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August 9, 2016

Trevor Higby, Administrator  
Horizon Hospice  
63 W Willowbrook Dr  
Meridian, ID 83642

Provider #131520

Dear Mr. Higby:

An unannounced on-site complaint investigation was conducted from July 11, 2016 to July 13, 2016 at Horizon Hospice. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00007153**

**Allegation #1:** Patients were admitted to and remained on hospice services without a terminal diagnosis and evaluation by a physician or midlevel provider.

**Findings #1:** An unannounced visit was made to the hospice agency from 7/11/16 to 7/13/16. During the investigation, 9 medical records were reviewed, conducted 2 home visits, and staff were interviewed.

All 9 patient medical records reviewed included documentation of terminal diagnoses and hospice qualifying criteria. Each patient's physician, as well as the hospice Medical Director, documented patient appropriateness for hospice and approval. Further, patient records included documentation of face-to-face evaluations by the midlevel practitioner for purpose of hospice evaluation.

For example one patient's record documented a 92 year old female admitted to the hospice on 2/25/15, for late effects of cerebral vascular disease. The admitting order documented the patient's hospice appropriateness, the scope of her plan of care, and the certification period.

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The patient's record documented she remained on hospice service through 2 benefit periods. It was anticipated the patient would enter her third benefit. Therefore a face-to-face evaluation was conducted.

The patient's record included a "Nurse Practitioner Attestation of Face-to-Face Encounter With Patient," dated 7/31/15, and signed by a Nurse Practitioner. Upon completion of the face-to-face evaluation, the Nurse Practitioner documented "I recommend recertification of hospice services due to ongoing decline from previous CVA (cerebrovascular accident). The clinical findings of this encounter are provided to the certifying physician for use in determining continued eligibility for hospice care."

The patient's medical record also included a physician verbal order, dated 8/13/15. The order documented the patient's hospice appropriateness, the scope of her plan of care, and the recertification period. Further, her record included a "Hospice Recert Summary Report," dated 8/27/16, which outlined, in detail, how the patient qualified for hospice services.

A second patient's record documented a 78 year old male admitted to the hospice on 5/07/16, for lung cancer. The patient's record included a physician's verbal order, dated 5/07/16. The order documented the patient's hospice appropriateness, the scope of his plan of care, and the certification period. Due to the period of time the patient had been receiving the hospice benefit, a recertification face-to-face evaluation was not required at the time of the investigation.

It could not be determined that patients were admitted to and remained on hospice services without a terminal diagnosis and evaluation by a physician or midlevel provider. Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** Patients are receiving inappropriate medications and their right to refuse medications is not being upheld.

**Findings #2:** An unannounced visit was made to the hospice agency from 7/11/16 to 7/13/16. During the investigation, policies and procedures and 9 patient records were reviewed, 2 home visits were conducted, and staff were interviewed.

The agency's "The Plan of Care," policy, revised March 2014, was reviewed. The policy stated "The plan of care will be provided to both the attending physician and the hospice Medical Director for approval of verbal orders. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes to evaluate progress toward goals."

All 9 patient records reviewed included medication orders identifying their purpose and prescribed reason. Documentation in the records included education by staff regarding the reasons for ordered treatment and medications.

Additionally, the agency's "Informed Consent/Refusal of Treatment," policy, revised March 2014, was reviewed. It documented the process by which patients and their representatives were empowered to take part in their plan of care, including refusal of therapies, medications, and treatments.

The RN Case Manager was interviewed on 7/12/16 at 10:20 AM. She stated all patients were included in their own plan of care, whether that was to participate or refuse treatment. The RN Case Manager stated medication refusals would be documented on the patient Medication Administration Record. She also stated treatment refusals would be documented in the patients' progress notes.

Three of the 9 records reviewed included documentation of refusals by the patients for medications or treatments. No documentation of patients being given medications or treatments which were refused could be found.

For example, one patient record documented a 78 year old male admitted to the agency on 5/07/16, for lung cancer. The patient's record included documentation that he had refused to use pain medication initially and his refusals were honored. However, the patient began accepting medications and the Registered Nurse (RN) documented that during her visit on 5/23/16, the patient was receiving relief and sleeping better with his non-narcotic prescription medication. Additionally, the RN documented the patient was not using his oxygen as ordered and she provided education to the patient regarding why the oxygen was ordered and its use.

A subsequent RN visit note, dated 6/08/16, documented the patient stated his worst pain level in the last 24 hours was an 8/10, on a 1 to 10 scale. The note also stated the patient had increasing shortness of breath. The RN documented that she again provided education to the patient about the use of oxygen for comfort and to decrease his shortness of breath. The RN also educated the patient about morphine use for pain relief.

A second patient's record documented a 92 year old female admitted to the agency on 2/25/15, for late effects of cerebral vascular disease. She resided at an Assisted Living Facility (ALF). The patient's record included a physician verbal order dated 8/21/15. The order stated a topical creme combination of Ativan, Benadryl, and Haldol was to be initiated to assist the patient in managing her anxiety and agitation. The patient's plan of care also stated the patient was to receive the cream containing 25 mg of Ativan, 25 mg of Benadryl, and 2 mg of Haldol.

The Director of the ALF, that the patient resided in, was interviewed on 7/13/16 at 8:00 AM. The Director stated all patient medication refusals would be documented on the ALF medication administration records. The patient's medication administration records were reviewed.

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The records documented the patient was to receive multiple medications including the cream, although the ALF medication record documented the cream was to contain 25 mg of Ativan, 25 mg of Benadryl, and 4 mg of Haldol.

The medication administration records documented the patient had multiple medication refusals, including multiple cream refusals from 8/21/15 until 10/14/15, when the cream was discontinued.

Further the patient's hospice record included multiple RN visit notes which documented the patient refused the cream, as well as, other medications. The record documented patient education regarding the medication use and the patient's response. When the patient's response was continued refusal, the patient's refusals were honored and she did not receive the cream or other medications.

It could not be determined that patients were receiving inappropriate medications or that their right to refuse medications was not being upheld. Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



LAURA THOMPSON  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

LT/pmt