28/16 at 9:22 AM, the Branch Director reviewed Patient #3's record and confirmed her Hospice Aide care plan was not updated to include precautions necessary to prevent further injury to her hip.</p> <p>The agency failed to ensure communication occurred with the Hospice Aide regarding Patient #3's fall or precautions necessary to avoid further injury to her hip.</p> <p>The agency failed to ensure communication and integration of services occurred between all disciplines providing care to Patient #3.</p> <p>2. Patient #8 was a 98 year old male admitted to the agency on 5/06/15 with a terminal diagnosis of coronary atherosclerosis. He died on 8/25/15. His record, including the POC, for the certification</p>	L 557	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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

PRINTED: 02/16/2016
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L 557	<p>Continued From page 23 period 7/05/15 to 9/02/15, was reviewed.</p> <p>Patient #8's record included an RN visit note, dated 7/17/15 and signed by the RN Case Manager. The note stated the ALF staff wanted to arrange a conference with Patient #8's family regarding interventions for his agitation.</p> <p>Patient #8's record included an SN visit note, dated 7/20/15 and signed by another RN. The RN documented she would coordinate with the RN Case Manager to schedule a conference with Patient #8's family.</p> <p>Patient #8's record included an RN visit note, dated 7/23/15 and signed by the RN Case Manager. The note stated a conference with Patient #8's family would be scheduled for the following week.</p> <p>However, Patient #8's record included a SW visit note, dated 7/30/15 and signed by the LMSW. The note did not include documentation of communication with Patient #8's RN Case Manager, communication with his family, or scheduling of a conference with his family.</p> <p>During an interview on 1/28/15 at 8:20 AM, the RN Case Manager confirmed there was no documentation of communication with his family between 7/13/15 and 8/12/15, and that there was no documentation of coordination with the IDG to ensure Patient #8's needs and the needs of his family were met.</p> <p>The agency failed to ensure communication and integration of services occurred between the RN Case Manager and the LMSW necessary to ensure the needs of Patient #8 and his family</p>	L 557	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

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L 557	<p>Continued From page 24 were met.</p> <p>3. Patient #2 was an 89 year old female who was admitted to hospice on 11/04/15. Her primary diagnosis was Alzheimers Disease. Additional diagnoses included HTN, Parkinson's Disease, and Constipation. Patient #2's record and POC for the certification period 11/04/15 to 2/01/16, was reviewed. Patient #2 remained on hospice services until her death 11/16/15.</p> <p>A nursing visit was completed on 11/09/15. The the narrative section of the Visit Note Report, completed by the RN stated "Dressed to open blisters to each foot, with assistance from facility staff [name of staff]. Applied Bacitracin gauze and secured with Tegaderm."</p> <p>An additional nursing visit was completed on 11/11/15, by a different RN. The Visit Note Report included documentation in the narrative section by the RN which stated "Noted ruptured blister to left instep and another to right heel. Removed old dressing cleansed wounds, applied antibiotic ointment, replaced dressing. Wounds are consistent with walking with ill fitting shoes."</p> <p>However, Patient #2's record did not include documentation her physician was notified of her wounds or that wound care orders were obtained.</p> <p>During an interview on 1/28/16 beginning at 9:55 AM, the RN Branch Director reviewed Patient #2's record and confirmed Patient #2's record included multiple entries of wound care that was provided to her feet, without documentation of physician notification, changes to the POC, or wound care orders.</p>	L 557	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

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L 557	Continued From page 25 The agency failed to ensure communication and integration of services occurred between the RN and the physician necessary to ensure Patient #2's wound care needs were met.	L 557	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	
L 558	418.56(e)(5) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. This STANDARD is not met as evidenced by: Based on agency policies, ALF records, and agreements, review of medical records and staff interview, it was determined the hospice failed to maintain a system of communication and integration to ensure information was shared between all non-hospice healthcare providers for 8 of 8 patients (#1 - #8) whose records were reviewed. This failure resulted in a lack of coordination of care and a potential lack of appropriate precautions being taken to prevent patient injury. Findings include: The governing body did not develop a system to ensure the roles of agency staff and other formal caregivers were defined. The policy "ADMISSIONS/CLIENT ASSESSMENT," revised 3/24/15, stated the admitting nurse "Completes the nursing home notification form or letter of agreement for residential care facilities as needed." The	L 558	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

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L 558	<p>Continued From page 26</p> <p>Governing Body did not ensure this policy was followed.</p> <p>The medical records of 8 hospice patients (#1 - #8) who resided in various ALFs were reviewed. The hospice did not have a documented agreement with any of the ALFs where these patients resided regarding the roles of each staff. The hospice did not have a documented way to define the roles of the ALF and the hospice in the care of patients.</p> <p>The Hospice Regional Administrator was interviewed on 1/28/16 beginning at 4:20 PM. He stated the agency did not have agreements with any ALFs where hospice patients resided.</p> <p>The failure to define the roles of the ALF and the hospice in the care of patients, interfered with the provision of care. Examples included, but were not limited to, the following:</p> <p>1. Patient #5 was a 92 year old male who resided in an ALF. He was admitted for hospice services on 10/29/15 with a terminal diagnosis of Alzheimers Disease. He died on 12/17/15.</p> <p>Patient #5 was admitted with orders for Divalproex, a seizure medication, and Sertraline, an anti-anxiety medication. On 12/05/15 at 11:04 PM, a progress note by the RN stated Patient #5 was extremely agitated and was yelling vulgarities at staff. On 12/16/15 at 12:55 PM, an order was obtained by the hospice RN for Risperdone, an anti-psychotic medication, 1 mg daily for agitation. A care coordination note by the RN, dated 12/16/15 but not timed, stated the ALF Administrator refused to allow Patient #5 to receive Risperdone in the facility. The note</p>	L 558	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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L 558	<p>Continued From page 27</p> <p>stated the Administrator's "GRANDMA WAS OVERLY SEDATED ON THIS MEDICATION." An order, dated 12/17/15 at 12:19 PM, stated "FACILITY ADMINISTRATOR REFUSES TO ADMINISTER RISPERDONE 1. DC RISPERDONE 2. BEGIN SEROQUEL [an anti-psychotic medication]..." 2 times a day.</p> <p>Patient #5's RN was interviewed on 1/27/15 beginning at 9:00 AM. She stated the ALF Administrator did not like certain medications, including Risperdone. She stated the Administrator refused to allow his staff to administer Risperdone to Patient #5. She stated ALF staff was responsible for administering medications. She stated the hospice then obtained an order for Seroquel, another anti-psychotic medication, that the ALF Administrator was agreeable to.</p> <p>The Hospice Regional Administrator was interviewed on 1/28/16 beginning at 4:20 PM. He stated the agency had not investigated the circumstances around the refusal of the ALF to administer ordered medication to Patient #5. He stated the agency had not developed a plan in the event that other patients at this ALF were admitted to hospice.</p> <p>The hospice allowed the ALF administrator to dictate the medical care provided to patients and to override legal orders. The hospice failed to define the role of the caregivers which interfered with the provision of patient care.</p> <p>2. Patient #3 was a 86 year old female who resided in an ALF. She was admitted to the agency on 8/10/15 with a terminal diagnosis of Alzheimer's disease. She died on 11/23/15. Her</p>	L 558	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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

