



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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CERTIFIED MAIL: 7000 1670 0011 3315 1491

March 7, 2016

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

RE: Horizon Home Health & Hospice, Provider #137065

Dear Mr. Higby:

Based on the survey completed at Horizon Home Health & Hospice, on February 19, 2016, by our staff, we have determined the agency is out of compliance with the Medicare Home Health Agency (HHA)

Conditions of Participation:

- **Patient Rights (42 CFR 484.10)**

To participate as a provider of services in the Medicare Program, a HHA 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 Horizon Home Health & Hospice, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

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.

Trevor Higby, Administrator

March 7, 2016

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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;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health agency into compliance, and that the home health agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed, on page 1 of **both the state and federal 2567 forms.**

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **March 21, 2016**. It is suggested that the Credible Allegation of Correction for each Condition of Participation and related standard level deficiencies show compliance no later than **April 4, 2016**, 45 days from survey exit. We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies compliance.

Please note, all references to regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Consistent with the provisions of 42 CFR 488, Alternative Sanctions for Home Health Agencies, the following remedies will be recommended to the Centers for Medicare/Medicaid (CMS) Region X Office:

- Termination 6 months from exit date [42 CFR 488.865]
- Civil Monetary Penalty [42 CFR 488.820(a)]

Please be aware, this notice does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal written notice of that determination.

If the revisit survey of the agency finds one or more of same Conditions of Participation out of compliance, CMS may choose to revise sanctions imposed.

Trevor Higby, Administrator

March 7, 2016

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In accordance with 42 CFR 488.745, you have one opportunity to question the deficiencies that resulted in the Conditions of Participation being found out of compliance through an informal dispute resolution (IDR) process. To be given such an opportunity, you are required to send your written request and all required information as directed in the attached document. This request must be received by **March 21, 2016**. If your request for IDR is received after **March 21, 2016**, the request will not be granted. An incomplete IDR process will not delay the effective date of any enforcement action. If the agency wants the IDR panel to consider additional evidence, the evidence and six (6) copies of the evidence must be received 15 calendar days before the IDR meeting (Refer to page 6 of the attached IDR Guidelines).

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,



SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

SC/pmt

Enclosures

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief

Marie Yamada, CMS Region X Office



HORIZON
HOME HEALTH & HOSPICE
63 W Willowbrook Dr
Meridian, ID 83646

March 18, 2016

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

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MAR 18 2016

FACILITY STANDARDS

Re: Credible Allegation of Compliance/Plan of Correction

Dear Ms. Creswell,

Pursuant to the survey completed at Horizon Home Health on February 19, 2016, please find attached the completed Statement of Deficiencies/Plan of Correction (CMS2567) along with attachments that give further evidence that Horizon Home Health complies with the Conditions of Participation.

As multiple references have been made in the Plan of Correction to the Horizon Home Health and Hospice Onboarding/Orientation Program, I have also included an attestation written by Jan Ireland, as to the content and training she received in this program. She is one of our first "graduates" from this program.

As evidenced in the Plan of Correction and the enclosures, we have and will continue to conduct staff education in each of the deficiencies cited and will continue to maintain evidence of compliance through chart audits and supervisory visits. The enclosures will speak to our compliance with the Conditions of Participation and include:

- Policies and Procedures:
 - Policy 1-010.1 (Revised) Complaint/Grievance Process
 - Policy 9-009 Hand Hygiene
 - Policy 9-014 Bag Technique
 - Policy 9-011 Infection Control
 - Policy 1-014.1 Performance Evaluations
 - Policy 2-018 Care Planning Process



HORIZON
HOME HEALTH & HOSPICE
63 W Willowbrook Dr
Meridian, ID 83646

- Policy 5-006 Entries Into the Clinical Record
- Policy 5-020 Patient Request for PHI
- Attachments:
 - PowerPoint Presentation of Training To Be Conducted in Branches Wk of 3/20/2016
 - New Horizon Home Health & Hospice Orientation Map
 - Branch Visit Notes indicating initial POC training of Branch Leaders
 - Home Health On-Site Supervisory Visit Note
 - Attendance Record of Training of Medical Records Staff on 2/24/16
 - Multidisciplinary Quarterly Clinical Record Review Form
 - Leadership Meeting/Employee Coaching and Discipline (Presented by Tina Ricketts, Cornerstone HR Resource)
 - Attestation of RN Training (Jan Ireland)

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

Please express our appreciation for the professionalism and helpfulness demonstrated by Teresa Hamblin, RN and Rebecca Lara, RN, during the conduction of our survey.

Sincerely,



Trevor Higby
Administrator

Horizon Home Health and Hospice



April 6, 2016

Rebecca Lara, RN
Health Facility Surveyor
Bureau of Facility Standards
PO Box 83720
Boise, ID 83720-0009

RE: Addendum to State Survey Plan of Correction

Dear Ms. Lara,

Per our telephone conversation of 4/6/2016 regarding Federal Tags 176 and 236:

G176- The process to monitor that the registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs will include, but not be limited to:

- Review by the Packet Review Team of 90-100% of submitted Starts of Care including the OASIS and the Plan of Care/485.
- As part of daily workflow, the Clinical Supervisor or RN designee reviews the Clinical Exception Coordination Notes which identify interventions that have not been performed or are outside of established parameters. The Clinical Supervisors contact the clinician for clarification of alerts to ensure proper documentation and follow-up with the physician and other clinicians occurs.
On a daily basis, the Clinical Supervisor/designee reviews/approves subsequent orders for additional services, medication changes and other changes to the home health plan of care.
- Quarterly chart audits will also be performed with results reported to the QA/Performance Improvement Committee with an action plan implementation for items with less than 90% compliance/accuracy.

G236- The process to monitor that that the clinical record system consistently provides accurate information to prevent the potential for inaccuracy of medical records will include, but not be limited to:

- Review by the Packet Review Team of 90-100% of submitted Starts of Care including the OASIS and the Plan of Care/485.
- As part of daily workflow, the Clinical Supervisor or RN designee reviews the Clinical Exception Coordination Notes which identify interventions that have not been performed or are outside of established parameters. The Clinical Supervisors contact the clinician for clarification of alerts to ensure proper documentation and follow-up with the physician and other clinicians occurs.



On a daily basis, the Clinical Supervisor/designee reviews/approves subsequent orders for additional services, medication changes and other changes to the home health plan of care.

- Quarterly chart audits will also be performed with results reported to the QA/Performance Improvement Committee with an action plan implementation for items with less than 90% compliance/accuracy.

Thank you for affording us the opportunity to clarify these processes. Should you have further questions, concerns or suggestions of how we can best become/remain in compliance with the Conditions of Participation, please do not hesitate to contact me.

Respectfully submitted for your review,

Carrie Birch, RN
Director of Nursing-Home Health
Horizon Home Health & Hospice

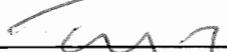
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/19/2016
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NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 63 WEST WILLOWBROOK DR MERIDIAN, ID 83646
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G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation survey of your home health agency on 2/16/16 through 2/19/16.</p> <p>The surveyors conducting the complaint investigation survey were:</p> <p>Teresa Hamblin, RN, MS, HFS - Team Lead Rebecca Lara, RN, BA, HFS</p> <p>Acronyms used in this report include:</p> <p>apt - Appointment CDC - Centers for Disease Control CFR - Code of Federal Regulations CHF - Congestive Heart Failure CM - Case Manager DON - Director of Nursing HH - Home Health HHA - Home Health Agency HR - Human Resources HTN - Hypertension IDAPA - Idaho Administrative Procedures Act lbs - pounds MD - Medical Doctor LPN - Licensed Professional Nurse PHI - Protected Health Information POC - Plan of Care pt - Patient RN - Registered Nurse SOC - Start of Care wnd - Wound</p>	G 000		
G 100	<p>484.10 PATIENT RIGHTS</p> <p>This CONDITION is not met as evidenced by: Based on observation, review of patient records,</p>	G 100		

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	3/17/16

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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G 100	Continued From page 1 complaint documentation, and agency policies, and interviews with staff, patients, family members and care givers, it was determined the agency failed to ensure patient/family member complaints were investigated and resolved, patients were allowed to participate in care planning, and medical records were provided to patients in a timely manner. Findings include: 1. Refer to G107 as it relates to the failure of the agency to ensure patient complaints and grievances were thoroughly investigated and resolved. The cumulative effect of these systemic failures impeded the ability of the agency to protect the rights and safety of patients. 484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint. This STANDARD is not met as evidenced by: Based on review of agency policy, complaint documentation, patient rights information, personnel files, and staff and patient/family/caregiver interview, it was determined the agency failed to investigate complaints or document the existence,	G 100	G107-The agency will ensure that the patient/family member's complaints are investigated and resolved, patients are allowed to participate in care planning and medical records are provided to patients in a timely manner. The Clinical Supervisors for Meridian and Caldwell branches were counseled on 3/2/16 regarding the complaints registered by patients #2, #3, #4, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20. Policy change: Complaint/Grievance Process [Revised Policy No.1-010.1] Procedure change: The direct-care field staff will be educated that the Clinical Supervisor or Branch Director will be notified within 24 working hours of alleged grievances. The Clinical Supervisor or Branch Manager will investigate the grievance within 2 working days and respond to the patient within 10 working days of receiving the complaint, or sooner, if the investigation is complete, verbally or in writing. If the grievance cannot be resolved to the patient's satisfaction, the patient, the caregiver, the Clinical Supervisor or DON will notify the Executive Director/Administrator who will then investigate the grievance and contact	G-100 Completion 4/11/16 per DON on 4/16/16 RL

