IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

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

September 25, 2018

Bridger Booras, Administrator
Horizon Home Health East
707 N 7th Avenue, Suite F
Pocatello, ID 83201-4063

RE: Horizon Home Health East, Provider #137114

Dear Mr. Booras:

This is to advise you of the findings of the complaint survey at Horizon Home Health East, which was concluded on September 17, 2018.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Home Health Agency into compliance, and that the Home Health Agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **October 8, 2018**, and keep a copy for your records.

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

Sincerely,

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosure

October 1, 2018

RECEIVED
OCT 02 2018
FACILITY STANDARDS

Bureau of Facility Standards
Attn: Dennis Kelly
3232 Elder Street
PO Box 83720
Boise, ID 83720

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

Dear Mr. Kelly,

Pursuant to the survey conducted at Horizon Home Health East on September 17, 2018, please find attached the completed Statement of Deficiencies/Plan of Correction (CMS-2567) along with attachments that give further evidence that Horizon Home Health East complies with the Conditions of Participation.

As evidenced in the Plan of Correction and the attachments, we have and will continue to conduct staff education in each of the deficiencies cited and will continue to maintain evidence of compliance through chart audits and by making the deficiencies a focus of our Quality Assurance Program. The attachments will further speak to our compliance with the Conditions of Participation.

In the event that you need additional information, please do not hesitate to contact me at either of the following numbers: 208-888-7877 or 208-514-5711 or by email at bbooras@horizonhh.com.

Sincerely,

Bridger Booras, Executive Director
Horizon Home Health & Hospice East

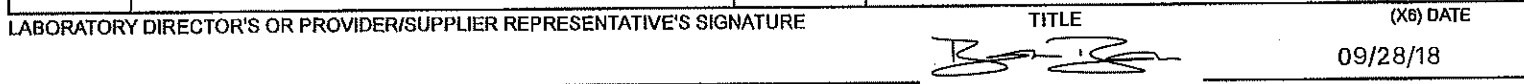
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137114	A. BUILDING ______ B. WING ______	C 09/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HOME HEALTH EAST	707 N 7TH AVENUE, SUITE F POCATELLO, ID 83201

(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
G 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation of your agency conducted on 9/17/18 to 9/17/18. Surveyors conducting the investigation were: James Brown, RN, HFS, Team Lead Brian Osborn, RN, HFS Acronyms used in this report include: APS - Adult Protective Services CHF - Congestive Heart Failure CKD - Chronic Kidney Disease CVA - Cerebrovascular Accident DM - Diabetes Mellitus DON - Director of Nursing OT - Occupational Therapy POA - Power of Attorney POC - Plan of Care PT - Physical Therapy RNCM - Registered Nurse Case Manager SN - Skilled Nursing ST - Speech Therapy	G 000	RECEIVED OCT 02 2018 FACILITY STANDARDS	
G 484	Document complaint and resolution CFR(s): 484.50(e)(1)(ii) Document both the existence of the complaint and the resolution of the complaint; and This ELEMENT is not met as evidenced by: Based on staff interview and review of medical records, agency policy, and complaints and grievances, it was determined the agency failed to ensure complaint resolutions were provided to 1 of 3 patients (Patient #3) who had a documented complaint and whose records were reviewed. This resulted in a lack of a thorough investigation and notification to the patient and/or	G 484	**G484 CFR(s): 484.50(e)(1)(ii) - Document complaint and resolution** This agency will ensure that patients have the opportunity to exercise rights and respect for the property/person is upheld by immediately investigating all alleged violations involving anyone furnishing services on behalf of the home health and immediately take action to prevent further violations while the alleged violation is being verified. Investigations and/or documentation or alleged violations will be conducted in accordance with established procedures; **Process Change:** Complaint reports will be processed through the HCHB workflow by the Director of Nursing who will ensure all pieces of the complaint report include an investigation and will ensure a safety plan and follow-up is documented on every complaint report prior to the final step of processing these complaint reports.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/28/18



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

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G 484	Continued From page 1 their representative as to the outcome of their concerns. Findings include: An agency policy "COMPLAINT/GRIEVANCE PROCESS," dated April 2013, stated "Response to the patient regarding the complaint will occur within ten (10) days of receipt" and "Resolution information will be communicated in writing to the patient or his/her representative filing the complaint." This policy was not followed. Patient #3 was an 82 year old male who was admitted to the agency on 4/06/18, with a primary diagnosis of DM Type 2 and foot ulcer. Additional diagnoses included hemiplegia, CVA, CHF, and CKD. He received SN, PT, OT, ST, and aide services. His record, including the POC, for the certification period 4/06/18 to 6/04/18, was reviewed. The agency complaint and grievance log included an entry for Patient #3, dated 5/10/18, which stated: "POA AND DAUGHTER FELT PATIENT WAS NOT GETTING APPROPRIATE CARE. PATIENT CURRENTLY LIVING IN THE TRAILER HOUSE WITH LIVE IN SIGNIFICANT OTHER AND SIGNIFICANT OTHERS FAMILY. PATIENTS FAMILY AND SIGNIFICANT OTHERS FAMILY HAD A MASSIVE FAMILY ARGUMENT. REPORTS OF PATIENT NEGLECT AND ABUSWE AGAINST SIGNIFICANT OTHER AND SIGNIFICANT OTHER FAMILY." There was no documented resolution to the complaint. Written resolution to the patient and/or patient's POA was not documented.	G 484	**Staff Education:** An in-service will be provided via Power Point Presentation by the leadership team in each branch locations for the home health staff to review the process of complaint reporting to include the complaint, provide and investigation and follow-up to ensure ongoing safety. This in-service will include education on policy 1-010.1 "Complaint /Grievance Process". Each staff member will receive a copy of the policy. Education will be provided on the expectations of processing the Complaint reports within HCHB and that resolutions were provided to patients and/or their representatives. Training will be completed by 10/ 18/18. Effective 9-24-18 our onboarding program includes a module on Patient Rights, policies and best practices which will be provided to all new home health staff by our Staff Education Coordinator. **Monitor:** Director of Nursing or designee will print off an complaint report weekly from HCHB and review 100% of each complaint report to ensure 90% compliance. Each report will be reviewed for the presence of the following 3 things: 1. The Complaint (What happened) 2. Evidence of Investigation 3. A follow-up and safety plan.	

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G 484	Continued From page 2 The DON was interviewed on 9/17/18, beginning at 12:00 PM, and Patient #3's complaint was reviewed in her presence. She confirmed Patient #3's complaint did not have a documented written resolution which was provided to him and/or his POA. The agency failed to ensure complaint resolutions were provided to patients and/or their representatives.	G 484	G484 cont. - **QAPI:** This process will be reported to and reviewed at a monthly meeting. If 90% compliance is not achieved by the end of November 29, 2018 an agency and or clinician specific Performance Improvement plan will be developed to monitor until there is 90% compliance for 3 months. **Responsible:** Director of Nursing and Administrator or designee has overall responsibility for the corrective action and ongoing completion of the deficiency. **Completion:** 10/18/18 and ongoing	
G 488	Immediate reporting of abuse by all staff CFR(s): 484.50(e)(2) Any HHA staff (whether employed directly or under arrangements) in the normal course of providing services to patients, who identifies, notices, or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the HHA and other appropriate authorities in accordance with state law. This ELEMENT is not met as evidenced by: Based on staff interview and review of medical records, agency policy, complaints and grievances, and Idaho State statutes, it was determined the agency failed to ensure HHA staff reported potential abuse and neglect to appropriate authorities in accordance with State law for 1 of 1 patient (Patient #3) who had documented potential abuse and neglect and whose record was reviewed. This had the potential for poor patient outcomes for all patients receiving care from agency staff. Findings include: "IDAHO STATUTES TITLE 39 HEALTH AND	G 488	**G488- Immediate reporting of abuse by all staff CFR(s): 484.50 (e)(2)** This agency will ensure that patients will be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of patient property. **Staff Education:** Home Health staff will be educated on appropriate notification of APS and the steps to take to ensure patients do not suffer further injuries. An in-service will be provided by Clinical Leaders in each branch for the home health staff to review the process of complaint reporting, provide an investigation and follow-up to ensure ongoing safety and that the patient remains safe immediately following the complaint. Will educate on policies1-008.1 "Ethical issues" and 2-013.1 "Assessment of Possible Abuse/Neglect A training will be completed by 10/18/18 and a log will be collected. Every new staff member receives a copy of the employee handbook. As part of this agency's annual on-line training , all new and current employees are required to view and be tested on a "Patient's Rights" module. within the employee handbook is a section titles "Neglect and Abuse", this is reviewed at orientation and each staff member will sign a document stating they have received this handbook. All new employees also are required to review this electronically and sign an electronic acknowledgment that it has been reviewed.Effective by 1-30, 2019 a document titled "Patient Rights" will be provided to each new staff member and scanned into employee file.	

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G 488	Continued From page 3 SAFETY CHAPTER 53 ADULT ABUSE, NEGLECT AND EXPLOITATION ACT," updated 7/01/18, states "39-5303. Duty to report cases of abuse, neglect or exploitation of vulnerable adults. (1) Any physician, nurse, employee of a public or private health facility, or a state licensed or certified residential facility serving vulnerable adults, medical examiner, dentist, osteopath, optometrist, chiropractor, podiatrist, social worker, police officer, pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the commission. Provided however, that nursing facilities defined in section 39-1301(b), Idaho Code, and employees of such facilities shall make reports required under this chapter to the department. When there is reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult, any person required to report under this section shall also report such information within four (4) hours to the appropriate law enforcement agency." This statute was not followed. An agency policy "ASSESSMENT OF POSSIBLE ABUSE/NEGLECT," dated April 2013, stated "The clinician will submit a verbal report of the suspected abuse/neglect to the proper authorities, in accordance with state law, and complete the internal occurrence report within 24 hours of the incident...". This policy was not followed. Patient #3 was an 82 year old male who was admitted to the agency on 4/06/18, with a primary	G 488	**Monitor:** A completion date will be set yearly for the online training. Starting 12 weeks prior to completion date the Human Resource Specialist will run weekly reports to be informed of the employees that have not completed online training modules and will inform supervisors. Employees will be suspended from the ability to provide patient care if they have not completed modules by the completion date. HR will run quarterly audits to ensure all staff members receive on hire the patient handbook and Patient's Rights document. This report will be given to the Director of Nursing or designee to review and ensure 90% compliance. **QAPI:** This process will be reported and reviewed at a monthly meeting. If 90% compliance is not achieved by November 29, 2018 an agency and or clinician specific Performance Improvement Plan will be developed to monitor until there is 90% compliance for 3 months. **Responsible:** Director of Nursing and Administrator or Designee has overall responsibility for the corrective action an ongoing completion of the deficiency. **Completion:** 10/18/18 and ongoing	

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September 25, 2018

Bridger Booras, Administrator
Horizon Home Health East
707 N 7th Avenue, Suite F
Pocatello, ID 83201-4063

Provider #137114

Dear Mr. Booras:

An unannounced on-site complaint investigation was conducted from September 17, 2018 at Horizon Home Health East. The complaint allegation, findings, and conclusions are as follows:

Complaint #ID00007897

Allegation: Agency staff did not report potential patient abuse and neglect to APS.

Findings: An unannounced visit was made to the agency on 9/17/18. Staff were interviewed. 4 medical records, agency policies, administrative documents, Idaho State statues, patients' rights, and complaint and grievance information were reviewed.

Agency staff did not report potential patient abuse and neglect to APS. Findings include:

One example was an 82 year old male who was admitted to the agency on 4/06/18, with a primary diagnosis of DM Type 2 and foot ulcer. Additional diagnoses included hemiplegia, CVA, CHF, and CKD. He received SN, PT, OT, ST, and aide services. His record, including the POC, for the certification period 4/06/18 to 6/04/18, was reviewed.

The agency complaint and grievance log included an entry for the patient, dated 5/10/18, which stated:

"POA AND DAUGHTER FELT PATIENT WAS NOT GETTING APPROPRIATE CARE. PATIENT CURRENTLY LIVING IN THE TRAILER HOUSE WITH LIVE IN SIGNIFICANT OTHER AND SIGNIFICANT OTHERS FAMILY. PATIENTS FAMILY AND SIGNIFICANT OTHERS FAMILY HAD A MASSIVE FAMILY ARGUMENT. REPORTS OF PATIENT NEGLECT AND ABUSE AGAINST SIGNIFICANT OTHER AND SIGNIFICANT OTHER FAMILY."

There was no documented APS referral regarding the patient's potential abuse and neglect concerns.

"IDAHO STATUTES TITLE 39 HEALTH AND SAFETY CHAPTER 53 ADULT ABUSE, NEGLECT AND EXPLOITATION ACT," updated 7/01/18, states "39-5303. Duty to report cases of abuse, neglect or exploitation of vulnerable adults. (1) Any physician, nurse, employee of a public or private health facility, or a state licensed or certified residential facility serving vulnerable adults, medical examiner, dentist, osteopath, optometrist, chiropractor, podiatrist, social worker, police officer, pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the commission. Provided however, that nursing facilities defined in section 39-1301(b), Idaho Code, and employees of such facilities shall make reports required under this chapter to the department. When there is reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult, any person required to report under this section shall also report such information within four (4) hours to the appropriate law enforcement agency." This statute was not followed.

An agency policy "ASSESSMENT OF POSSIBLE ABUSE/NEGLECT," dated April 2013, stated "The clinician will submit a verbal report of the suspected abuse/neglect to the proper authorities, in accordance with state law, and complete the internal occurrence report within 24 hours of the incident...". This policy was not followed.

The DON was interviewed on 9/17/18, beginning at 12:00 PM, and the patient's complaint was reviewed in her presence. She confirmed agency staff did not document if they contacted APS regarding the patient's potential abuse and neglect concerns.
The patient's RNCM was interviewed on 9/17/18, beginning at 1:00 PM, and his complaint was reviewed in her presence. She confirmed she was the agency staff who entered the patient's complaint regarding his potential abuse and neglect. When asked if she reported the patient's potential abuse and neglect to APS as required by agency policy and State statues, the RNCM stated no.

The agency failed to ensure HHA staff reported the patient's potential abuse and neglect to appropriate authorities in accordance with State law. Therefore, Federal deficiencies were cited at 42 CFR 484.50(e)(1)(ii) and 484.50(e)(2).

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

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

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

Sincerely,

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt