



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0036  
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**CERTIFIED MAIL: 7007 3020 0001 4038 9758**

November 12, 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 follow-up visit at your facility, Horizon Home Health & Hospice, on October 23, 2014, by our staff, we have determined that your facility continues to be out of compliance with the Medicare Condition of Participation of **Quality Assessment & Performance Improvement (42 CFR 418.58)**.

The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Also enclosed is your copy of a Post-Certification Revisit Report (CMS-2567B), listing deficiencies that have been corrected.

In our letter to you dated September 29, 2014, we stated: "failure to correct the deficiencies and achieve compliance will result in our recommending that the Centers for Medicare and Medicaid Services (CMS) Region X Office, Seattle, Washington, terminate your approval to participate in the Medicare program."

Because of your failure to correct, we have made that recommendation. CMS will be in contact with you regarding the procedures, timelines, and appeal rights associated with this recommendation that must be followed.

Sincerely,

SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

CS/pmt  
Enclosures

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



Horizon Home Health & Hospice  
Trevor Higby, Administrator  
63 W. Willowbrook Dr.  
Meridian, ID 83646  
208-88-7877

November 25, 2014

RECEIVED  
NOV 25 2014  
FACILITY STANDARDS

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

**Re: CREDIBLE ALLEGATION OF COMPLIANCE/PLAN OF CORRECTION**

Dear Mr. Guiles,

Pursuant to the follow-up phone conversation which occurred on 11-25-14, please find attached the updated Statement of Deficiencies/Plan of Correction (CMS2567) with the alleged dates of compliance added to Tags L560, L562, L563, L565, L566, L567, L569, L570, L572, and L573.

Thank you for your assistance and kindness extended to us during this process.

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](mailto:amcorn@horizonhh.com).

Sincerely,

Amanda Corn RN  
Director of Nursing  
Horizon Home Health and Hospice

cc: files

*Delivering Life Changing Service*

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

Emmett  
(208) 365-1693

Boise/Meridian Hospice  
(208) 884-5051  
(208) 884-5054 Fax

Mountain Home  
(208) 587-6854

Butley  
(208) 678-8500  
(208) 678-8600 Fax

Twin Falls  
(208) 733-2840

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

Weiser  
(208) 549-2104

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

PRINTED: 11/12/2014  
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  R 10/23/2014
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NAME OF PROVIDER OR SUPPLIER  HORIZON HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 800 N LINDER RD MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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(L 000)	INITIAL COMMENTS  The following deficiencies were cited during the follow up survey of your hospice agency conducted from 10/21/14 through 10/23/14. Surveyors conducting the survey were:  Gary Gules, RN, HFS, Nancy Bax, RN, BSN, HFS Cheri Samuels, BSN, MSEd, RN, HFS  Acronyms used in this report include:  CC - Continuous Care DON - Director of Nursing F2F - Face-to-Face [Assessment] GIP - General Inpatient [Care] IV - Intravenous Med - Medication PIP - Performance Improvement Projects POC - Plan of Care QAPI - Quality Assurance Performance Improvement QI - Quality Improvement	(L 000)		
(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 identified unique patient needs for 1 of 3 active patients (Patient #2) who were admitted since	(L 522)	L522 - 418.54 (a) Initial Assessment:  Agency will ensure an initial assessment is completed for each patient admitted to service which is comprehensive and patient specific, 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.	

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**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Amanda Brown</i>	TITLE <i>Director of Nursing</i>	(X6) DATE <i>11-25-14</i>
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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 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(L 522)	<p>Continued From page 1</p> <p>10/15/14 and whose SOC assessments were reviewed. This resulted in the agency not having comprehensive information critical to ensure a patient received adequate care. Findings include:</p> <p>Patient #2 was an 87 year old male admitted to the agency on 10/16/14 with a diagnosis of cirrhosis of the liver. He received SN, HA, and MSW services. His record, including the SOC assessment and POC for the certification period 10/16/14 to 1/13/2015, was reviewed.</p> <p>Patient #2's record included a SOC visit note, dated 10/16/14 and signed by the RN Case Manager. The skin assessment section of the visit note stated he had 1 wound identified as a stage 1 pressure ulcer. The National Pressure Ulcer Advisory Panel defines a stage 1 pressure ulcer as intact skin with non-blanchable redness, usually over a bony prominence. A stage 1 ulcer does not typically require the application of a dressing as the skin is intact. The visit note did not indicate where the stage 1 pressure ulcer was located.</p> <p>The narrative section of the SOC visit note stated Patient #2 had a wound on his left stump which was healing and indicated he was going to a wound care clinic for care of the wound. However, the note did not indicate the type of wound, and did not include wound measurements or a description of the wound.</p> <p>Patient #2's record included a wound assessment tool, completed on 10/16/14, and signed by the RN Case Manager. It documented a left leg stump wound described as an old ulcer. The areas of the tool used to document the length, width and depth of the wound, presence of</p>	(L 522)	<p>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 obtaining and following of orders, assessment and documentation of wounds and wound care within the electronic documentation system.</p> <p>Responsible: Director of Nursing or designee will review 10% of initial admission assessments on a quarterly basis per previous plan of correction. 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>Completion: 11-26-14</p>		

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{L 522}	Continued From page 2 drainage, color of surrounding skin and indication of healing were blank.  During an interview on 10/23/14 at 11:55 AM, the DON reviewed Patient #2's record and confirmed the SOC assessment lacked information regarding the location of his stage 1 pressure ulcer and description and measurements of the wound on his left leg stump.  Patient #2's assessment at the SOC was not comprehensive to include details related to his wounds.	{L 522}			
{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.  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 written plan of care developed by the hospice interdisciplinary group in collaboration with the attending physician was followed for 3 of 10 patients (#2, #3 and #5) 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:  1. Patient #2 was an 87 year old male admitted to	{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, 2046.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 patient such as wound care, missed visit notifications, and updating the visit frequency when adding PRN visits to the schedule.		