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G 107	<p>Continued From page 2</p> <p>investigation, and/or resolution of, patient/family member complaints for 13 of 16 patients (#2, #3, #4, #11, #12, #13, #14, #15, #16, #17, #18, #19, and #20) whose complaints were reviewed. This precluded the agency from taking appropriate corrective actions and interfered with patient satisfaction. Findings include:</p> <p>The agency's undated policy, "Complaint/Grievance Process," was reviewed. It included the following information:</p> <p>* "If the grievance cannot be resolved to the patient's satisfaction, the patient or his/her representative may notify the Executive Director/Administrator. The Clinical Supervisor or Director of Nursing may also notify the Executive Director/Administrator of the unresolved grievance. The Executive Director/Administrator or designee will then investigate the grievance and contact the patient or his/her representative regarding the grievance in an attempt to resolve the differences. The Executive Director/Administrator will respond to the patient within ten (10) days of notification of failure to resolve the complaint."</p> <p>* "Complaints and any action taken will be documented on a complaint log."</p> <p>* "Corrective action will be specific and related to the complaint."</p> <p>* "Resolution information will be communicated verbally or in writing to the patient or his/her representative filing the complaint."</p> <p>* "All complaints will be logged and investigated."</p>	G 107	<p>the patient/patient representative in an attempt to resolve the differences.</p> <p>Education Provided: One-on-one education of Leadership staff on policy changes/complaint/grievance process provided by Director of Operations and DON week of 2/28/16 in all branches. (Attendance role attached)</p> <p>A Clinical Supervisor training program will be developed including, but not limited to a review of the complaint policy and procedure and performance management training by June 30, 2016.</p> <p>Effective 3/21/2016, the Horizon Onboarding Program will include specific education on "Reporting Patient Complaints".</p> <p>Current full time nurses and therapists will be educated by members of the Horizon Leadership Team, on site, on revised policy via PowerPoint presentation of timely and thorough investigation process of patient complaints. Part time/PRN staff will be provided copies of education handouts.</p> <p>Director of Nursing will review "Patient Complaint" workflow weekly to ensure</p>	

compliance with investigation timelines

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G 107	<p>Continued From page 3</p> <p>The "Patient Information Booklet" was reviewed. It included a page, "Statement of Patient Rights and Responsibilities." This page included the following information:</p> <p>"All patients receiving home health services possess basic rights and responsibilities and the right to receive services regardless of age, race, sex, color religion, national origin or disability in compliance with 45 CFR parts 80, 84, 91. These include: The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or the lack of respect for the patient's property by anyone furnishing services on behalf of the Agency and must document both the existence and the resolution of the complaint."</p> <p>1. The agency's complaint log for 11/01/15 - 2/16/16 was reviewed. The log documented the existence of five complaints. Four out of the five complaints were filed against RN A. The agency's complaint policies and procedures were not followed. Examples include:</p> <p>a. The complaint log included documentation of a complaint from Patient #4, dated 1/04/16. It was received by telephone from Patient #4. Patient #4 alleged RN A did not take her vital signs or adequately assess her condition during a visit on 12/31/15. She reported being taken to the hospital by ambulance, after RN A's visit, and admitted with sepsis.</p> <p>Complaint documentation indicated RN A was interviewed, and he stated he took Patient #4's vital signs. Documentation also indicated RN A stated Patient #4 appeared to be in her normal</p>	G 107	<p>and proper follow through by Clinical Supervisors/Branch Managers.</p> <p>Responsible: Director of Nursing or designee has overall responsibility for the corrective action and ongoing completion of this deficiency.</p> <p>Completion: 4/11/2016 and ongoing</p>	

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G 107	<p>Continued From page 4</p> <p>state of health. The complaint documentation stated no changes were made to RN assignments "due to pt changed agency."</p> <p>An email, dated 1/05/16 at 10:14 AM, that was not included in the complaint file, was reviewed. It was written by the DON and sent to the RN Clinical Supervisor. It indicated the DON spoke with Patient #4 on 1/04/16. The email included the following information:</p> <p>"I called her yesterday and listened to her tell me over and over that [RN A] did not take her vitals and that he "just left me there to die." She also stated over and over that he left her sitting there because she was so out of it and did not respond promptly to his questions. She indicated that her son's caregiver was there and told her that [RN A] did not take her vitals, and that when she didn't respond, he just "took off". She indicated that she was going to contact the Board of Nursing. I also told her that we would have a conversation with [RN A] about this and let him know that she selected a different agency because of his actions. But I also told her that I could not share with her if there was any action taken with [RN A] because it would then be a personnel issue and those are confidential. I would like you, today, to contact all of the patients on [RN A's] schedule from yesterday, who are cognitively intact, and ask if he took their vital signs."</p> <p>An email response from the RN Clinical Supervisor to the DON was dated 1/05/16 at 3:06 PM. It included the following information: "I have contacted 8 patients from yesterday to 12/23 and asked if they were satisfied with our services and I then asked if vital signs were taken at all of our visits. All responses were positive with services</p>	G 107		
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G 107	<p>Continued From page 5</p> <p>provided and all but 1 said vital signs were taken at all visits." The communication continued to say Patient #12 alleged that RN A and an aide did not take vital signs.</p> <p>Patient #4 was interviewed by telephone on 2/18/16 at 9:40 AM. She stated that during RN A's home visit on 12/31/15, she had nausea, goose bumps, and chills and that RN A did not take her vital signs and kept telling her to wake up. She stated her son, and her son's caregiver, who was identified as a paramedic, were present during the visit. She stated that after RN A left, her son's caregiver, the individual identified as a paramedic, told her later that something was wrong, and they contacted Patient #4's daughter-in-law, who called for an ambulance. Upon the ambulance's arrival, her temperature was 104 F. Patient #4 stated she had complained repeatedly over the course of several months about RN A and his lack of nursing care, and her wish that he not be sent back. She stated "he never took my vital signs." She stated she had been pleased with the care she had received by another nurse before the agency switched nurses. She stated they kept sending RN A even after she requested they not do so. She provided contact information and verbal permission to speak with her daughter-in-law and the paramedic caregiver who was present during the agency's home visit on 12/31/15.</p> <p>The paramedic caregiver who was present in Patient #4's home during the 12/31/15 agency visit was interviewed by telephone on 2/18/16 at 10:49 AM. He stated he was in the same room as Patient #4 during the visit. He stated RN A became aggravated with Patient #4 because she was not answering his questions. He did not take</p>	G 107		

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G 107	<p>Continued From page 6</p> <p>her vital signs and left abruptly. The paramedic caregiver stated he knew something was wrong with Patient #4 because she was lethargic and not communicating well or able to answer RN A's questions. He stated Patient #4 was typically "loud and opinionated" and it was not normal for her not to respond. He stated she was not alert to person, place or time. He described her as slumped over in her wheelchair. He stated that after RN A left, he told Patient #4's son, that something was not right and Patient #4 needed to go to the hospital. As a result, Patient #4's son called Patient #4's daughter-in-law, who in turn, called an ambulance.</p> <p>Patient #4's daughter-in-law was interviewed by telephone on 2/18/16 at 10:34 AM. She stated she received a telephone call on 12/31/15 from the paramedic caregiver who was present in Patient #4's home during the agency's home visit. She stated she came right over and found Patient #4 "incoherent" and she could see she had goose bumps and was shaking. She called 911, and soon after, an ambulance arrived. She stated after the ambulance arrived and was en route to the hospital, she contacted the agency and they routed her to RN A, who reported Patient #4's vital signs as normal. She also stated she provided in-home care for Patient #4 three days per week, and she had been present on many visits when the agency was providing services, including the RN Case Manager and RN A. She stated she heard Patient #4 complain to the RN Case Manager about RN A and requested the agency not send him back. She also stated RN A did not take vital signs, except "about once in a dozen visits." She stated that Patient #4 was told that she had been assigned the nurses she had.</p>	G 107		

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G 107	<p>Continued From page 7</p> <p>Patient #4's record was reviewed. She was a 54 year old female admitted to the agency on 11/20/14. She was receiving care related to diabetes and wound care. A nursing visit, dated 12/31/15, documented her vital signs were taken between 2:57 and 2:58 PM. The visit concluded at 2:59 PM. The visit note included:</p> <p>* Vital signs: Temporal temperature: 99; Radial pulse: 84; Respirations: 18; Blood pressure: 128/86</p> <p>* Oxygen saturation level: 92 %</p> <p>* Neurologic: Alert, oriented to person, oriented to time, able to follow multi-step commands, able to follow simple commands, oriented to place</p> <p>* Narrative: "Brief synopsis of pts current condition: Pt very irritable on arrival, complaining of early arrival for wnd care, smoking on arrival, room very warm. Pt states being cold. Pt afebrile {sic} at time of assessment, VSS. Pt Remains Non-complaint with DM Management, diet, insulin use, wnd debridement preformed {sic} at wnd clinic yesterday. Wnd care provided per orders. Pt tolerated procedure well. Pt complaining of frequent chills. Advised to drink plenty of fluids."</p> <p>An ambulance report for Patient #4, dated 12/31/15 at 3:51 PM, was reviewed. It included, but was not limited to, the following documentation:</p> <p>* Vital signs: Temperature 104.4; Blood pressure 140/90; Heart rate 106; Respiratory Rate; 20</p> <p>* Blood glucose: 294</p>	G 107		
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G 107	<p>Continued From page 8</p> <p>A hospital "Critical Care Consultation," for Patient #4, dated 12/31/15, was reviewed. It stated Patient #4 was admitted to the Intensive Care Unit with "severe sepsis."</p> <p>Investigative documentation related to Patient #4's complaint was limited. Patient #4's son and daughter-in-law, and the paramedic caregiver, were not contacted to provide information on what they knew and witnessed. There was no documentation as to whether allegations were, or were not, substantiated, or whether there was follow-up with Patient #4. The email communication provided for surveyor review was not part of the complaint investigation information.</p> <p>The DON was interviewed on 2/18/16 at 1:25 PM. She stated she did not feel it was necessary to circle back around with Patient #4, since she was no longer a current patient with the agency.</p> <p>Additional complaints from Patient #4 were not recognized or addressed consistent with agency policies. Examples include:</p> <ul style="list-style-type: none"> * Patient #4's RN Case Manager, RN C, was interviewed on 2/16/16 at 2:57 PM. She stated Patient #4 "always complained." * A visit note report, dated 11/27/15, by RN A, documented " Pt with multiable [sic] complaints today, many different subjects expressed." There was no documentation to describe the complaints in the clinical record or in a complaint log. <p>RN A was interviewed on 2/17/15 beginning at 3:18 PM. When asked what the nature of the complaints were, he stated Patient #4 complained chronically, usually about staff showing up at the</p>	G 107		
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G 107	<p>Continued From page 9</p> <p>wrong time, or being unhappy with the type of supplies being used with her wound care, or "one thing or another."</p> <p>* The DON was interviewed on 2/17/16 at 9:25 AM. She stated Patient #4 made so many complaints, that a psychiatric referral was made to set boundaries.</p> <p>* A "Client Coordination Note Report," written by a psychiatric nurse, dated 12/02/15, was reviewed. It stated "I made an apt with pt and began admission paperwork. Pt had many comments and complaints about various people - I didn't engage her or argue. I just changed the subject and asked the next question. By the end of the visit she decided that since she was working with [name] she didn't need anyone to help with her depression. So this is a non-admit note."</p> <p>The psychiatric nurse who wrote the coordination note, RN D, was interviewed on 2/17/16 at 9:25 AM. The DON was also present during the interview. RN D, described Patient #4 as generally accusatory, polarizing staff, angry, demanding, impatient and intolerant. When asked for examples of the "many comments and complaints about various people" she offered one complaint, about staff not arriving for home visits on time. When asked if Patient #4's complaints were addressed or entered into the complaint log, she stated they were not addressed because it was her role to set boundaries. She stated she did talk with the RN Clinical Supervisor and the RN Case Manager, RN C about Patient #4 and that she notified Patient #4's physician as to why she would not be seeing Patient #4 for further visits.</p>	G 107		
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G 107	<p>Continued From page 10</p> <p>* The Clinical Supervisor was interviewed on 2/19/16 at 1:05 PM. She stated the RN C got Patient #4's permission to allow RN A to provide care. No documentation was provided during the survey to verify this occurred.</p> <p>A written statement was received 2/23/16, 2 working days after the survey exit date of 2/19/16, from Patient #4's Case Manager, RN C. The document included RN C's signature, however, did not include a date. The statement included, but not limited to, the following:</p> <p>"As the case manager I was requested by [Patient #4] to change nurses on many occasions. At first I had [RN A] as a back up to help with her visits. She then said that she no longer wanted [RN A] to come (some of the reasons she gave for not wanting [RN A] were, he wouldn't sit on the floor to do her wound care like I did and asked her to put her foot of [sic] the stool or couch; He didn't bring the supplies she wanted; he didn't call soon enough; he wasn't always able to do early visits)."</p> <p>There was no documentation that Patient #4's complaints to RN C, her case manager, were identified as complaints, investigated, and resolved.</p> <p>b. The log documented a complaint, dated 1/13/16, received by telephone from Patient #2. The complaint alleged RN A was unprofessional and not prepared for the home visit, lacking a stethoscope, and not assessing his hip incision and dressing during a home visit.</p> <p>Complaint documentation indicated the RN</p>	G 107		
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G 107	<p>Continued From page 11</p> <p>Clinical Supervisor counseled RN A on improving organization skills, being better prepared for the visit, and working with the clinical team lead to improve how he was perceived by clients. It also indicated another RN was assigned to care for Patient #2.</p> <p>No specific investigation was documented, indicating whether the complaints were or were not substantiated. There was no documentation to indicate resolution of the complaint was communicated verbally, or in writing, to the patient or his/her representative filing the complaint, or whether the patient's level of satisfaction had been assessed with the interventions that were taken.</p> <p>The complaint process for Patient #2 was incomplete.</p> <p>c. The log documented a complaint from Patient #3, dated 1/12/16. It was received 12/14/15, by Patient #3's RN Case Manager, RN C. The complaint alleged RN A rushed through the home visit, spending only ten minutes total and not taking vital signs.</p> <p>Complaint documentation indicated RN C discussed Patient #3's complaints with the RN Clinical Supervisor and RN A. It also indicated RN A was instructed to take vital signs at every visit and spend adequate time with clients.</p> <p>No specific investigation was documented stating whether the allegations were or were not substantiated. There was no documentation to indicate resolution of the complaint was communicated verbally or in writing to the patient or his/her representative filing the complaint or</p>	G 107		
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G 107	<p>Continued From page 12</p> <p>whether the patient's level of satisfaction had been assessed with the interventions that were taken.</p> <p>The complaint process for Patient #3 was incomplete.</p> <p>2. A personnel file was reviewed for RN A. A "Verbal Coaching," dated 6/26/15, indicated RN A was an LPN at the time of the coaching and was in his third month of employment with the agency.</p> <p>The following seven complaints from patients/families were documented in RN A's personnel file:</p> <p>a. Patient #11's family alleged the nurse "did not seem to know anything about the patient or her medications. He encouraged the patient to drink 8 bottles of water when she has a diagnosis of CHF and has fluid restrictions. Please do not send him back."</p> <p>There was no documentation Patient #11's complaint was investigated or resolved. The complaint was not included on a complaint log.</p> <p>b. Patient #12's daughter alleged RN A did not clean up after himself. She did not want him to return.</p> <p>There was no documentation Patient #12's complaint was investigated or resolved. The complaint was not included on the agency's complaint log.</p> <p>c. Patient #13 reported he had not seen RN A clean his hands or equipment.</p>	G 107		

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G 107	<p>Continued From page 13</p> <p>There was no documentation Patient #13's complaint was investigated or resolved. The complaint was not included on a complaint log.</p> <p>d. Patient #14 requested RN A not be allowed to return. "No reason given."</p> <p>There was no documentation that agency staff contacted or visited Patient #14 to determine the reason(s) Patient #14 did not want RN A to return. There was no documentation the complaint was investigated or resolved. The complaint was not included on a complaint log.</p> <p>e. Patient #15 requested RN A not be allowed to return. "No reason given."</p> <p>There was no documentation that agency staff contacted or visited Patient #15 to determine the reason(s) Patient #15 did not want RN A to return. There was no documentation the complaint was investigated or resolved. The complaint was not included on a complaint log.</p> <p>f. Patient #16 requested RN A not be allowed to return because he "scares her."</p> <p>There was no documentation Patient #16's complaint was investigated or resolved. The complaint was not included on a complaint log.</p> <p>g. Patient #17 complained regarding RN A's wound care procedure.</p> <p>There was no documentation Patient #17's complaint was investigated or resolved. The complaint was not included on a complaint log.</p> <p>The DON was interviewed on 2/17/16 at 1:30 PM.</p>	G 107		
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G 107	<p>Continued From page 14</p> <p>She stated that the complaints referenced in the employee file were not entered into the complaint log, and no formal investigation was conducted. She stated RN A, was an LPN in another branch of the agency at the time, and the meeting to discuss the complaints was an informal, verbal coaching. Documentation of the verbal coaching session was provided during the interview and reviewed.</p> <p>3. Three additional complaints regarding RN A were received after 6/26/15. They include the following:</p> <p>a. In a complaint, dated 6/29/15, Patient #18 alleged RN A did not clean his wound thoroughly, and grabbed and squeezed his neck when applying a bandage, causing him discomfort. He requested RN A not return to his home.</p> <p>Complaint documentation indicated the complaints were discussed with RN A and that RN A would not return to Patient #18's home. There was no documentation to indicate whether the allegations were or were not substantiated, or whether resolution of the complaint was communicated verbally or in writing to the patient. Additionally, there was no documentation identifying his/her representative filing the complaint or whether the patient's level of satisfaction had been assessed with the interventions that were taken.</p> <p>b. In a complaint, dated 10/22/15, Patient #19 alleged RN A "told her to take Advil for pain." Patient #19 said "she got Advil, and her son read later it's contraindicated with blood thinner which she was on."</p>	G 107		

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G 107	<p>Continued From page 15</p> <p>Complaint documentation indicated RN A was interviewed, and he was advised to talk with the physician prior to making suggestions on medication, and that the physician must order the medication first.</p> <p>There was no documentation to indicate whether the resolution of the complaint was communicated verbally or in writing to the patient or his/her representative filing the complaint. Additionally, there was no documentation indicating whether the patient's level of satisfaction had been assessed regarding the interventions that were taken.</p> <p>c. In a complaint, dated 10/15/15, Patient #20 alleged RN A did not call ahead before showing up for a visit.</p> <p>Complaint documentation indicated a conversation took place with RN A regarding the complaint. There was no documentation to indicate resolution of the complaint was communicated verbally or in writing to the patient or his/her representative filing the complaint. Additionally, there was no documentation indicating whether the patient's level of satisfaction had been assessed regarding the interventions that were taken.</p> <p>The agency failed to document, investigate, and resolve complaints, related to lack of thorough and accurate patient assessments, breeches of infection control standards, and potentially harmful directions given to patients. This had the potential to result in adverse patient outcomes, and may have resulted in delayed treatment of a patient with sepsis.</p> <p>4. Refer to G121 as it relates to the failure of the agency to ensure RN A followed infection control</p>	G 107		

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G 107	Continued From page 16 standards of practice. 5. Refer to G134 as it relates to the agency's failure to ensure staff performance was monitored and evaluations completed timely.	G 107	484.12 Compliance with Federal, State and Local laws, Disclosure and Ownership Information and Accepted Professional Standards and Principles	
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the agency failed to ensure its infection control policies and procedures were implemented for 1 of 2 patients (Patient #5) whose nursing care was observed during home visits. This resulted in the potential for cross contamination and subsequent patient infections. Findings include: The agency's policy, "Hand Hygiene," revised 2015, was reviewed. The policy included the following information: * "Personnel providing care in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines (Categories 1A, 1B and 1C) for hand hygiene in health care settings." * "Hand decontamination using an alcohol-based hand rub should be performed: A. Before having direct contact with patients B. Before donning sterile gloves when	G 121	G121-The agency will comply with accepted professional standards and principles that apply to professionals furnishing home health services to ensure infection control policies and procedures are implemented to avoid the potential for cross contamination and subsequent patient infections. Policies: Hand Hygiene [Policy #9-009], Bag Technique [Policy #9-014], Infection Control [Policy # 9-011] Procedure: Every Field Clinician will be accompanied by a Clinical Supervisor, Horizon-Certified RN Preceptor or Staff Education Coordinator on, at least, one home visit biannually. (One in conjunction with the employee's Annual Performance Evaluation and one at another time to be determined by the Clinical Supervisor and the Clinician) to ensure that clinicians are observing infection control policies and procedures (On-Site Tool Attached). HR will implement a system for tracking and to ensure 90-day evaluations and on-site	

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G 121	<p>Continued From page 17</p> <p>performing sterile procedures; before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices</p> <p>C. After contact with a patient's intact skin (when taking a pulse, blood pressure, or lifting a patient)</p> <p>D. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, if hands are not visibly contaminated</p> <p>E. When moving from a contaminated body site to a clean body site during patient care</p> <p>F. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient</p> <p>G. After removing gloves</p> <p>H. When there is no running water to wash hands."</p> <p>The policy, "Bag Technique," revised March 2014, was reviewed. It included the following information.</p> <p>* "When the visit is completed, reusable equipment will be cleaned using alcohol and/or soap and water as appropriate, hands will be washed, and equipment and supplies will be returned to the bag.</p> <p>* Stethoscope, bell, and diaphragm - alcohol/disinfectant wipes</p> <p>* Bandage scissors - alcohol/disinfectant wipes</p> <p>* Thermometer"</p>	G 121	<p>the Clinical Supervisor, the Preceptor or the Staff Education Coordinator that the clinician is failing to meet performance expectations, the Clinical Supervisor may schedule additional in-home visits, at least weekly, for two weeks. At the end of two weeks, if the clinician remains out of compliance with professional standards, the employee may be disciplined up to and including termination. If the employee's performance is such that the patient's safety is compromised, the Clinical Supervisor, in conjunction with the DON or Director of Rehabilitation and HR, reserve the right to immediately implement a Performance Improvement Plan, up to and including termination.</p> <p>Education: The Horizon Home Health and Hospice Onboarding Program for all new field staff will include, but will not be limited to, education on "How to Conduct a Home Visit", "Bag Technique", "Hand Hygiene" and "Infection Control" with review of policies.</p> <p>Additionally, clinicians may be referred to the Staff Education Coordinator for supplemental training on areas of concern.</p> <p>Bag Technique, Hand Hygiene and</p>	
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G 121	<p>Continued From page 18</p> <p>* "Hands will be decontaminated prior to returning clean equipment to bag."</p> <p>A visit was made to Patient #5's place of residence on 2/17/16 beginning at 10:15 AM to observe nursing care performed. Patient #5 was an 88 year old female who was receiving skilled nursing services primarily for wound care. RN A was not observed to follow the agency's infection control policies and procedures. Examples include:</p> <p>* RN A was not observed to sanitize his hands after taking Patient #5's pulse, blood pressure, and pulse oximetry.</p> <p>* RN A was not observed to sanitize his hands after contact with wound dressings or after removing his gloves. Gloves were observed to be changed three times during the visit.</p> <p>* RN A was not observed to clean equipment with alcohol/disinfectant wipes after use, such as the stethoscope, thermometer, and bandage scissors.</p> <p>During the visit, RN A stated he was having trouble opening a package of Kerlix gauze. He asked the surveyor, "do you have any nails?" seeking help to open the package. The surveyor declined using finger nails to help open the clean dressing package.</p> <p>RN A was interviewed on 2/17/16 at 2:55 PM. He explained he did not wash his hands between glove changes because it was hard to get wet hands into gloves. He explained he did not sanitize equipment in the home. RN A indicated</p>	G 121	<p>biannual Horizon Skills Fair with policy distribution where field staff are given the opportunity to practice skills and demonstrate competencies.</p> <p>Current full time nurses and therapists will be educated by members of the Horizon Leadership Team, on site, on Bag Technique, Hand Hygiene and Infection Control via PowerPoint presentation. Part time/PRN nurses and therapists will be provided copies of education handouts.</p> <p>Responsible: Director of Nursing or designee has overall responsibility for the corrective action and ongoing completion of this deficiency</p> <p>Completion: 4/11/2016 and ongoing.</p>		

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G 121	Continued From page 19 he placed contaminated equipment in his bag, then removed the equipment and cleaned it in his car or after having returned to the agency.	G 121	484.14(c) Administrator	
G 134	Infection control standards were not followed while providing care to Patient #5. 484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. This STANDARD is not met as evidenced by: Based on policy review, grievance documentation review, personnel record review, and staff interview, it was determined the agency failed to ensure timely and thorough staff evaluations for 1 of 1 nursing staff member, (RN A) who was identified by the agency as requiring progressive discipline, whose personnel record was reviewed. This resulted in unacceptable patient care and had the potential to interfere with quality and safety of patient care. Findings include: The policy, "Performance Management," dated 10/01/15, was reviewed. It included, but was not limited to, the following information: * "Employees who fail to observe work rules or performance standards are subject to progressive disciplinary action, up to and including, termination of employment." * "It is the responsibility of the Executive Director	G 134	G134-The Administrator will ensure qualified personnel who are employed by the agency receive adequate staff education and evaluations to ensure patients receive acceptable, quality and safe care. Policies: Performance Evaluations [Policy #1-014.1] Procedures: All new field staff will receive a 90-day evaluation with an on-site visit by a Horizon-certified RN preceptor, Clinical Supervisor, Staff Education Coordinator, DON or designee. Field staff will receive an annual evaluation with an on-site visit, utilizing a "Home Health On-Site Supervisory Visit Report" (attached) to directly observe employee skills and competencies by a Clinical Supervisor, Staff Education Coordinator, DON or designee. HR will implement a system to track and ensure that 90-day evaluations and on-site visits are scheduled. Education: Horizon Home Health & Hospice Leadership Team were educated on appropriate "Performance	

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G 134	<p>Continued From page 20 or Supervisor to monitor compliance. Disciplinary actions are to be administered fairly, consistently and in a respectful manner."</p> <p>* "Less serious infractions will be treated as such; however, the continuance or reoccurrence of the same infraction will lead to more serious disciplinary action. While most infractions start with a "counseling", some infractions are so serious that they may receive a stronger action for the first infraction."</p> <p>* Management reserves the right to determine the type, form, and severity of corrective and/or disciplinary action up to and including termination."</p> <p>* "It is the responsibility of the Executive Director and the HR/Payroll Representative to monitor compliance with this policy."</p> <p>* "All employees are hired on a 90-calendar-day introductory status during which time their performance and suitability for the job are carefully appraised by his or her supervisor. Management will make reasonable efforts to correct an introductory employee's unsatisfactory conduct or performance. If the employee fails to satisfactorily correct their conduct or performance, he or she may be terminated during the 90-calendar-day introductory period."</p> <p>The agency policy was not followed. An example follows:</p> <p>1. RN A's personnel file was reviewed. He began employment with the agency as an LPN on 4/27/15, and transferred from an agency branch office (after the 90 day probation) to the agency's</p>	G 134	<p>Management" policies and practices at the quarterly Leadership Meeting.</p> <p>Responsible: Administrator or designee has overall responsibility for the corrective action and ongoing completion of this deficiency.</p> <p>Completion: 4/11/2016 and ongoing.</p>	

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G 134	<p>Continued From page 21 parent office during August, 2015.</p> <p>a. The personnel file included documentation, dated 6/26/15, of seven complaints from patients/families. They included the following:</p> <ul style="list-style-type: none"> * Patient #13's family alleged RN A "did not seem to know anything about the patient or her medications. He encouraged the patient to drink 8 bottles of water when she has a diagnosis of CHF and has fluid restrictions. Please do not send him back." * Patient #14's daughter alleged RN A did not clean up after himself. She did not want him to return. * Patient #15 reported RN A did not clean his hands or equipment during a visit. * Patient #16 requested RN A not be allowed to return. "No reason given." * Patient #17 requested RN A not be allowed to return. "No reason given." * Patient #18 requested RN A not be allowed to return because he "scares her." * Patient #19 complained regarding RN A's wound care procedure. <p>b. The personnel file included documentation, dated 6/26/15, of six "Communication issues" that were discussed with RN A. They included:</p> <ul style="list-style-type: none"> * "Need to report on patients in a timely manner." * "Not reading report from CM and following 	G 134		

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G 134	<p>Continued From page 22 directions given."</p> <p>The "Employee Counseling and Performance Improvement Plan," dated 6/26/15, indicated RN A would be re-evaluated on 7/24/15. There was no documentation in the personnel file that RN A was re-evaluated on 7/24/15 or anytime prior to the end of his 90 day probationary period (approximately 7/27/15).</p> <p>The RN Clinical Coordinator and the HR Director were interviewed together on 2/16/16 beginning at 10:12 AM. They stated RN A improved performance for a while but there was no documentation of the evaluation of performance.</p> <p>Three additional documented complaints were received by the agency between 6/26/15 and 11/02/15. They included the following:</p> <ul style="list-style-type: none"> * A complaint, dated 6/29/15, related to Patient #20 who alleged RN A did not clean his wound thoroughly and grabbed and squeezed his neck when applying a bandage causing him discomfort. He requested RN A not return to his home. * A complaint, dated 10/22/15, related to Patient #21, alleged RN A told her to take Advil for pain. She said she got Advil and her son read later it 's contraindicated with blood thinner which she was on. * A complaint, dated 10/15/15, related to Patient #22, alleged RN A did not call ahead before showing up for a visit. <p>c. The personnel file included documentation, dated 11/02/15, of "Employee Counseling and</p>	G 134		
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G 134	<p>Continued From page 23 Performance Improvement Plan." It documented the following concerns:</p> <p>"infection control not following MD orders lack of communication with case managers not notifying clients prior to visits not ordering supplies"</p> <p>It further documented:</p> <p>"quality of patient care at risk pt at risk of agency acquired infection staff at risk for work related infection"</p> <p>It indicated there would be follow-up with RN A on 11/07/15.</p> <p>A summary of events, dated 2/18/16, was written by the RN Clinical Coordinator during the survey. It included, but was not limited to, the following information:</p> <p>* "October 12th I sat with [RN A] and reviewed the concerns and complaints that had been brought up the past few weeks from the [City Name] Team, see typed list in HR."</p> <p>* [RN A] made some improvements and no complaints came for approximately a month.</p> <p>There was no documentation that RN A received the counseling until 11/13/15, after the date of the scheduled follow-up. There was no indication the follow-up had been rescheduled to a new date.</p> <p>The DON was interviewed on 2/17/16 at 1:30 PM. She provided email documentation of two joint visits RN A completed with agency RNs on</p>	G 134		
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G 134	<p>Continued From page 24</p> <p>2/16/16, the survey entrance date. The visits were completed 3 months after the second documented employee counseling on 11/02/15. One joint visit did not include monitoring or oversight of RN A's performance. The email statement from the RN who completed the visit with RN A include:</p> <p>* The E-mail dated 2/16/16 AT 10:55 AM, documented by an RN Case Manager, stated - "[RN A] MET ME AT [PATIENT'S NAME] TO OBSERVE ASPIRA DRAIN CARE. [RN A] WASHED HANDS AND WORE GLOVES WHILE I DEMONSTRATED PROCEDURE OF DRAINING ASPIRA BAG AND EMPTYING DRAINAGE AND APPLYING NEW DRESSING WITH STERILE PROCEDURE. AND ASSISTED BY THROWING AWAY DIRTY ITEMS AND EMPTYING DRAIN BAG. [RN A] V/U [Verbal Understanding] OF PROCEDURE."</p> <p>The joint visit was a training session for RN A. His performance was not observed or monitored during the visit.</p> <p>The DON was interviewed on 2/16/16 beginning at 10:52 AM. The DON stated she did not have documentation of other joint visits being conducted, but there had been some. She stated the agency had recently developed a 4 week RN onboarding program, consisting of the first week of classroom training, the second week of joint visits with all disciplines, the third week with OASIS training and the fourth week with home visits with preceptors. When asked if RN A went through the training, she stated, he went through the OASIS training but did not attend the other three weeks. She stated she believed RN A provided safe care "even if he wasn't the best</p>	G 134		
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G 134	Continued From page 25 nurse."	G 134	G144-The agency will ensure the clinical records completely document/demonstrate care coordination to ensure quality and coordination of patient care by the interdisciplinary team.		
G 144	<p>The DON was interviewed on 2/17/16 at 4:00 PM. She stated that prior to the start of the survey, the agency was planning to terminate RN A's employment on 2/19/16, due to performance concerns. The DON stated the agency had to follow corporate employment guidelines and directions.</p> <p>The Director of Operations was interviewed on 2/18/16 at 2:40 PM. He stated RN A was terminated that morning."</p> <p>The agency did not provide adequate and timely follow-up evaluation to identified nursing performance issues for RN A.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>This STANDARD is not met as evidenced by: Based on policy review, record review, and staff interview, it was determined the agency failed to ensure the clinical records documented care coordination that had occurred for 1 of 7 patients (#4) whose records were reviewed. This resulted in incomplete information and had the potential to interfere with quality and coordination of patient care. Findings include:</p> <p>The policy "Entries into the Clinical Record,"</p>	G 144	<p>Procedure: Any "evaluation only" visits completed (i.e. Wound Care nurse, Psychiatric nurse or therapist) will be documented on a discipline-specific visit note. Following the evaluation visit, the clinician will complete a Physician Communication Coordination Note. Once the clinician "syncs" his/her device, this note goes to the Clinical Supervisor's workflow for review/approval and is then faxed to the physician. To ensure prompt coordination of care, the Clinical Supervisors will process Coordination Notes workflow on a daily basis. These notes become part of the patient's record under "Coordination Notes" for access by agency staff.</p> <p>Education: Current full time Nurses and therapists will be educated by members of the Horizon Leadership Team, on site, via Power Point presentation on appropriate coordination of patient care. Part time/PRN nurses and therapists will be provided copies of education handout.</p>		

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G 144	<p>Continued From page 26 revised March 2014, was reviewed. It included, but was not limited to, the following information:</p> <p>* "Documentation in the clinical record will be timely, detailed, accurate, and reflect the care or service provided."</p> <p>* "Entries into the clinical record will be clear, concise, and specific statements of fact."</p> <p>The policy was not followed. Examples include:</p> <p>1. A "Client Coordination Note Report, "dated 12/02/15, was written by a psychiatric nurse related to Patient #4. It stated "I made an apt with pt and began admission paperwork. Pt had many comments and complaints about various people - I didn't engage her or argue. I just changed the subject and asked the next question. By the end of the visit she decided that since she was working with {name} she didn't need anyone to help with her depression. So this is a non-admit note."</p> <p>The psychiatric nurse who wrote the coordination note was interviewed on 2/17/16 at 9:25 AM. The DON was also present during the interview. The psychiatric nurse described Patient #4 as generally accusatory, polarizing staff, angry, demanding, impatient and intolerant. When asked the nature of the "many comments and complaints about various people" that was referenced in the note, dated 12/02/15, she stated Patient #4 complained about staff not arriving at their scheduled times. The psychiatric nurse did not offer other complaints. When asked if Patient #4's complaints were addressed or entered into the grievance log, she stated they were not addressed because it was her role to set</p>	G 144	<p>Responsible: Director of Rehabilitation and Director of Nurses has overall responsibility for the corrective action and ongoing completion of this deficiency.</p> <p>Completion: 4/11/2016 and ongoing</p>	

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G 144	Continued From page 27 boundaries. She stated she did talk with the RN Clinical Supervisor and the Case Manager about Patient #4 and that she notified Patient #4's physician as to why she would not be seeing Patient #4 for further visits. None of the above referenced coordination of care was documented. This was confirmed by the DON during an interview on 2/17/16 at 1:30 PM. The visit note did not reflect the coordination of care that occurred on behalf of Patient #4.	G 144		
G 158	2. A visit note report, dated 11/27/15, by Nurse A, documented "Pt with multiable {sic} complaints today, many different subject expressed. "There was no documentation to describe the complaints in the clinical record or in a grievance log. Nurse A was interviewed on 2/17/15 beginning at 3:18 PM. When asked what the nature of the complaints were, he stated she complained chronically, usually about staff showing up at the wrong time, or the type of supplies being used with her wound care. The type of complaints was not documented in the clinical record or in the grievance log. The visit note did not include clear, specific, statements of fact regarding the alleged complaints by Patient #4. 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by:	G 158	484.18: Acceptance of Patients, Plan of Care and Medical Supervision G158-The agency will ensure care follows a physician's written plan of care and is periodically reviewed by a physician to avoid omissions of care and subsequent unmet patient needs. The visit nurses for patient #7 were counseled on 3/15/2016 regarding their failure to adhere to the physician's plan of care by not obtaining patient's weight at the scheduled visit and failing to report to the MD a weight gain/loss of 3 pounds or more. Policy: Care Planning Process [Policy #2-018] Procedure: For patients requiring visit specific interventions, a Point Care Alert (requires that every clinician read and acknowledge the alert before visit can begin) and a Buddy Code (features within the HCHB software that alert the clinician of a procedure that is required at that visit) will be utilized to prompt the appropriate clinician to complete that intervention (i.e. weight, labs, wound measurement, catheter change). Upon initial review of the Start of Care, the	

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G 158	<p>Continued From page 28</p> <p>Based on record review, policy review, and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 1 of 7 patients (Patient #7) whose records were reviewed. This resulted in omissions of care and unmet patient needs. Findings include:</p> <p>An agency policy 2-018.1, revised March 2014, titled "CARE PLANNING PROCESS," stated "...The plan of care will be based upon the physician's (or other authorized licensed independent practitioner's) orders and will encompass the equipment, supplies, therapeutic services, and nursing, physical therapy, occupational therapy, speech therapy, home health aide, or medical social worker services required to meet the patient's needs." The policy also included "...The plan of care will be revised as frequently as deemed necessary by the clinician, based on the ongoing assessments of the patient..." Also stated in the policy was "...Clinicians will inform the patient's physician of any changes that suggest a need to alter the plan of care, which will be documented in the clinical record." This policy was not followed. Examples include:</p> <p>Patient #7 was an 89 year old female admitted to the agency on 6/14/15. Her diagnoses included CHF (the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs), atrial fibrillation (an abnormal heart rhythm characterized by rapid and irregular beating) and protein-calorie malnutrition. Her record, including the POC, for the certification period 6/14/15 to 8/12/15, was reviewed.</p> <p>Patient #7's record included physician's orders,</p>	G 158	<p>Codes and Point Care Alerts have been assigned to visits as appropriate. The Clinical Supervisor's assigned workflow includes reviewing Clinical Exception Coordination Notes which identify interventions that have not been performed or are outside of established parameters. The Clinical Supervisors will then contact the clinician for clarification of alerts to ensure proper documentation and follow-up with the physician. Quarterly chart audits (Audit tool Attached) will also be performed with results reported to Quarterly QA/Performance Improvement Committee with action plan implementation for items with less than 90% compliance/accuracy.</p> <p>Education: Current full time nurses and therapists will be educated by members of the Horizon Leadership Team, on site, via PowerPoint Presentation on following the physician's written plan of care. Part time/PRN nurses and therapists will be provided copies of education handouts.</p> <p>Responsible: Director of Rehabilitation and Director of Nurses has overall responsibility for the corrective action and ongoing completion of this deficiency.</p>	

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G 158	Continued From page 29 dated and signed on 6/14/15. The physician ordered skilled nursing visits 2 times per week for 8 weeks, and 1 time per week for 1 week. Also included was an order to weigh the patient during every visit, and notify the physician of a weight gain/loss of 3 pounds or more. Nursing visit notes included, but were not limited to the following: * 6/14/15 - weight 121 lbs. (by RN E) * 6/16/15 - weight not documented (by RN F) * 6/24/15 - weight 124 lbs. (by RN A) * 6/26/15 - weight 124 lbs. (by RN E) * 6/30/15 - weight 114 lbs. (by RN F) * 7/09/15 - weight not documented (by RN E) * 7/16/15 - weight not documented (by RN E) * 7/22/15 - weight not documented (by RN F) * 7/28/15 - weight not documented (by LPN G) During interviews on 2/18/16 at 3:20 PM and 2/22/16 at 9:50 AM, the Home Health Team Lead reviewed Patient #7's record and confirmed Patient #7 was not weighed during every skilled nursing visit as ordered. She also confirmed the change in weight, documented on 6/30/15, was not reported to the physician as ordered. Patient #7's care was not provided as ordered by the physician.	G 158	484.30: Skilled Nursing Services G170-The agency will ensure skilled nursing services are furnished in accordance with the plan of care to ensure care is consistent, thereby, avoiding the potential for negative patient outcomes. Policy: Care Planning Process [Policy #2-018.1] Education: During the orientation process and ongoing as identified by the Clinical Supervisors, Packet Review Team (review of OASIS & Plan of Care) and QA Nurse, professional staff education will include, but will not be limited to, how to develop and follow a plan of care, how to write orders, how to utilize coordination notes, how to order supplies, how to reconcile medications.		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on policy review, medical record review	G 170	For patients requiring visit specific interventions, a Point Care Alert and a Buddy Code (features within the HCHB software) will be utilized to prompt the appropriate clinician to complete that intervention (i.e. weight, labs, wound measurement, catheter change).		

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G 170	<p>Continued From page 30</p> <p>and staff interview, it was determined the agency failed to ensure skilled nursing services were furnished in accordance with the POC for 1 of 7 patients (Patient #7) who received skilled nursing services and whose records were reviewed. Failure to follow the established POC resulted in omission of care, interfered with the consistency of services provided and had the potential to result in negative patient outcomes. Findings include:</p> <p>An agency policy 2-018.1, revised March 2014, titled "CARE PLANNING PROCESS," stated "...Based on the assessment and conclusions, the plan or care will include, but not be limited to:...Actions to be taken to meet the patient goals...and...Equipment and supplies..." Also included in the policy was "...The plan of care will be based upon the physician's (or other authorized licensed independent practitioner's) orders and will encompass the equipment, supplies, therapeutic services, and nursing, physical therapy, occupational therapy, speech therapy, home health aide, or medical social worker services required to meet the patient's needs." The policy also stated "...The plan of care will be revised as frequently as deemed necessary by the clinician, based on the ongoing assessments of the patient..." This policy was not followed. Examples include:</p> <p>Patient #7 was an 89 year old female admitted to the agency on 6/14/15. Her diagnoses included CHF (the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs), atrial fibrillation (an abnormal heart rhythm characterized by rapid and irregular beating) and protein-calorie malnutrition. Her record, including the POC, for the certification period 6/14/15 to</p>	G 170	<p>Upon initial review of the SOC including the Plan of Care, the Clinical Supervisor will ensure that Buddy Codes and Point Care Alerts have been assigned to visits as appropriate and that appropriate interventions are included in the POC. The Clinical Supervisor's assigned workflow includes reviewing Clinical Exception Coordination Notes which identify interventions that have not been performed or are outside of established parameters. The Clinical Supervisors will then contact the clinician for clarification of alerts to ensure proper documentation and follow-up with the physician. Quarterly chart audits (Audit tool Attached) will also be performed with results reported to Quarterly QA/Performance Improvement Committee with action plan implementation for items with less than 90% compliance/accuracy. If a new or current employee requires additional or re-education with this process, the Clinical Supervisor may provide supplemental education or refer the clinician to the Staff Education Coordinator or Preceptor for assistance.</p> <p>The Horizon Onboarding/Orientation Program will include education on Care</p>	

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NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 WEST WILLOWBROOK DR MERIDIAN, ID 83646		
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G 170	<p>Continued From page 31 8/12/15, was reviewed.</p> <p>Patient #7's record included physician's orders and the POC, dated and signed on 6/14/15. The physician ordered skilled nursing visits 2 times per week for 8 weeks, and 1 time per week for 1 week. Also included was an order to weigh the patient during every visit, and notify the physician of a weight gain/loss of 3 pounds or more.</p> <p>Nursing visit notes included, but were not limited to the following:</p> <ul style="list-style-type: none"> * 6/14/15 - weight 121 lbs. (by RN E) * 6/16/15 - weight not documented (by RN F) * 6/24/15 - weight 124 lbs. (by RN A) * 6/26/15 - weight 124 lbs. (by RN E) * 6/30/15 - weight 114 lbs. (by RN F) * 7/09/15 - weight not documented (by RN E) * 7/16/15 - weight not documented (by RN E) * 7/22/15 - weight not documented (by RN F) * 7/28/15 - weight not documented (by LPN G) <p>A "Client Coordination Note Report," dated 7/09/15, stated Patient #7's weight was not taken. The reason was documented as "NO SCALE." Evidence was not provided indicating actions had been taken regarding the need for a scale in Patient #7's home.</p> <p>During an interview on 2/18/16 at 3:20 PM, the RN Clinical Supervisor reviewed Patient #7's record and confirmed Patient #7 was not weighed during every skilled nursing visit as ordered. She also confirmed the change in weight, documented on 6/30/15, was not reported to the physician as ordered. Additionally, the RN Clinical Supervisor confirmed that the order for weights during every visit had not changed, and the POC had not been</p>	G 170	<p>Current full time nurses and therapists will be educated by members of the Horizon Leadership Team, on site, on POC development and following the POC via Power Point Presentation. Part time/PRN nurses and therapists will be provided copies of education handouts.</p> <p>Responsible: Director of Nursing or designee has overall responsibility for the corrective action and ongoing completion of this deficiency.</p> <p>Completion: Week of 4/11/2016 and ongoing</p>		

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G 170	Continued From page 32 revised.	G 170			
G 176	<p>Patient #7's nursing care was not provided in accordance with the established POC.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>This STANDARD is not met as evidenced by: Based on review of agency policies, medical record review and staff interview, it was determined the agency failed to ensure an RN appropriately prepared clinical notes for 1 of 7 patients (Patient #2) who received skilled nursing services and whose records were reviewed. These failures resulted in a lack of clarity regarding the care that was provided and had the potential to negatively impact quality and coordination of patient care. Findings include:</p> <p>An agency policy 2-018.1, revised March 2014, titled " ENTRIES INTO THE CLINICAL RECORD," stated "...Documentation in the clinical record will be timely, detailed, accurate, and reflect the care or services provided." Also included in the policy was "...Entries into the clinical record will be clear, concise, and specific statements of fact." This policy was not followed for Patient #2.</p> <p>Patient #2 was a 75 year old male admitted to the agency on 1/08/16, for services related to surgical replacement of the left hip and HTN. His record,</p>	G 176	<p>484.30(a) Duties of The Registered Nurse</p> <p>G176-The agency will ensure the registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs to ensure clarity regarding the care provided and to avoid a negative impact on the quality and coordination of patient care.</p> <p>Policy: Entries Into the Clinical Record [Policy #5-006 Attached]</p> <p>Education: A coordination note will be submitted to document notification of the interdisciplinary team of pertinent patient information, changes and needs . A Physician Communication Coordination Note will be generated to inform the MD of changes in the patient's condition and needs.</p> <p>During the orientation process, professional staff education will include, but will not be limited to, how to develop and follow a plan of care, how to write orders, how to utilize coordination notes, how to order supplies, how to reconcile medications.</p>		

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G 176	<p>Continued From page 33</p> <p>including the POC, for the certification period 1/08/16 to 3/07/16, was reviewed. Patient #2's POC included additional pertinent diagnoses of glaucoma and abnormalities of gait and mobility.</p> <p>The nursing admission visit note, dated 1/08/16, completed by RN H, included the following:</p> <ul style="list-style-type: none"> * EYES/EARS/NOSE/THROAT - visual disturbances requiring glasses or contacts, and bilateral glaucoma (abnormally high pressure in the eye that can result in damage to the optic nerve) * INTEGUMENTARY - left hip bruising and an intact, left hip dressing * FUNCTIONAL - bone/joint problems, pain/stiffness, decreased strength and limited range of motion <p>A nursing visit note, dated 1/11/16, completed by RN A, included the following:</p> <ul style="list-style-type: none"> * EYES/EARS/NOSE/THROAT - PERRL (pupils equal and reactive to light) * INTEGUMENTARY - no problems identified * FUNCTIONAL - WNL (within normal limits) <p>The note did not mention the existence of visual disturbances or glaucoma, or bruising around the operative site and the presence of an intact dressing. Additionally, there was no documentation describing Patient #2's altered functional status, resulting from recent hip replacement surgery. The 1/11/16 visit note/assessment did not accurately represent</p>	G 176	<p>If a new or current employee self-reports or the Packet Review team determine that the clinician requires additional/re-education with this process through increased errors in POC development, decreased productivity, increased documentation times, etc., the Clinical Supervisor may provide supplemental education or refer the clinician to the Staff Education Coordinator or Preceptor for one-on-one training.</p> <p>Current full time nurses and therapists will be educated by members of the Horizon Leadership Team, on site, on the development of and the need to know the content of the plan of care and how to access this information on their electronic devices prior to/during a visit. Part time/PRN nurses and therapists will be provided copies of education handouts.</p> <p>Responsible: Director of Nursing or designee has overall responsibility for the corrective action and ongoing completion of this deficiency.</p> <p>Completion: 4/11/2016 and ongoing</p>	

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G 236	<p>Continued From page 35 indicated "Duoderm applied." This was not observed to occur during the home visit where surveyor watched the wound care on 2/17/16. It was was not consistent with the plan of care.</p> <p>RNA, who provided the wound care and documented the note, was interviewed on 2/17/16 at 2:55 PM. He stated he did not write anything about Duoderm being applied and he did not know why that information was showing up on the note. The DON was present during the interview. She stated if the information had not been edited out at the time of note entry, it may have carried forward from prior information. This resulted in inaccurate information.</p> <p>Inaccurate information was included in Patient #5's visit note due to a medical record system issue.</p>	G 236	<p>notes, how to order supplies, how to reconcile medications.</p> <p>If a new or current employee self-reports or the Packet Review team determine that the clinician requires additional/re-education with this process through increased errors in POC development, decreased productivity, increased documentation times, etc., the Clinical Supervisor may provide supplemental education or refer the clinician to the Staff Education Coordinator or Preceptor for one-on-one training.</p> <p>Current full time nurses and therapists will be educated by members of the Horizon Leadership Team, on site, on the development of and the need to know the content of the plan of care and how to access this information on their electronic devices prior to/during a visit via PowerPoint presentation. Part time/PRN nurses and therapists will be provided copies of the education handouts.</p> <p>Responsible: Director of Nursing or designee has overall responsibility for the corrective action and ongoing completion of this deficiency.</p> <p>Completion: 4/11/2016 and ongoing</p>	
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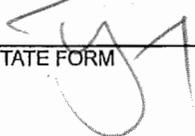
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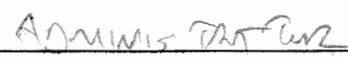
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N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation survey of your home health agency on 2/16/16 through 2/19/16.</p> <p>The surveyors conducting the complaint investigation survey were:</p> <p>Teresa Hamblin, RN, MS, HFS - Team Lead Rebecca Lara, RN, BA, HFS</p>	N 000	<p>N 024 03.07020. Admin.Gov.Body-The agency will ensure that patients/caregivers have access to medical records within 2 working days of the request.</p> <p>Policy change: Patient Request for PHI [Policy No. 5-020.2]</p> <p>Procedure: Medical Records staff were educated that Horizon Home Health and Hospice will act on the patient's request for access to PHI within two (2) working days and will provide a written copy no later than 30 days after receipt of the request.</p> <p>Patient/patient representative will be contacted by Horizon Home Health staff by phone of the acceptance of the request. Staff will enter the request on the "Medical Records Request" log. This log will also include documentation that the call has occurred and it will indicate whether the patient wants 2-day access or whether the record can be printed and mailed within 30 days. The patient's request/timeline will be honored.</p> <p>The DOO/Administrator will review the log with the responsible staff quarterly for compliance and to ensure that requests are being addressed in a timely manner.</p>	
N 024	<p>03.07020. ADMIN. GOV. BODY</p> <p>N024 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following:</p> <p>d.vi. A patient has the right to access information in his own record upon written request within two (2) working days.</p> <p>This Rule is not met as evidenced by: Based on review of patient information, medical record request documentation, and staff interview, it was determined the agency failed to ensure 2 of 2 patients/caregivers who requested medical record information (#4 and #22) were provided access to medical record within two workings of the request. This resulted in delayed patient access to medical records. Findings include:</p> <p>1. One request was made by Patient #4 on 1/20/16. The record had not been delivered to Patient #4 at the start of the survey on 2/16/16.</p> <p>Patient #4 was interviewed by telephone on 2/18/16 at 9:40 AM. She stated she had</p>	N 024		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM 



3/17/16

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N 024	<p>Continued From page 1</p> <p>contacted the agency by phone to request medical records. She stated the agency would not let her talk with anyone in the medical records department. She stated she was surprised to receive a telephone call the previous day (2/17/16) telling her to expect the records to be hand delivered the afternoon of 2/18/16. Patient #4's medical records were provided to her 29 days after the original request.</p> <p>2. A spreadsheet included documentation that a family member requested Patient #22's medical record on 12/11/15. The records were sent by Fedex on 12/14/15, 3 days after the original request.</p> <p>The DON was interviewed on 2/18/16 at 1:25 PM. She stated the agency's policy was to provide medical records within 30 days of the request.</p> <p>Patients' medical records were not provided to them within 2 working days of the requests.</p>	N 024	<p>Information has been included in the Patient Handbook which is provided to the patient at Start of Care to educate the patient on his/her right to have access to his/her medical record within 2 working days of receiving the request.</p> <p>Education: Medical Records/Office staff were educated on the revised policy and procedure on 2/24/16 (Attendance role attached)</p> <p>Responsible: Director of Operations/Administrator has overall responsibility for the corrective action and ongoing completion of this deficiency.</p> <p>Completion: Week of 2/24/2016 and ongoing</p>	
N 025	<p>03.07020. ADMIN. GOV. BODY</p> <p>N025 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following:</p> <p>d.vii. A patient has the right to voice grievances regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.</p>	N 025	<p>N 025 03.07020 Admin.Gov.Body- The agency will ensure that the patient is educated on his/her right to freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable</p>	

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N 025	Continued From page 2 This Rule is not met as evidenced by: Refer to Federal deficiency G 106, as it relates to the failure of the agency to ensure patients could voice grievances regarding treatment or care furnished.	N 025	interruption of care, treatment and services. Policy: Complaint/Grievance Process [Policy #1-010.1] Education: All active field staff will be educated on the patient's right to voice a complaint and where this right is explained in the admission consent in the Patient Handbook so that patients can be informed of their rights upon admission to home health services. Current full time nurses and therapists will also be educated of need to accurately and objectively document patient's concerns regarding the care provided by agency staff, agency staffing practices, scheduling, supplies provided, etc. Current full time nurses and therapists will be educated by members of the Horizon Leadership Team, on site, on the patient's right to voice complaints with reference to the Patient Information Booklet section and page numbers for "Complaint Procedure", "State of Idaho Hotline" and "Statement of Patient Rights and Responsibilities". Part time/PRN nurses and therapists will be provided copies of education handouts. Effective 3/21/2016, the Horizon Home Health & Hospice Onboarding/orientation program will include education on "Patient Rights".	
N 026	03.07020. ADMIN. GOV. BODY N026 04. Patients' Rights. Insure that patients' rights are recognized and Include as a minimum the following: d.viii. The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA and must document both the existence of the complaint and the resolution of the complaint. This Rule is not met as evidenced by: Refer to Federal deficiency G 107 as it relates to the failure of the agency to investigate complaints or document the existence of, or resolution of, complaints in accordance with agency policy.	N 026		
N 050	03.07021. ADMINISTRATOR N050 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: d. Insuring that personnel employed shall be qualified to perform	N 050		

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N 050	Continued From page 3 their assigned duties and that agency practices are supported by written personnel policies. This Rule is not met as evidenced by: Refer to Federal deficiency G 134 as it relates to the failure of the agency to ensure timely and thorough staff evaluations for a nurse subject to progressive disciplinary action.	N 050	Director of Nursing will review "Patient Complaint" workflow weekly to ensure compliance with investigation timelines and proper follow through by Clinical Supervisors/Branch Managers Responsible: Administrator, Director of Nursing and Director of Rehabilitation have overall responsibility for the corrective action and ongoing completion of this deficiency.	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to Federal deficiency G-144 as it relates to the failure the agency to ensure the clinical records documented care coordination.	N 062	Completion: 4/11/2016 and ongoing N 050 03.07021 Administrator: Refer to Federal deficiency G-144	
N 091	03.07024. SK.NSG.SERV. N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care. This Rule is not met as evidenced by: Refer to Federal deficiency G-170 as it relates to the failure of the agency to ensure skilled nursing	N 091	N 091 03.07024 Sk.Nsg.Serv: Refer to Federal deficiency G-170	

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N 091	Continued From page 4 services were furnished in accordance with the POC.	N 091	N 093 03.07024 Sk.Nsg.Serv: Refer to Federal deficiency G-176		
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to Federal deficiency G-176 as it relates to the failure of the agency to ensure and RN appropriately prepared clinical notes.	N 093			
N 097	03.07024. SK. NSG. SERV. N097 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: e. Prepares clinical and progress notes, and summaries of care; This Rule is not met as evidenced by: Refer to G-176 as it relates to the failure of the agency to ensure appropriate preparation of clinical notes.	N 097	N 097 03.07024 Sk.Nsg.Serv: Refer to Federal deficiency G-176		

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N 097	Continued From page 5 Refer to Federal deficiency G-176 as it relates to the failure of the agency to ensure nursing notes were complete and accurately represented the care that was provided.	N 097	N 098 03.07024 Sk.Nsg.Serv: Refer to Federal deficiency G-170	
N 098	03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to Federal deficiency G-170 as it relates to the failure of the agency to ensure nursing services were provided in accordance with the plan of care and a physician was notified of a patient's change in condition.	N 098		
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to Federal deficiency at G-170 as it relates to the failure of the agency to ensure skilled	N 152	N 152 03.07030.01 Plan of Care: Refer to Federal deficiency G-170	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/19/2016
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 WEST WILLOWBROOK DR MERIDIAN, ID 83646		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 152	Continued From page 6 nursing services were furnished in accordance with the POC.	N 152	N 174 03.07031.01 Plan of Care: Refer to Federal deficiency G-236	
N 174	03.07031.01 CLINICAL RECORDS N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services. This Rule is not met as evidenced by: Refer to Federal deficiency G236 as it relates to the failure of the agency to ensure the clinical record system consistently provided accurate information.	N 174		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 17, 2016

Bridger Booras, Administrator
Horizon Home Health
63 West Willowbrook Dr
Meridian, ID 83646-1656

Provider #137065

Dear Mr. Booras:

An unannounced on-site complaint investigation was conducted from February 16, 2016 to February 19, 2016 at Horizon Home Health. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007239

Allegation #1: Nursing care was inadequate. Nursing assessments were incomplete, such as not taking vital signs. A rapidly changing medical condition was not identified.

Findings #1: An unannounced visit was made to the agency between 2/16/16 and 2/19/16. During the visit, surveyors reviewed 7 medical records, 16 grievances, personnel files, policies and procedures, observed two home visits, interviewed patients, caregivers, and staff.

Nursing performance of one RN was found to be substandard. Multiple patient/caregiver complaints were documented, alleging failure to provide services, such as taking vital signs, adequate infection control practices, poor communication with patients and staff, etc. The agency failed to provide adequate education, supervision, evaluation, and oversight. Although the RN was employed at the beginning of the survey, on 2/16/16, and had been an employee since April of 2015, he was no longer an employee at the end of the survey.

The Home Health Agency was cited at Code of Federal Regulations 42 CFR 484.14(c) for failure to ensure adequate staff education and evaluations.

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

Allegation #2: Complaints regarding care were not adequately addressed.

Findings #2: Sixteen patient grievances were reviewed. There was lack of documentation that all complaints/grievances had been fully investigated and resolved to the satisfaction of patients in a manner that was consistent with the agency's policies.

For example, the grievance log documented a complaint was received by telephone on 1/04/16 from a patient who had a nurse visit her home on 12/31/15 to provide wound care. The complainant alleged the RN who provided care did not take her vital signs and did not adequately assess her during the visit. She reported ending up going to the hospital by ambulance the same day and being admitted for sepsis.

While there was documentation of some investigation, the investigation documentation was limited. For example, there was no documentation as to whether allegations were or were not substantiated, or whether there had been any follow-up with the complainant regarding the results of the investigation.

The Home Health Agency was cited at Code of Federal Regulations 42 CFR 484.10(b)(4) and 42 CFR 484.10(b)(5) for failure to thoroughly investigate and resolve grievances.

Conclusion #2: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #3: The agency failed to respond promptly to a request for medical records.

Findings #3: The agency's policy allows for 30 days to deliver medical records after a copy is requested. However, the "State Rules for Home Health Agencies, at IDAPA 16.03.07.04.vi, states the following: "A patient has the right to access information in his own record upon written request within two (2) working days."

The agency's policy and patient rights information did not disclose the patient's right, in accordance with the State rule, to access information within 2 working days.

A list of record requests made in the prior 3 months was requested during the Entrance conference of the survey. A list of names was provided. The list included 15 requests, 2 of which were from patients. The remainder of the requests were from third parties, such as insurance companies, attorneys, and/or coroners.

One request was made by a patient on 1/20/16. The record had not been provided to the patient as of the date the survey began on 2/16/15.

Bridger Booras, Administrator
August 17, 2016
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The patient was interviewed by telephone on 2/18/16 at 9:40 AM. She stated she had contacted the agency by phone to request medical records. She stated "they wouldn't let me talk to anyone in the records department." She stated she was surprised to receive a telephone call yesterday (2/17/16) and was told to expect the records to be hand delivered "this afternoon" (2/18/16), 29 days after the original request.

The Director of Nursing was interviewed on 2/18/16 at 1:25 PM. She stated it was the agency's policy to provide records within 30 days.

The agency's policy was not consistent with State rule requirements. Therefore, the agency did not provide access within 2 working days in accordance with IDAPA rules or inform patients of the right to access records within 2 days.

The Home Health Agency was cited at Code of Federal Regulations 42 CFR 484.10(d) for failure to make records accessible in a timely manner in accordance with State rules.

Conclusion #3: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

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

Sincerely,



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/pmt