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L 558	<p>Continued From page 28 record, including the POC, for the certification period 11/08/15 to 2/05/16, was reviewed.</p> <p>Patient #3's record included documentation of a SN visit by an LPN, on 11/12/15 beginning at 8:42 AM. The SN visit note stated her pain level was 7 on a scale of 0 to 10, with 10 being the worst pain. The note stated the staff reported Patient #3 had a fall 4 days prior, (on 11/07/15) resulting in bruising on her left hip. The note stated she was in bed, moaning and crying, with fists clenched. Additionally, the note stated she had a large hematoma (collection of blood within the tissue) and swelling over her left trochanter (upper end of the femur) and buttock area. The LPN documented she spoke with Patient #3's husband and the possibility of a hip fracture was discussed. Patient #3's husband declined an x-ray. Therefore, it was not determined if Patient #3 suffered a hip fracture.</p> <p>During an interview on 1/29/16 beginning at 10:45 AM, the LPN stated she was scheduled to see Patient #3 on 11/12/15. She stated she read about Patient #3's reported fall in her record, but did not communicate with her RN Case Manager prior to her visit. She stated she knew Patient #3 from previous visits and noted a change in her condition on 11/12/15. She stated Patient #3 was incontinent, and she (the LPN) and 2 aides worked together to roll Patient #3 to her side to clean her and provide skin care. She stated the movement was painful for Patient #3. The LPN stated she was informed by the ALF staff that there was no Morphine available for Patient #3. The LPN stated she called the NP to obtain an order for pain medication.</p> <p>a. Patient #3 received care from the ALF staff,</p>	L 558	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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L 558	<p>Continued From page 29 including transfers, repositioning and personal care. However, her record did not include documentation that Hospice staff instructed the ALF staff in precautions necessary to avoid further injury to her hip.</p> <p>During an interview on 1/29/16 at 10:45 AM, the LPN stated she did not communicate with the ALF staff, on 11/12/15, regarding Patient #3's fall or precautions necessary to avoid further injury to her hip.</p> <p>b. Patient #3's record also included an SN visit note, dated 11/12/15 and signed by an RN. The note stated upon arrival, the RN applied a Fentanyl transdermal patch (long lasting opioid analgesic) and administered a dose of Morphine at approximately 12:30 PM. The note stated "Pt fell out of bed today and has a large hematoma on left hip causing nonverbal pain signs." It was unclear if Patient #3 suffered an additional fall on 11/12/15 or if her pain was related to her reported fall on 11/07/15. The note did not state the RN completed an assessment of Patient #3's left lower extremity to determine the extent of injury.</p> <p>During an interview on 1/28/16 beginning at 9:05 AM, the RN who completed Patient #3's second visit on 11/12/15 stated the reason for her visit was to deliver and administer the Fentanyl patch and morphine. She stated she did not assess Patient #3's left leg. She stated it was her understanding Patient #3 fell on 11/12/15.</p> <p>The agency failed to ensure Patient #3's injury was assessed and her care was coordinated with ALF staff necessary to avoid further injury to her hip.</p>	L 558	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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L 558	<p>Continued From page 30</p> <p>c. Patient #3's record included documentation of a SN visit by an LPN, on 11/12/15 beginning at 5:29 PM. The SN visit note stated the LPN was following up on her earlier visit. The note stated ALF staff reported Patient #3 was starting to become agitated and restless. The note stated the on-call RN was contacted and ordered Haldol to be given. The note stated if after 49 minutes, Patient #3 was still restless and crying then Morphine could be given. The note did not include documentation that communication had occurred with the ALF staff regarding Patient #3's activities or precautions necessary to avoid further injury to her hip.</p> <p>During an interview on 1/29/16 at 10:45 AM, the LPN stated she did not communicate with the ALF staff, on 11/12/15, regarding Patient #3's fall or precautions necessary to avoid further injury to her hip.</p> <p>The agency failed to ensure communication occurred with the ALF staff regarding Patient #3's fall or precautions necessary to avoid further injury to her hip.</p> <p>3. Patient #8 was a 98 year old male admitted to the agency on 5/06/15 with a terminal diagnosis of coronary atherosclerosis. He died on 8/25/15. His record, including the POC, for the certification period 7/05/15 to 9/02/15, was reviewed.</p> <p>Patient #8's medication profile included ABHR cream to be applied every 4 hours as needed for anxiety or restlessness. The start date of the medication was 6/23/15. ABHR cream included Ativan, Benadryl, Haldol and Reglan.</p> <p>Patient #8's record included a Physician's Verbal</p>	L 558	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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(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)	(X6) COMPLETION DATE
L 558	<p>Continued From page 31</p> <p>Order dated 7/13/15, stating his family wanted to hold the ABHR cream.</p> <p>Patient #8's record included an RN visit note, dated 7/14/15 and signed by the RN Case Manager. The note stated the RN spoke with Patient #8's daughter, who was his POA. The note stated his daughter requested Patient #8's prn medications administered for anxiety be discontinued. Patient #8's daughter requested the ALF staff call her when Patient #8 was restless or anxious so she (Patient #8's daughter) could come to the facility and attempt to relieve his anxiety without medications. The note stated the ALF staff was informed of the daughter's request.</p> <p>Patient #8's record did not include an SN visit note on 7/15/15 or 7/16/15. There was no documentation of communication with the ALF regarding episodes of anxiety or whether his family was called to assist in relieving his anxiety.</p> <p>Additionally, Patient #8's record included a Physician's Verbal Order, dated 7/16/15 for ABHR cream to be applied to his forearm 3 times a day. The order stated he was having increased agitation.</p> <p>Patient #8's record included an RN visit note, dated 7/17/15 and signed by the RN Case Manager. The note stated the ALF staff administered ABHR cream for agitation. The note also stated the ALF staff wanted to arrange a conference with Patient #8's family regarding interventions for his agitation.</p> <p>Patient #8's record included an SN visit note, dated 7/20/15 and signed by another RN. The</p>	L 558	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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

PRINTED: 02/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131540	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2016
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L 558	<p>Continued From page 32</p> <p>RN documented she would coordinate with the RN Case Manager to schedule a conference with Patient #8's family.</p> <p>Patient #8's record included an RN visit note, dated 7/23/15 and signed by the RN Case Manager. The note stated a conference with Patient #8's family would be scheduled for the following week.</p> <p>However, Patient #8's "Hospice IDG Comprehensive Assessment and Plan of Care Update Report," dated 7/29/15, stated ABHR cream was resumed. The report did not state whether his family was able to assist in relieving his anxiety or document communication with his family regarding the resumption of anxiety medications.</p> <p>Patient #8's record included an RN visit note, dated 8/12/15 and signed by the RN Case Manager. The note stated a conference was scheduled with the family and ALF staff.</p> <p>During an interview on 1/28/15 at 8:20 AM, the RN Case Manager stated Patient #8's family expressed concern about his drowsiness and requested the ABHR cream be held, and his daughter be called to calm him down when he was anxious. She stated this was communicated to her on 7/13/15. She was unable to remember whether it was communicated to her by Patient #8's family or the ALF staff. She confirmed there was no documentation regarding Patient #8's response when the medication was held or whether his family was called to come to the ALF. She stated that was between the ALF and the family, and did not have anything to do with his hospice care.</p>	L 558	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

PRINTED: 02/16/2016
FORM APPROVED
OMB NO. 0938-0391

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L 558	<p>Continued From page 33</p> <p>The agency failed to ensure communication occurred with the ALF staff regarding Patient #8's anxiety and responses to changing intervention strategies.</p> <p>4. Patient #2 was an 89 year old female who resided in an ALF and was admitted to hospice on 11/04/15. Her primary diagnosis was Alzheimers Disease. Additional diagnoses included HTN, Parkinson's Disease, and Constipation. Patient #2's record and POC for the certification period 11/04/15 to 2/01/16, was reviewed. Patient #2 remained on hospice services until her death 11/16/15.</p> <p>A nursing visit was completed on 11/09/15. The the narrative section of the Visit Note Report, completed by the RN stated "Dressed to open blisters to each foot, with assistance from facility staff [name of staff]. Applied Bacitracin gauze and secured with Tegaderm."</p> <p>An additional nursing visit was completed on 11/11/15, by a different RN. The Visit Note Report included documentation in the narrative section by the RN which stated "Noted ruptured blister to left instep and another to right heel. Removed old dressing cleansed wounds, applied antibiotic ointment, replaced dressing. Wounds are consistent with walking with ill fitting shoes."</p> <p>However, Patient #2's record did not include documentation of coordination with ALF staff regarding Patient #2's shoes, the wounds on her feet or wound care.</p> <p>During an interview on 1/28/16 beginning at 9:55 AM, the RN Branch Director reviewed Patient</p>	L 558	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

PRINTED: 02/16/2016
FORM APPROVED
OMB NO. 0938-0391

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L 558	Continued From page 34 #2's record and stated the nursing note on 11/09/15, indicated the facility contacted the hospice RN to perform wound care. She confirmed that Patient #2's record did not include further documentation of coordination with the ALF regarding wound care.	L 558	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	
L 651	The agency failed to ensure Patient #2's foot and wound care was coordinated with ALF staff. 418.100(b) GOVERNING BODY AND ADMINISTRATOR 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. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, agency policies, ALF records, and agreements, it was determined the governing body failed to assume responsibility for the management of the hospice and the provision of all hospice services. This resulted in a lack of oversight of the agency and of the services provided. Findings include: 1. Refer to L540 as it relates to the Governing Body's failure to develop and maintain a system to ensure patients' needs and care were	L 651	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

PRINTED: 02/16/2016
FORM APPROVED
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L 651	Continued From page 35 evaluated and directed by RNs.	L 651	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	
L 700	2. Refer to L558 as it relates to the Governing Body's failure to develop a system to ensure the roles of agency staff and other non-hospice healthcare providers were defined and that a system communication and integration of patient services was maintained. 3. Refer to L700 as it relates to the Governing Body's failure to ensure a system which identified and addressed medication discrepancies was developed, implemented and maintained. 418.106(e)(3)(ii) LABEL DISPOSE STORAGE DRUGS (ii) Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled drugs must be investigated immediately by the pharmacist and hospice administrator and where required reported to the appropriate State authority. A written account of the investigation must be made available to State and Federal officials if required by law or regulation. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to ensure a system was developed to identify and investigate discrepancies in supplying and the disposal of controlled substances to ALFs. This failure directly impacted 8 of 8 patients (#1 - #8) whose records were reviewed and had the potential to impact all agency patients who received medications. This resulted in the potential for medications to be diverted. Findings include:	L 700	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

PRINTED: 02/16/2016
FORM APPROVED
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L 700	Continued From page 36 1. The policy "MEDICATIONS," revised 12/3/15/15, stated "Staff will encourage patients/caregivers/family members to dispose of all medications, especially those under the DEA rule on Disposal of Controlled Substances..." The policy did not state how the hospice would track controlled substances it provided to ALFs to prevent the diversion of these medications. The failure to monitor controlled substances resulted in a lack of accountability. Examples included, but were not limited to, the following: a. Patient #3 was a 66 year old female who resided in an ALF. She was admitted to the agency on 8/10/15 with a terminal diagnosis of Alzheimer's disease. She died on 11/23/15. Following a hip injury, An LPN visited Patient #3. She was unable to locate Patient #3's Morphine at the ALF, so she requested an RN bring narcotic medications to the patient. Patient #3's record included a visit note dated 11/12/15 and signed by an RN. The note stated upon arrival, the RN applied a Fentanyl transdermal patch (long lasting opioid analgesic) and administered a dose of Morphine at approximately 12:30 PM. During an interview on 1/29/16 beginning at 10:45 AM, the LPN stated she visited Patient #3 on 11/12/15. She stated Patient #3 had severe pain from a possible fractured hip and she asked the ALF staff for Patient #3's Morphine but they could not find it. She stated the Morphine may have expired and the ALF staff disposed of it. She stated she did not know what happened to it. She stated a hospice RN brought out more Morphine for Patient #3 as well as Fentanyl patches, another narcotic. The LPN stated she called the	L 700	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016

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

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FORM APPROVED
OMB NO. 0938-0391

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L 700	<p>Continued From page 37</p> <p>NP to obtain an order for more pain medication.</p> <p>Patient #3's RN Case Manager was interviewed on 1/28/16 beginning at 9:22 AM. She stated Patient #3's medications were fully stocked prior to 11/12/15. She stated the ALF had a comfort kit which included Morphine. She stated Morphine was included on Patient #3's MAR which meant it had been delivered. She stated she did not know why the Morphine was not available on 11/12/15.</p> <p>An incident report which described actions taken to investigate the missing Morphine was not documented.</p> <p>Patient #3's medical record stated a hospice RN delivered Morphine and Fentanyl to Patient #3 on 11/12/15. An RN visit note, dated 11/23/15 at 10:32 PM, stated Patient #3 died on 11/23/15. The note stated "COORDINATED DISPOSAL OF MEDICATIONS WITH FACILITY PERSONNEL...INSTRUCTED [ALF STAFF] THAT FACILITY WOULD NEED TO DESTROY MEDICATIONS WITH FACILITY NURSE." The record did not state if ALF staff participated in the destruction of the medications.</p> <p>A record of medication destruction following Patient #3's death was not present at the agency.</p> <p>b. Patient #6 was a 95 year old male who was a hospice patient from 8/25/15 to 12/04/15. He resided in an ALF. On 12/04/15, Patient #6 received Morphine, a Schedule II narcotic. The Morphine was supplied by the hospice as part of a comfort kit. Patient #6 received a Fentanyl patch on 12/03/15, which was also a Schedule II narcotic.</p>	L 700	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

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

PRINTED: 02/16/2016
FORM APPROVED
OMB NO. 0938-0391

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L 700	<p>Continued From page 38</p> <p>Patient #6 died on 12/04/15. A "Visit Note Report," by the RN and dated 12/04/15 at 7:04 PM, stated "SPOKE WITH [ALF personnel] WHO INFORMED THIS NURSE THAT THEY HAVE A POLICY OF MEDICATION DESTRUCTION THAT DOES NOT INCLUDE 3RD PARTY CARE PROVIDERS."</p> <p>The RN who wrote the above note was interviewed on 1/27/16 beginning at 3:20 PM. He stated the agency provided Morphine to ALFs as part of a comfort kit. He stated the ALF refused to allow him to participate in medication destruction after Patient #6's death. He stated the ALF did not allow non-ALF staff to participate. He stated he did not know if the ALF staff destroyed the medication or not.</p> <p>Further, the medical records of Patients #1, #2, #4, #5, #7, and #8 all documented they resided in ALFs and received medications. However, hospice agency records did not include complete documentation of receipt and disposition of the drugs.</p> <p>The Branch Director was interviewed on 1/27/16 beginning at 3:40 PM. She stated the agency did not monitor narcotic usage or follow up with ALFs to determine if narcotics had been destroyed after patient deaths. She stated the agency did not check narcotic counts or take other steps to track narcotics the hospice provided to ALFs.</p> <p>The Governing Body failed to monitor narcotics to prevent diversion of medications.</p>	L 700	Please see the attached Plan of Correction with the date of Alleged compliance noted as 3/4/2016	2/26/2016	

L533 418.54(d) Update of Comprehensive Assessment

Plan: 2/1/2016

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.

Governing Body Approval: 2/2/2016

The corrective action plan for the plan of correction was presented and approved by the Governing body.

Policy Review 02/25/2016

A review of policy:

- Service Delivery 10.0. Client Reassessment/Recertification was completed to confirm compliance to federal regulations. (See Attachment SD 10.0)

Inservice/Staff Education: Defensible Documentation/Requirements for Care.

Nampa: 2/8/2016

Twin Falls: 2/15/2016

Fruitland and weekend nurse: 2/19/2016

Additional staff not available on date of original training: 2/26/2016

Inservicing and Staff education provided by Ingrid Rich, RN, Clinical Operations, occurred at all locations for this Hospice provider number related to the requirements of care and the documentation associated with that care. Topics included but were not limited to:

- Medicare COP requirements
- Hospice eligibility
- Progression of disease documentation
- SOAP notes
- IDG meeting requirements
- Coordination of care
- Professional management of patient care
- Comprehensive assessment
- Need for ongoing reassessment and plan of care revision.

(See Attachments 1 and 5)

Follow up training, Reinforcement of training, Q and A's and examples of requirements: 2/9/2016

Follow up education was provided following the IDG related to the extensive training provided on the previous day. The training was provided by the Branch Director and the Administrator. The requirements and expectations were reinforced, Q and A's were addressed and examples of

situational experiences were provided to give a better understanding of the ongoing expectations.

(See Attachment 6)

Education/Inservicing related to updating the plan of care due to an update in the Comprehensive Assessment: 2/9/2016-2/19/2016

Training provided on a one on one basis for all skilled disciplines to provide guidance and direction on appropriately updating the patient's plan of care to assure that it reflects all changes to the patient's condition when updating the patient's comprehensive assessment. Ingrid Rich, RN, Clinical Operations, provided patient specific education and oversight to assist the clinicians in understanding how to update the plan of care to reflect the issues currently being addressed with the patient. All updates to the plans of care, review of the updates, request for and completion of any needed revisions will be completed by 3/4/2016.

Performance Improvement Plan: After Hours Care 2/8/2016

A Performance Improvement Plan was completed and implemented to assure appropriate response to and follow up of any after hour calls. The plan details the plan to assure a proper response to all after hour calls, the completion of any appropriate follow up visits, coordination with the appropriate IDG members, and a plan for interventions to assist with calls that were preventable.

- The on call was reviewed and revised as needed to assure ongoing RN coverage.
- The RN case managers will be notified each morning of all patient calls during afterhours, provide follow up to ensure patient needs are addressed and documentation of actions performed.
- The IDG team was educated on Patient Rights, responsibility for 24/7 availability of services.
- Review and follow up to after-hours calls to be performed to assure that the appropriate follow up was completed.
- Calls to all patients on Thursday/Friday to determine any needs that could be addressed, to prevent emergent needs over the weekend.

(See Attachment 2)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or their designee, with the review of all after hour calls and weekly chart audits to assure proper documentation and follow up to any new or identified issues. Assurance that these items are addressed will be reviewed by the Regional Administrator by onsite supervision.

Allegation of Compliance Date: 03/04/2016

L536 CONDITION: Care Planning, Coordination of Services

Please refer to the Plan of Correction for:

- L540 Approach to Service Delivery
- L554 Coordination of Services (e)(1)
- L556 Coordination of Services (e)(3)
- L557 Coordination of Services (e)(4)
- L558 Coordination of Services (e)(5)

Allegation of Compliance Date: 03/04/2016

L540 418.56 (a)(1) Approach to Service Delivery

Plan: 2/1/2016

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.

Governing Body Approval: 2/2/2016

The corrective action plan for the plan of correction was presented and approved by the Governing body.

Policy Review completed by 02/25/2016

A review of policies:

- Service Delivery 1.0: Scope of Services
- Service Delivery 5.0: Coordination of Services
- Service Delivery 10.0: Client Reassessment/Recertification
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal regulations.

(See Attachment SD 1.0, SD 5.0, SD 10.0, SD 14.0)

Inservice/Staff Education: Defensible Documentation/Requirements for Care.

Nampa: 2/8/2016

Twin Falls: 2/15/2016

Fruitland and weekend nurse: 2/19/2016

Additional staff not available on date of original training: 2/26/2016

Inservicing and Staff education provided by Ingrid Rich, RN, Clinical Operations, occurred at all locations for this Hospice provider number related to the requirements of care and the documentation associated with that care. Topics included but were not limited to:

- Medicare COP requirements
- Hospice eligibility
- Progression of disease documentation
- SOAP notes
- IDG meeting requirements
- Coordination of care
- Professional management of patient care
- Comprehensive assessment
- Need for ongoing reassessment and plan of care revision.

(See Attachments 1 and 5)

Follow up training, Reinforcement of training, Q and A's and examples of requirements: 2/9/2016

Follow up education was provided following the IDG related to the extensive training provided on the previous day. The training was provided by the Branch Director and the Administrator. The requirements and expectations were reinforced, Q and A's were addressed and examples of situational experiences were provided to give a better understanding of the ongoing expectations.

(See Attachment 6)

Education/Inservicing related to updating the plan of care due to an update in the Comprehensive Assessment: 2/9/2016-2/19/2016

Training provided on a one on one basis for all skilled disciplines to provide guidance and direction on appropriately updating the patient's plan of care to assure that it reflects all changes to the patient's condition when updating the patient's comprehensive assessment. Ingrid Rich, RN, Clinical Operations, provided patient specific education and oversight to assist the clinicians in understanding how to update the plan of care to reflect the issues currently being addressed with the patient. All updates to the plans of care, review of the updates, request for and completion of any needed revisions will be completed by 3/4/2016.

Performance Improvement Plan: Coordination of Care, IDG meeting 2/8/2016

A Performance Improvement Plan was completed and implemented to assure appropriate approach to service delivery. The plan included interventions to assure proper coordination of care, assure appropriate coverage when the case manager is not available, to assure that documentation supports the required care coordination, to assure the plan of care is appropriately updated, and to assure that all information is appropriately reflected in the IDG note showing the issues were discussed at IDG and a plan was formulated.

- The training, implementation and follow up related to appropriate care coordination.
- The training, implementation and follow up related to updating the plan of care to reflect the current needs of the patient.
- The training, implementation and follow up related to appropriately discussing and documenting the patient's status and the plan related to any changes in the patient's condition or treatment at IDG and in the IDG note.
- The training, implementation and follow up related to a best practice action in assuring coordination of care between the Hospice agency and patient's residing in Assisted Living Facilities.

(See Attachment 4)

Performance Improvement Plan: After Hours Care 2/8/2016

A Performance Improvement Plan was completed and implemented to assure appropriate response to and follow up of any after hour calls. The plan details the plan to assure a proper response to all after hour calls, the completion of any appropriate follow up visits, coordination with the appropriate IDG members, and a plan for interventions to assist with calls that were preventable.

- The on call was reviewed and revised as needed to assure ongoing RN coverage.
- The RN case managers will be notified each morning of all patient calls during afterhours, provide follow up to ensure patient needs are addressed and documentation of actions performed.
- The IDG team was educated on Patient Rights, responsibility for 24/7 availability of services.
- Review and follow up to after hour calls to be performed to assure that the appropriate follow up was completed.
- Calls to all patients on Thursday/Friday to determine any needs that require addressing to prevent emergent needs over the weekend.

(See Attachment 2)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or their designee, with weekly chart audits to assure proper documentation and follow up to any new or identified issues along with onsite supervision of the preparation for, the participation in, and the documentation of the IDG process. Assurance that these items are addressed, completed and followed up on an ongoing basis will be reviewed by the Regional Administrator with the attendance to and review of compliance to the new IDG process on at least a quarterly basis along with onsite supervision of and monitoring of the other items detailed in the plan.

Allegation of Compliance Date: 03/04/2016

L554 418.56 (e)(1) Coordination of Services.

Plan: 2/1/2016

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.

Governing Body Approval: 2/2/2016

The corrective action plan for the plan of correction was presented and approved by the Governing body.

Policy Review completed by 02/25/2016

A review of policies:

- Service Delivery 1.0: Scope of Services
 - Service Delivery 5.0: Coordination of Services
 - Service Delivery 14.0: Clinical Records
- were completed to confirm compliance to federal regulations.
(See Attachment SD 1.0, SD 5.0, SD 14.0)

Performance Improvement Plan: Coordination of Care, IDG meeting 2/8/2016

A Performance Improvement Plan was completed and implemented to assure appropriate approach to service delivery. The plan included interventions to assure proper coordination of care, assure appropriate coverage when the case manager is not available, to assure that documentation supports the required care coordination, to assure the plan of care is appropriately updated, and to assure that all information is appropriately reflected in the IDG note showing the issues were discussed at IDG and a plan was formulated.

- The training, implementation and follow up related to appropriate care coordination.
- The training, implementation and follow up related to updating the plan of care to reflect the current needs of the patient.
- The training, implementation and follow up related to appropriately discussing and documenting the patient's status and the plan related to any changes in the patient's condition or treatment at IDG and in the IDG note.
- The training, implementation and follow up related to a best practice action in assuring coordination of care between the Hospice agency and patient's residing in Assisted Living Facilities.

(See Attachment 4)

Inservice/Staff Education: Defensible Documentation/Requirements for Care.

Nampa: 2/8/2016

Twin Falls: 2/15/2016

Fruitland and weekend nurse: 2/19/2016

Additional staff not available on date of original training: 2/26/2016

Inservicing and Staff education provided by Ingrid Rich, RN, Clinical Operations, occurred at all locations for this Hospice provider number related to the requirements of care and the documentation associated with that care. Topics included but were not limited to:

- Medicare COP requirements
- Hospice eligibility
- Progression of disease documentation
- SOAP notes
- IDG meeting requirements
- Coordination of care
- Professional management of patient care
- Comprehensive assessment
- Need for ongoing reassessment and plan of care revision.

(See Attachments 1 and 5)

Follow up training, Reinforcement of training, Q and A's and examples of requirements: 2/9/2016

Follow up education was provided following the IDG related to the extensive training provided on the previous day. The training was provided by the Branch Director and the Administrator. The requirements and expectations were reinforced, Q and A's were addressed and examples of situational experiences were provided to give a better understanding of the ongoing expectations.

(See Attachment 6)

Education/Inservicing related to updating the plan of care due to an update in the Comprehensive Assessment: 2/9/2016-2/19/2016

Training provided on a one on one basis for all skilled disciplines to provide guidance and direction on appropriately updating the patient's plan of care to assure that it reflects all changes to the patient's condition when updating the patient's comprehensive assessment. Ingrid Rich, RN, Clinical Operations, provided patient specific education and oversight to assist the clinicians in understanding how to update the plan of care to reflect the issues currently being addressed with the patient. All updates to the plans of care, review of the updates, request for and completion of any needed revisions will be completed by 3/4/2016.

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or their designee, with weekly chart audits to assure proper documentation and follow up to any new or identified issues along with onsite supervision of the preparation for, the participation in, and the documentation of the IDG process. Assurance that these items are addressed, completed and followed up on an ongoing basis will be reviewed by the Regional Administrator, with the attendance to and review of compliance to the new IDG process on at least a quarterly basis along with onsite supervision of and monitoring of the other items detailed in the plan.

Allegation of Compliance Date: 03/04/2016

L556 418.56 (e)(3) Coordination of Services.

Plan: 2/1/2016

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.

Governing Body Approval: 2/2/2016

The corrective action plan for the plan of correction was presented and approved by the Governing body.

Policy Review completed by 02/25/2016

A review of policies:

- Service Delivery 5.0: Coordination of Services were completed to confirm compliance to federal regulations. (See Attachment SD 5.0)

Performance Improvement Plan: Coordination of Care, IDG meeting 2/8/2016

A Performance Improvement Plan was completed and implemented to assure appropriate coordination of care with all required entities included in the patients care, including the patients family. The plan included interventions to assure proper coordination of care and to assure that the documentation supports the required care coordination, to assure the plan of care is appropriately updated, and to assure that all information is appropriately reflected in the IDG note showing the issues were discussed at IDG and a plan was formulated.

- The training, implementation and follow up related to appropriate care coordination.
- The training, implementation and follow up related to updating the plan of care to reflect the current needs of the patient.
- The training, implementation and follow up related to appropriately discussing and documenting the patient's status and the plan related to any changes in the patient's condition or treatment at IDG and in the IDG note.
- The training, implementation and follow up related to a best practice action in assuring coordination of care between the Hospice agency and patient's residing in Assisted Living Facilities.

(See Attachment 4)

Inservice/Staff Education: Defensible Documentation/Requirements for Care.

Nampa: 2/8/2016

Twin Falls: 2/15/2016

Fruitland and weekend nurse: 2/19/2016

Additional staff not available on date of original training: 2/26/2016

Inservicing and Staff education provided by Ingrid Rich, RN, Clinical Operations, occurred at all locations for this Hospice provider number related to the requirements of care and the documentation associated with that care. Topics included but were not limited to:

- Medicare COP requirements
- Hospice eligibility
- Progression of disease documentation
- SOAP notes
- IDG meeting requirements
- Coordination of care
- Professional management of patient care
- Comprehensive assessment
- Need for ongoing reassessment and plan of care revision.

(See Attachments 1 and 5)

Follow up training, Reinforcement of training, Q and A's and examples of requirements: 2/9/2016

Follow up education was provided following the IDG related to the extensive training provided on the previous day. The training was provided by the Branch Director and the Administrator. The requirements and expectations were reinforced, Q and A's were addressed and examples of situational experiences were provided to give a better understanding of the ongoing expectations.

(See Attachment 6)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or their designee, with weekly chart audits to assure proper documentation and follow up to any change in the patient's condition is appropriately coordinated with the family when appropriate. Assurance that these items are addressed, completed and followed up on an ongoing basis will be reviewed by the Regional Administrator, by assuring that the auditing of the records are occurring and any appropriate follow up has been achieved.

Allegation of Compliance Date: 03/04/2016

L557 418.56 (e)(4) Coordination of Services.

Plan: 2/1/2016

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.

Governing Body Approval: 2/2/2016

The corrective action plan for the plan of correction was presented and approved by the Governing body.

Policy Review completed by 02/25/2016

A review of policy:

- Service Delivery 5.0: Coordination of Services were completed to confirm compliance to federal regulations. (See Attachment SD 5.0)

Performance Improvement Plan: Coordination of Care, IDG meeting 2/8/2016

A Performance Improvement Plan was completed and implemented to assure appropriate coordination of care with the physician for all changes in the plan of care or changes requiring the guidance and direction of a physician. The plan included interventions to assure proper coordination of care and to assure that the documentation supports the required care coordination, to assure the plan of care is appropriately updated, and to assure that all information is appropriately reflected in the IDG note showing the issues were discussed at IDG and a plan was formulated.

- The training, implementation and follow up related to appropriate care coordination.
- The training, implementation and follow up related to updating the plan of care to reflect the current needs of the patient.
- The training, implementation and follow up related to appropriately discussing and documenting the patient's status and the plan related to any changes in the patient's condition or treatment at IDG and in the IDG note.
- The training, implementation and follow up related to a best practice action in assuring coordination of care between the Hospice agency and patient's residing in Assisted Living Facilities.

(See Attachment 4)

Inservice/Staff Education: Defensible Documentation/Requirements for Care.

Nampa: 2/8/2016

Twin Falls: 2/15/2016

Fruitland and weekend nurse: 2/19/2016

Additional staff not available on date of original training: 2/26/2016

Inservicing and Staff education provided by Ingrid Rich, RN, Clinical Operations, occurred at all locations for this Hospice provider number related to the requirements of care and the documentation associated with that care. Topics included but were not limited to:

- Medicare COP requirements
- Hospice eligibility
- Progression of disease documentation
- SOAP notes
- IDG meeting requirements
- Coordination of care
- Professional management of patient care
- Comprehensive assessment
- Need for ongoing reassessment and plan of care revision.

(See Attachment 1 and 5)

Follow up training, Reinforcement of training, Q and A's and examples of requirements: 2/9/2016

Follow up education was provided following the IDG related to the extensive training provided on the previous day. The training was provided by the Branch Director and the Administrator. The requirements and expectations were reinforced, Q and A's were addressed and examples of situational experiences were provided to give a better understanding of the ongoing expectations.

(See Attachment 6)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or their designee, with weekly chart audits to assure proper documentation and follow up to any change in the patient's condition is appropriately coordinated with the physician. Assurance that these items are addressed, completed and followed up on an ongoing basis will be reviewed by the Regional Administrator, by assuring that the auditing of the records are occurring and any appropriate follow up has been achieved.

Allegation of Compliance Date: 03/04/2016

L558 418.56 (e)(5) Coordination of Services.

Plan: 2/1/2016

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.

Governing Body Approval: 2/2/2016

The corrective action plan for the plan of correction was presented and approved by the Governing body.

Policy Review completed by 02/25/2016

A review of policy:

- Service Delivery 5.0: Coordination of Services was completed to confirm compliance to federal regulations. (See Attachment SD 5.0)

A review of policy:

- Service Delivery 2.0: Admissions/Client Assessment was completed and it was determined that a revision needed to occur in order to better align with the Medicare federal requirements. The revision was completed on 2/26/2016, approved by the governing body and implemented with the staff by 3/1/2016. (See Attachment SD 2.0)

Performance Improvement Plan: Coordination of Care, IDG meeting 2/8/2016

A Performance Improvement Plan was completed and implemented to assure appropriate coordination of care with the Assisted Living Facility is conducted with any pertinent changes in the plan of care. The plan included interventions to assure proper coordination of care and to assure that the documentation supports the required care coordination, to assure the plan of care is appropriately updated, and to assure that all information is appropriately reflected in the IDG note showing the issues were discussed at IDG and a plan was formulated.

- The training, implementation and follow up related to appropriate care coordination.
- The training, implementation and follow up related to updating the plan of care to reflect the current needs of the patient.
- The training, implementation and follow up related to appropriately discussing and documenting the patient's status and the plan related to any changes in the patient's condition or treatment at IDG and in the IDG note.
- The training, implementation and follow up related to a best practice action in assuring coordination of care between the Hospice agency and patient's residing in Assisted Living Facilities.

(See Attachment 4)

Inservice/Staff Education: Defensible Documentation/Requirements for Care.

Nampa: 2/8/2016

Twin Falls: 2/15/2016

Fruitland and weekend nurse: 2/19/2016

Additional staff not available on date of original training: 2/26/2016

Inservicing and Staff education provided by Ingrid Rich, RN, Clinical Operations, occurred at all locations for this Hospice provider number related to the requirements of care and the documentation associated with that care. Topics included but were not limited to:

- Medicare COP requirements
- Hospice eligibility
- Progression of disease documentation
- SOAP notes
- IDG meeting requirements
- Coordination of care
- Professional management of patient care
- Comprehensive assessment
- Need for ongoing reassessment and plan of care revision.

(See Attachment 1 and 5)

Follow up training, Reinforcement of training, Q and A's and examples of requirements: 2/9/2016

Follow up education was provided following the IDG related to the extensive training provided on the previous day. The training was provided by the Branch Director and the Administrator. The requirements and expectations were reinforced, Q and A's were addressed and examples of situational experiences were provided to give a better understanding of the ongoing expectations.

(See Attachment 6)

Follow up training planned for 3/1/2016 related to "Coordination of Care" form being implemented as a best practice measure to show documented coordination with the Assisted Living Staff in caring for one of their residents. (See Attachment 4)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or their designee, with weekly chart audits to assure proper documentation of coordination of care with Assisted Living Facilities and the coordination of any alterations to the plan of care will also be documented. Assurance that these items are addressed, completed and followed up on an ongoing basis will be reviewed by the Regional Administrator, by assuring that the auditing of the records are occurring and any appropriate follow up has been achieved.

Allegation of Compliance Date: 03/04/2016

L651 418.100(b) Governing Body and Administrator

Please refer to the Plan of Correction for:

- L540 Approach to Service Delivery
- L558 Coordination of Services (e)(5)
- L700 Label Dispose Storage Drugs

Allegation of Compliance Date: 03/04/2016

L700 418.106(e)(3)(ii) Label Dispose Storage Drugs

Plan: 2/1/2016

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.

Governing Body Approval: 2/2/2016

The corrective action plan for the plan of correction was presented and approved by the Governing body.

Performance Improvement Plan: Medication Destruction Documentation 2/17/2016

A Performance Improvement Plan was completed and implemented to assure appropriate compliance to the tracking, acquisition, storage, dispensing, administration, disposal or return of controlled drugs. Part of the plan includes the expectation of an investigation to any discrepancies in any of the before mentioned areas. The PIP includes:

- Implementation of a process to include a weekly accounting of the controlled medications and the documentation of this accounting in the narrative of the clinical note.
- Training regarding the documentation to coordinate with the Assisted Living Facility in relation to the destruction of the controlled medications, as needed.
- Implementation of a medication diversion plan when any discrepancies are identified.

(See attachment 3)

Training for these processes will take place 3/1&2/2016 during the IDG meetings.

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or their designee, with weekly chart audits to assure proper documentation of the tracking of controlled medications and the coordination of destruction of the controlled medications with Assisted Living Facilities. Assurance that these items are addressed, completed and followed up on an ongoing basis will be reviewed by the Regional Administrator, by assuring that the auditing of the records are occurring and any appropriate follow up has been achieved.

Allegation of Compliance Date: 03/04/2016



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 17, 2016

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

Provider #131540

Dear Mr. Schellhous:

An unannounced on-site complaint investigation was conducted from January 26, 2016 to January 29, 2016 at Encompass Home Health & Hospice Of Idaho. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007222

Allegation #1: Hospice nurses are not licensed and the hospice prescribed medication to patients who had allergies to those medications, gave medications against the wishes of patients/guardians, and administered incorrect doses of medications to patients.

Findings #1: Hospice policies, personnel files, and medical records were reviewed and interviews were conducted during a complaint investigation survey conducted on 1/26/16 to 1/29/16.

The personnel files of 8 nurses were reviewed. All 8 files included documentation of current licensure. No nurses were identified who were not currently licensed.

The medical records of 8 patients were reviewed. All of the records listed the medications patients were receiving, as well as patient allergies. None of the records indicated patients were prescribed or received medications to which they had allergies or that patients had received incorrect doses of medications.

Randy Schellhous, Administrator
February 17, 2016
Page 2 of 5

For example, one patient record documented a 92 year old male who was a hospice patient from 10/29/15 until his death on 12/27/15. He resided in an assisted living facility (ALF). His terminal diagnosis was Alzheimers Disease. He also had a diagnosis of unspecified heart disease.