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{L 543}	<p>Continued From page 3</p> <p>the agency on 10/16/14 with a diagnosis of cirrhosis of the liver. He received SN, HA, and MSW services. His record, including the POC for the certification period 10/16/14 to 1/13/15, was reviewed.</p> <p>Patient #2's POC for the certification period 10/16/14 to 1/13/15, included an order for wound care to his left stump wound to be completed 2 times per week. His record included 2 visit notes for Patient #2's first week of services, dated 10/16/14 and 10/17/14, and signed by the RN Case Manager. However, neither of the notes documented wound care was completed to his left stump wound.</p> <p>During an interview on 10/23/14 at 11:55 AM, the DON reviewed Patient #2's record and confirmed there was no documentation of wound care to his left stump wound.</p> <p>Patient #2 did not receive wound care as ordered in his POC.</p> <p>2. Patient #5 was a 77 year old female admitted to the agency on 8/18/12, with a diagnosis of Alzheimer's Disease. She received SN, HA, and MSW services. Her record, including the POC for the certification period 8/08/14 to 10/06/14, was reviewed.</p> <p>Patient #5's record included a physician's order, signed by the Medical Director on 10/02/14. The order included SN visits 2 times a week for 2 weeks, effective 10/07/14. However, Patient #5's record included only 1 SN visit for the week of 10/12/14 to 10/18/14, dated 10/16/14.</p> <p>During an interview on 10/23/14 at 11:50 AM, the</p>	{L 543}	<p>Responsible: Director of Nursing or designee will review 10% of assessments and Plans of Care on a quarterly basis per previous plan of correction. 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>Completion: 11-26-14</p>		

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(L 543)	Continued From page 4 DON reviewed Patient #5's record and confirmed 2 visits were ordered by the physician and only 1 visit was completed for the week of 10/12/14 to 10/18/14.  Patient #5 did not receive SN visits as ordered in her POC.  3. Patient #3's medical record documented an 88 year old male who was admitted for hospice services on 10/15/14 and was currently a patient as of 10/23/14. His terminal diagnosis was lung cancer.  A "Visit Note Report" by the RN, dated 10/20/14 at 2:23 PM, stated Patient #3 had signs of infection at a chest drain site as evidenced by increased redness and a small amount of yellow green drainage from the insertion site. The note stated the RN applied a thin layer of antibiotic ointment to the red areas around the the insertion site. Patient #3's medical record did not contain orders to treat the infection at the insertion site.  The RN who cared for Patient #3 was interviewed on 10/23/14 beginning at 10:00 AM. She confirmed there was no order to treat the infected area at Patient #3's drain insertion site.  Patient #3's care did not follow a written plan of care, including orders for all treatments performed.	(L 543)			
(L 553)	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	(L 553)	L553 418.56 (d) Review of the Plan of Care  Director of Nursing or designee will provide staff education on the content of the patient's plan of care and ongoing		

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{L 553}	<p>Continued From page 5 of care.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure plans of care were revised to meet the ongoing needs of the patient for 1 of 10 current patients (#8) whose records were reviewed. The failure to revise plans of care placed the patient at risk to have unmet needs. Findings include:</p> <p>Patient #8 was a 50 year old female admitted to the agency on 8/11/14 with a diagnosis of malignant neoplasm of the brain. She received SN, HA, and MSW services. Her record, including the POC for the certification period 8/11/14 to 11/08/14, was reviewed.</p> <p>Patient #8's record included a SN visit note dated 10/14/14, and signed by the RN Case Manager. The note included a pain assessment that utilized a numeric pain scale to assess pain, with zero indicating no pain, and 10 indicating the most severe pain. The visit note stated Patient #2's goal was to keep her pain at a level of 4 or below, and she rated her pain as a 5 during the SN visit. The visit note documented Patient #8 stated she had pain all of the time, and her worst pain level in the last 24 hours was 10.</p> <p>Patient #8's record included a SN visit note dated 10/16/14, and signed by the RN Case Manager. The visit note documented Patient #8 rated her pain as an 8 during the SN visit. Additionally, it stated she reported she had pain all of the time, and the worst pain level in the last 24 hours was 9.</p>	{L 553}	<p>updates to the plan of care. Each plan of care will be individualized with specific interventions and measurable goals to meet the overall needs of the patient. Staff instruction will include review of Policy 2-044 The Plan of Care and 2-032 Pain Assessment. Education will include assessment and follow-up of pain ratings, and notification to the physician when pain is above the patient's acceptable level. Each plan of care is to reflect new or changed goals specific to the individual patient as necessary to accurately reflect and meet the patient's needs.</p> <p>Director of Nursing or designee will review 10% of initial admission assessments/evaluations 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><b>Responsible:</b> Director of Nursing is responsible for the overall correction of this standard.</p> <p><b>Completion:</b> 11-26-14</p>		

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{L 563}	Continued From page 6 Patient #8's record did not include documentation to indicate her physician had been contacted regarding her severe pain, or that her POC had been updated to address severe pain.  During an interview on 10/23/14 at 11:40 AM, the DON reviewed Patient #8's record and confirmed her POC had not been updated to address her severe pain.  Patient #8's POC was not updated to include interventions and goals related to her severe level of pain.	{L 563}			
{L 559}	418.68 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT  This CONDITION is not met as evidenced by: Based on staff interviews and review of QAPI documents, adverse event documents, and agency policies, it was determined the Hospice failed to ensure a QAPI program was fully developed, implemented, and maintained. This resulted in the Hospice's inability to monitor services and improve the quality of patient care based on relevant data and actions taken. Findings include:  1. Refer to L560 as it relates to the Hospice's failure to develop, implement, and maintain an ongoing QAPI program.  2. Refer to L562 as it relates to Hospice's failure to ensure adverse events were monitored and quality indicator data was analyzed.	{L 559}	L559 418.58 Quality Assessment & Performance Improvement  The Quality Assessment and Performance Improvement plan 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 analyzing and monitoring of that data to evaluate patient outcomes and agency processes. Revisions to the QAPI program include: a reformatted QAPI plan that encompasses and clearly defines all elements required, created and implemented a PIP recommendation form to demonstrate the Governing Body oversight, improved the quarterly meeting template, adopted a new PIP template, adopted a definition for adverse events and		

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{L 559}	<p>Continued From page 7</p> <p>3. Refer to L563 as it relates to Hospice's failure to ensure the QAPI program included all relevant data.</p> <p>4. Refer to L565 as it relates to the Hospice'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 Hospice'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 Hospice's failure to ensure the QAPI program demonstrated consideration of incidence, prevalence, and severity of problems in the design of its program.</p> <p>7. Refer to L569 as it relates to the Hospice's failure to ensure adverse patient events were analyzed and preventative measures were implemented.</p> <p>8. Refer to L570 as it relates to the Hospice's failure to ensure performance improvement actions were taken in response to the analysis of quality indicator data.</p> <p>9. Refer to L572 as it relates to the Hospice's failure to ensure PIPs reflected the scope and complexity of the agencies services and operations.</p> <p>10. Refer to L573 as it relates to the Hospice's failure to ensure PIPs reflected measurable progress.</p> <p>11. Refer to L574 as it relates to the failure of the Governing Body to ensure that an ongoing,</p>	{L 559}		

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{L 559}	Continued From page 8 data-driven QAPI program identified certain measures that will scope of services and be monitored and clarified which was developed, implemented quality measures will be tracked, The cumulative effect of adopted three PIPs that demonstrate seriously impeded the measured improvement, created a assess, monitor, and improve tool to aggregate data to better services. analyze and created several tools to support a comprehensive QAPI program. The hospice must develop Agency to instruct QAPI committee on maintain an effective, of the QAPI Program, meet quarterly and data-driven quality assessment improvement program. quarterly review and findings to be The hospice's governing submitted to the Governing Board via the program: reflects the summary report for approval. Through organization and service monitoring and evaluating, the QAPI services (including those committee will determine whether or under contract or arrangement not the care/service delivered is in indicators related to improve outcomes; and takes action accordance with the predetermined improvement in hospice indicators of care/service as well as hospice must maintain the specific criteria identified. When its quality assessment at the care/service delivered does not improvement program demonstrate its operation match the pre-determined indicators/ specific criteria, the discrepancy will be identified as a problem and This STANDARD is not be determined. Based on review of QAPI methods of resolving the problem will review, and staff interviews be determined. Hospice failed to ensure Responsible: Director of Nursing has program was developed, ultimate responsibility for the maintained. This resulted corrective action for overall and Hospice to evaluate its performance significantly impeded the ongoing completion. improve care and service Completion: 11/20/14	{L 559}	<b>L560 418.58 Quality Assessment &amp; Performance Improvement</b>  Revisions to the QAPI program include: a reformatted QAPI plan that encompasses and clearly defines all elements required, created and implemented a PIP recommendation form to demonstrate the Governing Body oversight, improved the quarterly meeting template, adopted a new PIP template, adopted a definition for adverse events and identified certain measures that will be monitored and clarified which quality measures will be tracked, adopted three PIPs that demonstrate marked improvement, created a tool to aggregate data to better analyze and created several tools to support a comprehensive QAPI program. Agency to instruct QAPI committee on the QAPI Program, meet quarterly and quarterly review and findings to be submitted to the Governing Board via summary report for approval. Through monitoring and evaluating, the QAPI	
{L 560}				

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{L 560}	<p>Continued From page 9</p> <p>On 10/21/14 at 1:30 PM, the Administrator and the DON, who was also the QAPI Coordinator, were interviewed. The Administrator provided a blank document titled "Quality Assessment and Performance Improvement Meeting 2014," which was not dated. The Administrator indicated this was the QAPI Plan. This document stated the goal was an 85% compliance rate for the 18 areas below:</p> <p>Election Statement Initial certifications Initial POC Verbal/Supp Orders Recert Orders F2F Compliance Clinical record documentation accuracy Timely filing of clinical records Med reconciliation Pain/symptom management Wound care IV therapies Management of CC, GIP, and Respite Coordination of care Bereavement assessment, POC Volunteer POC Live Discharges Death Discharges</p> <p>On 10/23/14, starting at 1:30 PM, the Administrator and DON were interviewed. When asked, they unable to provide the reasons for the selection of the 18 areas (above) or how they reflected the complexity of the organization and services provided. The Administrator and DON could not define what the 18 areas meant, what the quality indicators were, how they would be evaluated, or how the data would be used to</p>	{L 560}	<p>committee will determine whether or not 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 pre-determined indicators/specific criteria, the discrepancy will be identified as a problem and methods of resolving the problem will be determined.</p> <p>The Quality Assessment and Improvement (QAPI) plan has been revised to follow the required elements of a QAPI plan as per COP interpretive guidelines for 418.58. The plan is structured in a manner that both clearly instructs the QAPI committee as well as ensures all COPs are met. The outline of the plan is;</p> <ul style="list-style-type: none"> <li>-1.0 Program objectives</li> <li>-2.0 Program Administration and Coordination             <ul style="list-style-type: none"> <li>-2.1 Governance and Leadership</li> <li>-2.2 Schedule</li> </ul> </li> <li>-3.0 Monitoring and Evaluating             <ul style="list-style-type: none"> <li>-3.1 Routinely monitored data</li> <li>-3.2 Priorities for resolution of problems</li> <li>-3.3 Monitoring to determine effectiveness of action</li> </ul> </li> </ul>		

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{L 560}	Continued From page 10 show measurable improvement. They stated they had not had a QAPI meeting. When requested, they could not produce documentation of aggregate quality indicator data or quality indicator data analyses. The Administrator and the DON could not provide information related to how the quality measures were incorporated into the Hospice's QAPI plan. Additionally, the Administrator and DON could not provide documented evidence that the 18 areas identified in the QAPI plan were approved by the Governing Body. There was no aggregated quality indicator data, no analyzed quality indicator data, and no PIP's reflective of the 18 areas.	{L 560}	-3.4 Performance Improvement Projects -4.0 QAPI Program Review  The PIP template now includes a section that explains the reason for the PIP. The newly adopted QAPI plan incorporates a table referred to as the "Indicator/Outcome Schedule" which specifies the detail and frequency of QAPI data collection for the quality indicators adopted by Horizon and approved by the Governing Body.		
{L 562}	The Hospice's quality documentation did not demonstrate that an effective, ongoing, hospice-wide data-driven QAPI program had been developed, implemented, and maintained. 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 adverse event and QAPI document review, and staff interviews, it was determined that the Hospice failed to ensure adverse events were monitored and data was analyzed for all patients receiving care from the Hospice. This resulted in a lack of information related to adverse events and impeded the Hospice's ability to ensure safety and identify ways to improve patient outcomes. Findings include:	{L 562}	The QAPI plan dictates data collection for; occurrences (falls), infections, complaints and medication errors because these areas have been deemed high risk, high volume and problem prone areas. The QAPI plan now includes a signature line of approval for the Governing Body.  Date of Completion: 11-20-14  L 562 418 (a) (2) Program Scope  The QAPI program has been revised to ensure the agency is reviewing and		

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{L 562}	Continued From page 11 On 10/22/14 at 1:30 PM, adverse event data was requested from the DON. The DON provided a "QI Event Summary" printed 10/22/14 at 1:57 PM. The document included "Individual QI Event Detail Reports" on 6 patient events. Two of 3 "Client Occurrence Reports" included events of 2 patient falls. One patient fall occurred 10/15/14, and the other occurred 10/17/14.  The Hospice policy titled, Leadership-Incident Reporting, dated 3/2014, stated "The Director of Nursing, Clinical Supervisor, or designee will review and complete and process the incident report form, request any necessary follow-up from appropriate personnel, and initiate incident report follow-up, as required. The incident reports will be monitored by the Performance Improvement Coordinator for analysis and tracking. The Performance Improvement Coordinator will review the incidents and conduct follow-up as required."  On 10/23/14 at 1:30 PM, during an interview with the DON, data and/or analyses of the falls was requested. The DON was interviewed again at 3:20 PM on 10/23/14. She stated an investigation of the falls had not been conducted. She also stated the agency had not conducted analyses of adverse patient events.  The Hospice did not measure or analyze adverse events to prevent future occurrences.	{L 562}	monitoring adverse events (as defined in the QAPI plan in section 3.3). Additionally, all quality indicator data obtained from the clinical audits are analyzed for all patients receiving care and to establish the agency's ability to improve patient outcomes.  Date of Completion: 11-20-14		
{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}			

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{L 563}	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on QAPI document review, policy review, and staff interviews, it was determined the Hospice failed to ensure the QAPI program used quality indicator data. This resulted in missed opportunities to improve patient care and services. Findings include:</p> <p>The Hospice policy "Improving Organizational Performance" revised 3/2014, and updated 9/24/14, 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 Administrator and DON provided numerous documents that were incongruent in determining which specific quality indicators had been monitored. These included:</p> <ul style="list-style-type: none"> <li>- The Minutes of the Governing Body, dated April 22, 2014, indicated the Hospice would focus on: Pharmacy management Hospice formulary Managing PPD costs Compliance with Medicare Part D Patient diagnoses Correct diagnoses"</li> <li>- The policy titled "Leadership - Prioritization of Important Processes Routine Measurement of Indicators," dated 3/2014 and updated 9/24/14, listed 85 areas; but did not state which the Hospice would monitor.</li> <li>- A document titled "Quality Assessment and</li> </ul>	{L 563}	<p><b>L 563 418 (b) (1) Program Data</b></p> <p>Agency will utilize the data collected within the agency's EMR that is produced on certain reports. Quality data will be monitored in the following domains:</p> <ul style="list-style-type: none"> <li>-Referral statistics</li> <li>-Census Statistics</li> <li>-Finance and Development</li> <li>-Revenue and Costs per patient day</li> <li>-infections</li> <li>-Falls</li> <li>-Medication Safety</li> </ul> <p>Date of Completion: 11-20-14</p>		

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{L 563}	<p>Continued From page 13</p> <p>Performance Improvement Meeting 2014, Vesper Hospice" documented 7 patient fall areas to be monitored.</p> <p>- A document titled "Quality Assessment and Performance Improvement Meeting 2014," not dated, identified the following 18 areas as part of the QAPI program:</p> <ul style="list-style-type: none"> <li>Election Statement</li> <li>Initial certifications</li> <li>Initial POC</li> <li>Verbal/Supp Orders</li> <li>Recert Orders</li> <li>F2F Compliance</li> <li>Clinical record documentation accuracy</li> <li>Timely filing of clinical records</li> <li>Med reconciliation</li> <li>Pain/symptom management</li> <li>Wound care</li> <li>IV therapies</li> <li>Management of CC, GIP, and Respite</li> <li>Coordination of care</li> <li>Bereavement assessment, POC</li> <li>Volunteer POC</li> <li>Live Discharges</li> <li>Death Discharges</li> </ul> <p>The document did not mention quality indicator data or how such data would be gathered or used. No documents described quality indicator data.</p> <p>On 10/22/14 at 1:30 PM, the Administrator and DON were asked for documentation describing how quality indicator data would be gathered and used. The DON stated she did not have documentation as to how quality indicator data would be gathered and used. She stated the</p>	{L 563}			

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(L 563)	Continued From page 14 agency was currently conducting chart audits to gather data to design its program but this had not happened yet.	(L 563)			
(L 565)	The Hospice had not used quality indicator data in its QAPI program design. 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 review of QAPI documents, policy review, and staff interviews, 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 for implementation of a QAPI plan without appropriate oversight and input of the Governing Body. Findings include:  The policy "Governing Body" revised 3/2014, stated the "Relevant findings of performance improvement activities are consistently provided to the Governing Body." A policy stating the frequency and detail of the data collection would be approved by the hospice's governing body was not present.  On 10/22/14 at 1:30 PM, the Administrator and DON were interviewed. They both stated a QAPI plan that described the frequency and detail of data collection had not been developed.  The Governing Body did not approve the frequency and detail of the agency's QAPI	(L-565)	<b>L 565 418.58 (b) (3) Program Data</b>  The newly adopted QAPI plan incorporates a table referred to as the "Indicator/Outcome Schedule" which specifies the detail and frequency of QAPI data collection for the quality indicators adopted by Horizon and approved by the Governing Body.  Date of Completion: 11-20-14		

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{L 566}	Continued From page 15 program.	{L 566}			
{L 566}	<p>418.58(c)(1)(i) PROGRAM ACTIVITIES</p> <p>(1) The hospice's performance improvement activities must:</p> <p>(i) Focus on high risk, high volume, or problem-prone areas.</p> <p>This STANDARD is not met as evidenced by: Based on review of QAPI documents, policy review, and staff interviews, it was determined the hospice failed to ensure its QAPI program focused on high-risk, high volume, or problem prone areas. This resulted in the potential for adverse patient events to continue to occur without intervention to prevent future occurrences. Findings include:</p> <p>The hospice policy "Improving Organizational Performance" revised 3/2014 stated under "Procedures" that the hospice would "Adopt a scientific, problem-solving, data driven approach to quality assessment and performance improvement (QAPI). The scientific, problem-solving approach will include minimally: 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>On 10/22/14 starting at 1:30 PM, the Administrator and DON were interviewed. The Administrator stated the "Quality Assessment and Performance Improvement Meeting 2014", with 18 areas identified, was the agency's QAPI Plan.</p>	{L 566}	<p><b>L 566 418(c) (1) (i) Program Activities</b></p> <p>Agency will monitor the data that has been deemed as high risk, high volume and problem prone on the prescribed routine set within the QAPI plan. Agency will utilize the Clinical Audit tool provided to perform clinical audits/established clinical indicators for accuracy for the following which are high risk, high volume and may be problem prone areas and CMS mandatory reporting items. Agency collection of data will be a scientific, problem solving, data driven approach to quality assessment and performance.</p> <p>Election statement and consent form Initial Certifications for terminal illness Initial Plan of care Verbal/Supplemental orders Recertification Face to Face Clinical Record Documentation Timely Filing Medication reconciliation Pain/symptom management Wound Care</p>		

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{L 566}	Continued From page 16  The 18 areas on the "Quality Assessment and Performance Improvement Meeting 2014" form, not dated, were documented as:  Election Statement Initial certifications Initial POC Verbal/Supp Orders Recert Orders F2F Compliance Clinical record documentation accuracy Timely filing of clinical records Med reconciliation Pain/symptom management Wound care IV therapies Management of CC, GIP, and Respite Coordination of care Bereavement assessment, POC Volunteer POC Live Discharges Death Discharges  During the same interview on 10/22/14 starting at 1:30 PM, the Administrator and DON both stated, there was no documentation that specified what the high risk, high volume, problem-prone areas of the agency were. The DON stated she did not know which of the above 18 areas were high risk, high volume, problem-prone areas.  The agency could not demonstrate its QAPI plan incorporated high risk, high volume, or problem-prone areas.	{L 566}	IV therapy Professional Management - Continuous Care, Respite Care, GIP Coordination of Care Disciplines: MSW, Chaplain, HHA, Therapy (PT/OT/Speech) -- assessments/interventions/goals Bereavement Services - bereavement assessment -- plan of care Volunteer Services -- Plan of care Discharges: Live discharge/revocation EDN ABN Death discharge Disposal of medications  Clinical record review for the agency will be 10% of the average daily census or for a census less than 100 the agency will review 10 clinical records; 5 active and 5 discharges. Reviews will be performed by the Director of Nursing or designee each quarter, utilizing the clinical audit tool with indicators identified. Final review of all clinical records -- the indicators meet an 85% compliance rate. Indicators less than 85% will be placed on an action plan for correction to be written, presented to the QAPI committee quarterly. Corrective action will be implemented/documentated. The	
{L 567}	418.58(c)(1)(II) PROGRAM ACTIVITIES  (The hospice's performance improvement	{L 567}		

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{L 567}	Continued From page 17 activities must:] (ii) Consider incidence, prevalence, and severity of problems in those areas.  This STANDARD is not met as evidenced by: Based on review of QAPI documents, policy review, and staff interviews, it was determined the Hospice failed to ensure its QAPI program demonstrated consideration of incidence, prevalence, and severity of problems in the design of its program. This resulted in the potential for missed opportunities for performance improvement in areas most likely to affect patient outcomes. Findings include:  The Hospice policy "Improving Organizational Performance" revised 3/2014, stated under "Procedures" that the Hospice would "Adopt a scientific, problem-solving, data driven approach to quality assessment and performance improvement (QAPI). The scientific, problem-solving approach will include minimally: 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..."  On 10/22/14, during an interview starting at 1:30 PM, the Administrator and DON provided an undated document titled "Quality Assessment and Performance Improvement Meeting 2014." The document stated the goal was an "85% compliance rate" using an "Internal Audit Tool" for the following 18 areas:  Election Statement Initial certifications	{L 567}	agency will continue to audit the specific indicator until 85% compliance is achieved.  Date of Completion: 11-20-14:  L 567 418.58 (c) (1) (ii) Program Activities  Agency will monitor the data that has been deemed as high risk, high volume and problem prone on the prescribed routine set within the QAPI plan. Agency will utilize the Clinical Audit tool provided to perform clinical audits/established clinical indicators for accuracy for the following which are high risk, high volume and may be problem prone areas and CMS mandatory reporting items. Agency collection of data will be a scientific, problem solving, data driven approach to quality assessment and performance. Election statement and consent form Initial Certifications for terminal illness Initial Plan of care		

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{L 567}	Continued From page 18 Initial POC Verbal/Supp Orders Recert Orders F2F Compliance Clinical record documentation accuracy Timely filing of clinical records Med reconciliation Pain/symptom management Wound care IV therapies Management of CC, GIP, and Respite Coordination of care Bereavement assessment, POC Volunteer POC Live Discharges Death Discharges  The document did not describe what the 18 areas (listed above) meant or state the reason each was selected.  During the interview on 10/22/14 starting at 1:30 PM, the Administrator and DON were asked to identify the reasons the 18 areas were selected, what selection criteria was considered, and how an 85% compliance rate was determined acceptable for all areas, especially for areas such as IV therapy. The DON stated the chart audits were to determine areas to be monitored by the QAPI program but she said data had not been gathered and analyzed that would provide information on the prevalence and severity of problems.  The agency's QAPI plan did not take into consideration incidence, prevalence, and severity of problems.	{L 567}	Verbal/Supplemental orders Recertification Face to Face Clinical Record Documentation Timely Filing Medication reconciliation Pain/symptom management Wound Care IV therapy Professional Management - Continuous Care, Respite Care, GIP Coordination of Care Disciplines: MSW, Chaplain, HHA, Therapy (PT/OT/Speech) -- assessments/interventions/goals Bereavement Services - bereavement assessment -- plan of care Volunteer Services -- Plan of care Discharges: Live discharge/revocation EDN ABN Death discharge Disposal of medications  Clinical record review for the agency will be 10% of the average daily census or for a census less than 100 the agency will review 10 clinical records; 5 active and 5 discharges. Reviews will be performed by the Director of Nursing or designee each	
{L 569}	418.58(c)(2) PROGRAM ACTIVITIES	{L 569}		

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{L 569}	<p>Continued From page 19</p> <p>(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.</p> <p>This STANDARD is not met as evidenced by: Based on adverse event document review, policy review, and staff interviews, it was determined the Hospice failed to ensure adverse patient events were analyzed and preventative measures were implemented. This directly impacted 2 of 2 patients (Patients #11 &amp; #12) who experienced falls and whose Client Occurrence Reports were reviewed. This resulted in patients experiencing falls without evidence of investigation and preventive actions. Findings include:</p> <p>The Hospice policy titled Leadership, Incident Reporting dated 3/2014, stated "The Director of Nursing, Clinical Supervisor, or designee will review and complete and process the incident report form, request any necessary follow-up from appropriate personnel, and initiate incident report follow-up, as required. The incident reports will be monitored by the Performance Improvement Coordinator for analysis and tracking. The Performance Improvement Coordinator will review the incidents and conduct follow-up as required." This policy was not followed as evidenced by:</p> <p>Adverse event data was requested and the DON provided a document, "QI Event Summary" printed 10/22/14 at 1:57 PM which included "Individual QI Event Detail Reports" for 6 patients. Included with the "Individual QI Event Detail Reports" were "Client Occurrence Report" forms.</p>	{L 569}	<p>quarter, utilizing the clinical audit tool with indicators identified. Final review of all clinical records – the indicators meet an 85% compliance rate. Indicators less than 85% will be placed on an action plan for correction to be written, presented to the QAPI committee quarterly. Corrective action will be implemented/documented. The agency will continue to audit the specific indicator until 85% compliance is achieved.</p> <p>Date of Completion: 11-20-14</p> <p><b>L 569 418.58(c) (2) Program Activities</b></p> <p>Director of Nursing or designee will complete a 100% review of all occurrence/infection and complaints reported on a (workday) daily basis, investigate, follow through with resolution if deemed necessary, document on occurrence within a written log, track and trend quarterly through the QAPI program and report quarterly findings, completes action plans and submits to the QAPI committee quarterly.</p> <p>Date of Completion: 11-20-14</p>	
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{L 569}	<p>Continued From page 20</p> <p>Two "Client Occurrence Report" forms documented patients (Patient #11 &amp; #12) had experienced falls.</p> <p>Patient #12's fall occurred 10/15/14. The "Client Occurrence Report" form stated staff at Patient #12's place of residence reported Patient #12 fell from bed and the fall was unwitnessed and the cause unclear. It stated the cause was likely due to Patient #12's restlessness throughout the night.</p> <p>Patient #11's fall occurred 10/17/14. The "Client Occurrence Report" form documented the patient's son found her on the floor. Additionally, it stated she had apparently tried to transfer from her scooter to her bed and sustained a skin tear to her left lower extremity. The patient's son had put her in her scooter and wrapped a towel around her leg. The form also documented the hospice aide and nurse washed the patient and provided incontinence care and the wound was dressed with absorbent dressing as it was seeping serous fluid.</p> <p>Each of the "Client Occurrence Report" forms included areas to document physician notification and response, follow-up comments, and occurrence updates. These sections were not completed on Patient #11's and Patient #12's "Client Occurrence Report" forms. The forms did not include documentation of further investigation, analysis, and actions.</p> <p>On 10/23/14 at 1:30 PM, the DON was interviewed. She stated documentation of an action taken or follow-up investigation to the falls was not present. She also stated adverse events were not tracked by the QAPI program.</p>	{L 569}			

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{L 569}	Continued From page 21	{L 569}			
{L 570}	<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 review of QAPI documents and agency policies and staff interviews, it was determined the Hospice failed to ensure performance improvement actions were taken. This resulted in missed opportunities to improve patient care and services. Findings include:</p> <p>The Hospice policy "Improving Organizational Performance" revised 3/2014 and updated 9/24/14 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 Leadership policy "Sample QAPI Plan," revised 3/2014, and updated 9/24/14, stated the "Purpose" was "To conduct Performance Improvement Projects aimed at performance improvement and to track performance to ensure that it is sustained."</p> <p>The above two policies were not followed as</p>	{L 570}	<p><b>L 570 418.58(c) (3) Program Activities</b></p> <p>The Quality Assessment and Performance Improvement plan 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 analyzing and monitoring of that data to evaluate patient outcomes and agency processes.</p> <p><b>Date of Completion: 11-20-14</b></p>		

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{L 570}	Continued From page 22 evidenced by:  QAPI documents provided by the Administrator and DON were reviewed. Evidence of the initiation, monitoring, and tracking of identified quality improvement activities was not found in the QAPI documents.  Interviews were completed with the Administrator and DON on 10/21/14 at 11:30 AM, 10/22/14 at 1:30 PM, and 10/23/14 at 1:30 PM. During each of the interviews the Administrator and DON were asked to provide documented evidence of actions taken to improve quality, and subsequent monitoring and tracking of performance to ensure improvement was sustained. No evidence was provided. On 10/23/14 at 1:30 PM, the DON stated the agency was developing its plan and no actions had yet been taken to improve performance.	{L 570}			
{L 572}	The agency had not taken actions aimed at performance improvement. <b>418.58(d)(1) PERFORMANCE IMPROVEMENT PROJECTS</b>  (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 review of QAPI documents, policy review, and staff interviews, it was determined the	{L 572}	<b>L572 418.58(d) (1) Performance Improvement Projects</b>  The QAPI Committee will implement PIP topics indicated by data analysis. PIPs are implemented in accordance with CMS' protocol for conducting PIPs. Implementation of new PIPs or any significant changes proposed to existing PIPs will be subject to approval by a delegated representative, the Administrator. If the QAPI committee recommends a new PIP they will use the PIP recommendation form. PIPs have been selected in accordance with CMS guidelines, documented,		

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{L 572}	Continued From page 23 Hospice failed to conduct PIP's consistent with the needs of the agency. This resulted in the Hospice's inability to improve patient outcomes or services through its QAPI program. The findings include:  QAPI documents provided by the Administrator and DON were reviewed. Evidence of PIP's was not found in the QAPI documents.  PIP's were requested during interviews with the Hospice Administrator and DON on 10/21/14 at 11:30 AM, 10/22/14 at 1:30 PM, and 10/23/14 at 1:30 PM. On 10/23/14 at 1:30 PM, the DON stated the agency was developing its QAPI plan and had not yet implemented PIPs.  The Leadership policy "Sample QAPI Plan" revised 3/2014 and updated 9/24/14 stated the "Purpose" was "To conduct Performance Improvement Projects aimed at performance improvement and to track performance to ensure that it is sustained." This policy was not followed.	{L 572}	Implemented and show a measured improvement.  Date of Completion: 11-20-14	
{L 573}	PIP's were not conducted by the agency. <b>418.58(d)(2) PERFORMANCE IMPROVEMENT PROJECTS</b>  (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 review of QAPI documents, policy review, and staff interviews, it was determined the Hospice failed to ensure PIP's were initiated, the	{L 573}	<b>L 573 518.58(d) (2) Performance Improvement Projects</b>  The QAPI Committee will implement PIP topics indicated by data analysis. PIPs are implemented in accordance with CMS' protocol for conducting PIPs. Implementation of new PIPs or any significant changes proposed to existing PIPs will be subject to approval by a delegated representative, the Administrator. If the QAPI committee recommends a new PIP they will use the PIP recommendation form. PIPs have	

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NAME OF PROVIDER OR SUPPLIER  HORIZON HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N LINDER RD MERIDIAN, ID 83842		
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{L 573}	Continued From page 24 reasons for the PIP's specified, and measurable improvement documented. This resulted in the inability of the Hospice to measure and monitor the effectiveness of services. Findings include:  QAPI documents provided by the Administrator and DON were reviewed. Documentation that PIP's had been conducted was not present.  PIP's were requested during interviews with the Administrator and DON on 10/21/14 at 11:30 AM, 10/22/14 at 1:30 PM, and 10/23/14 at 1:30 PM. On 10/23/14 at 1:30 PM, the DON stated the agency was developing its QAPI plan and had not yet implemented PIPs.  The Leadership policy "Sample QAPI Plan" revised 3/2014 and updated 9/24/14 stated the "Purpose" was "To conduct Performance Improvement Projects aimed at performance improvement and to track performance to ensure that it is sustained." This policy was not followed.	{L 573}	been selected in accordance with CMS guidelines, documented, implemented and show a measured improvement.  Date of Completion: 11-20-14		
{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 QAPI document review, policy review, and staff interviews, it was determined the	{L 574}	<b>L 574 418.58(e)(1) Executive Responsibilities</b>  Resources will be made available to employees to assist them in gaining a basic understanding of QAPI principles. In-services will be held periodically to reinforce the knowledge base. Each employee is responsible for the quality of care and services provided. The following summary of responsibilities provides a framework for the process of quality assessment and performance improvement. As per interpretive guideline 418.58(b)(3) "...or it may		

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{L 574}	<p>Continued From page 25</p> <p>Governing Body failed to ensure the Hospice's QAPI program was developed and implemented. This resulted in a lack of direction and oversight of the QAPI program. Findings include:</p> <p>During a recertification survey of the agency, completed 9/10/14, a determination was made that the agency's QAPI program had not been developed, implemented, and maintained. A subsequent CMS Statement of Deficiencies was issued to the agency, showing noncompliance with the Condition of Participation of QAPI.</p> <p>An interview with the Administrator was conducted on 10/21/14 beginning at 11:25 AM. He stated a formal meeting of the governing body had not occurred since the Condition of Participation of QAPI had been found out of compliance. He stated the Governing Body had discussed the deficiencies and approved an audit tool for patient medical records in order to develop a QAPI plan. He stated there were no minutes of this. He stated a formal meeting to approve a QAPI plan had not been held and was not scheduled until the first week in November. He stated there was no documentation that the Governing Body had participated in the agency's QAPI program.</p>	{L 574}	<p><i>choose to appoint one or more individuals to handle the structure and administration of the QAPI program."</i></p> <p>As such, the governing body appoints the Administrator to oversee the structure and administration. The Administrator appoints the DON to serve also as the QAPI Coordinator.</p> <p>Responsible: Executive Director and Director of Nursing have ultimate responsibility for the corrective action for overall and ongoing completion of this standard.</p> <p>Completion:11/20/14</p>		
{L 626}	<p>The Governing Body failed to ensure a QAPI program had been developed and implemented.</p> <p>418.76(g)(1) HOSPICE AIDE ASSIGNMENTS 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</p>	{L 626}			

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{L 574}	Continued From page 25 Governing Body failed to ensure the Hospice's QAPI program was developed and implemented. This resulted in a lack of direction and oversight of the QAPI program. Findings include:  During a recertification survey of the agency, completed 9/10/14, a determination was made that the agency's QAPI program had not been developed, implemented, and maintained. A subsequent CMS Statement of Deficiencies was issued to the agency, showing noncompliance with the Condition of Participation of QAPI.  An interview with the Administrator was conducted on 10/21/14 beginning at 11:25 AM. He stated a formal meeting of the governing body had not occurred since the Condition of Participation of QAPI had been found out of compliance. He stated the Governing Body had discussed the deficiencies and approved an audit tool for patient medical records in order to develop a QAPI plan. He stated there were no minutes of this. He stated a formal meeting to approve a QAPI plan had not been held and was not scheduled until the first week in November. He stated there was no documentation that the Governing Body had participated in the agency's QAPI program.	{L 574}			
{L 625}	The Governing Body failed to ensure a QAPI program had been developed and implemented. 418.76(g)(1) HOSPICE AIDE ASSIGNMENTS AND DUTIES  (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	{L 625}	L625 418.76 (g ) (1) Hospice Aide Assignments and Duties  Director of Nursing or designee will in-service the RNs of how to formulate the Hospice Aide Plan of Care, including the handout: Job Aide: Hospice Aide Plan of Care, along with RN coordination of		

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(L 625)	<p>Continued From page 26</p> <p>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, observation, and staff interview, it was determined that the written patient care instructions for the hospice aide prepared by an RN were incomplete for 2 of 10 patients (#7 and #8) whose hospice aide care plans were reviewed. As a result, the hospice aide plans of care did not accurately reflect patients' needs and conditions. This had the potential to interfere with quality, completeness, and coordination of patient care. Findings include:</p> <p>1. Patient #7 was a 90 year old female admitted to the agency on 5/31/13, with a diagnosis of Alzheimer's Disease. She received SN, HA, and MSW services. Her record, including the POC for the certification period 9/23/14 to 11/21/14, was reviewed.</p> <p>Patient #7's POC indicated she was to receive HA visits 3 times a week. Her record included an Aide Care Plan, with an effective date of 10/16/14. The care plan indicated she should be weighed once a week by the aide.</p> <p>Patient #7's record included 3 HA visit notes for the week of 10/12/14 to 10/18/14, dated 10/14/14, 10/15/14 and 10/17/14, and signed by the HA. Patient #7's weight was not recorded on the 3 notes, and each noted stated, "Not needed on this visit."</p> <p>During an interview on 10/23/14 at 1:40 PM, the DON reviewed Patient #7's record and stated he</p>	(L 625)	<p>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 on a quarterly basis, 10% of Hospice aide plans of care, reviewing the plans for accuracy and instructions or tasks assigned are not outside the scope of practice for the Hospice aide. Variances indicated will be immediately corrected and communicated directly to the Hospice aide until 100% compliance is demonstrated. Indicators of less than 85% will require an action plan. Findings will be reported to the QAPI committee and governing body quarterly.</p> <p>Responsible: Director of Nursing has ultimate responsibility for the corrective action for overall and ongoing completion of this standard</p> <p>Completion: 11-26-14</p>	
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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 025}	<p>Continued From page 27</p> <p>was not steady enough to safely stand on a scale. She stated the RN Case Manager was no longer using weights to monitor his nutrition level and the HA care plan should have been updated to indicate this change in his POC. The DON confirmed the HA care plan was not accurate to reflect his current needs.</p> <p>Patient #7's HA care plan was not updated by the RN Case Manager to include accurate instructions for the HA.</p> <p>2. Patient #8 was a 50 year old female admitted to the agency on 8/11/14 with a diagnosis of malignant neoplasm of the brain. She received SN, HA, and MSW services. Her record, including the POC for the certification period 8/11/14 to 11/08/14, was reviewed.</p> <p>Patient #8's record included an Aide Care Plan, with an effective date of 10/02/14. The care plan indicated the HA should make 1 visit per week, to provide the following tasks: bathing, dressing, hair care, nail care, oral care, medication reminders, shampoo, skin care, offer fluids, prepare snack, and clean patient's room and bathroom.</p> <p>Patient #8's record included HA visit notes, dated 10/03/14 and 10/08/14, and signed by the HA. The visit note dated 10/03/14, documented all assigned tasks were not completed, and indicated either they were not needed, or refused. The visit note dated 10/08/14, documented a medication reminder was completed, however, all other assigned tasks were not completed, and indicated either they were not needed, or refused. Patient #8's record also included a missed visit notification, dated 10/15/14, and signed by the</p>	{L 025}		

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

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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  R 10/23/2014
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 28</p> <p>HA. It did not indicate the reason for the missed visit.</p> <p>Patient #8's record included an HA supervisory visit, dated 10/18/14, and signed by the RN Case Manager. It documented the HA followed the plan of care, and had the ability to perform the assigned tasks. Additionally, it documented the HA services met Patient #8's needs and no changes to the HA care plan were necessary. The supervisory visit note did not indicate the HA had not provided the assigned tasks to Patient #8.</p> <p>During an interview on 10/22/14 at 1:30 PM, the HA stated Patient #8 and/or her family had declined all services on her first 2 visits, and had refused a visit on 10/15/14. The HA stated she informed the RN Case Manager of the refusals.</p> <p>During an interview on 10/22/14 at 1:40 PM, the RN Branch Manager stated the decision was made to introduce HA services to Patient #8 before she actually required assistance with personal care. They wanted her to get to know the HA so she would be comfortable with her when she needed additional assistance due to an anticipated decline in her condition.</p> <p>During an interview on 10/23/14 at 11:40 AM, the DON reviewed Patient #8's record and confirmed the HA care plan did not reflect her current needs or contain appropriate instructions for the HA.</p> <p>Patient #8's HA care plan did not contain patient care instructions that were appropriate to meet her current needs.</p>	(L 625)			