



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

October 3, 2016

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

RE: Horizon Hospice, Provider #131520

Dear Mr. Higby:

Based on the survey completed at Horizon Hospice, on September 19, 2016, by our staff, we have determined Horizon Hospice is out of compliance with the Medicare Hospice Condition of Participation of **Patients' Rights (42 CFR 418.52) and Clinical Records (42 CFR 418.104)**. To participate as a provider of services in the Medicare Program, a hospice agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Horizon Hospice, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;

Trevor Higby, Administrator
October 3, 2016
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- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the hospice agency into compliance, and that the hospice agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before November 3, 2016. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than October 26, 2016.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 17, 2016.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

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

Sincerely,



DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt

Enclosures

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



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

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OCT 17 2016
FACILITY STANDARDS

October 17, 2016

ATTN: Dennis Kelly, RN

3232 Elder Street

Boise, ID 83720-009

Re: Credible Allegation of compliance/Plan of Correction

Dear Mr. Kelly

Pursuant to the survey completed at Horizon Hospice on September 19, 2016, please be advised that nurse A, mentioned in the survey findings, is no longer employed with Horizon Hospice.

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 evidenced in the Plan of correction and the enclosures, we have conducted staff education in each of the efficiencies cited and will continue to maintain evidence of compliance through continued education in each of the deficiencies cited and will continue to maintain evidence of compliance through chart audits and new staff orientation. The enclosures will speak to our compliance with the Conditions of Participation and include:

Policy No. 2-024 Hospice election Statement

Policy No. 2-030 Comprehensive Assessment

Policy No. 2-023 Admission Criteria and Process

Delivering Life Changing Service

Boise/Meridian
(208) 888-7877
(208) 888-7987 Fax

Mountain Home
(208) 587-6854
(208) 587-6872 Fax

Twin Falls/Burley
(208) 733-2840
(208) 733-2835 Fax

Caldwell/Nampa
(208) 455-1990
(208) 455-4274 Fax

Emmett
(208) 365-1693
(208) 365-1694 Fax

Weiser
(208) 549-2104
(208) 549-2108 Fax



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Policy No. 2-064 Care of the Dying Patient

Policy No. 1-001 Rights and Responsibilities

Attachments:

PowerPoint Presentation of Training conducted In Branches

Hospice Compliance In-service Quiz

Hospice care Conference Agenda/Attendance form

SOC Audit Sheet

Patient Information Sheet

Pharmacy Information Sheet

Horizon Hospice Consent Forms

Nurse's On Call Schedule

Advanced Directives Information Packet

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

Please express our appreciation for the professionalism and helpfulness demonstrated by the survey team during the conduction of our survey.

Sincerely



Bridger Booras

Administrator

Home Health and Hospice

Delivering Life Changing Service

Boise/Meridian
(208) 888-7877
(208) 888-7987 Fax

Mountain Home
(208) 587-6854
(208) 587-6872 Fax

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

PRINTED: 10/03/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/19/2016
NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83642		
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L 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey of your hospice from 9/14/16 to 9/19/16. Surveyors conducting the investigation were: Nancy Bax, RN, HFS, Team Leader Brian Osborn, RN, HFS Jennifer Davis, RN, HFS Acronyms used in this report include: ALF - Assisted Living Facility CHF - Congestive Heart Failure ED - Executive Director ER - Emergency Room GU - Genitourinary HSD - Health Service Director ID - Idaho LPN - Licensed Practical Nurse ml - milliliters POC - Plan of Care POA - Power of Attorney Q - every RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	L 000			
L 500	418.52 PATIENTS' RIGHTS This CONDITION is not met as evidenced by: Based on agency medical record review, ALF medical record review, agency staff interview, ALF staff interview, and patient representative interview, it was determined the agency failed to ensure patients were informed of their rights and that patient rights were upheld and promoted. This failure had the potential to result in lack of	L 500	L500- 418.52 PATIENT RIGHTS The Agency will ensure that patients are informed of their rights and that patient rights are upheld and promoted. Pursuant to the survey completed at Horizon Hospice, Nurse A, mentioned in these survey findings, is no longer employed with Horizon Hospice. The nursing staff of Burley and Twin Falls Branches were educated on 9/20/16 regarding the outcome of the complaint survey with specific changes and re-education of Horizon policies, procedures and best practices. A quiz was provided to staff in attendance to test understanding and retention of the education provided along with an outline of the discussion. A quiz will also be provided to staff in all agency locations following the in-service referenced in the Plan of Correction [attached].		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 10/21/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 500	Continued From page 1 advocacy due to insufficient information being readily available to patients and their representatives. Findings include: 1. Refer to L503 as it relates to the agency's failure to ensure written advance directive policy information was distributed to patients or their representatives. 2. Refer to L504 as it relates to the agency's failure to ensure patients or their representatives received a copy of the notice of rights and responsibilities. 3. Refer to L512 as it relates to the agency's failure to ensure patients received effective pain management and symptom control. 4. Refer to L513 as it relates to the agency's failure to ensure patients or their representatives were involved in the hospice plan of care. 5. Refer to L517 as it relates to the agency's failure to ensure patients were free from neglect. 6. Refer to L518 as it relates to the agency's failure to ensure patients or their representatives received information about the services covered under the hospice benefit. The cumulative effect of these systemic deficient practices resulted in the agency's inability to ensure patients were protected and their rights were upheld.	L 500	Consent change: The patient or patient representative will be provided a copy of the consent signed by the patient/patient representative and a Horizon representative which outlines the patient rights and responsibilities. To the acknowledgement section of the consents, the following will be added: "I have received a copy..." and when checked, the box by the specified patient rights, will indicate this occurred with the patient and/or the patient representative. The patient/patient representative's signature, located underneath the acknowledgement section of the consents, will further affirm that the patient has been informed of this policy verbally and in writing. Staff Education: An in-service will be provided via PowerPoint presentation by the Leadership Team in each of the branch locations for the hospice nursing, social services, intake/medical records staff to review the revised patient consents. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator. Office staff will be directed by the DON, Operations Manager or designee to ensure all new admit packets have old consent forms removed and replaced with new revised consent forms. Responsible: Director of Nursing and Operations Manager/Administrator or designee has overall responsibility for the corrective action and ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.		
L 503	418.52(a)(2) NOTICE OF RIGHTS AND RESPONSIBILITIES (2) The hospice must comply with the	L 503			

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L 503	<p>Continued From page 2</p> <p>requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure each patient right to receive information regarding advanced directives was upheld for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This failure had the potential to result in patients being denied access to services because they did not have an advance directive. Findings include:</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 with a terminal diagnosis of CHF. She resided in an ALF, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>Patient #8's partial record included an RN SOC visit note dated 8/26/16 at 5:41 PM to 6:34 PM, signed by RN A. The visit noted stated "NOTICED THAT PATIENT WAS FULL CODE INSTRUCTED DAUGHTER [name] WHO IS ALSO THE POA, SHE WILL HAVE TO SIGN A NEW POST [Physician Orders for Scope of Treatment] BECAUSE SHE WILL HAVE TO BE A DNR [Do Not Resuscitate].</p> <p>The Idaho Department of Health and Welfare website, accessed on 9/20/16, described the POST as a standardized form that allows all Idaho citizens over age 18 to express their</p>	L 503	<p>LS03- 418.52 (a)(2) NOTICE OF RIGHTS AND RESPONSIBILITIES The Agency will provide the patient/patient's representative a copy of the information on Advance Directives.</p> <p>Process Change: At the time of admission to hospice services, a copy of the Advanced Directive policy information will be provided to the patient/patient representative. A copy of the POST form, included in the Advance Directive information, will also be provided to the patient or patient representative at the time of admission to hospice services. This information will be inside the admission packets. In the acknowledgement section of the revised consent, the verbiage: "I have received a copy..." will be added and by checking the box next to Advanced Directives it will confirm that this process has completed. The patient signature located underneath the acknowledgement section of consents will further affirm that the patient has been informed of this policy verbally and in writing.</p> <p>Staff Education: Hospice nursing, social services and intake/medical records staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations, regarding the revised consents and written advanced directive policy. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator. Office staff will be directed to ensure all new admit packets contain copies of the agency's information on the policy Advanced Directives and a copy of the POST form.</p> <p>Responsible: Director of Nursing and Operations Manager or designee has overall</p>		

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L 503	Continued From page 3 wishes regarding medical treatment.	L 503	Responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.		
L 504	<p>During an interview on 9/15/16 at 9:40 AM, the hospice Clinical Supervisor stated it was not the agency's practice to require a DNR status for their patients. She stated RNA was educated regarding each patient's right to make decisions regarding their medical care.</p> <p>The agency failed to ensure patient's right to receive information regarding advanced directives was upheld.</p> <p>418.52(a)(3) NOTICE OF RIGHTS AND RESPONSIBILITIES</p> <p>(3) The hospice must obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the agency failed to ensure patients' or representatives' signatures were obtained to confirm receipt of the notice of rights and responsibilities for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This had the potential to result in a lack of patient or representative understanding of their rights and responsibilities. Findings include:</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16,</p>	L 504	<p>L504- 418.52(A)(3) NOTICE OF RIGHTS AND RESPONSIBILITIES</p> <p>The agency must obtain the patients or representatives signature confirming that he or she has received a copy of the notice of rights and responsibilities.</p> <p>The patient or patient representative will be provided a copy of the consent signed by the patient/patient representative and a Horizon representative which outlines the patient rights and responsibilities. To the acknowledgement section of the consents, the following will be added: "I have received a copy..." and when checked, the box by the specified patient rights, will indicate this occurred with the patient and/or the patient representative. The patient/patient representative's signature, underneath the acknowledgement section of the consents, will further affirm that the patient has been informed of this policy verbally and in writing.</p> <p>Staff Education: Hospice nursing, social services and intake/medical records staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations, regarding the revised consents and written advanced directive policy. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator.</p>		

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L 504	Continued From page 4 and she died on 8/28/16. The agency's policy "RIGHTS/RESPONSIBILITIES," undated, was reviewed. It stated "The patient will acknowledge having received the Patient Rights and Responsibilities form by signing the Patient Consent. The original form will be kept in the patient's clinical record." Patient #8's partial medical record was provided by the hospice Director of Operations on 9/14/16 at approximately 5:15 PM. The partial record did not include a signed consent or receipt of rights and responsibilities. A copy of Patient #8's signed consent for services, election of benefits, and receipt of rights and responsibilities was requested on 9/16/16 at approximately 9:00 AM. On 9/16/16 at 10:00 AM, the hospice Director of Operations and the hospice Clinical Supervisor stated they were unable to provide the requested documents. They stated the documents were shredded by the agency's office staff after Patient #8 revoked hospice services. The hospice Director of Operations and the hospice Clinical Supervisor stated a decision was made not to bill for Patient #8's services, so she was made a "non-admit" and her admission paperwork was destroyed. The agency failed to ensure a signed receipt of patient rights and responsibilities for Patient #8 was maintained.	L 504	Responsible: Director of Nursing and Operations manager or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing. L512- 418.5 (C)(1) RIGHTS OF THE PATIENT The agency will ensure patients receive effective pain management and symptom control for conditions related to their terminal illness and related conditions. Staff Education: Hospice nursing and social services staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations, regarding [Policy 2-064.1] Care of the Dying Patient and review the agency pharmacy and pharmacy availabilities focusing on after-hours services. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including the patient's right for pain management and symptom control. Non pharmacological interventions for symptom control will be reviewed. Bladder scanners will be purchased for each branch.	
L 512	418.52(c)(1) RIGHTS OF THE PATIENT The patient has a right to the following: (1) Receive effective pain management and	L 512	Responsible: Director of Nursing, Operations manager and/ or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.	

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L 512	<p>Continued From page 5 symptom control from the hospice for conditions related to the terminal illness;</p> <p>This STANDARD is not met as evidenced by: Based on agency medical record review, ALF medical record review, agency staff interview, ALF staff interview, and patient representative interview, it was determined the agency failed to provide patients with palliative treatment for symptom management related to the terminal diagnosis for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This resulted in a patient revoking services to seek symptom management. Findings include:</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>On 9/15/16 at 1:00 PM, a visit was made to the ALF where Patient #8 resided at the time of her admission to the hospice agency. The ALF ED and the HSD were interviewed. They stated when they have a resident who is receiving hospice services, the ALF Medication Aides are able to administer medications prepared by the hospice agency nurses. The ALF ED and the HSD stated oral liquid medications such as Morphine and Lorazepam are provided by the hospice agency in single dose syringes, for administration by the ALF Medication Aides.</p> <p>The ALF ED and HSD stated they did not feel</p>	L 512			

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L 512	<p>Continued From page 6</p> <p>Patient #8's symptoms were managed by the hospice agency. They stated Patient #8 became agitated and was crying out in pain late at night on 8/26/16. The ALF ED and the HSD stated their Medication Aide called RN A who made the SOC visit earlier that evening. They stated RN A instructed her to administer Lorazepam at 11:45 PM. The HSD stated RN A did not leave Lorazepam at the ALF for Patient #8.</p> <p>During a phone interview on 9/16/16 at 10:11 AM, the HSD stated the Medication Aide told her she was instructed by RN A to borrow a dose of Lorazepam from another hospice patient who resided in the ALF.</p> <p>The ALF ED and HSD presented the ALF's progress notes for Patient #8. An entry dated 8/27/16 was signed by the Medication Aide. The entry stated the Medication Aide called RN A at 12:56 AM on 8/27/16, but there was no answer. It stated the Medication Aide called RN A again at 1:40 AM, and told her Patient #8 was restless and yelling for help. The entry stated RN A instructed her to increase Patient #8's Morphine from every 2 hours to every 1 hour, but knew she did not have enough Morphine to administer hourly until the nurse would be there to provide more medication. The entry stated additional calls were made to the hospice agency, but no one from the hospice agency came to see Patient #8. The note stated the ALF ED instructed the Medication Aide to call 911 and send Patient #8 to the ER for pain relief. The entry stated Patient #8 was sent to the ER at approximately 4:55 AM on 8/27/16.</p> <p>The ALF provided a document titled "Controlled Drug Record" for Patient #8. It stated the initial</p>	L 512			

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L 512	<p>Continued From page 7</p> <p>quantity of Morphine doses, prepared by RN A, was 7. During an interview on 9/16/16 at 11:12 AM, the hospice Director of Operations and the hospice Clinical Supervisor confirmed RN A did not prepare enough syringes of Morphine for Patient #8 to allow for hourly administration.</p> <p>The ALF's progress notes for Patient #8 included an entry dated 8/27/16, signed by the HSD. The note included the following:</p> <ul style="list-style-type: none"> - 8:21 AM: Patient #8 returned to the ALF from the ER. - 9:45 AM: The ALF HSD called RN A and LPN C. The entry stated "Reviewed need for agency RN to respond to facility [ALF] to assess resident condition and conference with agency medical director for further orders as soon as possible due to facility staff reports of symptoms of agitation present currently and provide continuous care to resident until she is comfortable and able to safely remain in ALF." - 10:06 AM: The HSD received a phone call from hospice nurse stating she was still in Twin Falls, ID gathering supplies. The HSD stressed the need to respond as soon as possible to assess Patient #8's condition. - 10:53 AM: The ALF Medication Aide received a phone call from the hospice Regional Manager stating the agency nurse was on her way, approximately 40 minutes away from the ALF. - 11:31 AM: The HSD received a call from the hospice Clinical Supervisor who told her the on-call nurse obtained physician orders, was currently gathering supplies at the office in Twin 	L 512			

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L 512	<p>Continued From page 8</p> <p>Falls, ID and would arrive at the ALF in 30 to 40 minutes.</p> <p>- 12:07 PM: The HSD received a call from the hospice Clinical Supervisor who stated she spoke to Patient #8's daughter who told her they planned to transport Patient #8 back to the ER.</p> <p>The agency provided on-call notes contained in an e-mail sent to the hospice Director of Operations by LPN C, dated 8/28/16 at 2:16 PM. The notes documented calls regarding Patient #8 on 8/27/16. They stated LPN C received a call from the ALF Medication Aide at 3:58 AM, reporting Patient #8 was "SCREAMING FOR HELP AND CRYING IN PAIN." The notes stated the ALF needed more Lorazepam and Morphine syringes filled.</p> <p>The agency on-call notes stated LPN C received a call from the ALF ED at 4:23 AM, stating Patient #8 was being sent to the ER. The notes said the ED stated "[RN name] WAS ASKED TO PUT A CATHETER IN LAST NIGHT AND NOW THE DAUGHTER IS VERY UPSET. THE PATIENT IS SCREAMING, CLAPPING HER HANDS, AND NEEDS TO GO TO THE BATHROOM."</p> <p>Patient #8's hospital ER record was obtained. A physician's note stated she was examined on 8/27/16 at 5:10 AM. The note stated a bladder scan showed almost 1 liter of urine in her bladder. It stated "An in and out catheter was done which was helpful in relieving the pressure from her full bladder."</p> <p>Patient #8's partial record included an RN SOC visit note, dated 8/26/16 from 5:41 PM to 6:34</p>	L 512			

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L 512	<p>Continued From page 9</p> <p>PM, signed by RN A. The visit note included vital signs, oxygen saturation level, and a pain score of 2 on a scale of 0-10, with 10 being the worst pain. No additional pain assessment was documented.</p> <p>The SOC visit note stated "FILLED SYRINGES PER ORDER MORPHINE Q 2 HRS [hours] AND LORAZEPAM Q BEDTIME." The note did not state how many syringes were filled with each medication.</p> <p>The SOC visit note stated RN A spoke with Patient #8's daughter, who was her POA, about inserting a urinary catheter, and the catheter was declined by the daughter. The visit note did not include an assessment of Patient #8's GU status.</p> <p>RN A was interviewed by phone on 9/15/16 at 4:00 PM. She stated she prepared 8 syringes of Morphine for the ALF staff to administer to Patient #8. She stated she did not prepare syringes of Lorazepam because she did not have additional syringes. When asked how she could obtain more syringes, she stated she would have to drive to the Twin Falls, ID agency office which was 45 minutes away. When asked if she could obtain syringes at the local agency office in Burley, ID, RN A stated she did not know what supplies were available in the Burley, ID office. RN A stated it was a last minute admission on Friday evening and she was not prepared with additional syringes.</p> <p>RNA stated Patient #8 was moaning and groaning during the SOC visit. When asked if she assessed her GU status she stated she did not know when Patient #8 had last voided. RNA stated she believed the ALF staff told her they</p>	L 512			

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L 512	<p>Continued From page 10</p> <p>tried to toilet Patient #8 but she could not remember if she voided.</p> <p>RNA stated she did not contact LPN C who was on-call for the weekend, to give her information regarding Patient #8's admission and status. When asked if she received calls from the ALF staff on the night of Patient #8's admission, she stated she did not remember receiving calls. RN A stated she did not make a visit after the SOC visit.</p> <p>Patient #8's daughter, who was her POA, was interviewed by phone on 9/19/16 at 8:30 AM. She stated she was present for the RN SOC visit on 8/26/16. The daughter stated she told RN A she wanted a urinary catheter for her mother. She stated RN A told her a urinary catheter would not be available until Monday, 8/29/16. Additionally, the daughter stated RN A told her Patient #8's medications had not been delivered to the ALF, and she would borrow medication from another resident at the ALF.</p> <p>LPN C was interviewed by phone on 9/16/16 at 8:15 AM. LPN C stated she did not contact Patient #8's family the night of 8/26/16 to 8/27/16. She confirmed Patient #8 did not receive an SN visit to address her pain and urinary symptoms.</p> <p>RNA did not provide sufficient quantities of Morphine and Lorazepam to ensure Patient #8's pain and anxiety were controlled. RN A did not assess Patient #8's GU status during the SOC visit to determine the need for a catheter. RN A did not communicate with LPN C regarding Patient #8's status, including lack of sufficient medications. The agency did not provide SN visits to assess Patient #8's pain and GU status.</p>	L 512		

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L 512	Continued From page 11	L 512			
L 513	<p>The agency failed to ensure Patient #8's symptoms were controlled.</p> <p>418.52(c)(2) RIGHTS OF THE PATIENT</p> <p>[The patient has a right to the following:] (2) Be involved in developing his or her hospice plan of care;</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure the patient and/or representative was involved in developing the agency POC, for 1 of 1 patients (Patient #8) who transferred or revoked, and whose records were reviewed. This resulted in lack of input from the patient's representative regarding care received from the agency.</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>The agency provided on-call notes contained in an e-mail sent to the hospice Director of Operations from LPN C, who was on-call on 8/26/16 and 8/27/16. The email was dated 8/28/16 at 2:16 PM, and included notes beginning on 8/27/16. They stated LPN C received a call from the ALF Medication Aide at 3:58 AM, reporting Patient #8 was "SCREAMING FOR HELP AND CRYING IN PAIN." The notes stated the ALF needed more Lorazepam and Morphine syringes filled.</p>	L 513	<p>L513-418.52(c)(2) RIGHTS OF THE PATIENT The agency will ensure the patient or patient representative is involved in the development of the Hospice plan of care.</p> <p>Staff Education: Hospice nursing and social services staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations, regarding the Care Conference process. Contacting the patient's family with status changes and routine updates will also be reviewed. Every effort will be made to organize a Care Conference with family and with the facility staff when a patient resides in a facility, no greater than 10 days after admit and no greater than 10 days before or after recertification of the patient. An agenda/attendance record [attached] will be completed by hospice representative identifying the topics discussed, including a review of the plan of care. This form will be submitted to Medical Records to be attached to the patient's clinical record.</p> <p>Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including the Care Conference process.</p> <p>Responsible: Director of Nursing, Operations manager and/ or designee has overall responsibility for the corrective action an ongoing completion of this deficiency.</p> <p>Completion: 11/02/2016 and ongoing.</p>		

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L 513	<p>Continued From page 12</p> <p>The agency on-call notes stated LPN C was on her way to the ALF to see Patient #8 when she received a call from the ALF ED at 4:23 AM, stating Patient #8 was being sent to the ER. There was no documentation stating LPN C contacted Patient #8's family to determine whether they wanted her to go to the ER or remain at the ALF with hospice services.</p> <p>The agency on-call notes stated LPN C spoke with the ALF ED on 8/27/16 at 8:30 AM, after Patient #8 returned to the ALF. The ALF ED stated she would talk to Patient #8's family to determine whether they wanted to continue hospice services. There was no documentation stating LPN C contacted Patient #8's family to determine whether they wanted to continue hospice services.</p> <p>LPN C was interviewed by phone on 9/16/16 at 8:15 AM. LPN C stated she did not contact Patient #8's family the night of 8/26/16 to 8/27/16. She stated she communicated with the ALF staff. LPN C stated she should have spoken with Patient #8's family.</p>	L 513		
L 517	<p>418.52(c)(6) RIGHTS OF THE PATIENT</p> <p>[The patient has a right to the following:] (6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;</p>	L 517	<p>L517-418.52(c)(6) RIGHTS OF THE PATIENT The agency will ensure patients are free from mistreatment, neglect, or verbal, mental, sexual abuse, including injury of unknown source, and misappropriation of patient property.</p> <p>Staff Education: Hospice nursing and social services staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations, with a review and discussion of the</p>	

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L 517	Continued From page 13 This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure 1 of 1 patients (Patient #8) whose hospice services were revoked, and whose partial record was reviewed, received agency services necessary to avoid physical harm and/or mental anguish. This endangered the physical and mental safety of the patient. Findings include: REFER to L512 The agency failed to provide Patient #8 with sufficient medications, failed to ensure her pain and urinary symptoms were controlled, and failed to provide SN visits when notified of her distress.	L 517	neglect, or verbal, mental, sexual abuse, injury of unknown source..." and how to avoid. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including a discussion and definition of abuse, neglect, exploitation and misappropriation of property. Responsible: Director of Nursing, Operations manager and/ or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.		
L 518	418.52(c)(7) RIGHTS OF THE PATIENT [The patient has a right to the following:] (7) Receive information about the services covered under the hospice benefit; This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed, received information about the services covered under the hospice benefit. This failure resulted in the potential for patient needs to be unmet. Findings include: Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the	L 518	L518- 418.52(c)(7) RIGHTS OF THE PATIENT The agency will ensure patients or patient representatives receive information about the services covered under the hospice benefit. Consent Revision: The Admission consent will be revised to clarify the 4 levels of Hospice Care and at the time of admission, the start of care clinician will identify with a check mark, the level of care under which the patient is being admitted . To the acknowledgement section of the consents, the following will be added: "I have received a copy..." and when checked, the box by the specified patient rights, will indicate this occurred with the patient and/or the patient representative. The patient/patient representative's signature, located underneath the acknowledgement section of the consents, will further affirm that the patient has been informed verbally and in writing of the level of hospice care. Staff Education: Hospice nursing, social services and intake/medical records staff will		

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L 518	Continued From page 14 agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16. The agency provided on-call notes contained in an e-mail sent to the hospice Director of Operations by LPN C who was on-call, dated 8/28/16 at 2:16 PM. The notes outlined calls received by LPN C on 8/27/16, regarding Patient #8. The notes stated Patient #8 was sent to the ER twice on 8/27/16, due to unmanaged pain and urinary symptoms. The hospice's Administrator, Director of Operations, Director of Nursing, and Clinical Supervisor were interviewed together on 9/15/16 at 9:40 AM. They reviewed the on-call notes regarding Patient #8's hospice care on 8/26/16 to 8/27/16. The hospice Director of Operations stated Patient #8's needs could not be met by the staff at the ALF. He stated continuous care or general inpatient care was appropriate for her, and should have been provided by the agency. The hospice Director of Operations confirmed Patient #8's family was not given information about continuous care or general inpatient care services covered under the hospice benefit, or given the opportunity to choose those services. Patient #8's family was not informed of all services covered under the hospice benefit.	L 518	be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations, regarding the 4 Levels of Hospice Care and the need to identify, at the time of admission, the level of Hospice care in which the patient is being admitted. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including the 4 Levels of Hospice Care. Responsible: Director of Nursing, Operations manager and/ or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.		
L 522	418.54(a) INITIAL ASSESSMENT The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with §418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)	L 522			

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L 522	Continued From page 15 This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to conduct a patient specific comprehensive assessment that identified unique patient needs for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This resulted in the agency not having comprehensive information critical to ensure the patient received adequate care. Findings include: Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16. Patient #8's partial record included an RN SOC visit note, dated 8/26/16 from 5:41 PM to 6:34 PM, signed by RN A. The visit note included vital signs, oxygen saturation level, and a pain score of 2 on a scale of 0-10, with 10 being the worst pain. It did not state location, history, or type of pain. No additional pain assessment was documented. The note stated Patient #8's immunological and endocrine systems were assessed. There was no assessment documented of other systems, such as cardiac, respiratory, neurologic, or skin. The SOC visit note stated RN A spoke with Patient #8's daughter who was her POA, about inserting a urinary catheter, and the catheter was declined by the daughter. The visit note did not include an assessment of Patient #8's GU status to determine the need for a catheter.	L 522	L-522 - 418.54-INITIAL ASSESSMENT The agency will conduct a patient specific comprehensive assessment within 48 hours after the election of hospice care to identify unique patient needs (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours). Staff Education: Hospice nursing staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations, on the appropriate completion of a Comprehensive Assessment. For every patient admitted for hospice services, a Comprehensive Assessment will be completed in the Electronic Record. To ensure compliance, this will be monitored as part of the current QAPI process of 100% review of Admissions (see attached tool). Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which		

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L 522	Continued From page 16 RN A was interviewed by phone on 9/15/16 at 4:00 PM. RN A stated Patient #8 was moaning and groaning during the SOC visit. When asked if she assessed her GU status she stated she did not know when Patient #8 had last voided. RN A stated she believed the ALF staff told her they tried to toilet Patient #8, but she could not remember if she voided. RN A stated she did not document a comprehensive initial assessment because Patient #8 revoked hospice services the following day and the agency made her a "non-admit."	L 522	will be provided for all new Hospice staff by our Staff Education Coordinator including the Comprehensive Assessment completion and timeline. Responsible: Director of Nursing, Operations manager and/ or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.		
L 557	RN A failed to complete an initial assessment to determine Patient #8's immediate needs. 418.56(e)(4) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to maintain a system of communication and integration to ensure information was shared between all nurses providing care for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This failure resulted in a lack of coordination of care and failure to meet the patient's needs.	L 557	L-557-418.56(e)(4) COORDINATION OF SERVICES The agency will maintain a system of communication and integration to ensure information is shared between all disciplines.		

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L 557	<p>Continued From page 17</p> <p>Findings include:</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>Patient #8's partial record included an RN SOC visit note dated Friday 8/26/16 at 5:41 PM to 6:34 PM, signed by RN A. The note did not document communication with other nurses, including LPN C, who was on-call for the weekend.</p> <p>During a phone interview on 9/15/16 at 4:00 PM, RN A stated she did not have contact with LPN C until the morning of 8/27/16.</p> <p>During a phone interview on 9/16/16 at 8:15 AM, LPN C stated she was not aware of Patient #8's admission to hospice on 8/26/16, when she received a call from the ALF regarding Patient #8 on 8/27/16 at 3:58 AM. She stated RN A did not communicate with her on the day of Patient #8's admission. LPN C stated she received a call from the ALF stating Patient #8 needed additional pain medication but she did not know what medication and supplies were available at the ALF for Patient #8.</p> <p>During an interview on 9/16/16 at 11:12 AM, the hospice Director of Operations and the hospice Clinical Supervisor stated they expected RNs to communicate with the rest of the agency team by phone or e-mail following an SOC visit. They confirmed there was no documentation of communication by phone, and confirmed no e-mail was sent on 8/26/16, regarding Patient</p>	L 557	<p>Staff Education: Hospice nursing, social services and intake/medical records staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding the importance and procedure for the sharing of patient information. The clinician who performs the comprehensive assessment will provide detailed, patient-specific information to the interdisciplinary team via email and/or telephone report. This same procedure will be followed to communicate significant changes/impending changes in the patient's condition especially for the weekend and after-hours on call staff. A standup call will be conducted at all branch locations. This standup call will include Director of Nursing and or Branch Managers. A highlighted summary of these calls will be emailed to the Administrator and DON. An admission narrative will be entered in the electronic medical record. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including the need for sharing of patient information with the interdisciplinary staff.</p> <p>Responsible: Director of Nursing, Operations Manager and/or designee has overall responsibility for the corrective action and ongoing completion of this deficiency.</p> <p>Completion: 11/02/2016 and ongoing.</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/19/2016
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L 557	Continued From page 18 #8's admission to hospice.	L 557			
L 652	The agency failed to ensure communication between nurses providing care occurred. 418.100(c)(1) SERVICES (1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice: (i) Nursing services. (ii) Medical social services. (iii) Physician services. (iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling. (v) Hospice aide, volunteer, and homemaker services. (vi) Physical therapy, occupational therapy, and speech-language pathology services. (vii) Short-term inpatient care. (viii) Medical supplies (including drugs and biologicals) and medical appliances. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure inpatient care was implemented for pain control and symptom management for 1 of 1 patients (Patient #8) whose services were revoked and whose partial record was reviewed. This resulted in lack of pain control and symptom management for the patient. Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the	L 652			

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L 652	<p>Continued From page 19</p> <p>agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>During an interview on 9/14/16 at 1:55 PM, the hospice Director of Operations explained the agency's on-call process. He stated 1 RN and 1 LPN were on-call each day. The hospice Director of Operations stated patient calls went to an answering service, and the LPN on-call was the first person to be called by the answering service. If the LPN did not answer the answering service would call the RN on-call. Additionally, he stated the RN was available as a resource to the LPN.</p> <p>The hospice provided on-call notes contained in an e-mail sent to the hospice Director of Operations by LPN C, dated 8/28/16 at 2:16 PM. The notes were dated 8/26/16. The notes outlined calls received by LPN C, regarding Patient #8. The notes stated Patient #8 was sent to the ER twice on 8/27/16, due to unmanaged pain and urinary symptoms.</p> <p>The hospice's Administrator, Director of Operations, Director of Nursing, and Clinical Supervisor were interviewed together on 9/15/16 at 9:40 AM. They reviewed the on-call notes regarding Patient #8's hospice care on 8/27/16. The hospice Director of Operations stated Patient #8's needs could not be met by the staff at the ALF. He stated continuous care or general inpatient care was appropriate for her, and should have been provided by the agency.</p> <p>The hospice Director of Operations and hospice Clinical Supervisor stated education was provided to hospice nurses on 9/01/16 and 9/02/16. They stated the education included continuous care and general inpatient care. The hospice Director</p>	L 652	<p>The agency will ensure inpatient care is implemented for pain control and symptom management when indicated.</p> <p>Staff Education: Hospice nursing and social services staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding the 4 Levels of Hospice care with a focus on General Inpatient Care, the indicators for GIP and when/how to facilitate this process with inpatient facilities. When a patient's level of care changes, the hospice staff and leadership will be notified via email and/or phone of this change. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including the definition of and the process for implementing General Inpatient Care.</p> <p>Responsible: Director of Nursing, Operations manager and/ or designee has overall responsibility for the corrective action an ongoing completion of this deficiency.</p> <p>Completion: 11/02/2016 and ongoing.</p>		

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L 652	<p>Continued From page 20 of Operations and hospice Clinical Supervisor stated the nurses were given binders, with information on levels of care, to carry with them so they could easily refer to them.</p> <p>During an interview on 9/16/16 at 8:15 AM, LPN C stated she did not attend the agency training on 9/01/16 and 9/02/16. She stated all nurses were not able to attend as the agency had to ensure nurses were available to provide patient care. LPN C stated she did not receive the training or the binder provided by the agency.</p> <p>RN B, who was on-call on 8/26/16 and 8/27/16, was interviewed by phone on 9/16/16 at 9:40 AM. She stated she began working for the agency in July of 2015, but provided only home health visits, not hospice visits. She stated she started providing hospice visits for the agency on 8/16/16. RN B stated she attended the agency training on 9/01/16 and 9/02/16, and received the binder of information. When asked about her understanding of general inpatient care, RN B described it as providing hospice services to a resident of an ALF. She was unable to describe general inpatient care, when it would be appropriate for a hospice patient, or state how it would be initiated.</p> <p>The agency failed to ensure agency staff were educated and prepared to initiate general inpatient care when appropriate.</p>	L 652		
L 653	<p>418.100(c)(2) SERVICES</p> <p>(2) Nursing services, physician services, and drugs and biologicals (as specified in §418.106) must be made routinely available on a 24-hour basis 7 days a week. Other covered services</p>	L 653		

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L 653	<p>Continued From page 21</p> <p>must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.</p> <p>This STANDARD is not met as evidenced by: Based on agency record review, agency policy review, ALF medical record review, agency staff interview, ALF staff interview, and patient representative interview, it was determined the agency failed to ensure nursing services and medication were available 24 hours a day, 7 days a week, for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This resulted in lack of nursing services and medications to meet the patient's needs. Findings include:</p> <p>An agency policy "HOSPICE NURSING CARE," undated, was reviewed. The policy included "A hospice nurse will be available on a 24-hour basis to meet the physical, psychosocial, spiritual, and practical needs of patients and family/caregivers admitted to the hospice program."</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>RN A, who completed Patient #8's SOC visit, was interviewed by phone on 9/15/16 at 4:00 PM. She stated she prepared 8 syringes of Morphine for the ALF staff to administer to Patient #8. RN A stated she did not prepare syringes of Lorazepam because she did not have additional syringes. When asked how she could obtain more syringes, she stated she would have to drive to</p>	L 653	<p>L653 418.100(c)(2) SERVICES</p> <p>The agency will ensure nursing services, physician services and biologicals are routinely available 24 hours a day, 7 days a week.</p> <p>Staff Education: Hospice nursing and social services staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding this agency's pharmacy, nursing on call practices and medical director's availability 24 hours a day, 7 days a week. The name of the pharmacy, hours of operation and how to access the pharmacy after hours will be provided. An informational sheet will be included in the admission packet and made available to patients or patient's representative that includes 24/7 contact number for nursing staff and a statement of arrival time. The Admission Consent acknowledgement will affirm that the patient/patient representative has received 24/7 availability information verbally and in writing.</p> <p>Office staff will routinely check admit packets against a master list to ensure all incorporated materials are included in the packet taken to the patient. An on-call electronic calendar will be developed and maintained by the DON or designee. The answering service will also be provided a monthly on-call calendar in order to contact nursing staff after hours and on weekends. A printed on-call calendar will be provided to the hospice staff upon request.</p>		

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L 653	<p>Continued From page 22</p> <p>the Twin Falls, ID agency office which was 45 minutes away. When asked if she could obtain syringes at the local agency office in Burley, ID, RN A stated she did not know what supplies were available in the Burley, ID office. RN A stated it was a last minute admission on Friday evening and she wasn't prepared with additional syringes.</p> <p>On 9/15/16 at 1:00 PM, a visit was made to the ALF where Patient #8 resided at the time of her admission to hospice. The ALF ED and the HSD were interviewed. They stated Patient #8 became agitated and was crying out in pain late at night on 8/26/16. The ALF ED and the HSD stated their Medication Aide called RN A who instructed her to administer Lorazepam at 11:45 PM. The HSD stated RN A did not leave Lorazepam at the ALF for Patient #8.</p> <p>During a phone interview on 9/16/16 at 10:11 AM, the HSD stated the Medication Aide told her she was instructed by RN A to borrow a dose of Lorazepam from another hospice patient who resided in the ALF.</p> <p>The ALF ED and HSD presented the ALF's progress notes for Patient #8. An entry dated 8/27/16 was signed by the Medication Aide. The entry stated the Medication Aide called RN A at 12:56 AM on 8/27/16, but there was no answer. It stated the Medication Aide called RN A again at 1:40 AM, and told her Patient #8 was restless and yelling for help. The entry stated RN A instructed her to increase Patient #8's Morphine from every 2 hours to every 1 hour, but knew she did not have enough Morphine to administer hourly until the nurse would be there to provide more medication. The entry stated additional calls were made to the hospice agency but no one</p>	L 653	<p>Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including the 24-hour availability of nursing services, physician services and biologicals.</p> <p>Responsible: Director of Nursing, Operations Manager/Administrator or designee has overall responsibility for the corrective action an ongoing completion of this deficiency.</p> <p>Completion: 11/02/2016 and ongoing.</p>		

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L 653	Continued From page 23 from the hospice agency came to see Patient #8. It stated the ALF ED instructed the Medication Aide to call 911 and send Patient #8 to the ER for pain relief. Patient #8's daughter, who was her POA, was interviewed by phone on 9/19/16 at 8:30 AM. She stated she was present for the RN SOC visit on 8/26/16. Patient #8's daughter stated RN A told her Patient #8's medications had not been delivered to the ALF, and she would borrow medication from another resident at the ALF. The agency provided on-call notes contained in an e-mail sent to the hospice Director of Operations by LPN C, dated 8/28/16 at 2:16 PM. The notes outlined calls received from the ALF on 8/27/16, regarding Patient #8's pain. According to the on-call notes, no SN visit was provided to Patient #8 following her SOC visit. The agency failed to ensure necessary medications and SN visits were provided to Patient #8.	L 653			
L 660	418.100(f)(2) HOSPICE MULTIPLE LOCATIONS (2) The hospice must continually monitor and manage all services provided at all of its locations to ensure that services are delivered in a safe and effective manner and to ensure that each patient and family receives the necessary care and services outlined in the plan of care, in accordance with the requirements of this subpart and subparts A and C of this section. This STANDARD is not met as evidenced by: Based on agency medical record review, ALF medical record review, agency staff interview,	L 660			

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L 660	<p>Continued From page 24</p> <p>ALF staff interview, and patient representative interview, it was determined the agency failed to ensure the Burley, ID office location was able to provide services consistent with the services provided by the other agency office locations for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This resulted in lack of services provided and unmet patient needs. Findings include:</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>During an interview on 9/14/16 at 12:20 PM, the hospice Clinical Supervisor stated the agency did not have clinical or supervisory staff in Burley, ID. She stated the hospice services provided by the Burley, ID office were currently covered by the clinical and supervisory staff in another multiple location in Twin Falls, ID. The hospice Clinical Supervisor stated per MapQuest (official website finding driving directions) the drive time between the locations was 48 minutes. She stated the nurses who were on-call for hospice services provided in Burley, ID lived in the Twin Falls, ID area.</p> <p>The hospice's Administrator, Operations Manager, Director of Nursing and Clinical Supervisor were interviewed together on 9/15/16 at 9:40 AM. They stated patients who lived in Burley, ID and were admitted to hospice services were told at the time of admission that it would take at least 1 hour for a nurse to arrive at their home, following a call for assistance.</p>	L 660	<p>L660 418.100(f)(2) HOSPICE MULTIPLE LOCATIONS</p> <p>The agency will ensure hospice services in all locations are delivered in a safe and effective manner.</p> <p>Staff Education: Hospice nursing, social services and intake/medical records staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding this agency's pharmacy, nursing on call practices and medical director's availability 24 hours a day, 7 days a week. An informational sheet will be included in the admission packet and made available to patients or patient's representative that includes 24/7 contact number for nursing staff and a statement of arrival time. Branch office supply rooms will be inventoried routinely and stocked by Clinical Supervisors, or designee. Hospice nurses including on-call staff, will have access to the branch office 24/7. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including 24-hour availability of services and biologicals.</p> <p>Responsible: Director of Nursing, Operations manager and/ or designee has overall responsibility for the corrective action an ongoing completion of this deficiency.</p> <p>Completion: 11/02/2016 and ongoing.</p>	

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L 660	Continued From page 25 Patient #8's partial record included an RN SOC visit note, dated 8/26/16 from 5:41 PM to 6:34 PM, signed by RN A. Patient #8's partial record did not include documentation stating she and/or her family were told SN response time after a call for assistance would be at least 1 hour. The SOC visit note stated "FILLED SYRINGES PER ORDER MORPHINE Q 2 HRS [hours] AND LORAZEPAM Q BEDTIME." The note did not state how many syringes were filled with each medication. RN A was interviewed by phone on 9/15/16 at 4:00 PM. She stated she prepared 8 syringes of Morphine for the ALF staff to administer to Patient #8. She stated she did not prepare syringes of Lorazepam because she did not have additional syringes. When asked how she could obtain more syringes, RN A stated she would have to drive to the Twin Falls, ID agency office which was 45 minutes away. When asked if she could obtain syringes at the local agency office in Burley, ID, she stated she did not know what supplies were available in the Burley, ID office. RN A stated it was a last minute admission on Friday evening and she wasn't prepared with additional syringes. The SOC visit note stated RN A spoke with Patient #8's daughter who was her POA, about inserting a urinary catheter, and the catheter was declined by the daughter. Patient #8's daughter, who was her POA, was interviewed by phone on 9/19/16 at 8:30 AM. She stated she was present for the RN SOC visit on 8/26/16. Patient #8's daughter stated she told RN	L 660		

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L 660	<p>Continued From page 26</p> <p>A she wanted a urinary catheter for her mother. She stated RN A told her a urinary catheter would not be available until Monday 8/29/16. Additionally, Patient #8's daughter stated RN A told her Patient #8's medications had not been delivered to the ALF, and she would borrow medication from another resident at the ALF.</p> <p>During an interview on 9/15/16 at 4:00 PM, RN A stated Patient #8's medications were ordered from a pharmacy in Pocatello, Idaho. Per MapQuest the drive time between the locations was 1 hour and 28 minutes.</p> <p>On 9/15/16 at 1:00 PM, a visit was made to the ALF where Patient #8 resided at the time of her admission to hospice. The ALF ED and the HSD were interviewed. They stated Patient #8 became agitated and was crying out in pain late at night on 8/26/16. They stated their Medication Aide called RN A, who instructed her to administer Lorazepam at 11:45 PM. The HSD stated RN A did not leave Lorazepam at the ALF for Patient #8. During a phone interview on 9/16/16 at 10:11 AM, the HSD stated the Medication Aide told her she was instructed by RN A to borrow a dose of Lorazepam from another hospice patient who resided in the ALF.</p> <p>The ALF ED and HSD presented the ALF's progress notes for Patient #8. An entry dated 8/27/16 was signed by the Medication Aide. The entry stated the Medication Aide called RN A at 12:56 AM on 8/27/16, but there was no answer. It stated the Medication Aide called RN A again at 1:40 AM, and told her Patient #8 was restless and yelling for help. The entry stated RN A instructed her to increase Patient #8's Morphine from every 2 hours to every 1 hour, but knew she did not</p>	L 660			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/19/2016
NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83642		
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L 660	<p>Continued From page 27</p> <p>have enough Morphine to administer hourly until the nurse would be there to provide more medication. The entry stated additional calls were made to the agency but no one from the agency came to see the patient. It stated the ALF ED instructed the Medication Aide to call 911 and send Patient #8 to the ER for pain relief.</p> <p>The ALF's progress notes for Patient #8 included a note dated 8/27/16, signed by the HSD. The note included the following:</p> <ul style="list-style-type: none"> - 9:45 AM: The ALF HSD called RN A and LPN C. The entry stated "Reviewed need for agency RN to respond to facility [ALF] to assess resident condition and conference with agency medical director for further orders as soon as possible due to facility staff reports of symptoms of agitation present currently and provide continuous care to resident until she is comfortable and able to safely remain in ALF." - 10:06 AM: The HSD received a phone call from hospice nurse stating she was still in Twin Falls, ID gathering supplies. The HSD stressed the need to respond as soon as possible to assess Patient #8's condition. - 10:53 AM: The ALF Medication Aide received a phone call from the hospice Regional Manager stating the hospice nurse was on her way, approximately 40 minutes away from the ALF. - 11:31 AM: The HSD received a call from the hospice Clinical Supervisor who told her the on-call nurse obtained physician orders and was currently gathering supplies at the office in Twin Falls, ID and would arrive at the ALF in 30 to 40 minutes. 	L 660			

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L 660	Continued From page 28 - 12:07 PM: The HSD received a call from the hospice Clinical Supervisor who stated she spoke to Patient #8's daughter who told her they planned to transport Patient #8 back to the ER. During an interview on 9/16/16 at 8:15 AM, LPN C stated she received a call from the ALF staff regarding Patient #8 on 8/27/16 at 10:38 AM. She stated she talked to RN A and arranged to meet her at the office in Twin Falls, ID at 11:30 AM, prior to driving to the ALF to see Patient #8. She stated after she left the Twin Falls, ID office and was on her way to see Patient #8, she was contacted by ALF staff who stated they were sending Patient #8 to the ER due to her uncontrolled symptoms. LPN C confirmed she did not make it to the ALF to see Patient #8, prior to her transfer to the ER. The agency failed to provide timely and sufficient SN services and medications to Patient #8 who lived in the area serviced by the Burley, ID multiple location.	L 660			
L 670	418.104 CLINICAL RECORDS This CONDITION is not met as evidenced by: Based on medical record review, agency policy review, and staff interview, it was determined the agency failed to ensure medical records were complete and included comprehensive, timely information which was readily available. This failure resulted in a lack of information being available on which to base care decisions. Findings include:	L 670			

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L 670	Continued From page 29 1. Refer to L671 as it relates to the agency's failure to ensure patient medical records containing past and current findings were maintained for each patient. 2. Refer to L673 as it relates to the agency's failure to ensure authentication of patient medical record entries. 3. Refer to L681 as it relates to the agency's failure to ensure patient medical records were complete and retained for 6 years after patient death or discharge. 4. Refer to L682 as it relates to the agency's failure to ensure patient medical records included a discharge summary. 5. Refer to L683 as it relates to the agency's failure to ensure patient medical records included a discharge summary and documentation of physician notification upon revocation or discharge. 6. Refer to L685 as it relates to the agency's failure to ensure patient medical records were readily available upon request. The cumulative effect of these deficient practices resulted in the inability of the agency to ensure comprehensive patient information was available and that patient needs were met.	L 670	L670 418.104 CLINICAL RECORDS The agency will insure medical records are complete and include comprehensive, timely information and are readily available. Staff Education: Hospice nursing, social services and intake/medical records staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding clinical record completeness and availability. Staff will be educated that the term "non-admit" refers to a patient who has not signed admission consents. As such, any patient who has signed Admission consents will be considered an active hospice patient and documentation guidelines and timelines apply. When the decision is made to not admit a patient for hospice services, the Interdisciplinary team, referral source, physician and leadership will be notified. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including completeness of medical records and record availability. Responsible: Director of Nursing, Operations manager and/ or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.	
L 671	418.104 CLINICAL RECORDS A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's	L 671		

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L 671	<p>Continued From page 30</p> <p>attending physician and hospice staff. The clinical record may be maintained electronically.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure patient medical records were maintained with clear and accurate documentation for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This had the potential to interfere with quality and coordination of patient care. Findings include:</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>A partial medical record for Patient #8 was provided by the hospice Administrator on 9/14/16 at 4:30 PM. He stated Patient #8's partial medical record was still being assembled and would be provided in its entirety. As of 9/16/16 at 9:00 AM, copies of Patient #8's admission paperwork, consents, notice of rights, discharge summary, advanced directive, and election of benefits forms had not been provided.</p> <p>The hospice Director of Operations and hospice Clinical Supervisor were interviewed on 9/16/16 at 10:00 AM. Patient #8's partial medical record was reviewed in their presence. They stated Patient #8's admission paperwork, consents, notice of rights, and election of benefits forms had been shredded by office staff, as they were told Patient #8 was a "non-admit" after she</p>	L 671	<p>L671 418.104 CLINICAL RECORDS The agency will ensure that patient medical records are maintained with clear and accurate documentation.</p> <p>Staff education: Hospice nursing, social services, intake/medical records staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding need to maintain medical records with clear and accurate documentation. Compliance will be monitored by DON or designee through current QAPI process of 100% Admission audits. In the event of less than 90% compliance, a Performance Improvement Plan will be developed and presented to QAPI committee for approval. Quarterly reviews will continue until 90% compliance is achieved. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including Responsible: Director of Nursing, Operations manager and/ or designee has overall</p>	

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L 671	Continued From page 31 revoked hospice services. The hospice Director of Operations and hospice Clinical Supervisor acknowledged Patient #8 signed an election of benefits and was not a "non-admit." They stated Patient #8 was a patient of the agency and her documents should not have been destroyed. The hospice Director of Operations and hospice Clinical Supervisor confirmed Patient #8's partial medical record did not include a discharge summary, transfer summary, or advanced directive.	L 671	responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.		
L 673	418.104(a)(2) CONTENT [Each patient's record must include the following:] (2) Signed copies of the notice of patient rights in accordance with §418.52 and election statement in accordance with §418.24. This STANDARD is not met as evidenced by: Based on medical record review, agency policy review, and staff interview, it was determined the agency failed to ensure patient medical records included a signed copy of agency rights and responsibilities and election of benefits statement for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This resulted in a lack of clarity as to whether patients or their representatives received appropriate information upon admission, and had the potential to interfere with the exercise of patient rights. Findings include: An agency policy "HOSPICE ELECTION	L 673			

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L 673	<p>Continued From page 32</p> <p>STATEMENT," undated, was reviewed. The policy stated "The hospice election statement will be filed in the patient's clinical record, and a copy will be given to the patient."</p> <p>A second agency policy "ADMISSION CRITERIA AND PROCESS," undated, was reviewed. The policy stated "The patient or his/her representative will sign the required forms indicating election of hospice and receipt of patient rights and privacy information."</p> <p>A third agency policy "RIGHTS/RESPONSIBILITIES," undated, was reviewed. The policy stated "The patient will acknowledge having received the Patient Rights and Responsibilities form by signing the Patient Consent. The original form will be kept in the patient's clinical record."</p> <p>The agency failed to follow their policies and ensure Patient #8's partial medical record included a signed copy of agency rights and responsibilities and election statement as follows:</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>A partial medical record for Patient #8 was provided by the hospice Administrator on 9/14/16 at 4:30 PM. He stated Patient #8's partial medical record was still being assembled and would be provided in its entirety. As of 9/16/16 at 9:00 AM, copies of Patient #8's notice of rights and election of benefits forms had not been</p>	L 673	<p>L673 418.104(a)(2) CONTENT</p> <p>The agency will ensure that the patient's record included signed copies of the Notice of Patient Rights and Responsibilities and the Election of Benefits Statement.</p> <p>Staff Education: Hospice staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding the need for the patients to be informed of his/her rights/responsibilities. [Policy No. 2-024.1] Hospice Election Statement, [Policy No. 2-023.1-6] Admission Criteria and Process and [Policy No. 1-001.1] Rights and Responsibilities will be reviewed and made available to hospice staff.</p> <p>The patient or patient representative will be provided a copy of the consent signed by the patient/patient representative and a Horizon representative which outlines the patient</p>	

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L 673	Continued From page 33 provided. The hospice Director of Operations and hospice Clinical Supervisor were interviewed on 9/16/16 at 10:00 AM. Patient #8's partial medical record was reviewed in their presence. They stated Patient #8's notice of rights and election of benefits forms had been shredded by office staff, as they were told Patient #8 was a "non-admit" after she revoked hospice services. The hospice Director of Operations and hospice Clinical Supervisor acknowledged Patient #8 signed an election of benefits and was not a "non-admit." They stated Patient #8 was a patient of the agency and her documents should not have been destroyed.	L 673	rights and responsibilities and the election of benefits statement. To the acknowledgement section of the consents, the following will be added: "I have received a copy..." and when checked, the box by the specified patient rights, will indicate this occurred with the patient and/or the patient representative. The patient/patient representative's signature, located underneath the acknowledgement section of the consents, will further affirm that the patient has been informed of this policy verbally and in writing. Compliance will be monitored by DON or designee through current 100% Admission audits. In the event of less than 100% compliance, a Performance Improvement Plan will be developed and presented to QAPI committee for approval. Quarterly reviews will continue until 100% compliance is achieved. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including the content of patient consents.	
L 681	418.104(d) RETENTION OF RECORDS Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its State agency and its CMS Regional office where such clinical records will be stored and how they may be accessed. This STANDARD is not met as evidenced by: Based on medical record review, agency policy review, and staff interview, it was determined the agency failed to ensure medical records were retained for 6 years after the death or discharge	L 681	Responsible: Director of Nursing, Operations Manager/Administrator or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.	

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L 681	<p>Continued From page 34</p> <p>of patients for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This resulted in missing and incomplete patient documentation. Findings include:</p> <p>An agency policy "RETENTION OF RECORDS," revised 4/2013, was reviewed. The policy stated "The clinical record will be retained for seven (7) years from the month in which the organization's cost report to which the record(s) applies is filed with the intermediary, or seven (7) years after the end of the fiscal year to which the record(s) applies, unless state law stipulates longer."</p> <p>The agency failed to ensure the policy was implemented, as follows:</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>A partial medical record for Patient #8 was provided by the hospice Administrator on 9/14/16 at 4:30 PM. He stated Patient #8's partial medical record was still being assembled and would be provided in its entirety. As of 9/16/16 at 9:00 AM, copies of Patient #8's admission paperwork, consents, notice of rights, discharge summary, advanced directive, and election of benefits forms had not been provided.</p> <p>The hospice Director of Operations and hospice Clinical Supervisor were interviewed on 9/16/16 at 10:00 AM. Patient #8's partial medical record was reviewed in their presence. They stated</p>	L 681	<p>L681 418.104(d) RETENTION OF RECORDS The agency will ensure that medical records are retained for 6 years after the death or discharge of patients.</p> <p>Staff Education: Hospice nursing, social services and intake/medical records staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding the retention of medical records. Upon completion of the hospice admission, the consents and all other paperwork as deemed appropriate by agency policy, are scanned and attached to the electronic medical record which is retained indefinitely. After 30 days, the paper copies are shredded. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including record retention.</p> <p>Responsible: Director of Nursing, Operations Manager/Administrator or designee has overall responsibility for the corrective action an ongoing completion of this deficiency.</p> <p>Completion: 11/02/2016 and ongoing</p>		

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L 681	Continued From page 35 Patient #8's admission paperwork, consents, notice of rights, and election of benefits forms had been shredded by office staff. The hospice Director of Operations and hospice Clinical Supervisor confirmed Patient #8's partial medical record was incomplete and not properly retained.	L 681		
L 682	The agency failed to follow their policy and ensure Patient #8's medical record was retained for 6 years after her discharge. 418.104(e)(1) DISCHARGE OR TRANSFER OF CARE (1) If the care of a patient is transferred to another Medicare/Medicaid-certified facility, the hospice must forward, to the receiving facility, a copy of- (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested. This STANDARD is not met as evidenced by: Based on medical record review, agency policy review, and staff interview, it was determined the agency failed to ensure receiving facilities were provided a copy of the patient discharge summary upon transfer for 1 of 1 patients (Patient #8) whose services were revoked, and whose partial record was reviewed. This failure had the potential to result in an interruption and fragmentation in the provision of patient care. Findings include: An agency policy "DISCHARGE SUMMARY," revised 10/2015, was reviewed. The policy included "Each patient discharged from a service and from hospice will have a discharge summary filed in the clinical record."	L 682	L682 418.104(e)(1) DISCHARGE OR TRANSFER OF CARE	

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L 682	Continued From page 36 A second agency policy "TRANSFER INFORMATION," revised 4/2013, was reviewed. The policy included "Completed transfer summaries will be given to a clinical records clerk, who will send a copy to the receiving organization within 48 hours of transfer and file the original in the clinical record." The agency failed to ensure the policy was implemented, as follows: Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8 was transferred to the hospital and revoked hospice services on 8/27/16. Her partial record was reviewed and did not include a discharge summary. The hospice Director of Operations and hospice Clinical Supervisor were interviewed on 9/16/16 at 10:00 AM. Patient #8's partial medical record was reviewed in their presence and they confirmed a discharge summary and transfer summary were not completed.	L 682	The agency will ensure receiving facilities are provided a copy of the patient discharge summary. Staff Education: Hospice nursing, social services and intake/medical records staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding the policy and procedure on completion of the discharge summary. Upon discharge from hospice, a workflow task prompts medical records staff to submit an Episode Summary Report to the facility and is also retained in the electronic medical record. To ensure compliance this prompt does not "go away" until the task is completed. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including discharge summaries. Responsible: Director of Nursing, Operations Manager/Administrator or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.	
L 683	The agency failed to provide Patient #8's discharge summary to the receiving facility. 418.104(e)(2) DISCHARGE OR TRANSFER OF CARE (2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with §418.26, the hospice must forward to the patient's attending physician, a copy of- (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested.	L 683		

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L 683	Continued From page 37 This STANDARD is not met as evidenced by: Based on medical record review, agency policy review, and staff interview, it was determined the agency failed to forward to the attending physician a copy of the patient discharge summary for 1 of 1 patients (Patient #8) whose services were revoked and whose partial record was reviewed. This had the potential to impact continuity of services and provision of care. Findings include: An agency policy "DISCHARGE SUMMARY," revised 10/2015, was reviewed. The policy stated "Each patient discharged from a service and from hospice will have a discharge summary filed in the clinical record." An second agency policy "DISCHARGE FROM HOSPICE PROGRAM," revised 5/2015, was reviewed. The policy stated "When a patient is discharged, transferred, or referred to another organization, relevant information will include: A. The date of discharge, including the date the physician and the patient were informed of discharge...Documentation will be filed in the clinical record...A copy of the discharge summary will be sent to the attending physician within 72 hours of discharge. If requested, the patient's clinical record will also be provided." The agency failed to ensure the policies were implemented, as follows: Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the	L 683	L683 418.104(e)(2) DISCHARGE OR TRANSFER OF CARE The agency will ensure that a copy of the patient discharge summary is forwarded to the attending physician. Staff Education: Hospice staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding the policy and procedure on completion of the discharge summary. Upon discharge from hospice, a workflow task prompts medical records staff to submit an Episode Summary Report to the attending physician and is also retained in the electronic medical record. To ensure compliance this prompt does not "go away" until the task is completed. Effective 11/02/16 our onboarding program will include a module on Hospice consents,	

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L 683	Continued From page 38 agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16. The hospice Director of Operations and hospice Clinical Supervisor were interviewed on 9/16/16 at 10:00 AM. Patient #8's partial medical record was reviewed in their presence and they confirmed a discharge summary was not completed.	L 683	policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including discharge summaries. Responsible: Director of Nursing, Operations Manager/Administrator or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.	
L 685	418.104(f) RETRIEVAL OF CLINICAL RECORDS The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority. This STANDARD is not met as evidenced by: Based on medical record review, agency policy review, and staff interview, it was determined the agency failed to ensure the medical record was readily available upon request for 1 of 1 patients (Patient #8) whose services were revoked and whose partial record was reviewed. This resulted in an incomplete medical record for document review and had the potential to impact all patients whose records were retained by the agency. Findings include: An agency policy "RETENTION OF RECORDS," revised 4/2013, was reviewed. The policy stated "The clinical record will be retained for seven (7) years from the month in which the organization's cost report to which the record(s) applies is filed with the intermediary, or seven (7) years after the end of the fiscal year to which the record(s)	L 685		

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L 685	Continued From page 39 applies, unless state law stipulates longer." The agency failed to ensure the policy was implemented, as follows: Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16. A partial medical record for Patient #8 was provided by the hospice Administrator on 9/14/16 at 4:30 PM. He stated Patient #8's partial medical record was still being assembled and would be provided in its entirety. As of 9/16/16 at 9:00 AM, copies of Patient #8's admission paperwork, consents, notice of rights, discharge summary, and election of benefits forms had not been provided. The hospice Director of Operations and hospice Clinical Supervisor were interviewed on 9/16/16 at 10:00 AM. Patient #8's partial medical record was reviewed in their presence. They stated Patient #8's admission paperwork, consents, notice of rights, and election of benefits forms had been shredded by office staff. Patient #8's complete medical record could not be provided.	L 685	L685 418.104(f) RETRIEVAL OF CLINICAL RECORDS The agency will ensure that the medical record is readily available upon request. Staff Education: Hospice nursing, social services and intake/medical records staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding clinical record completeness and availability. Staff will be educated that the term "non-admit" refers to a patient who has not signed admission consents. As such, any patient who has signed Admission consents will be considered an active hospice patient and documentation guidelines and timelines apply. Medical records for all active and inactive patients will be made readily available to regulatory entities upon request. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including completeness of medical records and record availability. Responsible: Director of Nursing, Operations Manager/Administrator or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing	
L 691	418.106(c) DISPENSING OF DRUGS AND BIOLOGICALS The hospice must--	L 691		

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L 691	<p>Continued From page 40</p> <p>(1) Obtain drugs and biologicals from community or institutional pharmacists or stock drugs and biologicals itself.</p> <p>(2) The hospice that provides inpatient care directly in its own facility must:</p> <p>(i) Have a written policy in place that promotes dispensing accuracy; and</p> <p>(ii) Maintain current and accurate records of the receipt and disposition of all controlled drugs.</p> <p>This STANDARD is not met as evidenced by: Based on agency medical record review, agency staff interview, ALF staff interview, and patient representative interview, it was determined the agency failed to obtain drugs from community or institutional pharmacies, or its own stock, for 1 of 1 patients (Patient #8) whose care was revoked and whose partial record was reviewed. This had the potential to result in the misuse of drugs and patient harm. Findings include:</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16 at 5:41 PM with a terminal diagnosis of CHF. She resided in an ALF located in Burley, ID, and received SN services from the agency. Patient #8's hospice services were revoked on 8/27/16, and she died on 8/28/16.</p> <p>On 9/15/16 at 1:00 PM, a visit was made to the ALF where Patient #8 resided at the time of her admission to hospice. The ALF ED and the HSD were interviewed. They stated when they have a resident who is receiving hospice services, the ALF Medication Aides are able to administer medications prepared by the hospice nurses. They stated liquid medications such as Morphine and Lorazepam are provided by the hospice in single dose syringes, for administration by the ALF Medication Aides.</p>	L 691	<p>L691 418.106(c) DISPENSING OF DRUGS AND BIOLOGICALS</p> <p>The agency will ensure that drugs are obtained from community or institutional pharmacies or its own stock.</p> <p>Staff Education: Hospice nursing and social services staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding the 24-hour availability of pharmacy services. An informational sheet, branch specific, will be provided to every hospice nurse regarding the pharmacy, pharmacy numbers and how to access during business hours and after hours [attached].</p> <p>Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including the availability of pharmacy services.</p> <p>Responsible: Director of Nursing, Operations Manager/Administrator or designee has</p>		

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L 691	Continued From page 41 The ALF ED and HSD stated Patient #8 became agitated and was crying out in pain late at night on 8/26/16. They stated their Medication Aide called RN A who made the SOC visit earlier that evening. RN A instructed her to administer Lorazepam at 11:45 PM. The HSD stated RN A did not leave Lorazepam at the ALF for Patient #8. During a phone interview on 9/16/16 at 10:11 AM, the HSD stated the Medication Aide told her she was instructed by RN A to borrow a dose of Lorazepam from another hospice patient who resided in the ALF. Patient #8's daughter, who was her POA, was interviewed by phone on 9/19/16 at 8:30 AM. She stated she was present for the RN SOC visit on 8/26/16. The daughter stated RN A told her Patient #8's medications were not delivered to the ALF, and she would borrow medication from another resident at the ALF. During an interview on 9/15/16 at 4:00 PM RN A stated she prepared 8 syringes of Morphine to be available for ALF staff to administer to Patient #8. She stated she did not prepare syringes of Lorazepam because she did not have additional syringes with her. Patient #8's partial hospice record included a document titled "Disposal of Medications," dated 8/27/16 and signed LPN C. It stated Patient #8's medications were wasted after her revocation from hospice services on 8/27/16. It documented 30 ml of Morphine and 30 ml of Lorazepam were wasted, indicating the bottles were full and had not been used to prepare syringes for Patient #8.	L 691	an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.	

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L 691	Continued From page 42 It was unclear how Morphine was obtained to prepare 8 syringes for Patient #8. During an interview on 9/16/16 at 8:15 AM, LPN C confirmed she disposed of Patient #8's medications at the ALF on 8/27/16. She stated she destroyed 30 ml of Morphine and 30 ml of Lorazepam.	L 691		
L 696	418.106(e)(2)(i)(B) LABEL DISPOSE STORAGE DRUGS [At the time when controlled drugs are first ordered the hospice must:] (B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; This STANDARD is not met as evidenced by: Based on agency medical record review, policy review, agency staff interview, it was determined the agency failed to ensure a policy for managing the safe use and disposal of controlled medications was discussed with the patient or representative in a manner they understood for 1 of 1 patients (Patient #8) whose services were revoked and whose partial record was reviewed. This had the potential for the unsafe use and disposal of controlled medications. Findings include:	L 696	L696 418.(e)(2)(i)(B) LABEL DISPOSE STORAGE DRUGS The agency will ensure that a policy for managing the safe use and disposal of	

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L 696	Continued From page 43 An agency policy "HOME USE AND DISPOSAL OF CONTROLLED SUBSTANCES," revised 10/2015, was reviewed. The policy stated "Case Manager will verbally discuss this policy in a language and manner that they understand to ensure the safe use and disposal of controlled drugs." The agency failed to ensure the policy was implemented, as follows: Patient #8 was a 77 year old female admitted to the agency on 8/26/16, with a terminal diagnosis of CHF. She received SN services. Patient #8's hospice services were revoked on 8/27/16. She then transferred to a local hospital on 8/27/16, where she died on 8/28/16. The hospice Clinical Supervisor was interviewed on 9/16/16 at 11:05 AM, and Patient #8's partial medical record was reviewed in her presence. She confirmed there was no documentation of discussion of the agency's policy regarding controlled medication management with Patient #8 and/or her representative. The agency failed to follow their policy and ensure management, use, and disposal of controlled medications were discussed with the patient or representative in a manner they understood.	L 696	controlled medication is discussed with the patient or patient representative in a manner that is understood. Staff Education: Hospice nursing and social services staff will be educated via PowerPoint presentation by members of the Horizon leadership team, at each of the branch locations regarding the policy and procedure on proper use and disposal of all medications. Revised consents will be reviewed with emphasis on the acknowledgement section for check off above patients or patient representatives' signature to show proof that this information was received and discussed. Revised consents and the agency's policy on safe use and disposal of controlled medications will be placed in all admission packets. Admit packet will be checked regularly against a master list by office staff to ensure all applicable pieces are included. Effective 10/26/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including the correct policy and procedure for managing controlled drugs. Responsible: Director of Nursing, Operations Manager/Administrator or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.	
L 697	418.106(e)(2)(i)(C) LABEL DISPOSE STORAGE DRUGS [At the time when controlled drugs are first ordered the hospice must:] (C) Document in the patient's clinical record that	L 697		

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L 697	<p>Continued From page 44</p> <p>the written policies and procedures for managing controlled drugs was provided and discussed.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, agency policy review, and staff interview, it was determined the agency failed to ensure the written policy for managing controlled drugs was provided and discussed for 1 of 1 patients (Patient #8) whose services were revoked and whose partial record was reviewed. This resulted in an incomplete patient medical record and had the potential for unsafe controlled medication management. Findings include:</p> <p>An agency policy "HOME USE AND DISPOSAL OF CONTROLLED SUBSTANCES," revised 10/2015, was reviewed. The policy stated "The Case Manager will document in the clinical record that the patient and family/caregiver were given the written policy and procedure for managing controlled drugs and discussed the disposal of medications."</p> <p>The agency failed to ensure the policy was implemented, as follows:</p> <p>Patient #8 was a 77 year old female admitted to the agency on 8/26/16, with a terminal diagnosis of CHF. She received SN services. Patient #8's hospice services were revoked on 8/27/16. She then transferred to a local hospital on 8/27/16, where she died on 8/28/16.</p> <p>The hospice Clinical Supervisor was interviewed on 9/16/16 at 11:05 AM, and Patient #8's partial medical record was reviewed in her presence. She confirmed the receipt and discussion of the</p>	L 697	<p>L697 418.106(e)(2)(i)(C) LABEL DISPOSE STARAGE DRUGS</p> <p>The agency will ensure that the agency policy for managing controlled drugs is provided and discussed with the patient/patient representative.</p> <p>Staff Education: Hospice staff will be provided the policy and procedure on proper use and disposal of all medications. Revised consents will be reviewed with emphasis on the acknowledgement section for check off above patients or patient representatives' signature to show proof that this information was received and discussed. Revised consents and the agency's policy on safe use and disposal of controlled medications will be placed in all</p>		

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L 697	Continued From page 45 agency's policy regarding controlled medication management with the patient and representative was not documented. The agency failed to follow their policy and ensure the written policy for managing controlled medications was provided and discussed.	L 697	admission packets. Admit packet will be checked regularly against a master list by office staff to ensure all applicable pieces are included. Effective 11/02/16 our onboarding program will include a module on Hospice consents, policies, procedures and best practices which will be provided for all new Hospice staff by our Staff Education Coordinator including the correct policy and procedure for managing controlled drugs. Responsible: Director of Nursing, Operations Manager/Administrator or designee has overall responsibility for the corrective action an ongoing completion of this deficiency. Completion: 11/02/2016 and ongoing.		



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HEALTH & WELFARE

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October 24, 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 September 14, 2016 to September 19, 2016 at Horizon Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007372

Allegation #1: Patients' pain was not controlled.

Findings #1: An unannounced visit was made to the hospice agency from 9/14/16 to 9/19/16. During the investigation, 8 medical records were reviewed, 1 home visit was conducted, and staff and patient representative were interviewed.

Seven of 8 records reviewed documented adequate pain control. One record reviewed was of a 77 year old female admitted to the agency on 8/26/16 with a terminal diagnosis of congestive heart failure. She resided in an ALF (Assisted Living Facility), and received nursing services from the hospice agency.

The ALF Executive Director and Health Services Director were interviewed on 9/15/16 at 1:00 PM. They presented the ALF's progress notes for the patient. An entry dated 8/27/16 was signed by the Medication Aide.

Trevor Higby, Administrator
October 24, 2016
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The entry stated the Medication Aide called the hospice nurse at 12:56 AM on 8/27/16, but there was no answer. It stated the Medication Aide called the nurse again at 1:40 AM, and told her the patient was restless and yelling for help. The entry stated the nurse instructed her to increase the patient's Morphine from every 2 hours to every 1 hour, but knew she did not have enough Morphine to administer hourly until the nurse would be there to provide more medication. The entry stated additional calls were made to the hospice agency, but no one from the hospice agency came to see the patient or provide additional pain medication. The note stated the ALF Executive Director instructed the Medication Aide to call 911 and send the patient to the emergency room for pain relief.

The ALF's medication record stated the initial quantity of Morphine doses prepared by the hospice nurse was 7. During an interview on 9/16/16 at 11:12 AM, the hospice Director of Operations and the hospice Clinical Supervisor confirmed the hospice nurse did not prepare enough syringes of Morphine to allow for hourly administration.

The hospice RN was interviewed by phone on 9/15/16 at 4:00 PM. She stated she prepared 8 syringes of Morphine for the ALF staff to administer to the patient. She stated she did not have enough syringes to prepare more Morphine, and said she would have had to drive to the hospice office 45 minutes away to obtain more syringes.

The allegation the hospice agency did not ensure the patient's pain was controlled was substantiated, and a condition level deficiency was cited at 418.52 Patient's Rights.

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

Allegation #2: The agency failed to provide nursing services to meet the patients' needs.

Findings #2: An unannounced visit was made to the hospice agency from 9/14/16 to 9/19/16. During the investigation, 8 medical records were reviewed, 1 home visit was conducted, and staff and patient representative were interviewed.

Seven of 8 records reviewed documented nursing services provided met the patients' needs. One medical record reviewed was of a 77 year old female admitted to the agency on 8/26/16 with a terminal diagnosis of congestive heart failure. She resided in an ALF (Assisted Living Facility), and received nursing services from the hospice agency.

The patient's record included an admission assessment, completed by the hospice nurse on 8/26/16. The assessment stated the hospice nurse spoke with the patient's daughter who was her Power of Attorney, about inserting a urinary catheter, and the catheter was declined by the daughter.

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The patient's daughter was interviewed by phone on 9/19/16 at 8:30 AM. She stated she was present for the assessment visit on 8/26/16. She stated she told the hospice nurse she wanted a urinary catheter for her mother. She stated the nurse told her a urinary catheter would not be available until Monday 8/29/16.

The ALF's progress notes stated the ALF Health Services Director called the hospice nurse on 8/27/16 at 9:45 AM, reported symptoms of agitation, and requested the nurse make a visit to assess the patient's condition. The ALF notes stated the hospice nurse called at 10:06 AM, and stated she was gathering supplies for the patient. Another call from the hospice was documented at 10:53 AM, stating the nurse was approximately 40 minutes away. Another call was documented at 11:31 AM, stating the nurse was gathering supplies and would arrive at the ALF in 30 to 40 minutes. The progress notes stated the hospice nurse did not arrive to assess the patient, and the patient was sent to the emergency room at 12:07 PM.

The allegation the hospice agency failed to provide nursing services to meet the patient's needs was substantiated, and standard level deficiencies were cited at 418.54(a) Initial Assessment and 418.100(c)(2) Services.

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

Allegation #3: The agency failed to provide medications necessary to control the patients' symptoms.

Findings #3: An unannounced visit was made to the hospice agency from 9/14/16 to 9/19/16. During the investigation, 8 medical records were reviewed, 1 home visit was conducted, and staff and patient representative were interviewed.

Seven of 8 records reviewed documented medications were provided to meet patients' needs. One medical record reviewed was of a 77 year old female admitted to the agency on 8/26/16 with a terminal diagnosis of congestive heart failure. She resided in an ALF (Assisted Living Facility), and received nursing services from the hospice agency.

The patient's daughter, who was her Power of Attorney, was interviewed by phone on 9/19/16 at 8:30 AM. She stated she was present for her mother's initial assessment visit on 8/26/16. The daughter stated the hospice nurse told her medications for her mother were not delivered to the ALF, and she would borrow medication from another resident at the ALF.

During an interview on on 9/16/16 at 10:11 AM, the ALF's Health Services Director stated the ALF's Medication Aide told her she was instructed by the hospice nurse to borrow a dose of Lorazepam from another hospice patient who resided in the ALF.

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The patient's record included orders for Morphine and Lorazepam. During an interview on 9/15/16 at 4:00 PM, the hospice nurse stated she prepared 8 syringes of Morphine to be available for the ALF staff to administer to the patient. She stated she did not prepare syringes of Lorazepam for the patient because she did not have additional syringes with her.

The allegation the hospice agency failed to provide medications necessary to control the patient's symptoms was substantiated, and a standard level deficiency was cited at 418.106(c) Dispensing of drugs and biologicals.

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

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

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

Sincerely,



NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt