



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Bolsa, ID 83720-0009
PHONE 208-334-0825
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3315 1712

September 29, 2014

Trevor Higby, Administrator
Horizon Home Health & Hospice
1411 Falls Avenue East, Suite 615
Twin Falls, ID 83301

RE: Horizon Home Health & Hospice, Provider #131520

Dear Mr. Higby:

Based on the survey completed at Horizon Home Health & Hospice, on September 10, 2014, by our staff, we have determined Horizon Home Health & Hospice is out of compliance with the Medicare Hospice Conditions of Participation of **Initial & Comprehensive Assessment of Patient (42 CFR 418.54), IDG, Care Planning, Coordination of Services (42 CFR 418.56), Quality Assessment & Performance Improvement (42 CFR 418.58), Hospice Aide & Homemaker Services (42 CFR 418.76) 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 Home Health & Hospice, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;

Trevor Higby, Administrator
September 29, 2014
Page 2 of 2

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

Such corrections must be achieved and compliance verified by this office, before October 25, 2014. 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 15, 2014.

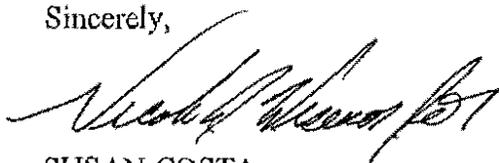
Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 14, 2014.**

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

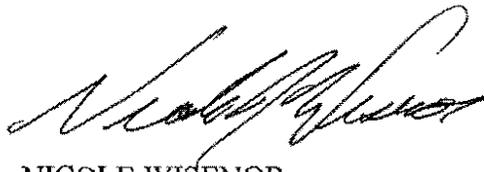
We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/pmt

Enclosures

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

Horizon Home Health and Hospice
Trevor Higby, Administrator
Amanda Corn RN, Director of Nursing
63 W. Willowbrook Dr.
Meridian, ID 83646
208-888-7877

October 14, 2014

RECEIVED

OCT 15 2014

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

FACILITY STANDARDS

Re: CREDIBLE ALLEGATION OF COMPLIANCE/PLAN OF CORRECTION

Dear Ms. Wisenor,

Pursuant to the survey conducted at Horizon Home Health and Hospice on September 10, 2014, please find the completed Statement of Deficiencies/Plan of Correction (CMS2567) attached.

As evidenced in the Plan of Correction, we will continue to conduct full staff education in each of the deficiencies cited and will continue to correct the deficiencies and to maintain evidence of compliance through chart audits and supervisory visits.

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

Please express our appreciation for the courtesy demonstrated by Nancy Bax, RN, Laura Thompson, RN, and Susan Costa RN during the conduction of our survey. We appreciate the opportunity to continue to refine our processes.

Sincerely,



Amanda Corn RN, CHPN
Director of Nursing
Horizon Home Health and Hospice

cc: files

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

PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131620	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
L 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your hospice agency conducted from 9/02/14 through 9/10/14. Surveyors conducting the survey were:</p> <p>Susan Costa, RN, HFS, Team Lead Nancy Bax, RN, BSN, HFS Laura Thompson, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ALF - Assisted Living Facility AFTT - Adult Failure to Thrive CEO - Chief Executive Officer CHF - Congestive Heart Failure CM - Case Manager CMS - Centers for Medicare and Medicaid COPD - Chronic Obstructive Pulmonary Disease DME - Durable Medical Equipment DON - Director of Nursing EMR - Electronic Medical Record FTF - Face to Face HA - Hospice Aide HTN - Hypertension IDG - Interdisciplinary Group LPN- Licensed Practical Nurse MD - Medical Doctor MSW - Medical Social Worker NHPCCO - National Hospice and Palliative Care Organization NOMNC - Notice of Medicare Non-Coverage NOS - Not otherwise specified PIP - Performance Improvement Plan POA - Power of Attorney POC - Plan of Care PPD - Pay per Day PRN - As needed</p>	L 000		

RECEIVED
OCT 15 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Manda Comra* TITLE: *Director of Nursing* (X6) DATE: *10-14-14*

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.

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 000	Continued From page 1 PT - Patient QAPI - Quality Assurance Performance Improvement RN - Registered Nurse RTP - Return to Provider SOC - Start of Care SN - Skilled Nurse SNF - Skilled Nursing Facility SW - Social Worker	L 000	L502 -- 412.52 (a) (1) Notice of Rights and Responsibilities		
L 502	418.52(a)(1) NOTICE OF RIGHTS AND RESPONSIBILITIES (1) During the initial assessment visit in advance of furnishing care the hospice must provide the patient or representative with verbal (meaning spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands. This STANDARD is not met as evidenced by: Based on staff interviews, record review, and review of admission documents, it was determined the agency failed to provide the patient representative with verbal and written notice of the patient's rights and responsibilities prior to furnishing care for 1 of 13 current patients (Patient #3) whose records were reviewed. This failure had the potential to result in a lack of advocacy due to insufficient information being readily available to the patient's representatives. Findings include: Patient #3 was an 87 year old female admitted to the agency on 5/24/14 with a diagnosis of dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 5/24/14 to 8/21/14 and 8/22/14 to 10/20/14, was reviewed.	L 502	Education to be provided to admitting staff regarding obtaining informed consent, providing notice of rights and responsibilities, and obtaining accurate and dated signed consents, in addition to obtaining verbal consent when the patient is unable to sign for own self and POA is unavailable at time for immediate signature. Policy 1.00.1 Informed Consent/Refusal of Treatment revised to include the process of obtaining signatures from the Patient's POA when it is determined the patient suffers from a disease process that affects their cognitive ability to understand and respond appropriately. Policy 2-023 Admission Criteria and Process to be reviewed by all admission staff.		

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

PRINTED: 09/29/2014
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 09/10/2014	
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 502	<p>Continued From page 2</p> <p>Patient #3's record included a form titled "HORIZON HOSPICE INFORMED CONSENT & TREATMENT AUTHORIZATION." The form included sections related to authorization for treatment, financial agreement, patient rights and responsibilities, and notice of privacy practices.</p> <p>The "HORIZON HOSPICE INFORMED CONSENT & TREATMENT AUTHORIZATION" also included a section titled "ACKNOWLEDGEMENT" which stated, "I acknowledge and agree to the terms and conditions described in the following documents: Informed Consent and Treatment Authorization, Medicare/Medicaid Hospice Benefit Election, Financial Agreement, Advance Directives, Pt's Rights & Responsibilities, Notice of Privacy Practices."</p> <p>The form documented Patient #3 was unable to sign due to dementia. The line titled "Name & Signature of legally authorized representative (if applicable)" contained the signature of Patient #3's sister, who was her POA. The line titled "Hospice Staff Signature/Discipline," contained the signature of Patient #3's RN Case Manager. Both signatures were dated 5/24/14, which was Patient #3's SOC date.</p> <p>However, a "Visit Note Report," dated 6/03/14 and signed by Patient #3's RN Case Manager, included documentation stating, "CONSENTS SIGNED BY POA."</p> <p>During an interview on 9/04/14 at 3:45 PM, the RN Case Manager confirmed the "HORIZON HOSPICE INFORMED CONSENT & TREATMENT AUTHORIZATION" was signed by</p>	L 502	<p>Office staff will track the consents that are sent to POA for signature and the date returned.</p> <p>Responsible: Director of Nursing or designee will review 100% of admission consents upon receiving initial admission paperwork and through the EMR workflow process. Variances will be addressed with the admitting nurse and may include further one-on-one education and/or counseling.</p> <p>10% of the average daily census will be audited on a quarterly basis. Indicators of 85% or less will require an action plan for corrections and findings will be reported to the PI committee and governing body on a quarterly basis.</p> <p>Completion: 10-15-14</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 000 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 502	Continued From page 3 Patient #3's sister on 6/03/14. She stated Patient #3's sister lived in another state and was unable to be present at the SOC visit on 5/24/14, so she signed the forms when she was in town on 6/03/14. The RN Case Manager confirmed she and Patient #3's sister signed the form on 6/03/14, and dated the signatures 5/24/14, to match the SOC date. The RN Case Manager confirmed she did not document receipt of verbal consent or confirmation of understanding of rights and responsibilities from Patient #3's sister prior to furnishing care. Patient #3 received hospice services before her POA was given notice of her rights and responsibilities on 6/03/14. Visits occurred as follows: - SN visits on 5/24/14, 5/27/14, and 5/29/14 - Chaplain visit on 5/27/14 - MSW visit on 5/28/14 - HA visits on 5/27/14, 5/29/14, 5/30/14, and 6/02/14 Patient #3's sister, who was her POA, was not provided with verbal and written notice of her rights and responsibilities prior to services being provided.	L 502	L520 – 418.54 Initial & Comprehensive Assessment of Patient Agency will ensure a comprehensive assessment is completed for each patient admitted to service which is patient specific and includes an initial bereavement assessment, is reviewed by the IDG and which adequately assesses the patient and family needs at the time of admission and that contributes to the overall plan of care for each patient with development of specific interventions The interventions will correct the following standards: L522, L531, and L533. Responsible: Director of Nursing is responsible for the overall correction of this condition.		
L 520	418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT This CONDITION is not met as evidenced by: Based on record review, review of agency policies, and staff interview, it was determined the agency failed to ensure a comprehensive assessment was completed for each patient that was patient specific, and included a bereavement	L 520	Completion: 10-15-14		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 520	Continued From page 4 assessment that contributed to the development of the plan of care for each patient. This failure resulted in the inability of the IDG to fully understand the patient needs and develop a plan to meet those needs. Findings include: 1. Refer to L522 as it relates to the failure of the agency to complete a comprehensive assessment which included information critical to ensure a patient received adequate care. 2. Refer to L531 as it relates to the failure of the agency to perform an initial bereavement assessment of each patient/family unit that would be used in the development of a bereavement plan of care. 3. Refer to L533 as it relates to the failure of the agency to update the patient plan of care to include bereavement need assessment. The cumulative effect of these deficiencies resulted in the inability of the agency to adequately assess patient and family needs and develop patient specific interventions.	L 520			
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.) This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to conduct a patient specific comprehensive assessment that	L 522	L522 – 418.52 (a) Initial Assessment In-service education to be provided to hospice admission staff by the Director of Nursing or designee by 10-15-14, which will include review of Policy 2-029.1 Initial Assessment and Policy 2-030.1 Comprehensive		

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

PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131620	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 522	<p>Continued From page 5</p> <p>identified unique patient needs for 1 of 13 active patients (Patient #10) whose records were reviewed. This resulted in the agency not having comprehensive information critical to ensure a patient received adequate care. Findings include:</p> <p>Patient #10 was an 86 year old female admitted to the agency on 8/26/14, for services related to necrotizing fasciitis (a serious bacterial infection that spreads rapidly and destroys the body's soft tissue). She received SN, HA, and MSW services. Her record, including the POC for the certification period 8/26/14 to 11/23/14, was reviewed.</p> <p>Patient #10's SOC assessment was completed by the RN Case Manager on 8/26/14. The assessment noted the presence of a wound and erythema (redness of the soft tissue). The assessment did not include documentation of the location or size of the wound. The location of the erythema was indicated as "ABD [abdomen] FROM PERINEUM." However, the assessment did not include a description of the erythema, to indicate appearance or size.</p> <p>During an interview on 9/08/14 at 4:30 PM, the RN Case Manager stated Patient #10 was receiving hospice care for palliation and management of necrotizing fasciitis, which caused her wound and erythema. She confirmed she did not measure Patient #10's wound or erythema, and her SOC assessment did not include a description of her wound or erythema. The RN Case Manager confirmed this resulted in difficulty assessing the progression of Patient #10's necrotizing fasciitis.</p> <p>Patient #10's comprehensive assessment at SOC</p>	L 522	<p>Assessment. Staff will be instructed on completion of the hospice initial assessment within 48 hours after the patient has elected the hospice benefit. Education to include instruction on gathering critical information necessary to treat the patient/families immediate care needs, physical, psychosocial, emotional and spiritual needs related to the terminal illness and related conditions. Additional areas to be covered include: obtaining and following or orders, assessment and documentation of wounds and wound care, recognizing infections, potential infections, and completion of the infection control form, and review of the forms and occurrence forms located within the electronic documentation system.</p> <p>Responsible: Director of Nursing or designee will review 100% of initial admission assessments/evaluations. Ongoing the DON or designee will perform a record review of 10% average daily census on a quarterly</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 522	Continued From page 6 did not include a detailed assessment of her terminal illness and wounds.	L 522	basis. Indicators with less than 85% compliance will require an action plan. All clinical review findings will be reported to the QAPI committee and governing body on a quarterly basis.		
L 531	418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care. This STANDARD is not met as evidenced by: Based on record review, agency policy review and staff interview, it was determined the agency failed to a bereavement risk assessment was completed 1 of 13 active patients (Patient #11) whose records were reviewed. This failure resulted in the potential for delayed identification of grief and loss issues in patients and their families, and impeded early interventions and services. Findings include: 1. Patient #11's record stated she was a 50 year old female admitted to the agency on 8/11/14, for hospice services related to Malignant Neoplasm of the Brain. Patient #11's record included documentation of concerns with family dynamics in a physician's progress note, dated 7/08/14, a month prior to her election of hospice services. The physician noted	L 531	Completion: 10-15-14 L531 418.54 (c) (7) Content of the Comprehensive Assessment Director of Nursing or designee will provide staff education on the content of the comprehensive assessment at the start of care and all subsequent evaluations, including bereavement assessment and review of Policy 2-005.1 Hospice Nursing Care, 2-030.1 Comprehensive Assessment, 2-034.1 Functional Assessment, 2-035.1 Psychosocial Assessment, 2-037.1 Bereavement Assessment, 2-044.1 The Plan of Care. Education will be provided to the RN Case Managers, Admitting Nurses, Chaplains, and Social Workers on completing the Bereavement Assessment at the Start of Care or as soon as possible after the SOC. Education will also include a review of the EMR assessment		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 531	Continued From page 7 "...there were multiple complicated social issues with regards to family members concerns for substance abuse, the patient feeling poorly overall, and some clear despondence on the part of the patient with regards to her clinical situation." However, Patient#11's initial comprehensive assessment, dated 8/11/14, completed by the RN Case Manager, noted no bereavement risks were identified. The nurse also noted there were no abnormal social or spiritual issues identified, and funeral arrangements were not finalized. Further, a nursing visit note dated 8/21/14, the RN documented "No bereavement risks identified." However, she noted the caregiver appeared to be emotionally unstable. There was no further documentation to clarify the statement made about the caregiver by the RN. As of 9/08/14, Patient #11 did not have a social work assessment, or chaplain visit. The POC did not include interventions to the bereavement needs of Patient #11 and her family. During an interview on 9/09/14 beginning at 11:30 AM, the DON reviewed Patient #11's record and confirmed a bereavement needs assessment was not performed. She confirmed the identification of family social concerns that were identified by Patient #11's physician were not addressed by the hospice staff. The agency failed to to ensure Patient #11's bereavements needs were assessed.	L 531	questions which capture the needs of the patient, family members, caregivers, or other individuals and focus on the social, spiritual, and cultural factors that may impact the individuals ability to cope with the patient's death. Information gathered from the initial/comprehensive assessment and subsequent assessments/evaluations will be incorporated into the plan of care and be considered in the bereavement plan of care thereby avoiding delay in meeting the needs of the patient/caregiver/family and other individuals. Responsible: Director of Nursing or designee will review 100% of initial admission assessments/evaluations. Ongoing the DON or designee will perform a record review of 10% average daily census on a quarterly basis. Indicators with less than 85% compliance will require an action plan. All clinical review findings will be reported to the QAPI committee and governing body on a quarterly basis.		
L 533	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT	L 533			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 533	<p>Continued From page 8</p> <p>The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, policy review and review of medical records it was determined the hospice failed to ensure the comprehensive assessment was updated in response to patient and family changes for 5 of 13 active patients (#2, #3, #4, #5, and #7) whose records were reviewed. This failure resulted in the potential for patient and family needs to be unmet. Findings include:</p> <p>1. Patient #4 was an 84 year old female admitted to the agency on 10/27/11, with a diagnosis of Breast Cancer. She received SN, SW, and HA services. Her record, including the POC, was reviewed for the certification period of 7/9/14 to 9/6/14.</p> <p>Patient #4's record included documentation regarding changes in her condition as follows:</p> <p>a. A "HOSPICE RECERT VISIT" dated 7/08/14 and signed by the RN Case Manager, included a reference to a flat affect. However, no other</p>	L 533	<p>Director of Nursing is responsible for the overall correction of this standard.</p> <p>Completion: 10-15-14</p> <p>L533 418.54 (d) Update of Comprehensive Assessment</p> <p>Director of Nursing or designee will provide staff education including review of Policy 2.044.1 The Plan of Care, 2-046.1 Verification of Physician Orders: Addendum 2.046.A Organization Specific Elements for Orders, 2.049.1 Interdisciplinary Group Coordination of Care, 2-053.1 Monitoring Patient's Response/Reporting to Physician, and 2-051.1 Patient Notification of Changes in Care. Instruction on the required update of the comprehensive assessment from the SOC and all subsequent evaluations, including the bereavement assessment at each patient with identification of changes and</p>		

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

PRINTED: 09/20/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 533	<p>Continued From page 9 alterations in mood or emotion were identified.</p> <p>b. An SN visit note, dated 7/11/14 and signed by the RN Case Manager, noted a flat affect. However, no other alterations in mood or emotion were identified.</p> <p>c. An SN visit note, dated 7/18/14 and signed by the RN Case Manager, noted Patient #4 had been sticking her finger in her mouth to make herself throw up and was observed to have emesis. However, there were no abnormal findings documented for gastrointestinal or psychosocial assessments.</p> <p>d. An IDG coordination note on 7/10/14 documented she was exhibiting periods of anxiety and increased confusion. However the POC was not updated to reflect changes that were identified during visits or discussed at the IDG meetings.</p> <p>e. An SN visit note, dated 7/23/14 and signed by the RN Case Manager, noted Patient #4 continued to have episodes of nausea and was witnessed by caregiver attempting to make herself throw up. The note documented medications were reviewed and changed.</p> <p>Patient #4's record did not include documentation that her assessment had been updated to include information related to the care and management of gastrointestinal problems or psychosocial health. There was no indication Patient #4's gastrointestinal and psychosocial needs had been comprehensively reassessed.</p> <p>During an interview with the RN Case Manager on 9/8/14 at 8:40 AM, the record was reviewed.</p>	L 533	<p>reporting these findings to the primary MD or Medical Director.</p> <p>IDG Team Members will also be educated on obtaining new orders or referrals, documenting of updates to the patients plan of care at each IDG meeting, at a minimum of every 15 days and more often if a specific patient need is unmet and/or identified. Instruction will include documentation requirements if the patient experiences changes such as: behaviors, wound care, new wounds, decrease in ADL/IADL functions that negatively affects the patient or caregiver's ability to perform needed cares, and any other specific care needs or assistance, needs for additional equipment and/or status change in caregiver/family bereavement needs.</p> <p>Director of Nursing is responsible for the overall correction of this standard.</p> <p>Completion: 10-15-14</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 533	<p>Continued From page 10</p> <p>She stated during her visits to Patient #4 she had consistently assessed the need for changes to Patient #4's interventions and goals. The RN Case Manager confirmed that Patient #4's interventions and goals had not been changed or updated in the record since 2013.</p> <p>Patient #4's comprehensive assessment was not updated in response to changes in her status.</p> <p>2. Patient #3 was an 87 year old female admitted to the agency on 5/24/14, with a diagnosis of dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 5/24/14 to 8/21/14, and 8/22/14 to 10/20/14, was reviewed.</p> <p>Patient #3's record included documentation regarding changes in her condition as follows:</p> <p>a. A "HOSPICE RECERT VISIT," dated 8/11/14 and signed by the RN Case Manager, included a reference to skin breakdown. However, it did not describe the breakdown.</p> <p>b. An HA visit note, dated 8/11/14 and signed by the HA, noted a skin tear on Patient #3's right forearm.</p> <p>c. An SN visit note, dated 8/21/14 and signed by the RN Case Manager, noted Patient #3 had a small open area on her perineum.</p> <p>d. An SN visit note, dated 8/25/14, and signed by the RN Case Manager, noted Patient #3 had a reddened area on her left outer knee and the RN applied a protective dressing.</p> <p>e. An SN visit note, dated 9/01/14, and signed by</p>	L 533		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
L 533	<p>Continued From page 11.</p> <p>the RN Case Manager, noted 2 new skin tears on her back. The note stated physician orders were received and wound care was completed.</p> <p>Patient #3's record did not include documentation that her assessment had been updated to include information related to the care and management of her skin issues. There was no indication Patient #3's skin and wound care needs had been comprehensively reassessed.</p> <p>During an interview on 9/04/14 at 3:45 PM, the RN confirmed the Patient #3's comprehensive assessment had not been updated to reflect her skin and wound care needs.</p> <p>Patient #3's comprehensive assessment was not updated to reflect changes in her condition since her initial assessment.</p> <p>3. Patient #2 was an 82 year old male admitted to the agency on 1/11/14, for hospice services related to Senile Degeneration of the Brain. He and his wife, who was also on hospice services, lived in an ALF.</p> <p>A visit was conducted at the ALF on 9/04/14 at 7:00 AM, to observe the HA providing care for Patient #2. During the visit it was noted that Patient #2 had difficulty standing up from his chair and getting up from his bed. Patient #2 was a tall man, and he was noted to perform several rocking back and forth movements to get momentum to stand.</p> <p>The HA stated Patient #2 needed to rock when he attempted to stand up, and encouraged him to grab the walker for assistance.</p>	L 533		

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

PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131620	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
L 533	<p>Continued From page 12</p> <p>In the recertification comprehensive assessment, dated 7/08/14, the RN noted Patient #2 required an assistive device for ambulation, and no problems were identified when she performed the musculoskeletal system assessment. The recertification assessment noted Patient #2 was incontinent, but did not describe issues related to saturating the bedding at night.</p> <p>During an interview on 9/08/14 beginning at 8:20 AM, the RN confirmed the comprehensive assessment did not include his rocking movements to stand, and agreed it could also be addressed on the POC.</p> <p>The agency failed to ensure Patient #2's assessment had been updated to reflect his current status and needs.</p> <p>4. A policy "BEREAVEMENT ASSESSMENT" revised March 2014, stated "On admission, the social worker or hospice registered nurse will complete a bereavement risk assessment that will be given to the Bereavement Coordinator." The policy further stated bereavement needs would be reassessed with each patient contact.</p> <p>However, patient records did not demonstrate the policy was implemented, as follows:</p> <p>a. Patient #7 was a 73 year old male admitted to the agency on 9/20/12 for hospice services related to "Adult Failure to Thrive." No further diagnoses were included.</p> <p>Patient #7's initial comprehensive assessment, dated 9/20/12, completed by the RN Case Manager, noted no bereavement risks were</p>	L 533		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 533	<p>Continued From page 13</p> <p>identified. The nurse also noted no abnormal social or spiritual issues were identified. However, the nurse noted Patient #7's spiritual preferences were unknown, as were his funeral arrangements.</p> <p>On the most recent recertification/comprehensive assessment dated 7/08/14, under the query of "Indicate patient's current social/ spiritual status," the RN Case Manager noted "no change." There was no entry related to a bereavement assessment on the form.</p> <p>The "Hospice POC Report" included bereavement goals dated 11/21/13. There was no indication the bereavement needs of Patient #7 and his family were assessed on an ongoing basis.</p> <p>During an interview on 9/04/14 beginning at 10:30 AM, the Branch Manager reviewed Patient #7's record and confirmed the comprehensive assessment did not include a bereavement assessment updates. He was unable to determine what an entry of "No Change" on the comprehensive assessment would indicate, and stated the nurse should have included a more descriptive statement.</p> <p>The agency failed to ensure ongoing bereavement assessment and updates occurred for Patient #7.</p> <p>b. Patient #2 was an 82 year old male admitted to the agency on 1/11/14, for hospice services related to senile degeneration of the brain. He and his wife, who was also on hospice services, lived in an ALF.</p>	L 533			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 533	<p>Continued From page 14</p> <p>Patient #2's initial comprehensive assessment, dated 1/11/14, completed by the RN Case Manager, noted no bereavement risks were identified. The nurse also noted no abnormal social or spiritual issues were identified, and it was unknown if funeral arrangements were finalized.</p> <p>On the most recent recertification/comprehensive assessment dated 7/08/14, there was no entry in the record related to social, spiritual needs, or of an updated bereavement assessment.</p> <p>The "Hospice POC Report" included bereavement goals dated 1/17/14. There was no indication the bereavement needs of Patient #2 and his family were assessed on an ongoing basis.</p> <p>During an interview on 9/08/14 beginning at 8:20 AM, the RN Case Manager reviewed Patient #2's record and confirmed the most recent comprehensive assessment did not include a bereavement assessment update.</p> <p>The agency failed to ensure ongoing bereavement assessment and updates occurred for Patient #2.</p> <p>c. Patient #5 was an 87 year old female admitted to the agency on 5/02/13, for hospice services related to Senile Dementia. Additional diagnoses included Adult Failure to Thrive.</p> <p>Patient #5's recertification/comprehensive assessment, dated 8/21/14, under the query of "Indicate patient's current social/ spiritual status," the RN Case Manager noted "no change." There was no entry related to a bereavement</p>	L 533			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
L 533	Continued From page 15 assessment on the form. The "Hospice POC Report" included bereavement goals dated 5/14/14. There was no indication the bereavement needs of Patient #2 and her family were assessed on an ongoing basis. During an interview on 9/09/14 at 11:30 AM, the DON reviewed Patient #5's record and confirmed the recent comprehensive assessment did not include documentation of an updated bereavement needs assessment. The agency failed to ensure ongoing bereavement assessment and updates occurred for Patient #5. The agency did not ensure comprehensive assessments were updated every 15 days and as the patients' needs changed.	L 533		
L 536	418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES This CONDITION is not met as evidenced by: Based on record review, review of agency policies, observation, and staff interview, it was determined the agency failed to ensure patient-specific plans of care, containing measurable outcomes, were developed, revised, and followed for each patient. This failure resulted in plans of care being developed without addressing all pertinent patient issues, and without a process in place to determine if patients were receiving services as needed to reach established goals. Findings include:	L 536		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 536	Continued From page 16 1. Refer to L543 as it related to the agency's failure to follow the patient's individualized POC. 2. Refer to L545 as it relates to the agency's failure to develop an individualized POC for each patient. 3. Refer to L550 as it relates to the agency's failure to include all services, medical equipment, and supplies in the POC necessary to meet the needs of the patient. 4. Refer to L553 as it relates to the agency's failure to revise the individualized plan of care as patient needs changed. 5. Refer to L554 as it relates to the agency's failure to ensure communication and of patient needs coordination with all disciplines. 6. Refer to L557 as it relates to the agency's failure to ensure communication between all disciplines regarding patient care concerns. The cumulative effect of these deficiencies resulted in the inability of the agency to adequately meet patient needs.	L 536			
L 543	418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.	L 543	L536 418.56 IDG, Care Planning, Coordination of Services All Hospice patients admitted to the agency will have an individual Plan of Care established by the IDG team members at the Start of Care. The Plan of Care will be reviewed/updated at a minimum of every 15 days or more frequently as necessary, in collaboration with the patient and/or family/caregiver and in accordance with the identified needs. Responsible: Director of Nursing is responsible for the overall correction of this condition. Completion: 10-15-14		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION).	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 543	Continued From page 17 This STANDARD is not met as evidenced by: Based on record review, a home visit, and staff interviews it was determined the agency failed to ensure an individualized written plan of care was followed by the hospice interdisciplinary group in collaboration with the attending physician for 1 of 13 patients (#4) whose records were reviewed. Failure to follow the individualized plan of care had the potential to interfere with hospice staff meeting the current medical needs of the patient. Findings include: Patient #4 was an 84 year old female admitted to the agency on 10/27/11, with a diagnosis of Breast Cancer. She received SN, SW, and HA services. Patient #4 resided in a skilled nursing facility. Her record, including the POC, was reviewed for the certification period of 7/9/14 to 9/6/14. Patient #4's record included a "HOSPICE RECERTIFICATION AND PLAN OF CARE" for the certification period of 7/9/14 to 9/6/14, completed by the Intake Nurse on 6/26/14, and signed by the Medical Director on 6/26/14. The section "Previously Ordered and Approved Medications" documented she was to have blood glucose tests completed daily. However, visit notes completed by the SN documented Patient #4 blood glucose levels were test three times weekly by the skilled nursing facility staff, rather than daily as ordered. During a visit to the skilled nursing facility on 9/4/14 at 10:00 AM, an interview was conducted with the RN responsible for Patient #4's medications and blood glucose tests. The skilled nursing facility RN stated Patient #4's blood	L 543	L543 418.56 (b) Plan of Care Director of Nursing or designee will provide staff education review of Policy 2.044 The Plan of Care, 2.046 Verification of Physician's Orders, 2-046.A Addendum: Organizational Specific Elements for Orders. Instruction will include formulation of the patient's plan of care in conjunction with the patient, caregiver/family with each plan of care to be individualized with specific interventions/measurable goals to meet the overall needs of the patient and family unit. Education provided will also include obtaining specific MD orders for required interventions at the Start of Care and ongoing to meet the needs of the hospice patients such as blood glucose readings, wound care		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 543	Continued From page 18 glucose was being tested three times a week and she was not aware that the tests had been ordered daily. During an interview with the RN Case Manager on 9/8/14 at 8:40 AM, the record was reviewed. She confirmed that she had documented the blood glucose tests as completed three times weekly. The RN Case Manager stated she was unaware the order stated the tests to be completed daily, per Patient #4's POC.	L 543	and updating the plan of care with changes in treatment, interventions, or medications. Director of Nursing or designee will review 100% of initial admission assessments/evaluations. Ongoing the DON or designee will perform a record review of 10% average daily census on a quarterly basis. Indicators with less than 85% compliance will require an action plan. All clinical review findings		
L 545	Patient #4's POC was not followed per the attending physician's orders. 418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure an individualized POC, which reflected patient goals and contained interventions based on comprehensive assessments, was developed for 1 of 13 active patients (Patient #10) whose records were reviewed. Failure to develop individualized plans of care had the potential to interfere with the ability of hospice staff to meet	L 545	will be reported to the QAPI committee and governing body on a quarterly basis. Responsible: Director of Nursing is responsible for the overall correction of this standard. Completion: 10-15-14 L545 418.56 (c) Content of the Plan of Care		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 545	<p>Continued From page 19 each patient's current needs. Findings include:</p> <p>1. Patient #10 was an 86 year old female admitted to the agency on 8/26/14, for services related to necrotizing fasciitis (a serious bacterial infection that spreads rapidly and destroys the body's soft tissue). She received SN, HA and SW services. Her record, including the POC, for the certification period 8/26/14 to 11/23/14, was reviewed.</p> <p>Patient #10's record included a "HOSPICE CERTIFICATION AND PLAN OF CARE" completed by the RN Case Manager on 8/26/14, and signed by Patient #10's physician on 8/28/14. Her POC was not comprehensive to include all services necessary for her care, as follows:</p> <p>a. Patient #10's SOC assessment was completed by the RN Case Manager on 8/26/14. The assessment noted the presence of a wound or wounds, and erythema (redness of the soft tissue). However, Patient #10's POC did not contain orders for SN interventions related to wound care, including cleansing of her wounds, or management of wound drainage.</p> <p>Patient #10's record included an SN visit note, dated 8/28/14, and signed by the RN Case Manager. It documented wound drainage, an increase in the number of wounds and an increase in the area of erythema. It also documented wound care was provided.</p> <p>During an interview on 9/08/14 at 4:30 PM, the RN Case Manager stated Patient #10's wounds had increased from 1 wound to 3 wounds since her SOC on 8/28/14. She stated she had</p>	L 545	<p>Director of Nursing or designee will provide staff education on the content of the patient's plan of care. Instruction will include review of Policy 2.044 The Plan of Care, which is to be completed in conjunction with the patient and/or family/caregiver. Each plan of care will be individualized with specific interventions and measurable goals to meet the overall needs of the patient. Education provided will also include obtaining specific orders and following MD orders as written at the start of care and throughout the episode of care to meet the identified needs of the patient. Specific education will be provided regarding wound care orders, documentation according to the specific orders, recognizing new wounds, reporting new wounds to the MD and obtaining specific wound care orders. Instruction will also include required order elements for urinary catheters such as size of the catheter, balloon size, how often the catheter is to be changed, who is responsible for catheter care/perineal care. Specific</p>		

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

PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131620	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 545	Continued From page 20 provided wound care which included cleansing the wounds with an antimicrobial agent, and applying a disposable brief to manage the wound drainage. The RN Case Manager confirmed Patient #10's POC did not include interventions related to wound care. b. Patient #10's SOC assessment, completed by the RN Case Manager on 8/26/14, noted the presence of an indwelling urinary catheter. However, Patient #10's POC did not contain orders for SN interventions related to her urinary catheter, including catheter care and cleansing, frequency of catheter changes, or type and size of catheter to be used. During an interview on 9/08/14 at 4:30 PM, the RN Case Manager confirmed Patient #10 had an indwelling urinary catheter. Additionally, she confirmed Patient #10's POC did not include orders for catheter care.	L 545	elements will be included in the orders and interventions. Director of Nursing or designee will review 100% of initial admission assessments/evaluations. Ongoing the DON or designee will perform a record review of 10% average daily census on a quarterly basis. Indicators with less than 85% compliance will require an action plan. All clinical review findings will be reported to the QAPI committee and governing body on a quarterly basis. Responsible: Director of Nursing is responsible for the overall correction of this standard.	
L 550	418.56(c)(5) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (5) Medical supplies and appliances necessary to meet the needs of the patient. This STANDARD is not met as evidenced by: Based on record review, review of agency policies, observation during home visits and staff interview, it was determined the agency failed to	L 550	Completion: 10-15-14 L550 418.56 (c) (5) Content of the Plan of Care Director of Nursing or designee will provide staff education on the content	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 550	<p>Continued From page 21</p> <p>ensure all DME and supplies necessary for patient care were identified on patient POCs for 1 of 13 active patients (Patient #3) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include:</p> <p>A policy titled "DURABLE MEDICAL EQUIPMENT AND SUPPLIES," revised March 2014, stated "All durable medical equipment and supplies provided by hospice, as appropriate, will have an order from the patient's physician (or other authorized licensed independent practitioner) and be included in the hospice plan of care."</p> <p>Patient #3's record did not demonstrate the policy was implemented, as follows:</p> <p>Patient #3 was an 87 year old female admitted to the agency on 5/24/14, with a diagnosis of dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 5/24/14 to 8/21/14, and 8/22/14 to 10/20/14, was reviewed.</p> <p>Patient #3's record did not include documentation of DME in accordance with her identified needs, as follows:</p> <p>The "DME and Supplies" section of Patient #3's POC, dated 5/24/14 to 8/21/14, was documented "NONE." However, the "Order" section of the POC included oxygen per nasal cannula for respiratory distress. Additionally, an SN visit note, dated 6/10/14, and signed by the RN Case Manager noted "self turning bed implemented."</p> <p>A visit was made to Patient #3's ALF on 9/03/14 at 9:30 AM, to observe an SN visit. Patient #3's</p>	L 550	<p>of the patient's plan of care, which is to be completed in conjunction with the caregiver/family as appropriate, with each plan of care individualized with specific interventions and measureable goals to meet the overall needs of the patient. Education will be provided to include obtaining specific orders and following MD orders as written at the start of care and throughout the episode of care to meet the identified needs of the patient.</p> <p>Staff instruction will include review of policy 2-044 The Plan of Care, 2-045 Interdisciplinary Group Plan of Care and will include medical equipment/supplies required and documentation of education provided. Medical equipment and supplies will be identified on the initial plan of care and ongoing will be updated with any changes identified. The plan of care is to be updated to reflect the changes. Specific instruction will include documentation of the patient's use of oxygen, including the rate of flow in liters/min,</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 550	Continued From page 22 bed was equipped with an alternating pressure mattress, to decrease the risk of skin breakdown. An oxygen concentrator was present in her room. During the visit, it was noted Patient #3 also required disposable briefs due to incontinence. Further, the RN utilized gloves and skin cleanser. The RN Case Manager was interviewed on 9/04/14 starting at 3:45 PM. She confirmed Patient #3's POC did not include documentation of DME and supplies used for her care. The RN stated Patient #3's POC should have included the use of gloves, skin cleanser, the oxygen concentrator and supplies, the alternating pressure mattress and incontinence briefs under the DME section.	L 550	how often oxygen is used: continuous or intermittent, and education provided to the patient and/or caregiver/family. In addition, oxygen is to be documented and included on the patient's medication profile. Any updates to the patient's use of oxygen will be made on the plan of care, including the medication profile.		
L 553	The agency failed to ensure Patient #3's DME was accurately reflected on her POC. 418.56(d) REVIEW OF THE PLAN OF CARE A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. This STANDARD is not met as evidenced by: Based on observation, patient and staff interview, review of agency policies, and record review it was determined the agency failed to ensure revised plans of care included all information from the patient's updated comprehensive assessment, and documentation of the patient's progress toward outcome and goals specified in the plan of care for 5 of 13 current patients (#1, #4, #7, #8, and #9) whose records were	L 553	Director of Nursing or designee will review 100% of initial admission assessments/evaluations. Ongoing the DON or designee will perform a record review of 10% average daily census on a quarterly basis. Indicators with less than 85% compliance will require an action plan. All clinical review findings will be reported to the QAPI committee and governing body on a quarterly basis. Responsible: Director of Nursing is responsible for the overall correction of this standard. Completion: 10-15-14		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 03642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 553	<p>Continued From page 23</p> <p>reviewed. The failure to revise plans of care placed the patients at risk to have unmet needs. Findings include:</p> <p>1. Patient #4 was an 84 year old female admitted to the agency on 10/27/11, with a diagnosis of Breast Cancer. She received SN, SW, and HA services. Her record, including the POC, was reviewed for the certification period of 7/09/14 to 9/06/14.</p> <p>Patient #4's POC included goals and interventions. The most recent entry on the POC for skilled nursing was dated 1/15/13. Nursing interventions included "patient verbalizes tolerance to pulse oximetry procedure," "instruct on patient/caregiver causes of decrease in level of consciousness, patient tolerates assessment of sensory/neurological status."</p> <p>A recertification comprehensive assessment was conducted on 7/08/14. The RN described Patient #4 as having a flat affect, confused, having no meaningful verbal communication, and chair bound.</p> <p>Additionally, Patient #4's IDG coordination note on 7/10/14, documented she was exhibiting periods of anxiety and increased confusion. The IDG coordination note on 7/23/14, documented Patient #4 was self-inducing vomiting.</p> <p>However, Patient #4's POC dated 1/15/13, was not updated to reflect her most recently assessed needs.</p> <p>During an interview with the RN Case Manager on 9/08/14 at 8:40 AM, the record was reviewed. She stated during her visits to Patient #4 she had</p>	L 553	<p>L553 418.56 (d) Review of the Plan of Care</p> <p>Director of Nursing or designee will provide staff education on the content of the patient's plan of care and ongoing updates to the plan of care. The plan of care will be completed in conjunction with the patient and/or family/caregiver. Each plan of care will be individualized with specific interventions and measureable goals to meet the overall needs of the patient.</p> <p>Staff instruction will include review of Policy 2-044 The Plan of Care, 2-045 Interdisciplinary Group Plan of Care, 2-049 Interdisciplinary Group Coordination of Care, and 2-050 Interdisciplinary Group Meeting. Education will include review and updating of the plan of care at a minimum of every 15 days and more often as necessary. The review and update will reflect any and all changes since the previous IDG meeting, including changes in level of care needs, medical equipment supplies, medication changes, caregiver</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 553	<p>Continued From page 24</p> <p>consistently assessed the need for changes to Patient #4's interventions and goals. The RN Case Manager confirmed that Patient #4's skilled nursing interventions and goals had not been changed or updated in the record since 2013.</p> <p>Patient #4's POC was not updated to include interventions based on to her current assessment and changing needs.</p> <p>2. Patient #8 was a 64 year old female admitted to the agency on 12/30/13, with a diagnosis of COPD. She received SN, SW, HA, and Chaplain services. Her record was reviewed for the certification periods of 7/01/14 to 8/29/14 and 8/30/14 to 10/28/14.</p> <p>Patient #8's POC included goals and interventions, however, the most recent entry on the POC was 1/07/14. The POC included dates from 1/02/14 to 1/07/14, and interventions included "patient verbalizes tolerance to pulse oximetry procedure," "patient's constipation is controlled related to opioid usage, patient's remains free from diarrhea."</p> <p>A recertification comprehensive assessment was conducted on 8/29/14. The RN described Patient #8 as needing supervision for all financial tasks, at high risk for falls, and having abdominal pain which interfered with her ability to enjoy activities. Additionally, Patient #8's IDG report dated 8/20/14 indicated she was having stomach pain and was unable to perform ADL's independently.</p> <p>Patient #8's POC was dated 1/07/14, and did not include information which indicated she was at high risk for falls, gastrointestinal problems, or required support for her ability to manage</p>	L 553	<p>changes, new psychosocial issues, falls, etc. Each plan of care is to reflect new or changed goals specific to the individual patient as necessary to accurately reflect the patient's needs.</p> <p>Director of Nursing or designee will review 100% of initial admission assessments/evaluations. Ongoing the DON or designee will perform a record review of 10% average daily census on a quarterly basis. Indicators with less than 85% compliance will require an action plan. All clinical review findings will be reported to the QAPI committee and governing body on a quarterly basis.</p> <p>Responsible: Director of Nursing is responsible for the overall correction of this standard.</p> <p>Completion: 10-15-14</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 553	<p>Continued From page 25 finances.</p> <p>During an interview with the MSW on 9/04/14 at 3:35 PM, the record was reviewed. She confirmed that Patient #8's interventions and goals had not been changed or updated in the record since January 2014 because her needs had not changed.</p> <p>During an interview over the phone with the RN Case Manager on 9/08/14 at 8:20 AM, the record was reviewed. She confirmed the interventions and goals had not been updated on the report in the last eight months.</p> <p>Patient #8's POC was not updated to include new interventions and goals according to her current needs based on the most recent comprehensive assessment.</p> <p>3. Patient #9 was a 71 year old male admitted to the agency on 9/09/13 with a diagnosis of CHF. He received SN, SW, and Chaplain services. His record, including the POC, was reviewed for the certification period of 7/16/14 to 9/13/14.</p> <p>Patient #9's POC included interventions and goals, however, the most recent entry on the POC was dated 9/24/13. The POC included dates from 9/19/13 to 9/24/13, and included interventions such as "patient's constipation is controlled related to opioid usage, patient remains free from diarrhea, patient/caregiver verbalize availability of 24-hour on call nurse."</p> <p>A recertification comprehensive assessment was conducted on 7/10/14, and described Patient #9 as being fearful that narcotics would hasten his death, he had a fear of respiratory depression,</p>	L 553			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 553	<p>Continued From page 26</p> <p>and he had 1-2 falls in the last three months. Additionally, an IDG report on 7/15/14 documented Patient #9 had two recent fall in the last two weeks, one on 6/26/14, and again on 7/12/14.</p> <p>Patient #9's POC was not updated to include information which was reflective of his risk for falls or of his fears related to medicine and respiratory status.</p> <p>During a phone interview with the RN Case Manager on 9/08/14 at 4:25 PM, the RN Case Manager reviewed Patient #9's record. She confirmed the interventions and goals had not been changed or updated in the record since 2013, and stated that she is new to the agency and still learning all the charting for the electronic medical record.</p> <p>Patient #9's POC was not updated to include new interventions and goals according to his current needs based on the most recent comprehensive assessment.</p> <p>The agency did not ensure updated comprehensive assessments that identified the patients' changing needs were incorporated into the POC.</p> <p>4. Patient #1 was a 77 year old female admitted to the agency on 8/18/12, for hospice services related to Alzheimers Disease.</p> <p>a. Patient #1's POC included nursing goals and interventions. The most recent entry on the POC was dated 12/17/13. The POC included dates from 8/21/12 to 12/17/13, and included such</p>	L 553			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 553	<p>Continued From page 27</p> <p>interventions as "patient verbalizes tolerance to pulse oximetry procedure," "instruct on safety measures, skilled teaching of nutrition and hydration."</p> <p>A recertification comprehensive assessment conducted on 8/07/14, described Patient #1 as being disoriented, and using 6 words or less with her speech. It was also noted that Patient #1 required assistance with standing. The assessment noted she did not have pain, and she was receiving antibiotics prophylactically for prevention of urinary infections.</p> <p>The POC did not include information which was reflective of Patient #1's updated comprehensive assessment related to her ambulation, disorientation, decreased speaking ability, or use of antibiotics.</p> <p>b. Patient #1's initial comprehensive assessment, dated 8/18/12, completed by the RN Case Manager, noted no bereavement risks were identified. The nurse also noted there were no abnormal social or spiritual issues identified.</p> <p>Patient #1's most recent recertification comprehensive assessment, dated 8/07/14, the RN Case Manager noted Patient #1's survivor was frail, elderly and dependent. The POC did not include interventions related to the caregiver needs, and interventions to ensure Patient #1 was adequately cared for.</p> <p>The most recent date on the POC related to bereavement was on 12/17/13, and included such interventions as: "...assist for integration of terminal illness and loss of loved one into meaningful experience, explore issues of</p>	L 553			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 553	<p>Continued From page 28</p> <p>forgiveness, invite patient to share life story, and encourage verbalization of grief issues."</p> <p>On 9/02/14 at 2:00 PM, the DON provided a printed copy of Patient #1's record. It included a form titled "Hospice POC Report." The DON stated the report included all current problems, interventions, and goals. She confirmed many of the dates were from 2012, and stated the Plan of Care had been updated and the interventions were current.</p> <p>The POC was not updated to reflect changes in Patient #1's needs based on the comprehensive assessment.</p> <p>5. Patient #7 was a 73 year old male admitted to the agency on 9/09/12, for hospice services related to Cerebral Artery Occlusion. Patient #7's record and POC were reviewed, as well as, all visit notes for the certification period 7/12/14 to 9/9/14.</p> <p>Patient #7's POC included goals and interventions, however, the most recent entry on the POC was dated 11/21/13. The POC was not updated to reflect his current status and needs, as follows:</p> <p>a. The POC included interventions for physical therapy, initiated on 10/03/12. The therapy section included such interventions as "establish and instruct patient in home exercise program to restore functional ability, instruct patient in ambulation methods with/without use of devices to enter and or exit home, instruct patient in safe and proper use of wheelchair relative to propelling, breaking and turning."</p>	L 553			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 553	<p>Continued From page 29</p> <p>However, his most recent comprehensive assessment, dated 7/08/14, noted Patient #7 was bed-bound and not able to ambulate, use the wheelchair, or participate in a home exercise program. The POC did not reflect the decline in his functional ability and adjustment of his goals accordingly.</p> <p>b. The Initial POC, dated 9/20/12, included generic standing orders for stage I and stage II pressure ulcers and orders to consult with the physician or a wound care nurse for stage III or IV ulcers.</p> <p>Patient #7's record visit notes for the certification period 7/12/14 to 9/9/14 were reviewed. The visit notes identified wounds on each of Patient #7's feet and a draining abscess on his left neck area. Additionally, Patient #7's most recent comprehensive assessment, dated 7/08/14, included notes regarding a wound on his left foot.</p> <p>However, his 9/20/12 POC did not include updated specific wound care orders.</p> <p>c. The initial comprehensive assessment, dated 9/20/12, noted Patient #7 was incontinent and was using diapers and under pads. The most recent comprehensive assessment, dated 7/08/14, noted Patient #7 had a foley catheter and indicated the date it was due to be changed.</p> <p>However, his 9/20/14 POC did not include interventions for catheter care or indicate when it was to be changed.</p> <p>During an interview on 9/08/14 beginning at 10:30 AM, the Branch Manager reviewed Patient #7's record and confirmed the POC was not updated</p>	L 553			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 553	Continued From page 30 since 2013. He stated the POC was reviewed by the RN Case Manager and at the IDG meetings. The Branch Manager further stated the physical therapy interventions should have been discontinued or updated, and the POC should have included wound and catheter care. Patient #7's POC was not updated based on his changing needs as as were noted in his comprehensive assessment. The agency did not ensure POC's were updated and current to meet the changing needs of each hospice patient.	L 553	L544 418.56 (e) (1) Coordination of Services The agency will ensure that care and services are provided in accordance with the plan of care. Instruction to be provided to staff with review of Policy 2-049.1 Interdisciplinary Group Coordination of Care, and 2-005		
L 554	418.56(e)(1) 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- (1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care was coordinated and supervised for 3 of 13 active patients (#3, #7, and #10) whose records were reviewed. This resulted in missed opportunities to alter the POC in response to patient needs. Findings include: 1. A policy, titled "HOSPICE NURSING CARE," revised 3/2014, delineated the responsibilities of the RN Case Manager. The responsibilities included ensuring communication between the	L 554	Hospice Nursing Care. Education to include the formulation of the Hospice Aide plan of care, including RN coordination of care with the hospice aide responding and follow-up on reported hospice aide concerns and documentation of follow-up. Hospice aide supervision with supervisory visits will occur at a minimum of every 14 days and will be documented within the clinical record. LPN supervision by the RN will occur at a minimum of every 30 days and the clinical record will include documentation pertaining to the RN's review of the LPN's documentation, adherence to the Plan of Care, and		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 554	<p>Continued From page 31 care providers and supervision of the LPN and HA.</p> <p>a. Patient #3 was an 87 year old female admitted to the agency on 5/24/14, with a diagnosis of dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 5/24/14 to 8/21/14, and 8/22/14 to 10/20/14, was reviewed.</p> <p>Patient #3's record included a Visit Note Report, dated 8/11/14, and signed by the HA. The note stated "Noted skin tear on right forearm. CM and facility notified..."</p> <p>Patient #3's record did not include documentation of action taken by the Case Manager or the agency related to the reported skin tear.</p> <p>Additionally, there was no documentation of a skin tear on Patient #3's right arm during SN visit notes, signed by the LPN on 8/14/14 and 8/18/14. Further, a subsequent SN visit note, signed by the RN Case Manager on 8/21/14 documented an open area on Patient #3's perineum. However, it did not include documentation of a skin tear on her right arm. The SN visit notes did not indicate an acknowledgement of the right arm skin tear as documented by the HA on 8/11/14.</p> <p>During an interview on 0/04/14 at 3:30 PM, the RN Case Manager stated she did not remember being contacted by the HA regarding a skin tear on Patient #3's arm, and she was not aware of the skin tear documented in the HA visit note. She stated the visits on 8/14/14 and 8/18/14, were completed by the LPN because she was out of town.</p>	L 554	<p>LPN's documentation of communication and collaboration with the RN and IDG team.</p> <p>The RN will be scheduled at a minimum of every 14 days to perform an on-site supervisory visit to the patient's home or those patients receiving hospice aide services with documentation to be completed by the RN and contained within the clinical. Scheduling will also ensure that supervisory visits are scheduled for the LPN every 30 days at a minimum. These visits will not be moved unless the RN and scheduler determine that the new visit date will still be in compliance for supervisory visits.</p> <p>The statement within the Electronic Medical Record Plan of Care Intervention "There is no willing or able caregiver to provide hygiene services" has been removed from the agency electronic medical record system.</p> <p>DON or designee will perform a record review of 10% average daily census on</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 554	<p>Continued From page 32</p> <p>During an interview on 9/08/14 at 9:40 AM, the LPN stated he did not recall being notified by the RN Case Manager or the HA of a skin tear on Patient #3's arm.</p> <p>The agency failed to ensure sufficient communication and coordination occurred for Patient #3.</p> <p>b. Patient #10 was an 86 year old female admitted to the agency on 8/26/14, for services related to necrotizing fasciitis (a serious bacterial infection that spreads rapidly and destroys the body's soft tissue). She received SN, HA and MSW services. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE," for the certification period 8/26/14 to 11/23/14, was reviewed.</p> <p>Patient #10's "HOSPICE CERTIFICATION AND PLAN OF CARE," for the certification period 8/26/14 to 11/23/14, included an order for HA services 2 times a week for 9 weeks and stated, "Home Health Aide service for assistance with personal care and ADL's [Activities of Daily Living] secondary to functional limitations, which prevent self care. There is no willing or able caregiver to provide for hygiene needs."</p> <p>Patient #10's record included an "Aide Care Plan Report" for the certification period 8/26/14 to 11/23/14, completed and signed by the RN Case Manager. The Care Plan included instructions for the HA to bathe Patient #10 two times per week.</p> <p>Patient #10's record included 2 documents titled "Visit Note Report" completed and signed by the HA on 8/29/14 and 9/02/14. The reports indicated bathing was not completed, with a note</p>	L 554	<p>a quarterly basis. Indicators with less than 85% compliance will require an action plan. All clinical review findings will be reported to the QAPI committee and governing body on a quarterly basis.</p> <p>Responsible: Director of Nursing is responsible for the overall correction of this standard.</p> <p>Completion: 10-15-14</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 554	<p>Continued From page 33</p> <p>stating, "not needed on this visit." The report dated 9/02/14 included a note in the narrative section stating, "We don't give shower, just visit, turn."</p> <p>During an interview on 9/08/14 at 12:45 PM, the DON reviewed Patient #10's record and explained the statement, "There is no willing or able caregiver to provide for hygiene needs" was automatically populated on the "HOSPICE CERTIFICATION AND PLAN OF CARE" whenever an HA was ordered. The DON stated the HA did not bathe Patient #10 because the staff at the facility where she lived provided baths. The DON confirmed the RN Case Manager and the HA did not communicate regarding the discrepancy between the HA assignment and Patient #10's needs.</p> <p>The agency failed to ensure sufficient communication and coordination occurred for Patient #10.</p> <p>c. Patient #7 was a 73 year old male admitted to the agency on 9/19/12, for hospice services related to Cerebral Artery Occlusion. Additional diagnoses included diabetes and HTN. His records for the certification period 7/12/14 to 9/09/14 were reviewed, including hospice aide visit notes.</p> <p>On 9/08/14 at 10:40 AM, the DON provided an "Aide Care Plan Report." The report included printed documentation it was developed by the RN Case Manager, and also noted the effective date of the "Current Aide Care Plan" was 8/28/13. The DON stated it was a current HA POC, and confirmed the dates.</p>	L 554			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 554	Continued From page 34 The HA documented in a visit note dated 8/08/14 that Patient #7's bottom was very red and she had applied Vaseline to his back and bottom. The note did not include documentation of notification to the RN Case Manager and the POC did not include orders for the HA to apply Vaseline. Additionally, the HA documented in a visit note dated 8/18/14 that Patient #7 had a very red area on his bottom. She documented she applied "calamide [sic]." There was no documentation of notification to the RN Case Manager. Additionally, the POC did not include orders for the HA to apply medications to his skin. During an interview on 9/08/14 beginning at 11:30 AM, the Branch Manager reviewed Patient #7's record and confirmed the HA duties on the HA POC and confirmed there were no orders on the HA POC to apply topical medications.	L 554			
L 557	418.56(e)(4) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (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.	L 557	418.56 (e) (4) Coordination of Services Agency will educate staff on Policy 2-044 Plan of Care and 2-046 Verification of Physician Orders. Agency will work with the electronic medical record IT support team to identify any changes that can be made to rectify the agency issue of system generated "physician verbal orders"		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 557	<p>Continued From page 35</p> <p>This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the agency failed to maintain a system of communication and coordination of information between all disciplines providing services for 2 of 13 active patients (#4 and #8) whose records were reviewed. This failure resulted in a lack of coordination of care. Findings include:</p> <p>1. The policy "Plan of Care," revised March 2014, stated the plan of care will be provided to both the attending physician and the hospice Medical Director for approval of verbal orders and certification of the terminal illness. However, the policy was not consistently implemented, as follows:</p> <p>a. Patient #4 was an 84 year old female admitted to the agency on 10/27/11, with a diagnosis of breast cancer. The POC was reviewed for the certification period of 7/09/14 to 9/06/14.</p> <p>The record contained the form "PHYSICIAN VERBAL ORDER" on which an order was written for re-certification of her terminal diagnosis and service changes by all disciplines involved with Patient #4's care for the 60 day certification period. The Attending Physician for Patient #4 was named on the form and a line underneath the name and address stated "Send to Physician: No." The bottom of the form was signed by the Medical Director. On the line for the Attending Physician's signature, "DO NOT SEND" was printed.</p> <p>During an interview on 9/04/14 beginning at 11:00 AM, the Branch Manager reviewed Patient #4's record and confirmed the order sheet indicated it</p>	L 557	<p>which are required to make changes within each disciplines schedule, add / correct supplies/DME, and make corrections to the medication profile. Physician Verbal Orders with the "Do Not Send" designation of the signature line must be utilized to make these changes within the EMR per the system manufacturers operating platform.</p> <p>Agency will continue to work with the electronic medical record IT support team to identify and request system changes from the manufacturer. Changes will be made and implemented when manufacturer is able to change the operating platform.</p> <p>Director of Nursing or designee will review 100% of initial admission assessments/evaluations. Ongoing the DON or designee will perform a record review of 10% average daily census on a quarterly basis. Indicators with less than 85% compliance will require an action plan. All clinical review findings will be reported to the QAPI</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
L 557	<p>Continued From page 36</p> <p>was not to be sent to the attending physician. He stated the orders would be signed during the IDG meetings by the Medical Director.</p> <p>Communication and coordination with Patient #4's attending physician did not occur as specified in the agency's policy.</p> <p>b. Patient #8 was a 64 year old female admitted to the agency on 12/30/13, with a diagnosis of COPD. Her POCs were reviewed for the certification periods of 7/01/14 to 8/29/14 and 8/30/14 to 10/28/14.</p> <p>The POC for the period 7/01/14 to 8/29/14 contained the form "PHYSICIAN VERBAL ORDER" on which an order was written for recertification of her terminal diagnosis and service changes by all disciplines involved with Patient #8's care; for that 90 day certification period. The Attending Physician for Patient #8 was named on the form, and a line underneath their name and address stated "Send to Physician: No." At the bottom, the form was signed by the Medical Director, but next to the Attending Physician Signature it stated "DO NOT SEND."</p> <p>The POC for the period 8/30/14 to 10/28/14 contained the form "PHYSICIAN VERBAL ORDER" on which an order was written for recertification of her terminal diagnosis and service changes by all disciplines involved with Patient #8's care, for that 90 day certification period. The Attending Physician for Patient #8 was named on the form, and a line underneath their name and address stated "Send to Physician: No." At the bottom, the form was signed by the Medical Director, but next to the</p>	L 557	<p>committee and governing body on a quarterly basis.</p> <p>Responsible: Director of Nursing is responsible for the overall correction of this standard.</p> <p>Completion: 10-15-14</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 557	Continued From page 37 Attending Physician Signature it stated "DO NOT SEND." During an interview on 9/04/14 beginning at 11:00 AM, the Branch Manager reviewed Patient #8's record and confirmed the order sheet indicated it was not to be sent to the attending physician. He stated the orders would be signed during the IDG meetings by the Medical Director. Communication and coordination with Patient #8's attending physician did not occur as specified in the agency's policy.	L 557		
L 559	418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT This CONDITION is not met as evidenced by: Based on staff interview and review of agency policies, and QAPI documents, it was determined the hospice failed to ensure a QAPI program was fully developed, implemented, and maintained. This resulted in the agency's inability to monitor its services and improve the quality of patient care based on relevant data. Findings include: 1. Refer to L574 as it relates to the failure of the Governing Body to ensure that an ongoing, data-driven QAPI program, that reflected the scope of services and complexity of the agency, was developed, implemented, and maintained.	L 559	559 418.58 Quality Assessment & Performance Improvement 1b) The Quality Assessment and Performance Improvement Program (QAPI) has been revised to objectively and systematically monitor and evaluate the quality of care and services provided for patients/families through the collection of data and then the analyzing and monitoring of that data to evaluate patient outcomes and agency processes.	
L 560	418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide	L 560	L560 418.56 Quality Assessment & Performance Improvement	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83842	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 560	<p>Continued From page 38</p> <p>data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of policies and quality documents, it was determined the hospice failed to ensure a comprehensive QAPI program had been developed, implemented and maintained. This resulted in the inability of the hospice to evaluate its processes and significantly impeded the agency's ability to improve care. Findings include:</p> <p>1. The agency's Improving Organizational Performance policy, revised 3/2014, stated the purpose of the policy was "To establish a performance improvement framework which integrates activities to improve organization performance, improve patient safety, reduce the risks for acquisition and transmission of infections and improve palliative care outcomes and services."</p> <p>The agency was asked, via email on 9/16/14 at 12:01 PM, for information related to the QAPI program. The agency responded via email from</p>	L 560	<p>The QAPI Program has been revised to objectively and systematically monitor and evaluate the quality of care/services provided for patients/families through the collection of data and then the analyzing and monitoring of that data to evaluate patient outcomes and agency processes. Revisions to the QAPI Program include: a written plan, Clinical Audit Tool, Action Plan, Quarterly QAPI Meeting template, follow up audits for specific occurrence reports such as a fall risk audit review, infection control, and complaint tracking, HR/Personnel record audit tool, and Volunteer HR record audit tool.</p> <p>Agency is to establish new QAPI committee to include Executive Director, Director of Nursing, RN, Chaplain, Medical Records, Medical Director and Governing Body member. Instruction to new committee members on the QAPI Program to include participation in QAPI, attendance at quarterly meetings, and quarterly reviews and</p>	

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

PRINTED: 09/29/2014
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 09/10/2014	
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L 560	<p>Continued From page 39</p> <p>the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 8:26 AM. The email included a letter and additional QAPI documentation as an attachment. The attached letter stated the agency's former Administrator had developed only a limited QAPI program. However, a new Administrator had been appointed on 9/16/13. The letter stated on 2/24/14 the agency provided QAPI training to the clinical staff and subsequently quality indicators were established as follows:</p> <p>Indicators established on 3/13/14 included the following:</p> <ul style="list-style-type: none"> - Pharmacy management - Patient diagnoses <p>Indicators established in 4/2014 included the following:</p> <ul style="list-style-type: none"> - Complaints and resolutions - Infections and control - Hospitalizations - Pain management <p>The agency was asked, via email on 9/17/14 at 3:35 PM, if it was the agency's position that the current indicators were sufficient, given the scope and complexity of the services the agency provided. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 4:46 PM. The email stated "yes."</p> <p>However, the facility's Scope of Services policy, revised March 2014, stated the facility provided services to 17 counties. Further, the agency's CMS-417 and CMS-843 forms, completed at the time of the survey, documented the agency had 6 multiple locations and offered services which</p>	L 560	<p>findings review. Quarterly review and findings will be submitted to the Governing Body for approval. Through monitoring and evaluating, the QAPI committee will determine whether the care/service delivered is in accordance with the predetermined indicators of care/service as well as the specific criteria identified. When the care/service delivered does not match the predetermined indicators/specific criteria, the discrepancy will be identified as a problem and methods of resolving the problem will be determined.</p> <p>Responsible: Director of Nursing has ultimate responsibility for the correction action for overall and on-going completion.</p> <p>QAPI Meetings for each quarter are to be completed by the following dates with documentation of each meeting including attendees, title or discipline and then presented to the Governing Body by the Executive Director.</p>				

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 560	<p>Continued From page 40</p> <p>included physician services, nursing services, medical social services, counseling services, physical therapy, occupational therapy, speech-language pathology, hospice aide services, homemaker services, and medical supplies. The agency had a current census of 124 patients.</p> <p>Additionally, the agency's letter and additional QAPI documentation, received via email from the agency's Counsel, with a cc to the agency Administrator, on 9/17/14 at 8:26 AM, included documentation that on 9/02/14, the DON had led a review of hospice reporting data for the first and second quarter of 2014. However, during an interview on 9/09/14 beginning at 9:00 AM, the DON stated the Hospice QAPI meeting, scheduled for 9/02/14, was canceled due to the arrival of the survey team. She stated the document she provided to the survey team was an agenda for the meeting, not minutes of a meeting.</p> <p>Corresponding data, found in email's attachments, related to the 9/02/14 meeting agenda, documented bar and line graph information for the first, second and third quarters of 2014. The data included information related to anxiety, depression, dyspnea, nausea, "On Call," oploid medication and advanced directives.</p> <p>However, the corresponding 9/02/14 "Hospice PIP/QAPI - 1st and 2nd quarter" Meeting agenda did not include information explaining what the data meant (e.g. was the downward trend demonstrated in the anxiety line graph an improvement or regression), analysis of the data was not present (e.g. what had caused there to be a downward trend demonstrated in the</p>	L 560	<p>QAPI Meeting Schedule:</p> <ul style="list-style-type: none"> • 1st Quarter: by May 5th • 2nd Quarter: by August 5th • 3rd Quarter: by November 5th • 4th Quarter: by February 5th <p>Responsible: Director of Nursing is responsible for the overall correction.</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 560	<p>Continued From page 41</p> <p>agency's depression line graph) and information related to how the measures were incorporated into the agency's QAPI plan was not present.</p> <p>The agency was asked, via email on 9/17/14 at 12:07 PM, when the agency had begun tracking the measures. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 2:11 PM. The email stated the data was available from "HomeCare HomeBase," but they were not necessarily all being tracked.</p> <p>The agency was asked, via email on 9/17/14 at 2:47 PM, for confirmation that the quality indicators of anxiety, depression, dyspnea, nausea, "On Call," opioid medications and advanced directives, had not yet been incorporated into the agency's QAPI program. The agency confirmed they had not, via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 2:58 PM.</p> <p>The agency's documentation did not demonstrate the anxiety, depression, dyspnea, nausea, "On Call," opioid medications and advanced directives data was not relevant to the agency's QAPI program. Additionally, the agency's documentation did not demonstrate that the 6 established quality indicators (pharmacy management, patient diagnoses, complaints and resolutions, infections and control, hospitalizations and pain management) were sufficient given the scope and complexity of the services the agency provided.</p> <p>Further, the agency could not demonstrate data was used appropriately to demonstrate measurable improvement in care for 4 of the 6</p>	L 560			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 560	<p>Continued From page 42</p> <p>established quality indicators. Sufficient data was not collected for one of the quality indicators (pharmacy management), data analysis was not demonstrated for 2 of the indicators (hospitalizations and pain management 48 hours after admission) and identifiable interventions could not be demonstrated for the quality indicator of infection control. Additionally, the agency could not demonstrate that adverse patient events had been incorporated into the agency's QAPI program or that action had been taken in response to adverse patient events.</p> <p>The agency's documentation did not demonstrate that an effective, ongoing, hospice-wide data-driven QAPI program had been developed, implemented, and maintained.</p> <p>2. Refer to L562 as it relates to agency's failure to ensure adverse events were monitored and quality indicator data was analyzed.</p> <p>3. Refer to L563 as it relates to agency's failure to ensure the QAPI program included all relevant data.</p> <p>4. Refer to L565 as it relates to the agency's failure to ensure the Governing Body approved the frequency and detail of QAPI data collection.</p> <p>5. Refer to L566 as it relates to the agency's failure to ensure the QAPI program demonstrated a focus on high-risk, high volume, or problem prone areas.</p> <p>6. Refer to L567 as it relates to the agency's failure to ensure the QAPI program demonstrated consideration of incidence, prevalence, and severity of problems in the design of its program.</p>	L 560			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 560	Continued From page 43 7. Refer to L569 as it relates to the agency's failure to ensure adverse patient events were analyzed and preventative measures were implemented. 8. Refer to L570 as it relates to the agency's failure to ensure performance improvement actions were taken in repose to quality indicator data analysis. 9. Refer to L572 as it relates to the agency's failure to ensure PIPs reflected the scope and complexity of the agencies services and operations. 10. Refer to L573 as it relates to the agency's failure to ensure PIPs reflected measurable progress.	L 560			
L 562	418.58(a)(2) PROGRAM SCOPE (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure adverse events were monitored and quality indicator data was analyzed for all patients receiving care from the agency. This resulted in a lack of information related to adverse events and impeded the agency's ability to ensure safety and identify way to improve patient outcomes. Findings include: 1. The agency's QAPI documents were reviewed.	L 562	L562 418.58 (a) (2) Program Scope The QAPI program has been revised to ensure the agency is reviewing and monitoring adverse events and all quality indicator data obtained from the clinical audits will be analyzed for all patients receiving care and to establish the agency's ability to improve patient outcomes. Revision to Policies 4-015/1 Addendum 4-015C and Addendum 4-015 D was completed on 9/24/14 to reflect updates. Agency will utilize the Clinical Audit tool to perform clinical audits of established clinical indicators for accuracy for the following items:		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 562	<p>Continued From page 44</p> <p>The documentation included the agency's undated "Annual Agency Evaluation." The Evaluation included data in the form of graphs and charts. The graphs and charts were related to adverse events including falls, adverse drug reactions, and medication errors. The report documented the data was related to the fourth quarter of 2013.</p> <p>Additional data for the first quarter of 2014, submitted via email on 9/17/14 at 8:26 AM, reflected adverse event data related to falls. No other adverse event data was submitted for 2014.</p> <p>The agency was asked, via email on 9/17/14 at 3:35 PM, about the fall data. The agency responded via email from the agency's Counsel, with a cc to the agency Administrator, on 9/17/14 at 4:46 PM, which stated falls were not yet being monitored but a program was being developed.</p> <p>The agency failed to ensure adverse events were incorporated into the QAPI program.</p> <p>2. The agency's Improving Organizational Performance policy stated, in the "Procedures" section, that the agency would "Adopt a scientific, problem-solving, data driven approach to quality assessment and performance improvement (QAPI)."</p> <p>The agency was asked, via email on 9/16/14 at 12:01 PM, for information related to the agency's QAPI program. The facility responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 8:26 AM. The email included a letter and additional QAPI documentation as an attachment. The attached letter stated the facility's QAPI measures included</p>	L 562	<ul style="list-style-type: none"> • Election Statement and Consent Form completion • Initial Certifications for terminal illness • Initial Plan of Care • Verbal/Supplemental orders • Recertification orders • Face to Face compliance • Clinical Record Documentation accuracy • Timely Filing of Clinical Records and Entries • Medication Reconciliation • Pain/Symptom Management • Wound Care • IV Therapies • Professional Management: Continuous Care, Respite, GIP • Coordination of Care • Discipline specific assessments/interventions/go als • Bereavement Services: assessment, Plan of Care, and documentation • Volunteer Services: Plan of Care • Discharges: 	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 562	Continued From page 45 the following: Indicators established on 3/13/14 included the following: - Pharmacy management - Patient diagnoses Indicators established in 4/2014 included the following: - Complaints and resolutions - Infections and control - Hospitalizations - Pain management The agency was asked, via email on 9/18/14 at 9:13 AM, for documentation of data analysis for the agency's identified quality indicators. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/18/14 at 3:49 PM. The email included an attachment. The attachment was titled "Home Health Quality Assessment and Performance Improvement Plan," and was dated "July 2014." However, the information included in the Plan was related to the hospice agency and was reflective of a 9/16/14 QAPI meeting, 6 days after the survey exit conference. The agency's documentation did not demonstrate that quality indicator data related to hospitalizations or pain management had been analyzed at the time of the survey.	L 562	<ul style="list-style-type: none"> ▪ Live Discharges and Revocation ▪ Death Discharge • Medication Destruction <p>1c) Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be written and presented to the QAPI committee on a quarterly basis. Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved.</p> <p>Responsible: Director of Nursing is responsible for the overall correction.</p>	
L 563	418.58(b)(1) PROGRAM DATA (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.	L 563	L563 418.58 (b) (1) Program Data	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83042		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 563	<p>Continued From page 46:</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of quality documents, it was determined the hospice failed to ensure the QAPI program included all relevant data. This resulted in the potential for opportunities to improve to be unidentified. Findings include:</p> <p>1. The agency's Improving Organizational Performance policy, revised 3/2014, stated the purpose of the policy was "To establish a performance improvement framework which integrates activities to improve organization performance, improve patient safety, reduce the risks for acquisition and transmission of infections and improve palliative care outcomes and services."</p> <p>The agency was asked, via email on 9/16/14 at 12:01 PM, for information related to the QAPI program. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 8:26 AM. The email included a letter and additional QAPI documentation as an attachment. The attached letter stated the agency's former Administrator had developed only a limited QAPI program. However, a new Administrator had been appointed on 9/16/13. The letter stated on 2/24/14 the agency provided QAPI training to the clinical staff and subsequently quality indicators were established as follows:</p> <p>Indicators established on 3/13/14 included the following: - Pharmacy management - Patient diagnoses</p> <p>Indicators established in 4/2014 included the</p>	L 563	<p>1c) Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be written and presented to the QAPI committee on a quarterly basis. Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved.</p> <p>Responsible: Director of Nursing is responsible for the overall correction.</p> <p>L563 418.58 (b) (1) Program Data</p> <p>Agency will utilize the Clinical Audit tool to perform clinical audits of established clinical indicators for accuracy for the following items:</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 563	<p>Continued From page 47 following:</p> <ul style="list-style-type: none"> - Complaints and resolutions - Infections and control - Hospitalizations - Pain management <p>Additionally, the agency's letter and additional QAPI documentation, received via email from the agency's Counsel, with a cc to the agency Administrator, on 9/17/14 at 8:26 AM, included documentation that on 9/02/14, the DON had led a review of hospice reporting data for the first and second quarter of 2014. However, during an interview on 9/09/14 beginning at 9:00 AM, the DON stated the Hospice QAPI meeting scheduled for 9/02/14, was canceled due to the arrival of the survey team. She stated the document she provided the survey team was an agenda for the meeting, not minutes of a meeting.</p> <p>Corresponding data, found in email's attachments, related to the 9/02/14 meeting agenda, documented bar and line graph information for the first, second and third quarters of 2014. The data included information related to anxiety, depression, dyspnea, nausea, "On Call," opioid medication, and advanced directives. The data included, but was not limited to, the following:</p> <p>a. A chart titled "Treatment Analysis: Anxiety Affect Patient" included bar graph and line graph information. The line graph documented the following:</p> <ul style="list-style-type: none"> - First quarter: 69% - Second quarter: 66% - Third quarter: 49% 	L 563	<ul style="list-style-type: none"> • Election Statement and Consent Form completion • Initial Certifications for terminal illness • Initial Plan of Care • Verbal/Supplemental orders • Recertification orders • Face to Face compliance • Clinical Record Documentation accuracy • Timely Filing of Clinical Records and Entries • Medication Reconciliation • Pain/Symptom Management • Wound Care • IV Therapies • Professional Management: Continuous Care, Respite, GIP • Coordination of Care • Discipline specific assessments/interventions/go als • Bereavement Services: assessment, Plan of Care, and documentation • Volunteer Services: Plan of Care • Discharges: 		

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

PRINTED: 09/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131620	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 563	<p>Continued From page 48</p> <p>The bar graph documented the following:</p> <ul style="list-style-type: none"> - First quarter: 36% - Second quarter: 31% - Third quarter: 42% <p>b. A chart titled "Treatment Analysis: Depression Affect Patient" included bar graph and line graph information. The line graph documented the following:</p> <ul style="list-style-type: none"> - First quarter: 58% - Second quarter: 37% - Third quarter: 28% <p>The bar graph documented the following:</p> <ul style="list-style-type: none"> - First quarter: 34% - Second quarter: 21% - Third quarter: 28% <p>However, the corresponding 9/02/14 "Hospice PIP/QAPI - 1st and 2nd quarter" Meeting agenda did not include information explaining what the data meant (e.g. was the downward trend demonstrated in the anxiety line graph an improvement or regression), analysis of the data was not present (e.g. what had caused there to be a downward trend demonstrated in the agency's depression line graph) and information related to how the measures were incorporated into the agency's QAPI plan was not present.</p> <p>The agency was asked, via email on 9/17/14 at 12:07 PM, when the agency had begun tracking the measures. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 2:11 PM.</p>	L 563	<ul style="list-style-type: none"> ▪ Live Discharges and Revocation ▪ Death Discharge ▪ Medication Destruction <p>1c) Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be written and presented to the QAPI committee on a quarterly basis. Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved.</p> <p>Responsible: Director of Nursing is responsible for the overall correction.</p>		

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

PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0301

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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 563	Continued From page 49 The email stated the data was available from "HomeCare HomeBase," but they were not necessarily all being tracked. The agency was asked, via email on 9/17/14 at 2:47 PM, for confirmation that the quality indicators of anxiety, depression, dyspnea, nausea, "On Call," opioid medications and advanced directives, had not yet been incorporated into the agency's QAPI program. The agency confirmed they had not, via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 2:58 PM. The agency's documentation did not demonstrate the indicator data of anxiety, depression, dyspnea, nausea, "On Call," opioid medications and advanced directives, were not relevant in the design of the agency's QAPI program. The agency failed to ensure all relevant data was used in the design of the QAPI program.	L 563			
L 565	418.58(b)(3) PROGRAM DATA (3) The frequency and detail of the data collection must be approved by the hospice's governing body. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and quality documents, it was determined the hospice failed to ensure the Governing Body approved the frequency and detail of QAPI data collection. This resulted in the potential lack of direction being provided to the agency's QAPI committee members. Findings include:	L 565	L565 418.58 (b) (3) Program Data Revision to the QAPI Program to be presented to the Governing Body which embraces the concept that the agency will strive to provide the highest quality of patient care and services and does in fact require the agency to maintain a comprehensive and integrated Quality Assessment and Improvement Program. As the Governing Body will maintain ultimate authority and responsibility for the QAPI program and this authority and responsibility for the overall implementation and management of the QAPI program is delegated to the Executive Director.		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
L 565	<p>Continued From page 50</p> <p>1. The agency's Improving Organizational Performance policy, revised 3/2014, stated in the "Procedures" section that the agency would "Adopt a scientific, problem-solving, data driven approach to quality assessment and performance improvement (QAPI). The scientific, problem-solving approach will include minimally:</p> <p>1. Planning for performance improvement with integration of information from other relevant activities that focus on high risk, high volume, problem prone areas and CMS mandatory reporting items..."</p> <p>The agency was asked, via email on 9/16/14 at 12:01 PM, for information related to the QAPI program. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 8:26 AM. The email included a letter and additional QAPI documentation as an attachment. The attached letter stated the agency's former Administrator had developed only a limited QAPI program. However, a new Administrator had been appointed on 9/16/13. The letter stated on 2/24/14 the agency provided QAPI training to the clinical staff and subsequently quality indicators were established as follows:</p> <p>Indicators established on 3/13/14 included the following:</p> <ul style="list-style-type: none"> - Pharmacy management - Patient diagnoses <p>Indicators established in 4/2014 included the following:</p> <ul style="list-style-type: none"> - Complaints and resolutions - Infections and control - Hospitalizations - Pain management 	L 565	<p>Clinical chart audits and QAPI activities will be completed quarterly, with the action plan if required and QAPI meetings for each quarter is to be completed by the following dates with documentation of each meeting including attendees and title or disciplines, then presented to the Governing Body by the Executive Director.</p> <ul style="list-style-type: none"> • 1st Quarter: by May 5th • 2nd Quarter: by August 5th • 3rd Quarter: by November 5th • 4th Quarter: by February 5th <p>Responsible: Executive Director and Director of Nursing have ultimate responsibility for the corrective action for overall and ongoing completion.</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 565	Continued From page 51 The agency was asked, via email on 9/17/14 at 3:35 PM, for information related to the frequency and detail of data collection for the identified quality indicators. The agency provided the requested information via email from the agency's Counsel, with a cc to the agency Administrator, on 9/17/14 at 4:46 PM. The agency was asked, via email on 9/17/14 at 5:05 PM, for agency documentation related to the quality indicator data collection and rationale. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/18/14 at 3:49 PM. The email included an attachment. The attachment was titled "Home Health Quality Assessment and Performance Improvement Plan," and was dated "July 2014." However, the information included in the Plan was related to the hospice agency and was reflective of a 9/16/14 QAPI meeting, held 6 days after the survey exit conference. The agency's documentation did not demonstrate that the frequency and detail of the data collection had been present at the time of the survey and it could not be established when the agency's Governing Body had approved the data collection methods.	L 565			
L 566	418.58(c)(1)(i) PROGRAM ACTIVITIES (1) The hospice's performance improvement activities must: (i) Focus on high risk, high volume, or problem-prone areas.	L 566	L566 418.58 (c) (1) (i) Program Activities Agency will utilize the Clinical Audit tool to perform clinical audits of established clinical indicators for accuracy for the following items which are high risk, high volume, and may be problem prone areas and CMS mandatory reporting items. Agency		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 03642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 566	<p>Continued From page 52</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of policies and quality documents, it was determined the hospice failed to ensure the QAPI program demonstrated a focus on high-risk, high volume, or problem prone areas. This resulted in the potential for a lack of performance improvement opportunities being missed in area mostly likely to impact patient outcomes. Findings include:</p> <p>1. The agency's Improving Organizational Performance policy, revised 3/2014, stated in the "Procedures" section that the agency would "Adopt a scientific, problem-solving, data driven approach to quality assessment and performance improvement (QAPI). The scientific, problem-solving approach will include minimally: 1. Planning for performance improvement with integration of information from other relevant activities that focus on high risk, high volume, problem prone areas and CMS mandatory reporting items..."</p> <p>The agency was asked, via email on 9/16/14 at 12:01 PM, for information related to the QAPI program. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 8:26 AM. The email included a letter and additional QAPI documentation as an attachment. The attached letter stated the agency's former Administrator had developed only a limited QAPI program. However, a new Administrator had been appointed on 9/16/13. The letter stated on 2/24/14 the agency provided QAPI training to the clinical staff and subsequently quality indicators were established as follows:</p> <p>Indicators established on 3/13/14 included the</p>	L 566	<p>collection of data will be a systematic, problem solving, data driven approach to quality assessment and performance improvement.</p> <ul style="list-style-type: none"> • Election Statement and Consent Form completion • Initial Certifications for terminal illness • Initial Plan of Care • Verbal/Supplemental orders • Recertification orders • Face to Face compliance • Clinical Record Documentation accuracy • Timely Filing of Clinical Records and Entries • Medication Reconciliation • Pain/Symptom Management • Wound Care • IV Therapies • Professional Management: Continuous Care, Respite, GIP • Coordination of Care • Discipline specific assessments/interventions/go als 		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 566	<p>Continued From page 53 following: - Pharmacy management - Patient diagnoses</p> <p>Indicators established in 4/2014 included the following: - Complaints and resolutions - Infections and control - Hospitalizations - Pain management</p> <p>The agency was asked, via email on 9/17/14 at 3:35 PM, for information related to the agency's rationale for monitoring the indicators, focusing on high risk, high volume, or problem-prone areas. The agency provided the requested information via email from the agency's Counsel, with a cc to the agency Administrator, on 9/17/14 at 4:46 PM.</p> <p>The agency was asked, via email on 9/17/14 at 5:05 PM, for agency documentation related to the quality indicator rationale. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/18/14 at 3:49 PM. The email included an attachment. The attachment was titled "Home Health Quality Assessment and Performance Improvement Plan," and was dated "July 2014." However, the information included in the Plan was related to the hospice agency and was reflective of a 9/16/14 QAPI meeting, held six days after the survey exit conference.</p> <p>The agency's documentation did not demonstrate that rationale for monitoring the indicators, focusing on high risk, high volume, or problem-prone areas had been present at the time of the survey or when the indicators were</p>	L 566	<ul style="list-style-type: none"> • Bereavement Services: assessment, Plan of Care, and documentation • Volunteer Services: Plan of Care • Discharges: <ul style="list-style-type: none"> ▪ Live Discharges and Revocation ▪ Death Discharge • Medication Destruction <p>1c) Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be written and presented to the QAPI committee on a quarterly basis. Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved.</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 566 L 567	Continued From page 54 established on 3/13/14 and in 4/2014. 418.58(c)(1)(ii) PROGRAM ACTIVITIES [The hospice's performance improvement activities must:] (ii) Consider incidence, prevalence, and severity of problems in those areas. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and quality documents, it was determined the hospice failed to ensure the QAPI program demonstrated consideration of incidence, prevalence, and severity of problems in the design of its program. This resulted in the potential for a lack of performance improvement opportunities being missed in areas mostly likely to impact patient outcomes. Findings include: 1. The agency's Improving Organizational Performance policy, revised 3/2014, stated in the "Procedures" section that the agency would "Adopt a scientific, problem-solving, data driven approach to quality assessment and performance improvement (QAPI). The scientific, problem-solving approach will include minimally: 1. Planning for performance improvement with integration of information from other relevant activities that focus on high risk, high volume, problem prone areas and CMS mandatory reporting items..." The agency was asked, via email on 9/16/14 at 12:01 PM, for information related to the QAPI program. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 8:26 AM. The email	L 566 L 567	Responsible: Director of Nursing is responsible for the overall correction. L567 418.58 (c) (1) (ii) Program Activities Agency will utilize the Clinical Audit tool to perform clinical audits of established clinical indicators for accuracy for the following items: <ul style="list-style-type: none"> • Election Statement and Consent Form completion • Initial Certifications for terminal illness • Initial Plan of Care • Verbal/Supplemental orders • Recertification orders • Face to Face compliance • Clinical Record Documentation accuracy • Timely Filing of Clinical Records and Entries • Medication Reconciliation • Pain/Symptom Management • Wound Care • IV Therapies 		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83842	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 567	<p>Continued From page 55</p> <p>included a letter and additional QAPI documentation as an attachment. The attached letter stated the agency's former Administrator had developed only a limited QAPI program. However, a new Administrator had been appointed on 9/16/13. The letter stated on 2/24/14 the agency provided QAPI training to the clinical staff and subsequently quality indicators were established as follows:</p> <p>Indicators established on 3/13/14 included the following: - Pharmacy management - Patient diagnoses</p> <p>Indicators established in 4/2014 included the following: - Complaints and resolutions - Infections and control - Hospitalizations - Pain management</p> <p>The agency was asked, via email on 9/17/14 at 3:35 PM, for information related to the agency's rationale for monitoring the indicators, considering incidence, prevalence, and severity of problems in those areas. The agency provided the requested information via email from the agency's Counsel, with a cc to the agency Administrator, on 9/17/14 at 4:46 PM.</p> <p>The agency was asked, via email on 9/17/14 at 5:05 PM, for agency documentation related to the quality indicator rationale. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/18/14 at 3:49 PM. The email included an attachment. The attachment was titled "Home Health Quality Assessment and Performance Improvement</p>	L 567	<ul style="list-style-type: none"> • Professional Management: Continuous Care, Respite, GIP • Coordination of Care • Discipline specific assessments/interventions/goals • Bereavement Services: assessment, Plan of Care, and documentation • Volunteer Services: Plan of Care • Discharges: <ul style="list-style-type: none"> ▪ Live Discharges and Revocation ▪ Death Discharge • Medication Destruction <p>1c) Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be written and presented to the QAPI</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 567	Continued From page 56 Plan," and was dated "July 2014." However, the information included in the Plan was related to the hospice agency and was reflective of a 9/16/14 QAPI meeting, held 6 days after the survey exit conference. The agency's documentation did not demonstrate that rationale for monitoring the indicators, considering incidence, prevalence, and severity of problems in those areas had been present at the time of the survey or when the indicators were established on 3/13/14 and in 4/2014.	L 567	committee on a quarterly basis. Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved. Responsible: Director of Nursing is responsible for the overall correction.		
L 569	418.58(c)(2) PROGRAM ACTIVITIES (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure adverse patient events were analyzed and preventative measures were implemented. This resulted in a potential lack of appropriate interventions designed to minimize patient risk. Findings include: 1. The agency's Improving Organizational Performance policy stated, in the "Procedures" section, that the agency would "Adopt a scientific, problem-solving, data driven approach to quality assessment and performance improvement (QAPI). The scientific, problem-solving approach will include, minimally:...2. Setting priorities for improvement and adjusting priorities in response to unusual or urgent events..."	L 569	L569 418.58 (c) (2) Program Activities Director of Nursing or designee will complete a 100% review of all occurrence/infection reports and complaint reports and will ensure follow up with resolution. Documentation will occur on occurrence reports, infection reports, and complaint logs monthly, tracking and trending will occur quarterly through the QAPI Program with reporting of quarterly findings and action plans submitted to the QAPI Committee quarterly. A paper form to track and trend employee infections to be implemented. Final review of adverse patient events will be submitted to the Governing		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 569	<p>Continued From page 57</p> <p>The agency's undated "Annual Agency Evaluation" included data in the form of graphs and charts. The graphs and charts were related to adverse events including falls, adverse drug reactions, and medication errors. The report documented the data was related to the fourth quarter of 2013.</p> <p>Additional data for the first quarter of 2014, submitted via email on 9/17/14 at 8:26 AM, reflected adverse event data related to falls.</p> <p>The agency was asked, via email on 9/18/14 at 9:13 AM, if analysis into the reported adverse events had been conducted. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/18/14 at 3:49 PM. The email included an attachment. The attachment was titled "Home Health Quality Assessment and Performance Improvement Plan," and was dated "July 2014." However, the information included in the Plan was related to the hospice agency and was reflective of a 9/16/14 QAPI meeting, held 6 days after the survey exit conference.</p> <p>The Plan included a section titled "Adverse Events." The section stated "This information was presented within a graph for the agency leaders. We are currently not working on a PIP for Adverse Events, Falls, Drug Reactions, Medication Errors [sic]. These areas will be a focus during upcoming quarters. Falls will be monitored in upcoming quarters also. Currently [name] is developing a Agency [sic] wide Fall program with PIP. Horizon plans to review and adopt this PIP when program and monitoring data points are completed."</p>	L 569	<p>Body for recommendations for improvement to agency programs.</p> <p>Director of Nursing or designee will review 100% occurrence reports, infection reports, and patient complaint reports as per agency policy and procedure. 100% of occurrence, infection, or patient complaint reports submitted will require a clinical chart audit and investigation by the Director of Nursing or designee with development of an action plan if applicable. Findings will be tracked and trended through the QAPI Program with quarterly findings and plans of action submitted to the QAPI Committee and then to the Governing Body for recommendations for improvement to agency programs.</p> <p>Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion.</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 569	Continued From page 58	L 569			
L 570	<p>The agency's documentation did not demonstrate that adverse events were analyzed and preventative measures were implemented.</p> <p>418.58(c)(3) PROGRAM ACTIVITIES</p> <p>(3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure performance improvement actions were taken in response to quality indicator data analysis. This resulted in the potential for missed opportunities to improve patient care. Findings include:</p> <p>1. The agency was asked, via email on 9/16/14 at 12:01 PM, for information related to the QAPI program. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 8:26 AM. The email included a letter and additional QAPI documentation as an attachment. The attached letter stated the agency's former Administrator had developed only a limited QAPI program. However, a new Administrator had been appointed on 9/16/13. The letter stated on 2/24/14 the agency provided QAPI training to the clinical staff and subsequently quality indicators were established, including a quality indicator related to infections and control established in 4/2014.</p> <p>The letter stated that on 9/02/14, the DON had</p>	L 570	<p>L570 418.58 (c) (3) Program Activities</p> <p>Agency will utilize the Clinical Audit tool to perform clinical audits of established clinical indicators for accuracy for the following items:</p> <ul style="list-style-type: none"> • Election Statement and Consent Form completion • Initial Certifications for terminal illness • Initial Plan of Care • Verbal/Supplemental orders • Recertification orders • Face to Face compliance • Clinical Record Documentation accuracy • Timely Filing of Clinical Records and Entries 		

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

PRINTED: 08/20/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPIGE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 570	<p>Continued From page 59</p> <p>led a review of hospice reporting data for the first and second quarter of 2014. However, during an interview on 9/09/14 beginning at 9:00 AM, the DON stated the Hospice QAPI meeting, scheduled for 9/02/14, was canceled due to the arrival of the survey team. She stated the document she provided to the survey team was an agenda for the meeting, not minutes of a meeting.</p> <p>The corresponding 9/02/14 meeting agenda documented infection data had been reviewed and analyzed from 1/2014 - 6/2014. The agenda documented 23 total infections and categorized them into areas of infection (e.g. skin, eye, oral, etc.) and identified if each infection was present at the patient's start of care. However, no additional information related to what intervention had been considered in response to the data analysis was present.</p> <p>The agency was asked, via email on 9/18/14 at 9:13 AM, if any additional analysis into the infection data had been conducted. The agency responded via email from the agency's Counselor, with a cc to the agency's Administrator, on 9/18/14 at 3:49 PM. The email included an attachment. The attachment was titled "Home Health Quality Assessment and Performance Improvement Plan," and was dated "July 2014." However, the information included in the Plan was related to the hospice agency and was reflective of a 9/16/14 QAPI meeting, held six days after the survey exit conference.</p> <p>The Plan included a section titled "Infections." The section included the same data reflect in the 9/02/14 meeting agenda. However, no additional information related to interventions taken in</p>	L 570	<ul style="list-style-type: none"> • Medication Reconciliation • Pain/Symptom Management • Wound Care • IV Therapies • Professional Management: Continuous Care, Respite, GIP • Coordination of Care • Discipline specific assessments/interventions/go als • Bereavement Services: assessment, Plan of Care, and documentation • Volunteer Services: Plan of Care • Discharges: <ul style="list-style-type: none"> ▪ Live Discharges and Revocation ▪ Death Discharge • Medication Destruction <p>1c) Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 570	Continued From page 60 response to the data analysis was submitted for review.	L 570	those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be written and presented to the QAPI committee on a quarterly basis.		
L 572	The agency's documentation did not demonstrate that performance improvement actions were taken in repose to quality indicator data analysis. 418.58(d)(1) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure PIPs reflected the scope and complexity of the agency's services and operations for all patients receiving services from the agency. This resulted in the agency's ability to improve patient outcomes being impeded. The findings include: 1. The agency's Scope of Services policy, revised March 2014, stated the facility provided services to 17 counties. Additionally, the agency's CMS-417 and CMS-643 forms, completed at the time of the survey, documented the agency had 6 multiple locations and offered offered services which included physician services, nursing services, medical social services, counseling services, physical therapy, occupational therapy, speech-language pathology, hospice aide services, homemaker services, and medical	L 572	Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved. Responsible: Director of Nursing is responsible for the overall correction. L572 418.58 (d) (1) Performance Improvement Projects Agency will utilize the Clinical Audit tool to perform clinical audits of established clinical indicators for accuracy for the following items: <ul style="list-style-type: none"> • Election Statement and Consent Form completion • Initial Certifications for terminal illness • Initial Plan of Care • Verbal/Supplemental orders • Recertification orders • Face to Face compliance 		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 572	<p>Continued From page 61 supplies. The agency had a current census of 124 patients.</p> <p>During an interview on 9/09/14 beginning at 9:00 AM, the DON stated the QAPI committee was currently addressing 2 PIPs, which were related to the hospice formulary and hospice diagnosis. Additionally, she stated the agency continued to monitor patients' level of pain 48 hours after admission, which was related to a previous PIP.</p> <p>The agency's PIPs were reviewed. The PIP titled "Review of Hospice Formulary" initiated 3/2014 stated in the "Statement of the problem and supporting data" section that "It has been identified throughout Horizon that the use of a hospice formulary would increase patient care by providing a structured list of medications that the hospice pharmacy would always carry thus decreasing time spent in waiting for the medication to be delivered to the patient, and to decrease PPD. Current PPD is \$12.23, with a goal of \$8.00 (still above the national standard of \$6.50) by the end of October."</p> <p>The second PIP titled "Determination of Appropriate Hospice Diagnosis for AFTT, Debility, and NOS Dementia" initiated 6/2014 stated in the "Statement of the problem and supporting data" section stated "By October 1, 2014, CMS will RTP any claim that is submitted with AFTT, Dementia NOS, or Debility listed as the primary diagnosis. Currently there are 17 patients listed with these diagnoses as the primary."</p> <p>The agency's documentation did not demonstrate the PIPs reflected the scope and complexity of the agency's services and operations.</p>	L 572	<ul style="list-style-type: none"> • Clinical Record Documentation accuracy • Timely Filing of Clinical Records and Entries • Medication Reconciliation • Pain/Symptom Management • Wound Care • IV Therapies • Professional Management: Continuous Care, Respite, GIP • Coordination of Care • Discipline specific assessments/interventions/goals • Bereavement Services: assessment, Plan of Care, and documentation • Volunteer Services: Plan of Care • Discharges: <ul style="list-style-type: none"> ▪ Live Discharges and Revocation ▪ Death Discharge • Medication Destruction <p>1c) Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the</p>		

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

PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0301

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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 573 L 573	Continued From page 62 418.58(d)(2) PERFORMANCE IMPROVEMENT PROJECTS (2)The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure PIPs reflected measurable progress. This resulted in the potential for the agency to be unable to ensure the effectiveness of their interventions. Findings include: 1. The agency's Improving Organizational Performance policy, revised 3/2014, stated the purpose of the policy was "To establish a performance improvement framework which integrates activities to improve organization performance, improve patient safety, reduce the risks for acquisition and transmission of infections and improve palliative care outcomes and services." The agency's records included 2 PIPs. The PIP titled "Review of Hospice Formulary," initiated 3/2014, stated in the "Statement of the problem and supporting data" section that "It has been identified throughout Horizon that the use of a hospice formulary would increase patient care by providing a structured list of medications that the hospice pharmacy would always carry thus decreasing time spent in waiting for the medication to be delivered to the patient, and to decrease PPD. Current PPD is \$12.23, with a goal of \$8.00 (still above the national standard of	L 573 L 573	Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be written, performance improvement plan to be developed, and presented to the QAPI committee on a quarterly basis. Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved. Responsible: Director of Nursing is responsible for the overall correction. L573 418.58 (d) (2) Performance Improvement Projects Agency will utilize the Clinical Audit tool to perform clinical audits of established clinical indicators for accuracy for the following items: • Election Statement and Consent Form completion		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 573	<p>Continued From page 63 \$6.50) by the end of October."</p> <p>The PIP did not include additional information or quality indicator data related to how the problems of patients waiting for medications were identified. Additionally, while specific data related to current average costs and the agency's cost goals were present, the PIP did not include information related to the average amount of time patients were waiting for medications or measurable agency goals to decrease the wait time.</p> <p>The agency's Hospice PIP/QAPI first and second quarter meeting agenda, dated 9/02/14, documented data related to pharmacy hospice costs per day during the January 2014 - June 2014 time period. However, no data related to the "decreased time spent in waiting for the medications to be delivered to the patient" could be found.</p> <p>The agency was asked, via email on 9/18/14 at 7:15 PM, if data had been captured related to patient wait times. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/18/14 at 3:49 PM. The email stated data had been captured in the form of complaints.</p> <p>The agency's Hospice PIP/QAPI first and second quarter meeting agenda, dated 9/02/14, documented complaint data from 1/2014 - 6/2014. The meeting agenda documented 2 complaints related to medication wait times had been investigated and addressed. One complaint was related to the pharmacy's inability to deliver medications due to a patient moving and the pharmacy failing to update the patient's address. The second complaint was related to the</p>	L 573	<ul style="list-style-type: none"> • Initial Certifications for terminal illness • Initial Plan of Care • Verbal/Supplemental orders • Recertification orders • Face to Face compliance • Clinical Record Documentation accuracy • Timely Filing of Clinical Records and Entries • Medication Reconciliation • Pain/Symptom Management • Wound Care • IV Therapies • Professional Management: Continuous Care, Respite, GIP • Coordination of Care • Discipline specific assessments/interventions/go als • Bereavement Services: assessment, Plan of Care, and documentation • Volunteer Services: Plan of Care • Discharges: <ul style="list-style-type: none"> ▪ Live Discharges and Revocation 		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 573	Continued From page 64 pharmacy being unable to deliver medications due to a large snow storm. The agency's corresponding complaint reporting data documented the incidents occurred on 2/04/14 (related to the snow storm) and 3/13/14 (related to the patient move). It could not be established that the 2 reported complaints for medication delivery delays were related to the agency's PIP interventions. No other data related to the amount of time patients were waiting for their medications or documentation to support the hospice formulary was effective in reducing the wait time was submitted for review. The agency's documentation did not demonstrate measurable progress had been achieved related to patient wait times.	L 573	<ul style="list-style-type: none"> ▪ Death Discharge • Medication Destruction 1c) Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be written and presented to the QAPI committee on a quarterly basis.	
L 574	418.58(e)(1) EXECUTIVE RESPONSIBILITIES The hospice's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the Governing Body failed to ensure the agency's QAPI program was adequately developed, implemented and maintained. This resulted in a lack of adequate, on-going quality improvement activities and the potential for performance improvement opportunities to be unidentified. Findings include:	L 574	Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved. Responsible: Director of Nursing is responsible for the overall correction. L574 418.58 (e) (1) Executive Responsibilities Revision to the QAPI Program with revised clinical audit tools, action	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 574	Continued From page 65 1. The agency's undated "Company Information" manual stated in the "Governing Body" section that the Governing Body was comprised of 4 members including the President/CEO, Legal Counsel, the Nexus Cluster Leader, and the Executive Director/Administrator. The agency's "Leadership" policy, revised March 2014, stated the "...senior management will maintain written mechanism for participation in policy decisions affecting the organization." The procedures section of the policy stated the "Senior management will meet monthly to discuss any of the following, as pertinent, but not limited to: A. Quality assessment and performance improvement program/activities, including measures, outcomes, results, and performance improvement team activities and the effectiveness of staff communication..." The agency was asked, via email on 9/16/14 at 12:01 PM, for information related to the QAPI program. The agency responded via email from the agency's Counsel, with a cc to the agency's Administrator, on 9/17/14 at 8:26 AM. The email included a letter and additional QAPI documentation as an attachment. The attached letter stated the agency's former Administrator had developed only a limited QAPI program. However, a new Administrator had been appointed on 9/16/13 and was designated as the leader responsible for oversight of the agency's QAPI program. The letter stated the Administrator's responsibilities included "...the responsibility to define, implement, and maintain the QAPI program, determine priorities for tracking and evaluating data, use those programs to evaluate and design programs and activities to	L 574	plans, QAPI Meeting template, with expectations on use of forms and the number of clinical audits to be completed each quarter by the Director of Nursing or designee. The Director of Nursing or designee will complete 100% review of all occurrence/infection and complaint reports and follow through with resolution and documentation is completed monthly. Tracking and trending will occur quarterly through the QAPI Program and reporting of quarterly findings and action plans will be submitted to the QAPI Committee quarterly and then to the Governing Body. Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 574	Continued From page 66 improve outcomes, and to report on QAPI efforts at least annually. In so doing, Horizon's Governing Body met its obligations under the rule." No additional information related to Governing Body's monitoring and oversight of the QAPI program, under the new Administrator's leadership was submitted for review. The agency's documentation did not demonstrate the Governing Body provided sufficient oversight and monitoring necessary to ensure an effective on-going QAPI program was developed, implemented and maintained. 2. Refer to L560 as it relates to the failure of the agency to ensure an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program had been developed, implemented, and maintained.	L 574	written and presented to the QAPI committee on a quarterly basis. Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved. Responsible: Executive Director and Director of Nursing have ultimate responsibility for the overall correction and ongoing completion.		
L 584	418.62(a) LICENSED PROFESSIONAL SERVICES Licensed professional services provided directly or under arrangement must be authorized, delivered, and supervised only by health care professionals who meet the appropriate qualifications specified under §418.114 and who practice under the hospice's policies and procedures. This STANDARD is not met as evidenced by: Based on record review, policy review and staff interviews, it was determined the agency failed to	L 584	L584 418.62 (a) Licensed Professional Services Director of Nursing or designee will provide education to RN's on Policy 4-008 Responsibilities / Supervision of Clinical Services and Addendum 4-008.A LPN Supervision requirements. LPN supervision by the RN will occur at a minimum of every		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 584	<p>Continued From page 67</p> <p>ensure SN services provided by the LPN were supervised by an RN for 2 of 5 active patients (#3 and #9) who received LPN nursing visits. This had the potential to result in unmet patient needs. Findings include:</p> <p>1. A policy "RESPONSIBILITIES/SUPERVISION OF CLINICAL SERVICES," revised March 2014 stated the LPN/LVN will be supervised by an RN at least every 30 days as directed by the State Practice Act. Additionally, it stated the RN will review the POC and the services provided by the LPN every 2 weeks and document the review in the patient's clinical record. However, the policy was not consistently implemented, as follows:</p> <p>a. Patient #3 was an 87 year old female admitted to the agency on 5/24/14, with a diagnosis of dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 5/24/14 to 8/21/14, and 8/22/14 to 10/20/14, was reviewed.</p> <p>Patient #3's SN visits were provided by an LPN on 6/27/14, 8/14/14 and 8/18/14. Patient #3's record did not include documentation of communication between the LPN and the RN. Additionally, her record did not include documentation of RN supervision of the LPN.</p> <p>During an interview on 9/04/14 at 3:45 PM, the RN Case Manager stated she was out of town on the days the LPN completed Patient #3's SN visits. She stated she read the LPN visit notes but did not communicate with the LPN or document supervision of the LPN.</p> <p>Patient #3's SN visits completed by the LPN were not supervised by the RN.</p>	L 584	<p>30 days and the clinical record will include documentation pertaining to the RN's review of the LPN's documentation, adherence to the Plan of Care, and LPN's documentation of communication and collaboration with the RN and IDG team.</p> <p>The RN will be scheduled at a minimum of every 30 days to perform an on-site supervisory visit to the patient's home or those patients receiving LPN services, either with or without the LPN present and documentation by the RN will be included within the clinical record regarding the supervisory functions. Scheduling will also ensure that these supervisory visits are scheduled for the RN every 30 days at a minimum. These visits will not be moved unless the RN and scheduler determine that the new visit date will still be in compliance for supervisory visits.</p> <p>Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 584	Continued From page 68 b. Patient #9 was a 71 year old male admitted to the agency on 9/09/13 with a terminal diagnosis of CHF. His record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification period of 7/16/14 to 9/13/14, was reviewed. Patient #9's SN visits were provided by an LPN on 7/22/14, 8/18/14 and 8/25/14. Patient #9's record did not include documentation of communication between the LPN and the RN. Additionally, his record did not include documentation of RN supervision of the LPN. During a phone interview with the RN Case Manager on 9/08/14 at 4:25 PM, the record was reviewed. She confirmed that visits were done on the above dates by the LPN and that no RN supervisory visits were completed. Patient #9's SN visits completed by the LPN were not supervised by the RN.	L 584	utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be written and presented to the QAPI committee on a quarterly basis. Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved. Responsible: Director of Nursing has ultimate responsibility for the overall correction and ongoing completion. Completion: 10-15-14		
L 596	418.64(d)(1) COUNSELING SERVICES Counseling services must include, but are not limited to, the following: (1) Bereavement counseling. The hospice must: (i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. (ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when	L 596	L596 418.64 (d) (1) Counseling Services Agency has designated a Bereavement Coordinator who has the overall responsibility for the bereavement program. Director of Nursing will instruct the staff on Policy 2-010		

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

PRINTED: 09/29/2014
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 _____ D. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 596	<p>Continued From page 69</p> <p>appropriate and identified in the bereavement plan of care.</p> <p>(iii) Ensure that bereavement services reflect the needs of the bereaved.</p> <p>(iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in §418.204(c).</p> <p>This STANDARD is not met as evidenced by: Based on record review, policy review and staff interview, it was determined the agency failed to ensure bereavement needs were identified and services were provided to the bereaved for 12 of 84 patients (#24 - #28 and #31 - #37) who had died in the last 12 months. This resulted in the potential for needs of the bereaved to be unmet. Findings include:</p> <p>1. A policy titled "BEREAVEMENT SERVICES" revised March 2014, stated "A bereavement risk assessment will be completed by the hospice social worker or Registered Nurse if social services are refused by the patient, at the time of admission to hospice. Information gathered will be incorporated into the plan of care and considered in the bereavement plan of care...After the bereavement risk assessment is completed, a plan will be developed to address bereavement/grief issues and will be implemented and updated as needed."</p> <p>Additionally, the "BEREAVEMENT ASSESSMENT" policy, revised March 2014, stated after the social worker or hospice registered nurse completed the bereavement risk assessment it was to be given to the</p>	L 596	<p>Bereavement Services, Addendum 2-010A Bereavement Phases of Hospice Care, and 2-037 Bereavement Assessment . Agency will complete a bereavement assessment initially at the start of care or as soon after as is appropriate. Ongoing review and updating of the bereavement assessment will occur as needed to meet the patient and caregiver/family needs. The Bereavement Coordinator will revise the current program to meet the policy as written with specific mailings, follow-up with families and/or caregivers, and document the activities per policy.</p> <p>Director of Nursing, Bereavement Coordinator or designee will review 100% of active Bereavement records by 10-31-14 to ensure that all activities have been or are being performed as required by evidence of documentation by the assigned Chaplain, Social Worker, or Bereavement Coordinator as scheduled. Variances will be tracked and trended, action plans developed if</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 596	<p>Continued From page 70</p> <p>"Bereavement Coordinator." The policy stated "Within three to five weeks after the patient's death, a bereavement assessment will be completed by the bereavement counselor following the family/caregiver. This assessment will identify grief issues. The bereavement counselor will render a professional judgment as to whether the bereaved is experiencing normal grief, moderate grief, or a severe grief reaction."</p> <p>Upon surveyor request, the Bereavement Coordinator provided a "Bereavement Activity Report." The report included a list of deceased patients for the last 12 months and identified a bereavement contact for each of the deceased patients. The risk levels were documented as "LOW," "STANDARD," "MODERATE," or "HIGH" to indicate the level of grief, per facility policy.</p> <p>However, a bereavement risk level was not identified for all patient contacts. The "Bereavement Activity Report" documented an "UNKNOWN" risk level for the contacts of Patient #31 (deceased 4/5/2014), Patient #32 (deceased on 6/20/14), Patient #33 (deceased 4/29/14), Patient #34 (deceased 5/1/2014), Patient #35 (deceased 4/15/2014), Patient #36 (deceased 5/17/2014), and Patient #37 (deceased 2/7/2014).</p> <p>During an interview with the Bereavement Coordinator on 9/03/14 at 1:30 PM, the records were reviewed. He confirmed that no bereavement assessments were done as outlined in the Bereavement policy for the contact of each patient's family members.</p> <p>The agency failed to perform a bereavement assessment for patients' contacts, per facility policy.</p>	L 596	<p>required, and reported to the QAPI committee quarterly until 85% compliance is achieved.</p> <p>Responsible: Bereavement Coordinator and Director of Nursing have ultimate responsibility for the overall correction and ongoing completion.</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 906 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 596	<p>Continued From page 71</p> <p>2. The "BEREAVEMENT SERVICES" policy stated:</p> <ul style="list-style-type: none"> - "Within two weeks after the death of a patient, a sympathy card will be sent to the bereaved." - "After three weeks, a bereavement letter will be sent to the bereaved, offering support and outlining the hospice bereavement services." - "Within three to five weeks after the patient's death, a bereavement assessment will be completed by the bereavement counselor following the family/caregiver. This assessment will identify grief issues. The bereavement counselor will render a professional judgment as to whether the bereaved is experiencing normal grief, moderate grief, or a severe grief reaction." - "In addition to the services outlined above, persons deemed to be experiencing moderate or severe grief will be followed by the bereavement program with increased services and contact offered at intervals defined in the plan of care." <p>Each record included a form "Bereavement Services Plan of Care," which detailed the procedure for interventions. "All Risk Levels" indicated every bereavement case would receive these services. Each risk level would then be supplemented with additional interventions as determined by the bereavement coordinator.</p> <p>"All Risk Levels"</p> <ul style="list-style-type: none"> - Initial Condolence Call - Bereavement Risk Assessment (due 1st IDG after death) - Sympathy Card/Letter (due 7 working days after 	L 596			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 596	<p>Continued From page 72</p> <p>death)</p> <ul style="list-style-type: none"> - Attend Memorial or Funeral - Initial Bereavement Packet (4 weeks after death) - 90 day phone call (optional) <p>"High"</p> <ul style="list-style-type: none"> - Offer 7-14 day visit & Re-evaluate Risk Level - Offer 30 day visit & Re-evaluate Risk Level - Offer 90 day visit & Re-evaluate Risk Level <p>Upon request, the Bereavement Coordinator provided a "Bereavement Activity Report." The report included a list of deceased patients for the last 12 months, and identified a bereavement contact for each of the deceased patients. A risk level was assigned to each contact. The risk levels were, "LOW," "STANDARD," "MODERATE," or "HIGH." A random selection of patient records (#24, #25, #26, #27, #28), whose family members accepted bereavement services and had a designated risk for bereavement as "High," were reviewed. The agency's records did not demonstrate interventions were provided to the high risk bereaved, as follows:</p> <p>a. Patient #24 was a 79 year old male admitted to the agency on 7/22/13. His record documented he died on 3/01/14. His record did not include documentation that his high risk Bereavement POC interventions (including attending the memorial or funeral, sending the initial bereavement packet, offering a 7-14 day visit and re-evaluating the risk level of the bereaved, offering a 30 day visit and re-evaluating the risk level of the bereaved, and offering a 90 day visit and re-evaluating the risk level of the bereaved) had been implemented, per agency policy.</p>	L 596			

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

PRINTED: 09/29/2014
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 09/10/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 596	<p>Continued From page 73</p> <p>b. Patient #25 was a 64 year old male admitted to the agency on 10/15/13. His record documented he died on 11/28/13. His record did not include documentation that his high risk Bereavement POC interventions (including attending the memorial or funeral, offering a 30 day visit and re-evaluating the risk level of the bereaved, and offering a 90 day visit and re-evaluating the risk level of the bereaved) had been implemented, per agency policy.</p> <p>c. Patient #26 was a 75 year old male admitted to the agency on 1/17/14. His record documented he died on 1/30/14. His record did not include documentation that his high risk Bereavement POC interventions (including sending a sympathy card or letter, attending the memorial or funeral, offering a 7-14 day visit and re-evaluating the risk level of the bereaved, offering a 30 day visit and re-evaluating the risk level of the bereaved, and offering a 90 day visit and re-evaluating the risk level of the bereaved) had been implemented, per agency policy.</p> <p>d. Patient #27 was a 68 year old female admitted to the agency on 11/08/13. Her record documented she died on 1/02/14. Her record did not include documentation that her high risk Bereavement POC interventions (including offering a 7-14 day visit and re-evaluating the risk level of the bereaved, offering a 30 day visit and re-evaluating the risk level of the bereaved, and offering a 90 day visit and re-evaluating the risk level of the bereaved) had been implemented, per agency policy.</p> <p>e. Patient #28 was a 75 year old male admitted to the agency on 8/06/13. His record documented he died on 2/13/14. His record did not include</p>	L 596		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 000 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 596	Continued From page 74 documentation that his high risk Bereavement POC interventions (including offering a 7-14 day visit and re-evaluating the risk level of the bereaved, offering a 30 day visit and re-evaluating the risk level of the bereaved, and offering a 90 day visit and re-evaluating the risk level of the bereaved) had been implemented, per agency policy. During an interview with the Bereavement Coordinator on 9/03/14 at 1:30 PM, the records were reviewed. He confirmed that not all of the interventions were done as outlined in the Bereavement POC for each patient.	L 596			
L 607	The agency failed to follow up on the needs of the bereaved as defined in their policy and outlined in patient POCs. 418.76 HOSPICE AIDE AND HOMEMAKER SERVICES This CONDITION is not met as evidenced by: Based on observation, medical record review, policy review and interview, it was determined the agency failed to ensure hospice aide services were sufficient to meet patient needs. Failure to ensure that hospice aides had an appropriate POC available to follow, provided care in accordance with that POC, were adequately supervised, and communicated changes in patient status to an RN had the potential to negatively impact patient care. Findings include: 1. Refer to L615 as it relates to the agency's failure to ensure hospice aides successfully completed competency evaluations prior to	L 607	L607 418.76 Hospice Aide and Homemaker Services Agency will complete a plan of care for those patients receiving hospice aide services prior to the implementation of the services. Aides are to be supervised every 14 days and instructed on how to communicate changes in the patient's status as required and to meet the Conditions of Participation standards: L625, L626, L628, L629, and L633. Responsible: Director of Nursing is responsible for the overall correction of this Condition. Completion: 10-15-14		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 607	Continued From page 75 Initiating patient care. 2. Refer to L625 as it relates to the agency's failure to ensure written patient care instructions for the hospice aide prepared by an RN were complete and updated when required by hospice policy or changes in patient condition. 3. Refer to L626 as it relates to the agency's failure to ensure hospice aides provided care in accordance with the patient-specific POC generated by the RN. 4. Refer to L628 as it relates to the agency's failure to ensure hospice aides reported significant changes to an RN. 5. Refer to L629 as it relates to the agency's failure to ensure RN supervisory visits of the hospice aide was conducted on site every 14 days. 6. Refer to L633 as it relates to the agency's failure to ensure supervising nurses adequately evaluated the care delivered by hospice aides. The cumulative effective of these systemic practices resulted in the potential to negatively impact quality and coordination of hospice aide care.	L 607	L615 418.76 (c) (1) Competency Evaluation All hospice aides hired by the agency will have an evaluation of their performance of the tasks as outlined per the Hospice Aide Skills Checklist, which requires the Hospice aide to demonstrate competency prior to providing patient care. Documentation of completion of this evaluation is to be placed in the Hospice Aide's Personnel record. Director of Nursing or designee will review 100% active hospice aide personnel files to ensure that all required demonstrated competencies have been completed before providing patient care. Incompletes will require the hospice aide to		
L 615	418.76(c)(1) COMPETENCY EVALUATION An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of	L 615			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 615	Continued From page 76 this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel records, it was determined the hospice failed to ensure HAs successfully completed competency evaluations prior to initiating patient care for 4 of 30 aides (Staff H, S, V, W) whose employee files were reviewed. This had the potential to negatively impact the safety and quality of patient care. Findings include: 1. Personnel files of HAs were reviewed. The records did not include competency evaluations for HA S (hired on 10/31/11), HA V (hired 3/21/13), or HA W (hired 12/11/12). Additionally, HA H was hired on 7/18/13. However, the competency evaluation was completed on 2/11/14 (7 months after hire). During an interview on 9/5/14 beginning at 3:00 PM, the Human Resources Assistant confirmed the HA's records did not include competency evaluations completed before they provided hospice patient care duties. The hospice failed to ensure hospice aides successfully completed competency evaluations prior to providing patient care.	L 615	complete the competency prior to providing any further patient care. Ongoing all new hospice aides will meet with an RN Preceptor, review and complete all competencies prior to the provision of care. The agency had recognized this problem in February of 2014 and had made a correction and reached 100% completion of hospice aide competencies as required by the Conditions of Participation. Ongoing the agency will continue the process put in place at that time to ensure 100% compliance continues. Variances of less than 100% will be tracked and trended, action plans developed if required, and reporting to the QAPI Committee quarterly until 100% compliance is achieved. Responsible: Director of Nursing is responsible for the overall correction and ongoing completion. Completion: 10-15-14		
L 625	418.76(g)(1) HOSPICE AIDE ASSIGNMENTS	L 625			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 625	<p>Continued From page 77 AND DUTIES</p> <p>(1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on patient record review and staff interview, it was determined the agency failed to ensure complete written patient care instructions were provided to the HA for 1 of 8 active patients (#3) who received hospice aide services. This had the potential to interfere with the quality and completeness of HA services. Findings include:</p> <p>1. Patient #3 was an 87 year old female admitted to the agency on 5/24/14, with a diagnosis of dementia. Her record, including the "AIDE CARE PLAN REPORT" for the certification periods of 5/24/14 to 8/21/14, and 8/22/14 to 10/20/14, was reviewed.</p> <p>A "Visit Note Report" dated 8/07/14, and signed by the RN Case Manager on 8/08/14, stated the HA was taught how to apply Duoderm (an opaque dressing that adheres to the skin) to pressure points on Patient #3's outer knees and upper back. However, Patient #3's "AIDE CARE PLAN REPORT" was not updated to include instructions for the HA to apply Duoderm.</p> <p>During an interview on 9/04/14 at 3:45 PM, the RN Case Manager stated she completed Patient #3's "AIDE CARE PLAN REPORT" which included the written instructions for the HA. She</p>	L 625	<p>L625 418.76 (g) (1) Hospice Aide Assignments</p> <p>Director of Nursing or designee will educate the RN's on how to formulate the Hospice Aide Plan of Care and RN Coordination of Care with the hospice aide responding and follow up on reported hospice aide concerns and documentation of follow up.</p> <p>The Director of Nursing or designee will review 100% of Hospice Aide Plans of Care reviewing the plans for accuracy and ensuring that instructions or tasks assigned are not outside the scope of practice for the hospice aides. Variances indicated will be immediately corrected and communicated directly to the Hospice aide until 100% compliance is demonstrated.</p> <p>Clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L-625	Continued From page 78 confirmed the HA was taught how to apply Duoderm to Patient #3's outer knees and upper back on 8/07/14, and had been applying it since that date. Additionally, she confirmed Patient #3's "AIDE CARE PLAN REPORT" was not updated to include the application of Duoderm. The RN Case Manager stated the electronic medical record system did not allow updates to the "AIDE CARE PLAN REPORT."	L-625	findings will be compiled and those indicators that meet less than an 85% compliance rate will be placed on an action plan for correction to be written and presented to the QAPI committee on a quarterly basis. Correction action will be implemented and documented. The agency will continue to audit the specific indicator until 85% compliance is achieved.		
L 626	Written instructions for Patient #3's HA were not complete to include all duties provided by the HA. 418.76(g)(2) HOSPICE AIDE ASSIGNMENTS AND DUTIES (2) A hospice aide provides services that are: (i) Ordered by the interdisciplinary group. (ii) Included in the plan of care. (iii) Permitted to be performed under State law by such hospice aide. (iv) Consistent with the hospice aide training. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the HA followed the POC for 2 of 8 active patients (#6 and #7) who received HA services. This resulted in the HA not performing the tasks assigned by the RN Case Manager. Findings include: 1. Patient #6 was an 81 year old male admitted to the agency on 8/02/13 for a terminal diagnosis of Dementia. His record was reviewed for the certification period of 7/28/14 to 9/25/14 and documented he was to receive HA visits two times a week for nine weeks.	L 626	Responsible: Director of Nursing has ultimate responsibility for the overall correction and ongoing completion. Completion: 10-15-14 L626 418.76 (g) (2) Hospice Aide Assignments and Duties Director of Nursing or designee will educate RN's on how to formulate the Hospice Aide Plan of Care, including the handout "Job Aide: Hospice Aide Plan of Care." Education will include coordination with the hospice aide-responding and follow-up on reported- Hospice Aide concerns and documentation of follow-up.		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 626	<p>Continued From page 79</p> <p>Patient #6's record included a "Aide Care Plan Report" which documented skin care and transfers from the bed to a chair and from the chair to the bed, were to be completed during every HA visit. However, her Visit Note Reports documented skin care was not completed for 11 of 13 visits during the 7/28/14 to 9/25/14 time period. Additionally, her Visit Note Reports documented the HA did not complete the bed to the chair, chair to the bed transfers during 13 of 13 visits in the time period of 7/28/14 to 9/25/14.</p> <p>During a phone interview with the HA on 9/05/14 at 4:30 PM, the record was reviewed. The HA confirmed that he had not done transfers with every visit because Patient #6 did not need to be transferred, he stated he was usually out of bed and in a chair when he arrived. He also confirmed that skin care was not done at every visit because Patient #6 did not want it done.</p> <p>The HA POC was not followed for Patient #6.</p> <p>2. Patient #7 was a 73 year old male admitted to the agency on 9/19/12, for hospice services related to Cerebral Artery Occlusion. Additional diagnoses included diabetes and HTN. His records for the certification period 7/12/14 to 9/09/14 were reviewed, including hospice aide visit notes.</p> <p>On 9/08/14 at 10:40 AM, the DON provided an "Aide Care Plan Report." The report included printed documentation it was developed by the RN Case Manager, and also noted the effective date of the "Current Aide Care Plan" was 8/28/13. The DON stated it was a current HA POC, and confirmed the dates. The HA POC documented he was to receive HA visits 2 times a week for 8</p>	L 626	<p>The Director of Nursing or designee will review 100% of current Hospice aide plans of care, reviewing the plans for accuracy and ensuring that instructions or tasks that are assigned are not outside the scope of practice for the hospice aide. Variances indicated will be corrected and communicated directly to the hospice aide until 100% compliance is demonstrated. Ongoing, through clinical record review the Director of Nursing or designee will review 10% of the average daily census on a quarterly basis. Indicators of less than 85% compliance will require an action plan. Findings will be reported to the QAPI committee quarterly and then to the Governing Body quarterly.</p> <p>Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion.</p> <p>Completion: 10-15-14</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 626	<p>Continued From page 80 weeks.</p> <p>a. The HA POC included vital sign parameters and listed the HA services to be provided. The POC included bed to chair transfers, chair to bed transfers, bathing, catheter care, shaving, nail care, and dressing. The POC noted the HA was to use an electric shaver, as Patient #7 was diabetic. However, nail care was also ordered, which was contraindicated for diabetic patients and must be provided by a licensed nurse or podiatrist.</p> <p>The HA POC included HA care which was not permitted.</p> <p>b. The HA documented in a visit note dated 8/08/14 that Patient #7's bottom was very red and she had applied Vaseline to his back and bottom. The note did not include documentation of notification to the RN Case Manager and the POC did not include orders for the HA to apply Vaseline.</p> <p>Additionally, the HA documented in a visit note dated 8/18/14 that Patient #7 had a very red area on his bottom. She documented she applied "calamide [sic]." There was no documentation of notification to the RN Case Manager. Additionally, the POC did not include orders for the Aide to apply medications to his skin.</p> <p>The HA provided interventions which were not on Patient #7's HA POC.</p> <p>c. No vital signs were documented in the HA Visit Note Reports for the current certification period of 7/12/14 through 9/09/14.</p>	L 626			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 626	Continued From page 81 The HA failed to provide interventions as indicated on Patient #7's HA POC.	L 626			
L 628	During an interview on 9/08/14 beginning at 11:30 AM, the Branch Manager reviewed Patient #7's record and confirmed the Aide duties on the Aide POC. He noted the vital sign parameters on the list, and stated he would expect the Aide to take vital signs with each visit. Additionally, he confirmed there were no orders on the HA POC to apply topical medications. The Branch Manager confirmed there were orders for nail care, and stated he did not know why the RN listed nail care for a diabetic patient. 418.76(g)(4) HOSPICE AIDE ASSIGNMENTS AND DUTIES (4) Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures. This STANDARD is not met as evidenced by: Based on staff interview and review of patient records, it was determined the hospice failed to ensure the HA reported changes in patient needs to the RN for 1 of 8 active patients (#2) who received HA services. This had the potential to interfere with patients' needs being met in a timely manner. Findings include: The "HOSPICE AIDE SERVICES" policy, revised 3/2014, stated "Hospice aide duties may include,	L 628	L628 418.76 (g) (4) Hospice Aide Assignments Director of Nursing or designee will educate RN's on how to formulate the Hospice Aide Plan of Care, including the handout "Job Aide: Hospice Aide Plan of Care," and review of Policy 2-006.1 Hospice Aide Services, and 4-008 RN Coordination of Care. Education will include coordination with the hospice aide responding and follow-up on reported Hospice Aide concerns and documentation of follow-up. The Director of Nursing or designee will review 100% of current Hospice aide plans of care, reviewing the plans for accuracy and ensuring that instructions or tasks that are assigned		

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

PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131620	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 628	Continued From page 82 but are not limited to ... Reporting changes in the patient's condition and needs to the RN Case Manager." However, Patient #2 was an 82 year old male admitted to the agency on 1/11/14, for hospice services related to Senile Degeneration of the Brain. He and his wife, who was also on hospice services, lived in an ALF. A visit was conducted at the ALF on 9/04/14 at 7:00 AM, to observe the HA providing care for Patient #2. During the visit he and his wife stated that the ALF staff did not change the bedding during the night if it was wet and soiled. They stated the sheets were wet and cold, and they would have to wait until the HA came in to change the sheets. HA visit notes were reviewed from 7/10/14 through 8/28/14, there was no documentation the HA reported to the RN Case Manager that Patient #2 was found in a wet or soiled bed. During an interview on 9/08/14 beginning at 8:20 AM, the RN Case Manager reviewed Patient #2's record and stated she was not aware of Patient #2 and his wife remaining in a wet bed, and stated she would speak with the ALF staff where they resided. The HA did not ensure the RN Case Manager was informed for Patient #2's incontinence concerns and needs.	L 628	are not outside the scope of practice for the hospice aide. Variances indicated will be corrected and communicated directly to the hospice aide until 100% compliance is demonstrated. Ongoing, through clinical record review the Director of Nursing or designee will review 10% of the average daily census on a quarterly basis. Indicators of less than 85% compliance will require an action plan. Findings will be reported to the QAPI committee quarterly and then to the Governing Body quarterly. Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion. Completion: 10-15-14		
L 629	418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES (i) A registered nurse must make an on-site visit	L 629	L629 418.76 (h) (1) (i) Supervision of Hospice Aides		

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

PRINTED: 09/29/2014
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 _____ D. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 000 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 629	<p>Continued From page 83</p> <p>to the patient's home: (I) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the hospice failed to ensure RNs completed supervisory visits for HAs at least every 14 days for 1 of 8 active patients (#3) who received hospice aide services. This failure allowed hospice aides to provide care without adequate oversight from a RN. Findings include:</p> <p>1. Patient #3 was an 87 year old female admitted to the agency on 5/24/14, with a diagnosis of dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 5/24/14 to 8/21/14, and 8/22/14 to 10/20/14, was reviewed. Her POC included an order for HA visits 3 times a week for 10 weeks.</p> <p>The agency utilized a Visit Note Report to document HA visits and SN visits, including RN Supervisory visits. All Visit Note Reports were reviewed and documented HA visits were conducted 3 times a week between 5/27/14 and 8/21/14. However, Patient #3's SN Visit Note Reports did not include documentation that RN Supervisory visits had been conducted.</p> <p>An interview was conducted with the RN on 9/04/14 starting at 3:45 PM. At that time, the RN stated she had completed RN Supervisory visits</p>	L 629	<p>Director of Nursing or designee will educate RN's on Policy 4-008 RN Coordination of Care to ensure that supervision is maintained per policy. Aide Supervision with supervisory visits every 14 days and documented within the clinical record by the assigned RN. All hospice aide supervisory visits are to be scheduled within the electronic scheduling console with the appropriate service code. Direct hospice aide supervisory visits will be made upon hire and every 12 months.</p> <p>The Director of Nursing or designee will review 100% of current Hospice aide plans of care, reviewing the plans for accuracy and ensuring that instructions or tasks that are assigned are not outside the scope of practice for the hospice aide and ensuring supervisory visits are made according to policy. Variances indicated will be corrected and communicated directly to the hospice aide until 100% compliance is demonstrated. Ongoing, through clinical record review the Director of Nursing or designee will</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 629	Continued From page 84 every 2 weeks and would have to locate the records. A subsequent interview with the DON was conducted on 9/08/14 starting at 11:30 AM. The DON confirmed no RN Supervisory visits had been completed from 5/24/14 to 8/21/14. She stated the RN utilized the wrong form, which did not prompt her to complete the supervisory review.	L 629	to policy. Variances indicated will be corrected and communicated directly to the hospice aide until 100% compliance is demonstrated. Ongoing, through clinical record review the Director of Nursing or designee will review 10% of the average daily census on a quarterly basis. Indicators of less than 85% compliance will require an action plan. Findings will be reported to the QAPI committee quarterly and then to the Governing Body quarterly.		
L 633	418.76(h)(3) SUPERVISION OF HOSPICE AIDES (3) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to-- (i) Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse. (ii) Creating successful interpersonal relationships with the patient and family. (iii) Demonstrating competency with assigned tasks. (iv) Complying with infection control policies and procedures. (v) Reporting changes in the patient's condition. This STANDARD is not met as evidenced by: Based on staff interview, patient record review and review of personnel records, it was determined the hospice failed to ensure RNs provided sufficient supervision and oversight for 2	L 633	Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion. Completion: 10-15-14 L633 418.76 (h) (3) Supervision of Hospice Aides Director of Nursing or designee will educate RN's on Policy 4-008 RN Coordination of Care to ensure that		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 633	<p>Continued From page 85 of 13 active patients (#3 and #10). This resulted in a lack of adequate communication and oversight between HAs and RN Case Managers, necessary to ensure patient needs were accurately identified and addressed. Findings include:</p> <p>1. A policy, titled "HOSPICE NURSING CARE," revised 3/2014, delineated the responsibilities of the RN Case Manager. The responsibilities included ensuring communication between the care providers and supervision of the LPN and HA.</p> <p>Policy was not implemented, as follows:</p> <p>a. Patient #3 was an 87 year old female admitted to the agency on 5/24/14, with a diagnosis of dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 5/24/14 to 8/21/14, and 8/22/14 to 10/20/14, was reviewed.</p> <p>Patient #3's record included a Visit Note Report, dated 8/11/14, and signed by the HA. The note stated "Noted skin tear on right forearm. CM and facility notified..."</p> <p>Patient #3's record did not include documentation of action taken by the Case Manager or the agency related to the reported skin tear.</p> <p>Additionally, there was no documentation of a skin tear on Patient #3's right arm during SN visit notes, signed by the LPN on 8/14/14 and 8/18/14. Further, a subsequent SN visit note, signed by the RN Case Manager on 8/21/14, documented an open area on Patient #3's perineum. However, it did not include documentation of a</p>	L 633	<p>supervision is maintained per policy. Aide Supervision with supervisory visits every 14 days and documented within the clinical record by the assigned RN. All hospice aide supervisory visits are to be scheduled within the electronic scheduling console with the appropriate service code. Direct hospice aide supervisory visits will be made upon hire and every 12 months.</p> <p>The Director of Nursing or designee will review 100% of current Hospice aide plans of care, reviewing the plans for accuracy and ensuring that instructions or tasks that are assigned are not outside the scope of practice for the hospice aide and ensuring supervisory visits are made according to policy. Variances indicated will be corrected and communicated directly to the hospice aide until 100% compliance is demonstrated. Ongoing, through clinical record review the Director of Nursing or designee will review 10% of the average daily census on a quarterly basis. Indicators of less than 85% compliance will</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 633	<p>Continued From page 86</p> <p>skin tear on her right arm. None of the SN visit notes included information to acknowledge an assessment of the right arm skin tear as documented by the HA on 8/11/14.</p> <p>During an interview on 9/04/14 at 3:30 PM, the RN Case Manager stated she did not remember being contacted by the HA regarding a skin tear on Patient #3's arm, or reading documentation of a skin tear in the HA visit note. She stated the visits on 8/14/14 and 8/18/14, were completed by the LPN because she was out of town.</p> <p>During an interview on 9/08/14 at 9:40 AM, the LPN stated he did not recall being notified by the RN Case Manager or the HA of a skin tear on Patient #3's arm.</p> <p>The agency failed to ensure Patient #3's care was coordinated and supervised.</p> <p>b. Patient #10 was an 86 year old female admitted to the agency on 8/26/14, for services related to necrotizing fasciitis (a serious bacterial infection that spreads rapidly and destroys the body's soft tissue). She received SN, HA and MSW services. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE," for the certification period 8/26/14 to 11/23/14, was reviewed.</p> <p>Patient #10's "HOSPICE CERTIFICATION AND PLAN OF CARE," for the certification period 8/26/14 to 11/23/14, included an order for HA services 2 times a week for 9 weeks and stated, "Home Health Aide service for assistance with personal care and ADL's [Activities of Daily Living] secondary to functional limitations, which prevent self care. There is no willing or able caregiver to</p>	L 633	<p>require an action plan. Findings will be reported to the QAPI committee quarterly and then to the Governing Body quarterly.</p> <p>Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion.</p> <p>Completion: October 15, 2014</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 633	Continued From page 87 provide for hygiene needs." Patient #10's record included an "Aide Care Plan Report" for the certification period 8/28/14 to 11/23/14, completed and signed by the RN Case Manager. The Care Plan included instructions for the HA to bathe Patient #10 two times per week. Patient #10's record included 2 documents titled "Visit Note Report" completed and signed by the HA on 8/29/14 and 9/02/14. The reports indicated bathing was not completed, with a note stating "not needed on this visit." The report dated 9/02/14 included a note in the narrative section stating, "We don't give shower, just visit, turn." During an interview on 9/08/14 at 12:45 PM, the DON reviewed Patient #10's record and stated the statement, "There is no willing or able caregive to provide for hygiene needs" was automatically populated on the "HOSPICE CERTIFICATION AND PLAN OF CARE" whenever an HA was ordered. The DON stated the HA did not bathe Patient #10 because the staff at the facility where she lived provided baths. The DON confirmed the RN Case Manager and the HA did not communicate regarding the discrepancy between the HA assignment and Patient #10's needs. Patient #10's RN Case Manager and HA did not maintain communication regarding the duties required and performed by the HA.	L 633			
L 661	418.100(g)(1) TRAINING (1) A hospice must provide orientation about the hospice philosophy to all employees and	L 661	L661 418.100 (g) (1) Training All new employees will be assigned an orientation program upon hire, to be monitored by the Director of Nursing or designee, as per policy and procedure manual which will include (not inclusive list): Mission, Policies/Procedures, Competency testing, orientation specific to the		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 661	<p>Continued From page 88</p> <p>contracted staff who have patient and family contact.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of personnel records, it was determined the hospice failed to ensure orientation about the hospice philosophy was provided to 9 of 41 staff (I, J, L, M, N, O, R, T, and V) whose employee files were reviewed. This had the potential for staff to lack the understanding of hospice philosophy necessary to care for hospice patients. Findings include:</p> <p>Personnel files were reviewed and did not include documented evidence of orientation to the hospice philosophy for each employee, as follows:</p> <ul style="list-style-type: none"> - RN L was hired 3/26/13 and did not attend orientation until 6/2013. - RN O was hired 5/06/13 and did not attend orientation until 7/7/13. - MSW M was hired 6/27/13 and did not attend orientation until 8/2013. - HA J was hired 3/08/13 and did not attend orientation until 6/19/13. - HA V was hired 3/21/13 and did not attend orientation until 6/6/13. - HA R was hired 3/21/13 and did not attend orientation until 6/20/13. - HA I was hired 4/09/13 and did not attend orientation until 6/4/14. 	L 661	<p>hospice philosophy of care, pain management, infection control, HIPAA, Compliance, etc. The agency will utilize the Competency Checklist and Orientation schedule from the policy and procedure manual. On-site supervisory forms to be utilized to perform a supervisory visit with the new employee prior to independent practice by the Director of Nursing or designee. Hospice staff will have an annual competency skills reviewed along with performance evaluations with on-site supervisory visit. The HR department will utilize a tracking system to track current employees for the return of the competency forms (all staff to be completed by 12-31-14), completion of educational programs with return of attestation statements/post tests. All current staff will complete the self-study program "Hospice and Palliative Care" by 11-10-14 with completion of the post test and have a passing score of 100%. Employees with less than 100% will be required to review the course with the Director of Nursing or designee and retake the post-test.</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 661	<p>Continued From page 89 - HA N was hired 1/20/14 and did not attend orientation until 4/2014.</p> <p>Additionally, HA T was hired 1/03/12. HA T's record did not contain any documentation of orientation training.</p> <p>During an interview on 9/05/14 beginning at 3:00 PM, the Human Resource Assistant reviewed the employee files reference above and confirmed the employees did not receive orientation about the hospice philosophy prior to having contact with patients and family. Additionally, she stated the agency had implemented an online staff education program in June of 2013. Employees who were hired in the spring of 2013 did not receive orientation until the new system was available.</p>	L 661	<p>The agency had recognized this problem in February of 2014 and had made a correction and reached 100% completion of new employee orientation as required by policy.</p> <p>Ongoing, the Director of Nursing or designee will review 25% of all personnel educational records for completeness with personnel and educational audit tool, variances will be tracked and trended, and less than 95% compliance will be reported to the QAPI Committee and Governing Body quarterly.</p>	
L 668	<p>418.102(c) RECERTIFICATION OF THE TERMINAL ILLNESS</p> <p>Before the recertification period for each patient, as described in §418.21(a), the medical director or physician designee must review the patient's clinical information.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the agency failed to ensure timely Face to Face attestations for 2 of 2 patients (#20 and #22), who were discharged as a result of the delay. This resulted in patients</p>	L 668	<p>Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion.</p> <p>Completion: 10-15-14</p> <p>L668 418.102 (c) Recertification of the Terminal Illness</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 668	<p>Continued From page 90 being discharged from the agency unnecessarily. Findings include:</p> <p>1. Patient #22 was a 69 year old female admitted to the agency on 12/13/12, for hospice care related to liver cancer. A "Discharge-Transfer Summary Report," undated, documented Patient #22 was discharged to home or self care due to a move out of the agency service area on 3/05/13.</p> <p>Patient #22 was admitted to hospice 3/07/13, and revoked her hospice benefit on 7/05/13. The DON stated on 9/08/14 beginning at 4:30 PM, Patient #22 did not have the FTF as required by Medicare, so she was discharged and readmitted. She stated it was a "desk discharge," and patient care was not interrupted.</p> <p>Patient #22 was admitted to hospice on 7/06/13, and revoked on 11/18/13. The DON did not explain the circumstances related to the revocation.</p> <p>Patient #22 was again admitted to hospice on 11/21/13.</p> <p>The agency was not able to provide further documentation related to the additional admissions and revocations for Patient #22 despite multiple requests.</p> <p>The physician failed to perform a timely FTF assessment and resulted in Patient #22 being discharged.</p> <p>2. Patient #20 was a 73 year old female admitted to the agency on 10/18/13, for hospice care related to obstructive chronic bronchitis with acute exacerbation.</p>	L 668	<p>Director of Nursing or designee will provide education to office staff on using the Electronic Medical Record to assist with tracking of benefit dates to ensure that Face to Face encounters occur timely and per policy and regulations. Office staff will monitor each patient's benefit period and will review the patient's electronic eligibility report from CMS to ensure that the patient is admitted into the correct benefit period to ensure a timely face to face encounter occur and to reduce the chance of the patient being placed into the incorrect benefit period in the EMR.</p> <p>Ongoing, clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators identified. Audit record findings will be compiled and those indicators that meet less than an 85% compliance rate will require an action plan. Findings will be reported to the QAPI committee</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 668	<p>Continued From page 91</p> <p>a. Her record included a visit note report dated 2/09/14, that indicated no patient visit was made, and the note was "for data collection only." The note documented Patient #20 was discharged from the agency as the physician completed the FTF late.</p> <p>In a visit note dated 2/11/14 at 11:07 AM, the SW documented she educated Patient #20 regarding the agency having to discharge her because the physician did not perform the FTF within the timeline required by Medicare. The SW documented it was explained to Patient #20 that she would be readmitted to hospice once the physician completed the FTF visit.</p> <p>Two visit notes, both dated 2/19/14, one identified as the "RN Visit" at 11:38 AM, and the other as "Hospice RN Start of Care" at 10:37 PM, indicated Patient #20 was readmitted to hospice care. Copies of her signed consents were included in her record.</p> <p>b. Patient #20's record also included a visit note report dated 5/08/14, that indicated no patient visit was made, and the note was "for data collection only." The note documented Patient #20 was discharged on 4/18/14 from the agency as the physician completed the FTF late.</p> <p>Her record did not include information that she was advised of her discharge related to a late FTF, as when she was informed by the SW on 2/11/14.</p> <p>The RN indicated on a visit note report, dated 4/22/14, that a start of care assessment was performed. Consents for hospice treatment were</p>	L 668	<p>quarterly and then to the Governing Body quarterly.</p> <p>Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion.</p> <p>Completion: 10-15-14</p>	

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 668	<p>Continued From page 92 signed and dated 4/22/14.</p> <p>In an interview on 9/08/14 at 4:35 PM, the DON reviewed Patient #20's record and stated the physician did not complete the FTF as required by Medicare, so she was discharged and readmitted. She confirmed this occurred on both 2/09/14 and 5/08/14 due to the FTF not being completed on time. The DON stated the patient was not affected by the "discharge," it was only on paper, and care was provided to her during the time between the "discharge" and the readmit on each occasion.</p> <p>Patient #20's record did not include documentation of why the FTF was delayed resulting in a discharge on each occasion.</p> <p>The physician failed to perform a timely FTF assessment and resulted in a discharge and readmission on two occasions.</p> <p>418.102(d) MEDICAL DIRECTOR RESPONSIBILITY</p> <p>The medical director or physician designee has responsibility for the medical component of the hospice's patient care program.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the Medical Director failed to ensure sufficient oversight was provided meet the needs of 7 of 13 patients (#1, #3, #4, #7, #8, #9, and #10) whose active records were reviewed, and 2 of 2 patients (#20 and #22), whose discharge records were reviewed. This failure resulted in plans of care that were not patient specific, not</p>	L 668	<p>L669 418.102 (d) Medical Director Responsibility</p> <p>Director of Nursing or designee will provide education to office staff on using the Electronic Medical Record to assist with tracking of benefit dates to ensure that Face to Face encounters occur timely and per policy and regulations. Office staff will monitor each patient's benefit period and will review the patient's electronic eligibility report from CMS to ensure that the patient is admitted into the correct benefit period to ensure a timely face to face encounter occur and to reduce the chance of the patient being placed into the incorrect benefit period in the EMR. All Hospice patients will be reviewed during IDG meetings for required upcoming Face to Face encounters and deadlines for such. The Medical Directors will be notified by each branch office staff at least 15 days prior to the end of the patient's episode to ensure a timely face to face encounter occurs.</p> <p>Refer to response for L536 and L668</p>	
L 669		L 669		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 669	Continued From page 93 updated, and not being followed for each patient, and a lack of timely Face to Face attestations. Findings include: 1. During an interview on 9/05/14 beginning at 4:00 PM, the DON stated the agency had a total of 7 Medical Directors, and 2 Nurse Practitioners. She stated there was a Primary Medical Director, but he did not go to some of the multiple locations, and the other Medical Directors covered them. She confirmed the Primary Medical Director was responsible for the oversight of the entire agency. a. Refer to L536 Condition of Participation: Interdisciplinary Group, Care Planning, and Coordination of Services and related standard level deficiencies as they relate to the Medical Director's failure to ensure patient-specific plans of care, containing measurable outcomes, were developed, revised, and followed for each patient. b. Refer to L668 as it relate to the failure of the Medical Director to provide oversight and to ensure timely Face to Face assessments were performed.	L 669	Ongoing, clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators. Audit findings will be compiled and indicators that meet less than 85% compliance rate will require an action plan. Findings will be reported to the QAPI committee and the Governing Body quarterly. Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion. Completion: 10-15-14		
L 670	418.104 CLINICAL RECORDS This CONDITION is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure clinical 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	L670 418.104 Clinical Records The agency will ensure that documentation is submitted timely and accurately into the electronic medical record of the patient to meet the Conditions of Participation standards L671, L673, L674, L679, L682, and L683. Reports generated within the EMR will be monitored to		

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

PRINTED: 09/29/2014
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 _____ D. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 670	Continued From page 94 1. Refer to L671 as it relates to the agency's failure to ensure records were current, accurate, and complete. 2. Refer to L673 as it relates to the agency's failure to ensure admission documents were signed and dated at the time the hospice benefit was elected. 3. Refer to L679 as it relates to the agency's failure to ensure timely authentication of patient record entries. 4. Refer to L682 as it relates to the agency's failure to ensure transfer summaries were sent to receiving agencies for those patients who transferred. 5. Refer to L683 as it relates to the agency's failure to ensure patient's physicians were provided with a discharge summary at the time of transfer or revocation of care. 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 being met.	L 670	ensure compliance with the agencies policy and procedures of timely submission of documentation. Ongoing, clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators. Audit findings will be compiled and those indicators that meet less than 85% compliance rate will require an action plan. Findings will be reported to the QAPI committee quarterly and then to the Governing Body quarterly. Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion.		
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 attending physician and hospice staff. The clinical record may be maintained electronically. This STANDARD is not met as evidenced by:	L 671	Completion: 10-15-14 L671 418.104 Clinical Records Director of Nursing or designee will provide education to all staff regarding updating, accurate entries, and maintaining clinical records in		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 671	<p>Continued From page 95</p> <p>Based on record review, home visit, and staff interview, it was determined the agency failed to maintain a current clinical record which contained correct clinical information for 4 of 13 active patients (#3, #4, #8 and #10) whose records were reviewed. This resulted in incorrect and incomplete documentation in the clinical record. Findings include:</p> <p>1. Patient #4 was an 84 year old female admitted to the agency on 10/27/11, with a diagnosis of breast cancer. Her record, including the POC, was reviewed for the certification period of 7/9/14 to 9/6/14.</p> <p>In the "CLIENT COORDINATION NOTE REPORT" dated 7/10/14, the RN Case Manager had documented Patient #4's mid-arm circumference (a measurement used to indicate body fat when unable to weigh a patient) was 30.8 cm which decreased from 33 cm. On a subsequent "CLIENT COORDINATION NOTE REPORT" dated 8/20/14, the RN Case Manager had documented Patient #4's mid-arm circumference was 33 cm, increased from 30.8 cm.</p> <p>During an interview with the RN Case Manager on 9/8/14 at 8:40 AM, the record was reviewed. The RN Case Manager confirmed she documented an incorrect measurement of the mid-arm circumference on the note dated 7/10/14. She stated that she did not document that the measurement was incorrect in the medical record.</p> <p>The medical record did not contain correct clinical information for Patient #4.</p>	L 671	<p>addition to review of Policy 5-006.1 Entries into the Clinical Record. All staff will complete electronic documentation and submit electronic documentation via the EMR and/or paper based documentation per policy. Policy 5-006.1 updated for accuracy.</p> <p>Ongoing, clinical record review for the agency will be 10% of the average daily census on a quarterly basis. Reviews will be performed by the Director of Nursing or designee each quarter utilizing the clinical audit tool with indicators. Audit findings will be compiled and those indicators that meet less than 85% compliance rate will require an action plan. Findings will be reported to the QAPI committee quarterly and then to the Governing Body quarterly.</p> <p>Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion.</p> <p>Completion: 10-15-14</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 671	<p>Continued From page 96</p> <p>2. Patient #3 was an 87 year old female admitted to the agency on 5/24/14, with a diagnosis of dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 5/24/14 to 8/21/14, and 8/22/14 to 10/20/14, was reviewed.</p> <p>Patient #3's "Client Medication Report" 9/02/14 documented she was to receive Hydrocodone and Morphine Concentrate for pain. The medications were also on the medication list that was received from the ALF where Patient #3 resided.</p> <p>However, a Physician Verbal Order dated 8/21/14 and signed by the physician and RN, documented the Hydrocodone 5/325 half tab every six hours, Hydrocodone 5/325 half tab every 4 hours and PRN, and Morphine 20 mg/ml 0.25 ml every six hours were to be discontinued.</p> <p>During a home visit on 9/04/14 at 9:45 AM, the record was reviewed with the RN at the ALF. The RN confirmed that all medications on the medication record were current and she was not aware of the order to discontinue the pain medications.</p> <p>During an interview on 9/04/14 at 3:45 PM, the RN Case Manager reviewed Patient #3's record and confirmed that the medication report was not updated.</p> <p>Patient #3's medication report did not accurately reflect her medication orders.</p> <p>3. Patient #8 was a 64 year old female admitted to the agency on 12/30/13, with a diagnosis of COPD. She received SN, SW, HA, and Chaplain</p>	L 671			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 671	<p>Continued From page 97</p> <p>services. Her record was reviewed for the certification period of 7/1/14 to 8/29/14 and 8/30/14 to 10/28/14.</p> <p>Patient #8's "Client Medication Report" dated 9/02/14, did not include Oxyfast 20 mg/ml, Fentanyl Liquid 50 mcg/ml, and Oxybutin 5mg.</p> <p>However, a signed verbal order, dated 8/25/14 at 11:37 AM, included Oxyfast 20 mg/ml 0.5ml every eight hours. On 8/26/14 another signed verbal order, included Fentanyl Liquid 50 mcg/ml for use in a nebulizer respiratory treatment as part of an air hunger cocktail, and Oxybutin 5 mg, two tablets by mouth every day for urinary frequency.</p> <p>During an interview on 9/08/14 at 8:25 AM, the RN Case Manager reviewed the record and confirmed the medications were not on the medication report. She stated she was unsure if Patient #8 had received the medications and was using them as ordered. On 9/8/14 at 8:25, the DON called the pharmacy to confirm the medication orders had been filled. She also confirmed the medications were not on the current medication report.</p> <p>Patient #8's medication report was not accurate with current medications.</p> <p>4. Patient #10 was an 86 year old female admitted to the agency on 8/26/14, for services related to necrotizing fasciitis (a serious bacterial infection that spreads rapidly and destroys the body's soft tissue). She received SN, HA and SW services. Her record, including the POC, for the certification period 8/26/14 to 11/23/14, was reviewed. Patient #10's record did not include accurate information, as follows:</p>	L 671		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 671	<p>Continued From page 98</p> <p>a. Patient #10's record included a physician order dated 8/27/14, and signed by her physician on 8/27/14. The order listed Patient #10's current medications as:</p> <ul style="list-style-type: none"> -Ativan -Zofran -Tylenol tablets -Tramadol -Lidocaine -Morphine Sulfate -Haldol -Atropine -Tylenol suppository -Compazine <p>Patient #10's record included a "Client Medication Report" dated 9/02/14. It included the medications listed above. Additionally, it included the following medications:</p> <ul style="list-style-type: none"> -Albuterol Sulfate Inhalation -Armour Thyroid -Coreg -Lasix -Ondansetron -Potassium Chloride -Protonix -Prozac <p>Patient #10's record did not include orders for the additional medications.</p> <p>During an interview on 9/08/14 at 12:45 PM, the DON reviewed Patient #10's record and confirmed the "Client Medication Report" dated 9/02/14, included medications that were not ordered by her physician.</p> <p>Patient #10's medication report included</p>	L 671		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 671	<p>Continued From page 99</p> <p>medications that were not ordered by her physician.</p> <p>b. Patient #10's "HOSPICE CERTIFICATION AND PLAN OF CARE", for the certification period 8/26/14 to 11/23/14, included an order for HA services 2 times a week for 9 weeks and stated, "Home Health Aide service for assistance with personal care and ADL's [Activities of Daily Living] secondary to functional limitations, which prevent self care. There is no willing or able caregiver to provide for hygiene needs."</p> <p>Patient #10's record included an "Aide Care Plan Report" for the certification period 8/26/14 to 11/23/14, completed and signed by the RN Case Manager. The Care Plan included instructions for the HA to bathe Patient #10 two times per week. However, Patient #10's record included 2 documents titled "Visit Note Report" completed and signed by the HA on 8/29/14 and 9/2/14. The reports indicated bathing was not completed, with a note stating "not needed on this visit." The report dated 9/02/14 included a note in the narrative section stating, "We don't give shower, just visit, turn."</p> <p>During an interview on 9/08/14 at 12:45 PM, the DON reviewed Patient #10's record and stated the HA did not bathe Patient #10 because the staff at the facility where she lived provided baths. Additionally, the DON explained the statement, "There is no willing or able caregiver to provide for hygiene needs" was automatically populated on the "HOSPICE CERTIFICATION AND PLAN OF CARE" whenever a HA was ordered.</p> <p>Patient #10's medical record contained inaccurate information related to the availability of</p>	L 671		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 671	Continued From page 100 a caregiver.	L 671	L673 418.104 (a) (2) Content		
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 record review and interview, it was determined the agency failed to ensure the clinical record contained a copy of the notice of patient rights and responsibilities with an accurate date of signature obtained for 1 of 13 current patients (Patient #3) whose records were reviewed. This resulted in inaccurate information in the clinical record. Findings include: Patient #3 was an 87 year old female admitted to the agency on 5/24/14, with a diagnosis of dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 5/24/14 to 8/21/14, and 8/22/14 to 10/20/14, was reviewed. Patient #3's record included a form titled "HORIZON HOSPICE INFORMED CONSENT & TREATMENT AUTHORIZATION". The form included sections titled, "Treatment Authorization", "Financial Agreement", "MEDICARE/MEDICAID HOSPICE BENEFIT ELECTION", "HOSPICE SERVICES", "PATIENT RIGHTS AND RESPONSIBILITIES", "ADVANCE DIRECTIVES", "RELEASE OF PATIENT RECORDS", "RECEIPT OF INFORMATION", and "ACKNOWLEDGEMENT,"	L 673	Education to be provided to admitting staff regarding obtaining informed consent, providing notice of rights and responsibilities, and obtaining accurate and dated signed consents, in addition to obtaining verbal consent when the patient is unable to sign for own self and POA is unavailable at time for immediate signature. Policy 1.00.1 Informed Consent/Refusal of Treatment revised to include the process of obtaining signatures from the Patient's POA when it is determined the patient suffers from a disease process that affects their cognitive ability to understand and respond appropriately. Policy 2-023 Admission Criteria and Process to be reviewed by all admission staff. Office staff will track the consents that are sent to POA for signature and the date returned.		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 673	<p>Continued From page 101</p> <p>The section titled "ACKNOWLEDGEMENT" stated, "I acknowledge and agree to the terms and conditions described in the following documents: Informed Consent and Treatment Authorization, Medicare/Medicaid Hospice Benefit Election, Financial Agreement, Advance Directives, Pt's Rights & Responsibilities, Notice of Privacy Practices."</p> <p>The form documented Patient #3 was unable to sign due to dementia. The line titled "Name & Signature of legally authorized representative (if applicable)" contained the signature of Patient #3's sister, who was her Power of Attorney. The line titled, "Hospice Staff Signature/Discipline" contained the signature of Patient #3's RN Case Manager. Both signatures were dated 5/24/14, which was the date Patient #3 elected the hospice benefit.</p> <p>A visit note report dated 6/03/14, and signed by Patient #3's RN Case Manager, included documentation stating, "CONSENTS SIGNED BY POA".</p> <p>During an interview on 9/04/14 at 3:45 PM, the RN Case Manager confirmed the "HORIZON HOSPICE INFORMED CONSENT & TREATMENT AUTHORIZATION" was signed by Patient #3's sister on 6/03/14. She stated Patient #3's sister lived in another state and was unable to be present at the initial visit on 5/24/14, so she signed the forms when she was in town on 6/03/14. The RN Case Manager confirmed she and Patient #3's sister signed the form on 6/03/14, and dated the signatures 5/24/14, to match the election of hospice benefits date.</p> <p>Patient #3's consent for hospice benefits election</p>	L 673	<p>Director of Nursing or designee will review 100% of admission consents upon receiving initial admission paperwork and through the EMR workflow process. Variances will be addressed with the admitting nurse and may include further one-on-one education and/or counseling.</p> <p>Ongoing, 10% of the average daily census will be audited on a quarterly basis. Indicators of 85% or less will require an action plan for corrections and findings will be reported to the PI committee and governing body on a quarterly basis.</p> <p>Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion.</p> <p>Completion: 10-15-14</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 673	Continued From page 102 and notice of patient rights were pre-dated by the admitting RN 10 days before the POA reviewed and signed the forms.	L 673	L679 418.104 (b) Authentication Director of Nursing or designee will provide education to all staff regarding submitting timely entries to the patient's clinical records in addition to review of Policy 5-006.1 Entries into the Clinical Record. All staff will complete electronic documentation and submit electronic documentation via the EMR and/or paper based documentation per policy. Policy 5-006.1 revised to update timeframes for completion and submission of clinical record entries.		
L 679	418.104(b) AUTHENTICATION All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice. This STANDARD is not met as evidenced by: Based on record review, policy review and staff interview, it was determined the facility failed to ensure patient record entries were timely and in accordance with policy for 9 of 13 active patients (#1, #2, #3, #4, #6, #7, #8, #10, and #13) whose records were reviewed. This resulted in the potential for a lack of comprehensive information being available to the IDG on which to base POC decisions. Findings include: 1. The Entries into Clinical Records policy, revised March 2014, stated "Entries into the clinical record will be made on the day care is provided to the patient. All documentation will be turned in to the office at the end of the workday." Additionally, the policy stated "Late entries and amendments will be documented, stating 'late entry or amendment for visit of (date and time of visit)' and include:" - "The date the entry is made (month, day, year)" - "The date and documentation that was originally omitted or amended" - "The signature and title of the staff member making the late entry" However, patient clinical records did not	L 679	Responsible: Director of Nursing or designee will review 100% of admission consents upon receiving initial admission paperwork and through the EMR workflow process. Variances will be addressed with the admitting nurse and may include further one-on-one education and/or counseling. Ongoing, 10% of the average daily census will be audited on a quarterly basis. Indicators of 85% or less will		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 679	<p>Continued From page 103</p> <p>demonstrate clinical entries were completed on the day service was provided, and did not identify late entries as directed by the facility's policy, as follows:</p> <p>a. Patient #3 was an 87 year old female admitted to the agency on 5/24/14, with a diagnosis of dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 5/24/14 to 8/21/14, and 8/22/14 to 10/20/14, was reviewed.</p> <p>Patient #3's POC for the certification period 5/24/14 to 8/21/14, documented she was to receive care which included SN visits once a week for the first week, then twice a week for 13 weeks. Her record did not consistently include evidence of timely or accurately labeled entries. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - A visit note report documented an RN visit was made on 5/24/14 at 7:43 PM. The documentation was not initiated until 5/25/14 at 1:27 PM, not completed until 5/25/14 at 9:20 PM, and not documented as a late entry. - A visit note report documented an RN visit was made on 6/12/14 at 12:51 PM. The documentation was not initiated until 6/14/14 at 6:52 PM, and was not documented as a late entry. - A visit note report documented an RN visit was made on 6/17/14 at 3:03 PM. The documentation was not initiated until 6/20/14 at 11:44 AM, was not completed until 6/20/14 at 6:04 PM, and was not documented as a late entry. 	L 679	<p>require an action plan for corrections and findings will be reported to the PI committee and governing body on a quarterly basis.</p> <p>Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion.</p> <p>Completion: 10-15-14</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L-679	<p>Continued From page 104</p> <p>- A visit note report documented an RN visit was made on 7/03/14 at 11:30 AM. The documentation was not initiated until 7/05/14 at 1:07 PM, and was not documented as a late entry.</p> <p>- A visit note report documented an RN visit was made on 7/29/14 at 11:22 AM. The documentation was not initiated until 7/31/14 at 9:54 PM, and was not documented as a late entry.</p> <p>- A visit note report documented an RN visit was made on 8/25/14 at 11:09 AM. The documentation was not initiated until 8/26/14 at 7:26 PM, and was not documented as a late entry.</p> <p>- A visit note report documented an LPN visit was made on 8/29/14 at 8:29 AM. The documentation was not initiated until 9/01/14 at 7:47 AM, and was not documented as a late entry.</p> <p>- A visit note report documented an RN visit was made on 9/01/14 at 4:47 PM. The documentation was initiated on 9/01/14 at 5:04 PM, and then labeled as "Incomplete" at 5:11 PM. The documentation was "Resumed" on 9/02/14 at 7:10 PM, and not completed until 9/03/14 at 8:50 AM. None of the entries were documented as late entries.</p> <p>Patient #3's visit note reports were not completed and submitted in accordance with agency policy.</p> <p>b. Patient #10 was an 86 year old female admitted to the agency on 8/26/14, for services related to necrotizing fasciitis (a serious bacterial infection that spreads rapidly and destroys the</p>	L 679			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 679	<p>Continued From page 105</p> <p>body's soft tissue). She received SN, HA and SW services. Her record, including the POC, for the certification period 8/26/14 to 11/23/14, was reviewed.</p> <p>Patient #10's 7/9/14 POC documented she was to receive care which included SN visits twice a week for 13 weeks and MSW services once a week for 12 weeks. Her record did not consistently include evidence of timely or accurately labeled entries. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - A visit note report documented an RN SOC visit was made 7/09/14 at 3:23 PM. The documentation was initiated 7/09/14 at 5:05 PM, and then labeled as "incomplete" at 5:17 PM and not completed until 7/10/14 at 10:55 PM. The entry was not documented as a late entry. - A visit note report documented a SW visit was made 7/14/14 at 1:42 PM. The documentation was not initiated until 7/15/14 at 8:47 AM, and was not documented as a late entry. - A visit note report documented an RN visit was made on 7/17/14 at 10:31 AM. The documentation was not initiated until 7/18/14 at 8:52 PM, and was not completed until 7/19/14 at 9:19 AM. The entries were not documented as late entries. <p>Patient #10's visit note reports were not completed and submitted in accordance with agency policy.</p> <p>3. Patient #4 was an 84 year old female admitted to the agency on 10/27/11, with a diagnosis of</p>	L 679			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 679	<p>Continued From page 106</p> <p>breast cancer. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 7/09/14 to 9/06/14 was reviewed.</p> <p>Patient #4's POC for the period 7/9/14 to 9/6/14, documented she received care which included SN visits once a week for the first week, twice a week for six weeks, three a week for one week, the four a week for one week. Her record did not consistently include evidence of timely or accurately labeled entries. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - A visit note report documented an RN visit was made on 7/25/14 and documentation started at 11:01 AM. Documentation was then resumed on 7/28/14 at 9:25 AM and was completed on 7/28/14 at 9:31 AM. It was not documented as a late entry. - A visit note report documented an RN visit was made on 8/08/14 and documentation started at 6:24 PM. Documentation was then resumed on 8/08/14 at 11:19 AM and was completed on 8/08/14 at 11:31 AM. It was not documented as a late entry. - A visit note report documented an RN visit was made on 8/08/14 and documentation started at 1:09 PM. Documentation was then resumed on 8/12/14 at 11:09 PM and was completed on 8/12/14 at 11:18 PM. It was not documented as a late entry. - A visit note report documented an RN visit was made on 8/29/14 and documentation started at 5:02 PM. Documentation was then resumed on 8/31/14 at 4:52 PM and was completed on 	L 679			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 679	<p>Continued From page 107</p> <p>8/31/14 at 5:26 PM. It was not documented as a late entry.</p> <p>Pt #4's visit notes were not completed and submitted in accordance with agency policy.</p> <p>4. Patient #0 was an 81 year old male admitted to the agency on 8/02/13, with a diagnosis of Dementia. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 7/09/14 to 9/06/14 was reviewed.</p> <p>Patient #6's POC for the period 7/28/14 to 9/25/14, documented he received care which included SN visits twice a week for eight weeks, then one visit a week for one week. His record did not consistently include evidence of timely or accurately labeled entries. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - A visit note report documented an RN visit was made on 8/13/14, and documentation started at 3:02 PM. Documentation was then resumed on 8/15/14 at 11:57 AM and was completed on 8/15/14 at 12:11 PM. It was not documented as a late entry. - A visit note report documented an RN visit was made on 8/15/14, and documentation started at 4:58 PM. Documentation was then resumed on 8/18/14 at 7:24 AM and was completed on 8/18/14 at 7:53 AM. It was not documented as a late entry. - A visit note report documented an RN visit was made on 8/26/14, and documentation started at 3:00 PM. Documentation was then resumed on 8/26/14 at 8:58 AM and was completed on 	L 679		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 679	<p>Continued From page 108 8/26/14 at 9:08 AM. It was not documented as a late entry.</p> <p>Patient #6's visit notes were not completed and submitted in accordance with agency policy.</p> <p>5. Patient #8 was a 64 year old female admitted to the agency on 12/30/13, with a diagnosis of COPD. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 7/01/14 to 8/29/14 was reviewed.</p> <p>Patient #8's POC for the period 7/01/14 to 8/29/14, documented she received care which included SN visits twice a week for seven weeks, four visits a week for one week, and three visits for one week. Her record did not consistently include evidence of timely or accurately labeled entries. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - A visit note report documented an LPN visit was made on 7/08/14 and documentation started at 3:46 PM. Documentation was then resumed on 7/10/14 at 8:13 PM and was completed on 7/10/14 at 8:28 PM. It was not documented as a late entry. - A visit note report documented an LPN visit was made on 7/25/14 and documentation started at 3:15 PM. Documentation was then resumed on 7/27/14 at 9:49 PM and was completed on 7/27/14 at 10:10 PM. It was not documented as a late entry. - A visit note report documented an RN visit was made on 8/01/14 and documentation started at 4:37 PM. Documentation was then resumed on 	L 679			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 679	<p>Continued From page 109</p> <p>8/04/14 at 12:02 PM and was completed on 8/04/14 at 12:17 PM. It was not documented as a late entry.</p> <p>-A visit note report documented an LPN visit was made on 8/22/14 and documentation started at 4:26 PM. Documentation was then resumed on 8/24/14 at 10:48 PM and was completed on 8/22/14 at 11:00 PM. It was not documented as a late entry.</p> <p>-A visit note report documented an RN visit was made on 8/29/14 and documentation started at 3:49 PM. Documentation was then resumed on 9/02/14 at 7:36 AM and was completed on 9/02/14 at 7:49 AM. It was not documented as a late entry.</p> <p>Patient #8's visit notes were not completed and submitted in accordance with agency policy.</p> <p>6. Patient #13 was a 59 year old male admitted to the agency on 10/03/13, with a diagnosis of COPD. His record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE" for the certification periods of 7/30/14 to 9/27/14 was reviewed.</p> <p>Patient #13's POC for the period 7/30/14-9/27/14, documented he received care which included SN visits once a week for one week, then twice a week for eight weeks. His record did not consistently include evidence of timely or accurately labeled entries. Examples included, but were not limited to, the following:</p> <p>- A visit note report documented an RN visit was made on 8/14/14 and documentation started at 10:22 AM. Documentation was then resumed on</p>	L 679			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 679	<p>Continued From page 110</p> <p>8/16/14 at 4:49 PM and was completed on 8/16/14 at 5:12 PM. It was not documented as a late entry.</p> <p>- A visit note report documented an RN visit was made on 8/28/14 and documentation started at 11:42 AM. Documentation was then resumed on 8/30/14 at 8:39 AM and was completed on 8/30/14 at 8:45 AM. It was not documented as a late entry.</p> <p>Patient #13's visit notes were not completed and submitted in accordance with agency policy.</p> <p>7. Patient #7 was an 87 year old male admitted to the agency on 9/19/12 for hospice services related to Cerebral Artery Occlusion. His record for the certification period 7/12/14 to 9/09/14, was reviewed.</p> <p>Patient #7's POC documented he was to receive nursing services twice weekly for 9 weeks. His record did not include evidence of timely entries. Examples included, but were not limited to, the following:</p> <p>- A visit note report documented the initial comprehensive visit was made 9/20/12 at 2:19 PM. The documentation was initiated 9/20/12 at 2:24 PM and labeled as "Incomplete" at 3:03 PM. It was not completed until 9/24/14 at 11:51 AM. The entry was not documented as a late entry.</p> <p>- A visit note report documented an RN visit was made 7/08/14 at 3:42 PM. The documentation was initiated 7/08/14 at 3:42 PM and labeled as "Incomplete" at 4:12 PM. It was not completed until 7/12/14 at 10:48 AM. The entry was not documented as a late entry.</p>	L 679			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 679	Continued From page 111 - A visit note report documented an RN visit was made 7/29/14 at 3:53 PM. The documentation was initiated 7/29/14 at 3:53 PM, and labeled as "Incomplete" at 4:18 PM. It was not completed until 7/31/14 at 9:17 AM. The entry was not documented as a late entry. - A visit note report documented an RN visit was made 8/01/14 at 3:06 PM. The documentation was initiated 8/01/14 at 3:06 PM and labeled as "Incomplete" at 3:37 PM. It was not completed until 8/04/14 at 11:34 PM. The entry was not documented as a late entry. - A visit note report documented an RN visit was made 8/22/14 at 3:41 PM. The documentation was initiated 8/22/14 at 3:41 PM, and labeled as "Incomplete" at 4:10 PM. It was not completed until 8/25/14 at 10:05 PM. The entry was not documented as a late entry. - A visit note report documented an RN visit was made 8/29/14 at 12:02 PM. The documentation was initiated 8/29/14 at 12:02 PM, and labeled as "Incomplete" at 12:28 PM. It was not completed until 9/01/14 at 8:41 AM. The entry was not documented as a late entry. 8. Patient #2 was a 72 year old male admitted to the agency on 1/11/14 for hospice services related to Senile Degeneration. His record for the certification period 7/10/14 to 9/07/14, was reviewed. Patient #2's POC documented he was to receive nursing services twice weekly for 9 weeks. His record did not include evidence of timely entries. Examples included, but were not limited to, the	L 679			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 679	<p>Continued From page 112 following:</p> <ul style="list-style-type: none"> - A visit note report documented an RN visit was made 8/01/14 at 3:06 PM. The documentation was initiated 8/01/14 at 3:06 PM and labeled as "incomplete" at 3:22 PM. It was not completed until 8/04/14 at 8:03 AM. The entry was not documented as a late entry. - A visit note report documented an RN visit was made 8/08/14 at 1:19 PM. The documentation was initiated 8/08/14 at 1:19 PM and labeled as "incomplete" at 1:35 PM. It was not completed until 8/12/14 at 11:04 AM. The entry was not documented as a late entry. - A visit note report documented an RN visit was made 8/12/14 at 1:38 PM. The documentation was initiated 8/12/14 at 1:38 PM and labeled as "incomplete" at 1:53 PM. It was not completed until 8/14/14 at 5:31 PM. The entry was not documented as a late entry. - A visit note report documented an RN visit was made 8/15/14 at 12:54 PM. The documentation was initiated 8/15/14 at 12:54 PM and labeled as "incomplete" at 1:14 PM. It was not completed until 8/18/14 at 6:58 AM. The entry was not documented as a late entry. - A visit note report documented an RN visit was made 8/22/14 at 1:46 PM. The documentation was initiated 8/22/14 at 1:46 PM and labeled as "incomplete" at 2:01 PM. It was not completed until 8/25/14 at 12:42 PM. The entry was not documented as a late entry. <p>9. Patient #1 was a 77 year old female admitted to the agency on 1/18/12 for hospice services</p>	L 679			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 679	Continued From page 113 related to Alzheimers Disease. Her record from 8/18/14 to 9/18/14, was reviewed. Patient #1's POC documented she was to receive nursing services twice weekly for 9 weeks. Her record did not include evidence of timely entries. Examples included, but were not limited to, the following: - A visit note report documented an RN visit was made 8/07/14 at 3:24 PM. The documentation was initiated 8/07/14 at 3:24 PM and labeled as "Incomplete" at 3:56 PM. It was not completed until 8/11/14 at 10:31 PM. The entry was not documented as a late entry. - A visit note report documented an RN visit was made 8/18/14 at 9:30 PM. The documentation was initiated 8/18/14 at 9:30 PM and labeled as "Incomplete" at 9:32 PM. It was not completed until 8/20/14 at 12:30 PM. The entry was not documented as a late entry. During an interview with the hospice manager on 9/08/14 at 10:30 AM the records were reviewed. He confirmed the documentation on the patient records were not done according to agency policy. The agency did not ensure documentation of patient visits was completed on the day of service.	L 679	L682 418.104 (e) (1) Discharge or Transfer of Care Director of Nursing to provide education to office and clinical staff regarding discharge and transfer of care, including required documentation and review of Policy 2-058 Revocation of Hospice Benefit Election, 2-069 Change of Designated Hospice, 2-070 Transfer Information, 2-071 Discharge from Hospice Program, and 2-072 Discharge Summary. Agency to work with Electronic Medical Record IT Support Team to repair agencies electronic Discharge Summary to meet Conditions of Participation L682. Office staff to monitor that all required pieces of the discharge/transfer process are completed and on record. Ongoing, 10% of the average daily census will be audited on a quarterly basis. Indicators of 85% or less will require an action plan for corrections and findings will be reported to the PI committee and governing body on a quarterly basis.		
L 682	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-	L 682			

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

PRINTED: 09/29/2014
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 09/10/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

L 682	<p>Continued From page 114</p> <p>(i) The hospice discharge summary; and (ii) The patient's clinical record, if requested.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records, agency policies, and staff interview, it was determined the hospice failed to ensure that receiving facilities were provided a copy of the patient discharge summary upon transfer for 5 of 5 patients (#18, #19, #21, #24, and #25) who transferred to another hospice agency, and whose records were reviewed. This failure had the potential to result in an interruption in the provision of adequate patient care. Findings include:</p> <p>1. An agency policy "CHANGE OF DESIGNATED HOSPICE," revised March 2014, stated "The Case Manager will notify the attending physician of the need to change hospice providers." The policy noted the RN Case Manager was to complete a transfer form, and the attending physician would sign a transfer order. Additionally, the RN Case Manager or Clinical Supervisor was to provide relevant information to the organization to which the patient was to be transferred to. The policy concluded that the RN Case Manager or Clinical Supervisor was to contact the receiving hospice to provide a full report on the patient and family/caregiver care needs and to facilitate a smooth transition for the patient.</p> <p>Another policy "TRANSFER INFORMATION," revised March 2014, included the requirements for documentation of patients transferred to another hospice organization. The policy stated all patients transferred from hospice will have a transfer summary completed and filed in the</p>	L 682	<p>Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion.</p> <p>Completion: 10-15-14</p>	
-------	--	-------	---	--

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

PRINTED: 09/20/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 682	<p>Continued From page 115</p> <p>clinical record. The transfer summary was to be completed within 48 hours of transfer. The completed transfer summary would be sent to the receiving organization within 72 hours of transfer and the original would be filed in the patient clinical record. Additionally, the transferring clinician was to provide a verbal report to the receiving organization and this was to be documented in the clinical record.</p> <p>Upon request, the agency provided the surveyors with a copy of all non-death discharges. The list included revocations, discharges and transfers. A random selection of patient records who were transferred to another hospice agency were reviewed for documentation of required activities as detailed in the policy. The activities included documentation of physician notification, a discharge summary sent to the receiving agency, and the verbal report to the agency by the transferring clinician. The hospice did not provide transfer information to the accepting hospice agency or document verbal reports were given as follows:</p> <p>a. Patient #24 was an 89 year old male admitted on 9/28/12 for hospice care related to unspecified heart disease.</p> <p>A "Discharge-Transfer Summary Report," undated, indicated Patient #24 transferred to another hospice agency. His record included a "CHANGE OF HOSPICE PROVIDERS" form, dated 8/02/13.</p> <p>The discharge/transfer summary documented his SOC of 9/28/12 and a last visit date of 8/02/13.</p> <p>Patient #24's record did not include</p>	L 682			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 682	<p>Continued From page 116</p> <p>documentation that a verbal or written report was provided to the receiving organization as indicated in the agency policy.</p> <p>During an interview on 9/08/14 at 4:30 PM, the DON reviewed Patient #24's record and confirmed the record did not include documentation of a verbal report to the receiving agency.</p> <p>The hospice did not provide patient information to Patient #24's receiving agency.</p> <p>b. Patient #25 was a 90 year old female admitted to the agency on 3/10/14 for hospice care related to failure to thrive.</p> <p>A "Discharge-Transfer Summary Report," undated, indicated Patient #25 transferred to another hospice agency. The summary report noted her last hospice visit date was 5/22/14. However, her record included a "CHANGE OF HOSPICE PROVIDERS" form, signed and dated 5/16/14 and included a visit note report dated 5/13/14.</p> <p>During an interview on 9/08/14 at 4:00 PM, the DON reviewed Patient #25's record and stated the last visit was on 5/13/14. She was unable to provide documentation that a verbal or written report was provided to the receiving agency.</p> <p>Patient #25's record did not include documentation that a verbal or written report was provided to the receiving organization as indicated in the agency policy.</p> <p>3. Patient #19 was a 68 year old female admitted to the agency on 11/19/13 for hospice care</p>	L 682			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 682	<p>Continued From page 117 related to colon cancer.</p> <p>Her record included a "CHANGE OF HOSPICE PROVIDERS" form, signed and dated 4/14/14. A "Discharge-Transfer Summary Report," undated, indicated Patient #19 transferred to another hospice agency. Patient #19's record did not include documentation that a verbal or written report was provided to the accepting agency or to her physician.</p> <p>During an interview on 9/08/14 beginning at 4:20 PM, the DON reviewed Patient #19's record. She was unable to provide a copy of the discharge report that would have been provided to the accepting agency and to Patient #19's physician.</p> <p>Patient #19's record did not include documentation that a verbal or written report was provided to the receiving organization as indicated in the agency policy.</p> <p>4. Patient #18 was a 90 year old female admitted to the agency on 12/11/13 for hospice care related to senile dementia. A "Discharge-Transfer Summary Report," undated, documented Patient #18 was discharged to a hospital on 1/04/14, after a fall in which she broke her hip.</p> <p>The discharge/transfer summary that was provided did not have a date as to when it was prepared, and did not include the name of the individual who prepared the document. The summary indicated Patient #18's last visit date was 1/06/14, however, the summary also noted Patient #18 was admitted to a hospital on 1/04/14. The discharge/transfer summary also included information related to a home health admission from 9/05/13 to 9/22/13, with SN and</p>	L 682			

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

PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0301

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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 000 N LINDER RD MERIDIAN, ID 83042		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 682	<p>Continued From page 118 OT services.</p> <p>During an interview on 9/08/14 beginning at 4:40 PM, the DON reviewed Patient #18's record and confirmed the information in the discharge/transfer summary included home health information. She stated she was unsure why that information was populated into the report. The DON stated Patient #18 was not discharged, and not a revocation. She stated Patient #18 fractured her hip and required hospitalization and elected to receive Medicare Part A benefits for rehabilitation, so she was discharged. It was unclear to the surveyor if Patient #18 was discharged, transferred, or revoked her hospice benefit, as specific terminology was not used.</p> <p>The DON provided a "Client Coordination Note Report," dated 9/07/14, with the following statement: "Upon review of chart, it was identified that RN documented that "pt revoked to seek aggressive treatment." The note written by the DON also stated the patient and her family chose to go to a skilled rehabilitation facility for aggressive treatment. After their decision, Patient #18 was discharged to allow access to the Medicare Part A rehab days.</p> <p>Patient #18's record did not include evidence that a discharge/transfer report was sent to her attending physician or to the receiving facility at the time of her discharge.</p> <p>5. Patient #21 was a 67 year old female admitted to the agency on 5/15/13 for hospice care related to an autoimmune disorder affecting the nerve cells in the spinal cord and optic nerves. A "Discharge-Transfer Summary Report," undated,</p>	L 682			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 682	Continued From page 119 documented Patient #21 was transferred on 7/29/13 to a facility for aggressive treatment. A nursing visit note dated 10/22/13 at 10:27 AM, the RN documented Patient #21 had a blood pressure of 80/50, and she was in early active dying. The visit note included documentation that Patient #21 revoked services, contacted 911 to be transported to the hospital, and the RN gave a verbal report to the paramedics. The record did not include documentation the hospital was contacted to give report, or that a discharge/transfer summary was sent to the facility or to her attending physician. During an interview on 9/08/14 beginning at 5:10 PM, the DON reviewed Patient #21's record and confirmed she revoked her hospice benefit on 7/24/13 to pursue aggressive treatment, and a transfer summary was not provided. Patient #21's record did not include a transfer summary that represented Patient #21's hospice activities and current status at the time of the transfer. The hospice did not ensure that accepting agencies were provided with current, accurate information, both verbally and written, to facilitate a smooth transition when changing hospice providers.	L 682			
L 683	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-	L 683	683 418.104 (e) (2) Discharge or Transfer of Care		

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

PRINTED: 08/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 683	<p>Continued From page 120</p> <p>(i) The hospice discharge summary; and (ii) The patient's clinical record, if requested.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records, agency policies, and staff interview, it was determined the hospice failed to ensure that the attending physicians were provided a copy of the patient discharge summary for 8 of 8 patients (#15-18, and #20-23) who were discharged from the agency or who revoked their hospice benefit. This failure had the potential to result in an interruption in the provision of adequate patient care. Findings include:</p> <p>An agency policy titled "REVOCATION OF HOSPICE BENEFIT ELECTION," revised March 2014, that noted a revocation of election of hospice care statement must be signed and filed in the patient's clinical record. The policy also stated the record was to include documentation that a discharge summary was sent to the attending physician.</p> <p>An agency policy titled "DISCHARGE FROM HOSPICE PROGRAM," revised March 2014, noted that the Medical Director and/or the attending physician would determine the patient was not hospice appropriate. The IDG was to develop a discharge plan, which included counseling, education or other services prior to discharge. The NOMNC form and transfer or revocation form, and discharge summary was to be completed and placed in the record within 72 hours of discharge/revocation.</p> <p>Upon request, the agency provided surveyors with a copy of all non-death discharges. The list</p>	L 683	<p>Director of Nursing to provide education to office and clinical staff regarding discharge and transfer of care, including required documentation and review of Policy 2-068 Revocation of Hospice Benefit Election, 2-069 Change of Designated Hospice, 2-070 Transfer Information, 2-071 Discharge from Hospice Program, and 2-072 Discharge Summary. Agency to work with Electronic Medical Record IT Support Team to repair agencies electronic Discharge Summary to meet Conditions of Participation L682. Office staff to monitor that all required pieces of the discharge/transfer process are completed and on record.</p> <p>Ongoing, 10% of the average daily census will be audited on a quarterly basis. Indicators of 85% or less will require an action plan for corrections and findings will be reported to the PI committee and governing body on a quarterly basis.</p> <p>Responsible: Director of Nursing has ultimate responsibility for the</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 683	<p>Continued From page 121</p> <p>included revocations, discharges and transfers. A random selection of patient records who were discharged or revoked their hospice benefits were reviewed for documentation of required activities as detailed in each policy. The activities included documentation of physician notification and a discharge summary sent to the attending physician. Patient records did not include documentation that the policies were implemented as follows:</p> <p>a. Patient #22 was a 69 year old female admitted to the agency on 12/13/12 for hospice care related to liver cancer. A "Discharge-Transfer Summary Report," undated, documented Patient #22 was discharged to home or self care due to a move out of the agency service area. Her last visit date was noted as 3/05/13.</p> <p>The discharge/transfer summary that was provided did not have a date as to when it was prepared and did not include the name of the individual who prepared the document. The summary indicated Patient #22's last visit date was 3/05/13. However, the summary included interventions and goals as recent as 11/27/13.</p> <p>Patient #22's record did not include evidence that a discharge/transfer report was sent to her attending physician at the time of her discharge and there was no documentation of a physician order or a discharge plan.</p> <p>During an interview on 9/08/14, beginning at 4:35 PM, the DON reviewed Patient #22's record and confirmed the discharge/transfer summary included dates of activities 9 months after her discharge. The DON stated the discharge/transfer document was generated</p>	L 683	<p>corrective action for overall and ongoing completion.</p> <p>Completion: 10-15-14</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 683	<p>Continued From page 122</p> <p>when a discharge occurs in the EMR. She stated the information in the summary was pulled from multiple sources. She was unable to explain why the dates after the discharge appeared in the summary. She stated Patient #22 was admitted to the hospice agency multiple times. The DON reviewed the record and confirmed the following:</p> <ul style="list-style-type: none"> - Patient #22 was initially admitted to hospice on 12/13/12, and was discharged on 3/05/13. - Patient #22 was admitted to hospice 3/07/13, and revoked her hospice benefit on 7/05/13. The DON stated Patient #22 did not have the FTF as required by Medicare, she was discharged and readmitted. She stated it was a "desk discharge," and patient care was not interrupted. - Patient #22 was admitted to hospice on 7/06/13, and revoked on 11/18/13. The DON did not explain the circumstances related to the revocation. - The record indicated Patient #22 was again admitted to hospice on 11/21/13. <p>The agency was not able to provide further documentation related to the additional admissions and revocations for Patient #22 despite multiple requests.</p> <p>Patient #22's record did not include physician's orders for discharge, or discharge summaries that accurately represented her current status at the time of the discharges.</p> <p>b. Patient #18 was a 90 year old female admitted to the agency on 12/11/13 for hospice care related to senile dementia. A "Discharge-Transfer</p>	L 683			

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

PRINTED: 00/20/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 683	<p>Continued From page 123</p> <p>Summary Report," undated, documented Patient #18 was discharged to a hospital on 1/04/14, after a fall in which she broke her hip.</p> <p>The discharge/transfer summary that was provided did not have a date as to when it was prepared, and did not include the name of the individual who prepared the document. The summary indicated Patient #18's last visit date was 1/06/14. However, the summary also noted Patient #18 was admitted to a hospital on 1/04/14. The discharge/transfer summary also included information related to a home health admission from 9/05/13 to 9/22/13, with SN and OT services.</p> <p>During an interview on 9/08/14 beginning at 4:40 PM, the DON reviewed Patient #18's record and confirmed the information in the discharge/transfer summary included home health information. She stated she was unsure why that information was populated into the report. The DON stated Patient #18 was not discharged, and not a revocation. She stated Patient #18 fractured her hip and required hospitalization and elected to receive Medicare Part A benefits for rehabilitation, so she was discharged. It was unclear if Patient #18 was discharged, transferred, or revoked her hospice benefit, as specific terminology was not used.</p> <p>The DON provided a "Client Coordination Note Report," dated 9/07/14, with the following statement: "Upon review of chart, it was identified that RN documented that "pt revoked to seek aggressive treatment." The note written by the DON also stated the patient and her family chose to go to a skilled rehabilitation facility for aggressive treatment. After their decision,</p>	L 683			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 683	<p>Continued From page 124</p> <p>Patient #18 was discharged to allow access to the Medicare Part A rehabilitation days.</p> <p>Patient #18's record did not include evidence that a discharge report was sent to her attending physician at the time of her discharge.</p> <p>c. Patient #23 was a 78 year old male admitted to the agency on 4/01/13 for hospice care related to lung cancer. A "Discharge-Transfer Summary Report," undated, documented Patient #23 was discharged per client request on 12/04/13. A "REVOCATION OF ELECTION STATEMENT OF HOSPICE CARE," dated 12/04/13 included the reason for revocation as "seeking further curative treatment."</p> <p>The discharge/transfer summary that was provided did not have a date as to when it was prepared, and included documentation and goals as recent as 6/11/14.</p> <p>Patient #23's record did not include evidence that a discharge/transfer report was sent to his attending physician at the time of his revocation.</p> <p>During an interview on 9/08/14, beginning at 3:45 PM, the DON reviewed Patient #23's record and confirmed the discharge/transfer summary included dates of activities 6 months after his discharge. The DON stated the discharge/transfer document is generated when a discharge occurs in the EMR. She stated the information in the summary is pulled from multiple sources. She was unable to explain why the dates after the discharge appeared in the summary, she stated Patient #23 was admitted to the hospice agency multiple times. The DON reviewed the record and confirmed the following:</p>	L 683			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 683	<p>Continued From page 125</p> <ul style="list-style-type: none"> - Patient #23 was admitted to hospice services on 4/01/13, and revoked her benefits on 12/04/13. - She was admitted on 12/31/13, and revoked 3/11/14 to pursue aggressive treatment. - Patient #23 was admitted on 3/20/14, and presently still remains on hospice. <p>The agency was not able to provide further documentation related to the additional admissions and revocations for Patient #23 despite multiple requests.</p> <p>Patient #23's record did not include physician's orders for discharge or discharge summaries that accurately represented Patient #23's current status at the time of the discharges.</p> <p>d. Patient #21 was a 67 year old female admitted to the agency on 5/15/13 for hospice care related to an autoimmune disorder affecting the nerve cells in the spinal cord and optic nerves. A "Discharge-Transfer Summary Report," undated, documented Patient #21 was transferred on 7/29/13 to a facility for aggressive treatment. A "REVOCATION OF ELECTION STATEMENT OF HOSPICE CARE," was dated 10/22/13. Additionally, the summary included documentation of home health orders for wound care, therapy services and catheter care from 2/29/08 through 5/11/13.</p> <p>Additionally, the RN documented on a nursing visit note dated 10/22/13 at 10:27 AM, Patient #21 had a blood pressure of 80/60, and she was in early active dying. The visit note included documentation that Patient #21 revoked services,</p>	L 683			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 683	<p>Continued From page 126</p> <p>contacted 911 to be transported to the hospital, and the RN gave a verbal report to the paramedics. The record did not include documentation the hospital was contacted to give report, or to her attending physician.</p> <p>During an interview on 9/08/14 beginning at 5:10 PM, the DON reviewed Patient #21's record and confirmed the discharge/transfer summary that was provided to the surveyors indicated Patient #21 was discharged on 7/29/13. The DON was unable to explain why the summary included information from her home health visits before the election of hospice benefits occurred. The DON stated Patient #21 was admitted to the hospice multiple times. The DON reviewed the record and confirmed the following:</p> <ul style="list-style-type: none"> - Patient #21 was admitted on 5/15/13, and revoked her hospice benefit on 7/24/13 to pursue aggressive treatment. - Patient #21 was admitted to hospice on 7/29/13, and revoked her benefit on 10/22/13. - She was admitted on 10/25/13 and remained on hospice services until 12/12/13 when she expired. <p>The agency did not provide further documentation related to the additional admissions and revocations for Patient #21 despite multiple requests.</p> <p>Patient #21's record did not include physician's orders for discharge, or discharge summaries that accurately represented Patient #21's hospice activities and current status at the time of the discharges.</p>	L.683		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 683	<p>Continued From page 127</p> <p>e. Patient #16 was an 88 year old female admitted to the agency on 4/11/14 for hospice care related to CHF. A "Discharge-Transfer Summary Report," undated, documented Patient #16 was discharged on 7/14/14 due to no longer meeting hospice terminal illness criteria.</p> <p>On a form titled "Face to Face Encounter," dated 7/03/14, the hospice Medical Director wrote "...Cannot confirm that pt. [patient] is end-stage. Rec: [recommend] Discharge from hospice after arrangements complete, & pt's doctor will re-assume care."</p> <p>Patient #16's record included a form titled "Advance Beneficiary Notice of Noncoverage," dated 6/09/14. The form indicated Patient #16 and her guardian were informed that she no longer met criteria for hospice. The Guardian wrote on the form "Disagree, I am appealing your decision & getting [Patient #16] evaluated by another Hospice MD."</p> <p>Patient #16's record did not include documentation of discharge planning, a discharge order, or evidence that her physician would re-assume her care. Additionally, her record did not document if a discharge summary was provided to her accepting physician.</p> <p>During an interview on 9/08/14 beginning at 3:45 PM, the DON reviewed Patient #16's record and confirmed she was discharged on 7/14/14. Initially, the DON stated the FTF document, dated 7/03/14, served as an order of discharge from the hospice. However she confirmed it was a recommendation and not an order. The DON was not able to provide documentation of a discharge order, evidence of discharge planning</p>	L 683			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 683	<p>Continued From page 128</p> <p>with Patient #16 and her family/guardian, or that she had a physician that would assume her care. The DON confirmed that the record did not indicate a discharge summary was provided to her accepting physician.</p> <p>The hospice did not provide a discharge summary to the attending physician following Patient #16's revocation.</p> <p>f. Patient #17 was a 55 year old female admitted to the agency on 1/17/14 for hospice care related to chronic alrway obstruction. A "Discharge-Transfer Summary Report," undated, documented Patient #17 revoked her hospice benefit on 4/16/14 to pursue curative treatment.</p> <p>The discharge/transfer summary that was provided did not have a date as to when it was prepared, and did not include the name of the individual who prepared the document. The summary indicated Patient #17's last visit date was 4/16/14. However, a visit note on 4/16/14 from 8:05 PM to 8:10 PM indicated no visit was made to the patient. Additionally, the summary included interventions and goals as recent as 6/12/14. The summary also included 485 information and orders from 12/19/13 and 1/01/14 which was home health information and orders, not hospice related.</p> <p>The record included a document titled "Event-Stages History Report," that indicated Patient #17 revoked her hospice benefit on 4/16/14 and her primary physician was notified on 4/21/14, which was 5 days after the revocation. The agency policy specified the discharge/transfer form was to be completed within 72 hours.</p>	L 683		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 683	<p>Continued From page 129</p> <p>During an interview on 9/08/14 beginning at 3:55 PM, the DON reviewed Patient #17's record and confirmed the visit note was not an actual home visit to Patient #17 and she was not able to provide documentation when the last visit to Patient #17 occurred. The DON stated Patient #17 was admitted back on hospice services on 6/09/14, and was a current patient. She stated the home health information and the hospice information on the discharge summary did not provide accurate information regarding Patient #17's hospice cares that were provided. She stated it was a software issue and was not sure how the information appeared on the summary.</p> <p>The hospice did not provide a discharge summary to the attending physician following Patient #17's revocation.</p> <p>g. Patient #15 was an 85 year old female admitted to the hospice on 3/05/14 for hospice care related to pancreatic cancer.</p> <p>Her record included a "Discharge-Transfer Summary Report," undated, that documented Patient #15 revoked her hospice benefit on 3/17/14 to pursue curative treatment.</p> <p>The discharge/transfer summary did not have a date as to when it was prepared, and did not include the name of the individual who prepared the document. The summary indicated Patient #15's last visit date was 3/17/14. However, there were interventions and goals as recent as 4/13/14.</p> <p>Her record also included a "Discharge-Transfer Summary Report," undated, that documented</p>	L 683			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 683	<p>Continued From page 130</p> <p>Patient #15 was admitted to hospice on 4/11/14, and revoked her hospice benefit on 5/18/14 to move back to her country of origin.</p> <p>The discharge/transfer summary did not have a date as to when it was prepared and did not include the name of the individual who prepared the document. The summary included documentation of orders and interventions from her initial hospice admission 3/05/14, as well as her home health admission from 3/21/14 to 4/10/14.</p> <p>During an interview on 9/08/14 beginning at 4:10 PM, the DON reviewed Patient #15's record and confirmed the documentation was not clear and specific to her separate episodes of hospice. She was not able to provide documentation to indicate the discharge summary was sent to Patient #15's physician after revoking her hospice benefit on 3/17/14. She stated there was no need to send a discharge summary after the final revocation, as she was going out of country.</p> <p>The hospice did not provide a discharge summary to the attending physician following Patient #15's revocation.</p> <p>h. Patient #20 was a 73 year old female admitted to the agency on 10/18/13 for hospice care related to obstructive chronic bronchitis with acute exacerbation.</p> <p>Her record included a visit note report dated 2/09/14, that indicated no patient visit was made, and the note was "for data collection only." The note documented Patient #20 was discharged from the agency as the physician completed the FTF late.</p>	L 683			

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
L 683	Continued From page 131 In a visit note dated 2/11/14 at 11:07 AM, the SW documented she educated Patient #20 regarding the agency having to discharge her because the physician did not perform the FTF within the timeline required by Medicare. The SW documented it was explained to the patient that she will be readmitted to hospice once the physician completed the FTF visit. Two visit notes dated 2/19/14, one identified as the "RN Visit" at 11:38 AM, the other as a "Hospice RN Start of Care" at 10:37 PM, indicated Patient #20 was readmitted to hospice care. Copies of her signed consents were included in her record. Patient #20's record also included a visit note report dated 5/08/14, that indicated no patient visit was made and the note was "for data collection only." The note documented Patient #20 was discharged on 4/18/14 from the agency as the physician completed the FTF late. Her record did not include information that she was advised of her discharge related to a late FTF, as when she was informed by the social worker on 2/11/14. In a visit note report, dated 4/22/14, the RN indicated a start of care assessment was performed. Consents for hospice treatment were signed and dated 4/22/14. Patient #20's record did not include documentation of a discharge summary or other information to the attending physician to indicate she was discharged.	L 683		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 683	Continued From page 132 In an interview on 9/08/14 at 4:35 PM, the DON reviewed Patient #20's record and stated the physician did not complete the FTF as required by Medicare, so Patient #20 was discharged and readmitted. She confirmed this occurred on both 2/09/14 and 5/08/14 due to the FTF not being completed on time. The DON stated the patient was not affected by the "discharge," it was only on paper, and care was provided to her during the time between the "discharge" and the readmit on each occasion. She was not able to provide a policy related to what documents were required for a "desk discharge" related to delayed FTF. The hospice did not provide a discharge summary to the attending physician following Patient #20's discharges. The agency did not ensure their policy was followed after discharging patients for revocation and discharges.	L 683			
L 774	418.112(d)(1) HOSPICE PLAN OF CARE The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the hospice failed to ensure the hospice POCs for 1 of 2 patients (#10) who resided in a SNF and whose records were reviewed, identified which provider was responsible for performing the specific functions	L 774	L774 418.112 (d) (1) Hospice Plan of Care The agency will ensure that care and services are provided in accordance with the plan of care and that the provision of care to patients residing in facilities is clearly delineated. Instruction to be provided to staff with review of Policy 2-059.1 Provision of Care to Resident's of SNF/NF or ICF/MR, and 2-005 Hospice Nursing Care. Education to include the formulation of the collaborative Plan of Care, delineation of services to be provided		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 774	<p>Continued From page 133</p> <p>needed to care for those patients. This resulted in a lack of direction to hospice and SNF staff defining each party's roles in patient care. Findings include:</p> <p>Patient #10 was an 86 year old female admitted to the agency on 8/26/14, for services related to necrotizing fasciitis (a serious bacterial infection that spreads rapidly and destroys the body's soft tissue). She received SN, HA and MSW services. Her record, including the "HOSPICE CERTIFICATION AND PLAN OF CARE," for the certification period 8/26/14 to 11/23/14, was reviewed.</p> <p>Patient #10's "HOSPICE CERTIFICATION AND PLAN OF CARE," for the certification period 8/26/14 to 11/23/14, included an order for HA services 2 times a week for 9 weeks and stated, "Home Health Aide service for assistance with personal care and ADL's [Activities of Daily Living] secondary to functional limitations, which prevent self care. There is no willing or able caregiver to provide for hygiene needs."</p> <p>Patient #10's record included an "Aide Care Plan Report" for the certification period 8/26/14 to 11/23/14, completed and signed by the RN Case Manager. The Care Plan included instructions for the HA to bathe Patient #10 two times per week.</p> <p>Patient #10's record included 2 documents titled visit note report completed and signed by the HA on 8/29/14 and 9/02/14. The reports indicated bathing was not completed, with a note stating "not needed on this visit." The report dated 9/02/14 included a note in the narrative section stating, "We don't give shower, just visit, turn."</p>	L 774	<p>between the facility and the hospice using the Facility/Hospice Checklist, communication and coordination of care, documentation to support this, and creating the hospice aide plan of care for facility patients.</p> <p>The statement within the Electronic Medical Record Plan of Care Intervention "There is no willing or able caregiver to provide hygiene services" has been removed from the agency electronic medical record system.</p> <p>Director of Nursing or designee will review 100% of facility hospice patients for evidence of completion of the Facility/Hospice Checklist. Variances of less than 100% will require an action plan for correction with results provided to the QAPI Committee quarterly and then to the Governing Body on a quarterly basis.</p> <p>Ongoing, the Director of Nursing or designee will perform a record review of 10% average daily census on a quarterly basis. Indicators with less than 85% compliance will require an</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 774	Continued From page 134 During an interview on 9/08/14 at 12:45 PM, the DON reviewed Patient #10's record and stated the statement, "There is no willing or able caregive to provide for hygiene needs" was automatically populated on the "HOSPICE CERTIFICATION AND PLAN OF CARE" whenever an HA was ordered. The DON stated the HA did not bathe Patient #10 because the staff at the SNF where she lived provided baths. The DON confirmed the RN Case Managor did not communicate with the SNF staff at the SOC to determine who was responsible for providing bathing services to Patient #10. Patient #10's RN Case Manager did not communicate with the SNF staff to determine which provider was responsible for providing bathing services.	L 774	action plan. All clinical review findings will be reported to the QAPI committee and governing body on a quarterly basis. Responsible: Director of Nursing is responsible for the overall correction of this standard.		
L 795	418.114(d)(1) CRIMINAL BACKGROUND CHECKS The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records. This STANDARD is not met as evidenced by: Based on review of personnel records and interviews with staff, it was determined the hospice failed to ensure criminal background checks had been conducted for 7 of 7 physicians (Staff A - G) who had direct patient contact or access to patient records. This had the potential to allow persons with unknown criminal clearance	L 795	L795 418.114 (d) (1) Criminal Background Checks The Agency will ensure that all employees will have criminal background checks performed, cleared, and on file in the employee's personnel file. The HR department will audit employee's files per Policy 1-004.1 Selection and Hiring of Personnel to ensure that the background checks are completed and on file prior to the employee providing patient care or accessing		

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

PRINTED: 09/29/2014
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 _____ D. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 795	<p>Continued From page 135</p> <p>information access to patients and/or their confidential medical records. Findings include:</p> <p>Hospice personnel records were reviewed on 9/08/14 beginning at 8:15 AM. Each of the physicians records were missing evidence of criminal background checks as follows:</p> <p>Staff A - The agency's Primary Medical Director, whose hire date was 9/9/13,</p> <p>Staff B - A Medical Director, whose hire date could not be determined by the agency,</p> <p>Staff C - A Medical Director, who was hired on 6/16/14,</p> <p>Staff D - A Medical Director, who was hired on 1/20/12,</p> <p>Staff E - A Medical Director, who was hired on 9/1/14,</p> <p>Staff F - A Medical Director, whose hire date could not be determined by the agency,</p> <p>Staff G - A Medical Director, who was hired on 4/1/14.</p> <p>During an interview on 9/05/14 beginning at 3:00 PM, the Human Resource Assistant stated criminal background checks were not required for the Medical Directors, and therefore, had not been obtained.</p> <p>During an interview on 9/06/14 beginning at 11:30 AM, the Administrator confirmed the physicians' personnel records lacked criminal background checks. He stated the physicians provided direct</p>	L 795	<p>patient files. The HR department will utilize a tracking system to track current and future employees for the completion and clearance of background checks to meet the requirements of the Conditions of Participation.</p> <p>Ongoing, the Director of Nursing or designee will review 25% of all personnel educational records for completeness with personnel and educational audit tool, variances will be tracked and trended, and less than 95% compliance will be reported to the QAPI Committee and Governing Body quarterly.</p> <p>Responsible: Director of Nursing is responsible for the overall and ongoing correction.</p> <p>Completion: Review 10-15-14. Due to time constraints with scheduling through H&W and obtaining the cleared background checks, the agency will have the required background checks on file for the seven Medical Directors by 11-05-14.</p>		

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

PRINTED: 09/29/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
L 795	Continued From page 136 contact with patients and had access to all patient records. The hospice did not obtain criminal background checks on all hospice employees who had direct patient contact or access to patient records.	L 795			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

December 16, 2014

Trevor Higby, Administrator
Horizon Home Health & Hospice
1411 Falls Avenue East, Suite 615
Twin Falls, ID 83301

Provider #131520

Dear Mr. Higby:

On **September 10, 2014**, a complaint survey was conducted at Horizon Home Health & Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006476

Allegation #1: The agency did not ensure nursing and other disciplines provided patient visits as ordered by the physician and the plan of care.

Findings #1: An unannounced, on site complaint investigation was conducted from 9/02/14 to 9/10/14. Twenty five patient records were reviewed, facility policies were reviewed, and patient and staff interviews were conducted.

Both open and closed patient records were reviewed for nursing and other agency services completing home visits and patient care as ordered on the plan of care. The records contained evidence that the nursing, therapy, and social work staff provided patient visits as ordered by their physician and according to their plan of care.

However, one record included a social worker note that was described as a phone call and not a visit to the patient home. During an interview, the Social Worker stated many times she was able to speak with family members on the phone, and especially when dealing with multiple family members, she found it easier to meet with them on the phone rather than trying to schedule a face to face meeting. The social worker stated she would always meet with the patient and family for the first assessment visit in the patient's home.

Trevor Higby, Administrator
December 16, 2014
Page 2 of 3

During the six home visits that were conducted, patients and families verbalized satisfaction with the services that were provided, and there were no concerns regarding missed visits.

It could not be established that the agency did not provide visits as ordered by the physician and the plan of care. Therefore, the allegation was unsubstantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The agency did not ensure accurate initial skin assessments were completed.

Findings #2: An unannounced complaint investigation was conducted from 9/02/14 through 9/10/14. Twenty five records of current and discharged patients were reviewed for evidence of accuracy of wound and skin assessments, nursing notes, and care provided.

Twenty four of the twenty five records reviewed included accurate documentation of skin assessments. However, one patient record was that of a patient that was admitted to hospice services on 8/26/14 for services related to a terminal condition that involved a bacterial infection that spread rapidly. The nursing admission assessment identified the wound, but the documentation did not include location or size of the wound. The Registered Nurse did not include a description of the appearance of the wound. No measurements were performed at the time of the assessment.

During an interview on 9/08/14 at 4:30 PM, the Case Manager who completed the Start of Care assessment confirmed she did not measure the wound and she did not include a description of the wound. The agency failed to ensure that patient specific comprehensive assessments were completed that identified their unique patient needs.

The allegation that the nursing staff did not complete accurate assessments was substantiated, and a standard level deficiency was cited at 418.54(a) Initial Assessment.

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

Allegation #3: The agency accepted patients that did not have an available care giver resulting in the patients being required to self administer medication.

Findings #3: An unannounced complaint investigation was conducted from 9/02/14 to 9/10/14. Ten records of current patients that lived at home were reviewed for evidence of care giver availability for provision of care and administration of medications if needed.

Trevor Higby, Administrator
December 16, 2014
Page 3 of 3

During an interview on 9/04/14 beginning at 3:00 PM, the Director of Nursing (DON) discussed how the agency determined if a patient met hospice criteria. She stated when patients remained in their home, if they lived alone, a caregiver had to be identified, and confirm they would be able to provide for the needs of the patient around the clock. The DON stated if a patient did not have a care giver, they would not be safe and the agency could not admit them for services.

Additionally, the records of 10 current patients included documentation that each patient had a caregiver that was able and willing to administer medications if needed.

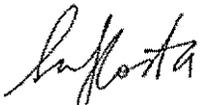
It could not be established that the agency accepted patients that did not have an available care giver to assist them with medication administration as needed. Therefore, the allegation was unsubstantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/pmt