His plan of care stated he was allergic to Dilantin, an anti-seizure medication. No other records indicated he had other allergies. He was prescribed the medication Divalproex for seizures but did not receive Dilantin.

The patient also had routine orders for Sertraline (an antidepressant medication) 0.5 mg (milligram) daily. He also had orders for Haldol (an antipsychotic medication) 1 mg as needed and Morphine 5 mg in individual doses of 0.25 ml (milliliter) of solution. The Haldol and Morphine were supplied in pre-measured doses so the ALF staff did not have to measure the medications.

The patient's record included medication administration records which documented what medications the patient had been given. For example, ALF staff administered 1 dose of Haldol on 12/16/15 and 2 doses of Haldol on 12/17/15. In addition, the hospice RN administered 1 dose (5 mg) of Morphine at approximately 11:30 AM. The Morphine was administered for rapid respirations and other breathing problems. The package insert for oral Morphine stated the recommended dose was 10 to 20 mg every 4 hours as needed for pain.

It could not be determined the patient was given medications he was allergic to or received incorrect doses of medications. However, the patient's record included a progress note by the Registered Nurse (RN), dated 12/15/15 at 11:04 PM, which stated the patient became agitated and the ALF staff requested a medication "...SUCH AS RISPERDAL DAILY FOR EXTREME AGITATION RELATED TO SUNDOWNERS."

On 12/16/15 at 12:55 PM, an order was obtained by the hospice RN for Risperdone, an anti-psychotic medication, 1 mg daily for agitation. A care coordination note by the RN, dated 12/16/15 but not timed, stated the ALF Administrator refused to allow the patient to receive Risperdone in the facility. Seroquel, another antipsychotic medication, was identified as an alternative. The hospice obtained approval from the ALF Administrator and the patient's daughter for the Seroquel. The hospice obtained an order for the Seroquel on 12/17/15 at 12:19 PM. The patient died before the Seroquel was delivered.

The patient's RN was interviewed on 1/27/15 beginning at 9:00 AM. She stated the ALF Administrator did not like certain medications, including Risperdone. She stated the Administrator refused to allow his staff to administer Risperdone to the patient.

Randy Schellhous, Administrator
February 17, 2016
Page 3 of 5

She stated ALF staff was responsible for administering medications. She stated the hospice then obtained an order for Seroquel, another anti-psychotic medication, that the ALF Administrator was agreeable to.

The Hospice Regional Administrator was interviewed on 1/28/16 beginning at 4:20 PM. He stated the agency had not investigated the circumstances around the refusal of the ALF to administer ordered medication to the patient. He stated the agency had not developed a plan in the event that other patients at this ALF were admitted to hospice.

The hospice allowed the ALF administrator to dictate the medical care provided to patients and to override legal orders. Further, the policy "ADMISSIONS/CLIENT ASSESSMENT," revised 3/24/15, stated the admitting nurse "Completes the nursing home notification form or letter of agreement for residential care facilities as needed." The Governing Body did not ensure this policy was followed.

The 8 medical records reviewed documented all 8 patients resided in various ALFs. The hospice did not have a documented agreement with any of the ALFs where these patients resided regarding the roles of each staff. The hospice did not have a documented way to define the roles of the ALF and the hospice in the care of patients.

The Hospice Regional Administrator was interviewed on 1/28/16 beginning at 4:20 PM. He stated the agency did not have agreements with any ALFs where hospice patients resided.

The failure to define the roles of the ALF and the hospice in the care of patients, interfered with the provision of care and coordination with patients and their family members. For example, one patient's record documented a 98 year old male admitted to the agency on 5/06/15 with a terminal diagnosis of coronary atherosclerosis. He died on 8/25/15.

His medication profile included ABHR cream to be applied every 4 hours as needed for anxiety or restlessness. The start date of the medication was 6/23/15. ABHR cream included Ativan, Benadryl, Haldol and Reglan. The patient's record included a physician's verbal order, dated 7/13/15, stating his family wanted to hold the ABHR cream.

The record included an RN visit note, dated 7/14/15 and signed by the RN Case Manager. The note stated the RN spoke with the patient's daughter, who was his legal representative. The note stated his daughter requested the patient's anxiety medications, which were administered as needed, be discontinued. The patient's daughter requested the ALF staff call her when the patient was restless or anxious so she (the patient's daughter) could come to the facility and attempt to relieve the patient's anxiety without medications. The note stated the ALF staff was informed of the daughter's request.

The patient's record did not include an a nursing visit note on 7/15/15 or 7/16/15. There was no documentation of communication with the patient's family after 7/14/15. Information regarding the patient's episodes of anxiety or whether his daughter was able to assist in relieving his anxiety could not be found.

The patient's record included a physician's verbal order, dated 7/16/15, for ABHR cream to be applied to his forearm 3 times a day. The order stated he was having increased agitation. The patient's record did not include documentation of communication with his family regarding the new order for ABHR cream.

During an interview on 1/28/15 at 8:20 AM, the RN Case Manager stated the patient's family expressed concern about his drowsiness and requested the ABHR cream be held, and his daughter be called to calm him down when he was anxious. She stated this was communicated to her on 7/13/15. She was unable to remember whether it was communicated to her by the patient's family or the ALF staff. She confirmed there was no documentation regarding the patient's response when the medication was held or whether his family was called to come to the ALF. She stated that was between the ALF and the family, and did not have anything to do with his hospice care. The RN Case Manager confirmed she did not communicate with the patient's family regarding the resumption of ABHR cream on 7/16/15. She confirmed there was no documentation of communication with his family between 7/13/15 and 8/12/15

The agency failed to ensure communication with the patient's family was maintained and that his care was coordinated with the ALF staff.

The hospice failed to ensure care was coordinated with ALF staff, patients and patient's family members necessary to ensure the needs of the patients and their family members were met. Therefore, the allegation was substantiated and deficient practice was cited at 418.56(e)(3) and 418.56(e)(5).

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: The hospice Medical Director listed an incorrect cause of death on a deceased patient's death certificate.

Findings #2: The filing of death certificates is a legal process and is not addressed by Medicare hospice regulations. The determination of cause of death is likewise not addressed by Medicare hospice regulations. Therefore, this was not investigated due to a lack of regulatory authority.

Conclusion #2: Unsubstantiated. Lack of regulatory authority.

Randy Schellhous, Administrator
February 17, 2016
Page 5 of 5

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,



GARY GILES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/pmt