DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
701 Fifth Avenue, Suite 1600
Seattle, WA 98104

IMPORTANT NOTICE – PLEASE READ CAREFULLY

May 15, 2015

Kim Lane, Administrator
Intermountain Homecare Hospice - Cassia
1031 East Main Street
Burley, ID 83318-2029

CMS Certification Number: 13-1542

Re: Notice of Enforcement Action
Complaint Investigation Survey completed 04/23/2015
Conditions of Participation Not Met – IJ Abated 05/12/2015
Placed on 90-day termination track starting today

Dear Ms. Lane:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Intermountain Homecare Hospice - Cassia no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. This is to notify you that the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with Intermountain Homecare Hospice – Cassia, if not back in substantial compliance by **August 13, 2015.**

BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a hospice agency must meet all the Conditions of Participation established by the Secretary of Health and Human Services. When a hospice provider is found to be out of compliance with the Medicare Conditions of Participation, the facility no longer meets these requirements. The Social Security Act Section 1866(b) authorizes the Secretary to terminate a hospice Medicare provider agreement if the hospice no longer meets these regulatory requirements. Regulations at 42 CFR § 489.53 authorize the Centers for Medicare and Medicaid Services to terminate Medicare provider agreements when a provider, such as Intermountain Homecare Hospice - Cassia, no longer meets the Conditions of Participation.

On April 23, 2015, the Idaho Bureau of Facility Standards (State survey agency) completed a complaint survey at your facility and notified you about Immediate Jeopardy findings regarding the Medicare

Conditions of Participation. Briefly, the facility failed to identify and immediately report potential violations resulting in lack of investigations and appropriate corrections to protect patients from serious harm, impairment and/or death due to ongoing neglect. In addition, the governing body failed to provide oversight and supervision necessary to ensure patients were protected from abuse and neglect and received safe and appropriate medical and nursing services. The Immediate Jeopardy was removed on **May 12, 2015.**

We agree with the State survey agency's findings that the following Conditions of Participation were not met which limit the capacity of Intermountain Homecare Hospice - Cassia to furnish services of an adequate level and quality. The Statement of Deficiencies (Form CMS-2567) reflecting all deficient practices are enclosed for your reference.

42 CFR § 418.52 Patient's Rights (Immediate Jeopardy –Abated)

42 CFR § 418.100 Organization and Administration of Services (IJ Abated)

42 CFR § 418.102 Medical Director

PUBLIC NOTICE OF TERMINATION

In accordance with 42 CFR § 489.53(d), legal notice of our action will be published in the newspaper within your locale fifteen days prior to termination.

APPEAL RIGHTS

You have the right to appeal this determination by requesting a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). The regulations governing this process are set out in 42 CFR § 498.40 et seq. You will find the DAB's e-filing procedures on the internet at the following URL:

http://www.hhs.gov/dab/divisions/civil/procedures/filing-and-service.html

If you do not have access to a computer, you may file your appeal in writing and send it to:

Chief, Civil Remedies Division **Departmental Appeals Board MS 6132** **Cohen Building, Room 637-D** **330 Independence Avenue, SW** **Washington, D.C. 20201**	**Please also send a copy to:**	**Chief Counsel** **Office of General Counsel** **DHHS** **701 Fifth Avenue, Suite 1620** **Seattle, WA 98104**

A request for a hearing should identify the specific issues, and the findings of fact, and conclusions of law with which you disagree. 42 CFR § 498.40(b)(1) The request should also specify the basis for contending that the findings and conclusions are incorrect. 42 CFR § 498.40(b)(2). Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own

expense. **A hearing request must be filed not later than 60 days after the date you receive this letter.**

This 90-day termination action can be avoided by correcting your deficiencies. CMS must receive and approve a **credible allegation of compliance** in a timely manner, verified by an unannounced revisit by the State survey agency that the deficiencies have been corrected. **Complete your plan of correction in the space provided on the CMS-2567 and submit to CMS 10 days from the date of this notice or by May 25, 2015.** An acceptable plan of correction, which includes acceptable completion dates, must contain the following elements:

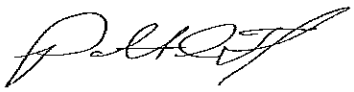
- Plan of Correction for each specific deficiency cited;
- Procedure/process for implementing the acceptable plan of correction for each deficiency cited;
- Monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements;
- Address process improvement and demonstrate how the hospital has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice.
- A completion date for correction of each deficiency cited;
- The plan must include the individual responsible for implementing the acceptable plan of correction with signature and title.

CMS strongly encourages that your plan of correction be fully implemented by no later than **June 29, 2015.** Please send your plan of correction to CMS:

Center for Medicare and Medicaid Services Attention: Fe Yamada
Division of Survey, Certification & Enforcement – Region 10
701 Fifth Avenue, Suite 1600, MSRX-400, Seattle, WA 98104

If you have any questions, please contact Fe Yamada of my staff at (206) 615-22381 or by email at marie.yamada@cms.hhs.gov.

Sincerely,



Patrick Thrift
Manager, Seattle Regional Office
Division of Survey, Certification & Enforcement

cc: Idaho Bureau of Facility Standards
Office of General Counsel, DHHS
National Government Services

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
701 Fifth Avenue, Suite 1600
Seattle, WA 98104

IMPORTANT NOTICE – PLEASE READ CAREFULLY
AMENDED LETTER

May 11, 2015

Kim Lane, Administrator
Intermountain Homecare Hospice - Cassia
1031 East Main Street
Burley, ID 83318-2029

CMS Certification Number: 13-1542

Re: Amended Notice of Enforcement Action
Complaint Investigation Survey completed 04/23/2015
Two Conditions of Participation Not Met
Placed on 23-day Termination Track starting 05/11/2015

Dear Ms. Lane:

By letter dated May 4, 2015, this office notified you of its intent to terminate Intermountain Home Healthcare and Hospice. After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Intermountain Homecare Hospice - Cassia no longer meets the requirements for participation as a provider of hospice services in the Medicare program established under Title XVIII of the Social Security Act. This is to notify you that effective **June 3, 2015** the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with Intermountain Homecare Hospice - Cassia.

BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a hospice agency must meet all the Conditions of Participation established by the Secretary of Health and Human Services. When a hospice provider is found to be out of compliance with the Medicare Conditions of Participation, the facility no longer meets these requirements.

The Social Security Act Section 1866(b) authorizes the Secretary to terminate a hospice Medicare provider agreement if the hospice no longer meets these regulatory requirements. Regulations at 42 CFR § 489.53 authorize the Centers for Medicare and Medicaid Services to terminate Medicare provider agreements when a provider, such as Intermountain Homecare Hospice - Cassia, no longer meets the Conditions of Participation.

contending that the findings and conclusions are incorrect. 42 CFR § 498.40(b)(2). Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense. **A hearing request must be filed not later than 60 days after the date you receive this letter.**

If you have any questions, please contact Aileen Renolayan of my staff at (206) 615-2313 or by email at aileen.renolayan@cms.hhs.gov.

Sincerely,

Patrick Thrift
Manager, Seattle Regional Office
Division of Survey, Certification & Enforcement

cc: Idaho Bureau of Facility Standards
Office of General Counsel, DHHS
National Government Services

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

CERTIFIED MAIL: 7000 1670 0011 3315 1590

April 27, 2015

Kim Lane, Administrator
Intermountain Homecare Hospice - Cassia
1031 East Main Street
Burley, ID 83318-2029

RE: Intermountain Homecare Hospice - Cassia, Provider #131542

Dear Ms. Lane:

This is to notify you that we are recommending to the Centers for Medicare/Medicaid Services (CMS) that it terminate its Medicare provider agreement with your Hospice based on the findings of the complaint survey completed on April 23, 2015.

We have notified CMS that the following Conditions of Participation are not met. In addition, we have informed CMS that substantial noncompliance representing an immediate and serious threat to patient health and safety has been identified. The Conditions that represents an immediate and serious threat to patients is:

42 CFR (418.52) Condition of Participation: Patient Rights and associated standard level deficiencies as they relate to the agency's failure to ensure policies and procedures were sufficiently developed, implemented and monitored necessary to ensure patients' rights were upheld and that they were free from abuse, neglect, and mistreatment.

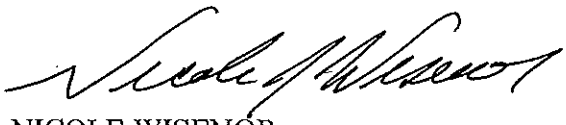
42 CFR (418.100) Condition of Participation: Governing Body and the associated standard level deficiency as they relate to the governing body's failure to provide oversight and supervision necessary to ensure patients were protected from neglect and received safe and appropriate care.

This was discussed with you and/or your staff during the complaint survey completed on April 23, 2015. The Statement of Deficiencies reflecting the immediate jeopardy is enclosed for your

reference. A full report, reflecting all deficient practices will be sent to you by CMS, with formal notice of process steps.

I would like to extend a thank you to you and your staff for the courtesies and assistance provided to us during the investigation. If you have any questions, or if we can be of assistance to you, please contact me at (208) 334-6626, option 4.

Sincerely,



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/pt
Enclosures
ec: CMS Region X Office
Debra Ransom, R.N., R.H.I.T., Bureau Chief

Plan of Abatement:
Intermountain Hospice-Cassia

L648: 42 CFR §418.100 Condition of Participation: Organization and administration of services

- Significant change of management. The Nurse Manager and Home Health Administrator who had the reporting responsibilities in issue during the survey have been replaced 5/9/15 & 5/7/15.
  - ✓ New Interim Nurse Administrator to be in place 5/7/15
  - ✓ Quality Consultant focused review of all records begun 5/4/15
  - ✓ Education Consultant on-site 2-3 days per week beginning 5/7/15
  - ✓ Physical Therapy Leadership on-site support 1-2 days weekly 5/13/15
  - ✓ Corporate Hospice Administrator on-site support weekly

- All staff are being re-educated by the Corporate Nurse Administrator on conditions of participation, TJC national patient safety goals, reportable events, policies and procedures, patient safety, following plans of care, communication with team and physicians, medication reconciliation, and documentation requirements
  - ✓ To begin on 5/7/15 with completion within two weeks

- To address the Idaho leadership and authority concerns, the Nurse Manager role in Idaho will be upgraded to a Home Health & Hospice Administrator role in Idaho which requires a higher skill set and education background. This position will be supported by the Corporate Home Health Administrator and the Corporate Hospice Administrator.
  - ✓ To be completed/posted by 5/9/15

- The Nurse Hospice Administrator and Regional Compliance Officer updated the Hospice organizational chart to accurately demonstrate the corporate and governing body oversight in effect
  - ✓ Completed 4/28/15

- Hospice Administrator and site manager implementing monthly meetings to review agency financials and operational concerns
    - ✓ Implemented 4/24/15 by Nurse Hospice Administrator and ongoing

- Hospice Administrator has increased oversight by receiving report on the following items at least 3 times per week, and as needed
    - Number of patients at home
    - Number of patients in SNF
    - Number of patients in ALF
    - Patients without Advance Directives and actions to resolve
    - Patient care issues
    - Any staff level concerns
    - Any staff performance issues
    - Review of event reports
    - Verification physician/provider communication, including new orders, has been shared with all providers/physicians involved in patient care
    - ✓ Implemented 4/27/15 and ongoing

- Hospice Medical Director has been reoriented on job responsibilities including patient evaluations, executing plans of care timely, accurate documentation, and preventing neglect.
    - ✓ To be completed by 5/15/15

- Partner experienced hospice system Medical Director's with Cassia Medical Director to work in a peer to peer relationship for thirty (30) days to confirm Director understands roles and responsibilities of this position and can consult as needed. Competency will be performed at the end of thirty days to confirm knowledge.
    - ✓ To be completed by 05/17/15

L500: §418.52 Condition of participation: Patient's rights.

- Office manager has been re-educated by the Corporate Education Manager, Regional Compliance office and Hospice Administrator on job responsibilities, with an emphasis

on investigating events, follow-up reporting to compliance, applicable state authorities and hospice administrator investigating and follow-up reporting to compliance, applicable state authorities and hospice administrator

- ✓ Completed 4/28/15 prior to removal from position

- Hospice Leadership has developed and circulated new guidelines for hospice staff's response to events
  - ✓ Completed 4/28/15

- All staff have received re-education and retraining from the Hospice Manager on their obligations and responsibilities for reporting abuse, neglect, maltreatment, and patient complaints to the Administrator and appropriate law enforcement. All staff performed return demonstrations on reporting obligations prior to next working shift.
  - ✓ Completed 4/24/15

- Adult Protective Services provided staff training on abuse assessment and reporting on 5/515 and Child Protective Services provided staff training on abuse assessment and reporting on 5/7/15. Staff attended in person or reviewed material independently.
  - ✓ Completed 5/7/15

- The Hospice Manager has re-educated all office and field staff on the requirements and process for reporting abuse/neglect. Reviewed and discussed by Interim Home Health Administrator and CNO on 5/8/15.
  - ✓ Completed 4/24/15 & 5/8/15

- Nurse Manager and Corporate Education Department have ensured that all staff have completed on-line retraining about reporting obligations and procedures
  - ✓ Completed 4/30/15

- Nurse Manager and Corporate Education Department have ensured that all staff have completed an on-line education module about abuse and neglect and were required to complete the module before they worked their next shift following the survey
  - ✓ Completed 4/28/15 with 100% compliance

- Nurse Manager has ensured that all staff were required to review and confirm understanding of abuse and neglect policies before they worked their next shift following the survey
    - ✓ Completed 4/28/15 with 100% complete

- Nurse Manager and Corporate Education Department created, printed and distributed to all clinical staff laminated reference cards with the contact information for Adult Protective Services (APS) and Child Protective Services (CPS)
    - ✓ Completed 4/24/15

- Corporate Education Manager has distributed stickers to be affixed to all field staff laptops that include critical phone numbers to report suspected abuse
    - ✓ Completed 5/1/15

- Nurse Manager has been conducting daily rounds on all patients to monitor patients to give staff the opportunity to discuss any potential concerns about abuse or neglect and to ensure staff is completing accurate and complete reports as needed. Amended to Interim Nurse Administrator role will conduct daily rounds M-F on 5/9/2015.
    - ✓ Implemented 4/27/15

- HIM and office coordinator under direction of hospice manager completed a 100% review of all hospice patients on service to ensure the attending physician on the Notice of Election (NOE) matches the attending physician on the Hospice Plan of Care (POC)
    - ✓ Completed 4/28/15

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

PRINTED: 05/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	131542		C 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERMOUNTAIN HOMECARE HOSPICE - CASSIA	1031 EAST MAIN STREET BURLEY, ID 83318

(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	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation of your hospice agency conducted from 4/21/15 through 4/23/15. The surveyors conducting the survey were: Susan Costa, RN, HFS, Team Lead Laura Thompson, RN, BSN, HFS Acronyms used in this report include: ALF - Assisted Living Facility ADL - Activity of Daily Living CBC - Complete Blood Count CEO - Chief Executive Officer CHF - Congestive Heart Failure CKD - Chronic Kidney Disease CMP - Complete Metabolic Panel CNO - Chief Nursing Officer COO - Chief Operations Officer COPD - Chronic Obstructive Pulmonary Disease DC - Discontinue DVT - Deep Vein Thrombosis EMT - Emergency Medical Technician IDT - Interdisciplinary Team MAR - Medication Administration Record MD - Medical Doctor MSW - Master of Social Work PCP - Primary Care Provider POC - Plan of Care PRN - As needed PT/INR - Prothrombin Time/ International Normalized Ratio, a blood test to measure blood clotting times pt - patient RN - Registered Nurse SN - Skilled Nurse	L 000	RECEIVED MAY 19 2015 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Lisa Musgrave CNO Kim Lane Hospice nurse administrator 05/18/2015

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

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L 000	Continued From page 1 VP - Vice President During the survey it was determined that deficient practices at the following 2 Conditions of Participation placed the health and safety of patients in immediate jeopardy of serious harm, impairment, or death and had the potential to impact all patients receiving services at the agency. 42 CFR §418.52 Patient Rights 42 CFR §418.100 Governing Body The agency was notified of the immediate jeopardy verbally on 4/23/15 at 1:30 PM and was not able to submit an acceptable immediate plan.	L 000		
L 500	418.52 PATIENTS' RIGHTS This CONDITION is not met as evidenced by: Based on record review and staff interviews, it was determined the agency failed to ensure policies and procedures for the detection and prevention of abuse, neglect, mistreatment, injuries of an unknown source or misappropriation of patient property, were sufficiently developed, implemented and monitored necessary to ensure all patients receiving services from the agency were not subjected to ongoing violations. This failure of agency staff to identify and immediately report potential violations resulted in a lack of investigation and a lack of appropriate correction being implemented necessary to protect patients from serious and immediate harm, impairment, and/or death due to ongoing neglect. The findings include:	L 500		5/14/15

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L 500	Continued From page 2 1. The agency's "Abuse Policy," effective October 2008, was a corporate policy. The "Scope" of the policy included hospitals, the medical group, homecare, and Ambulatory Surgical Centers. The policy did not include information specific to the operations of the hospice agency. The policy stated "Appropriate staff is educated about abuse and neglect." The policy did not identify which hospice staff were to be trained or who was responsible to ensure the training occurred. During a telephone interview, on 4/23/15 at 11:30 AM, the Corporate Compliance Director stated all incidents were to be documented on an "Event Report." The agency provided multiple "Event" policies and procedures which included an "Event Reporting Policy," a "Reportable Events Procedure," and a "Risk Event Management Procedure." The policy and procedures documented they were all effective March 2014. The agency also provided a "Patient Grievance Policy" which was also effective March 2014 and a "Patient Grievance Procedure," which was effective October 2014. All of the submitted policies and procedures were related to corporate process. The policies and procedures included information related to corporate operations in both Utah and Idaho and were applicable to various types of healthcare facilities such as hospitals, homecare agencies, etc. The corporate policies and procedures did not include information specific to the operations of the hospice agency.	L 500		

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L 500	Continued From page 3 The corporation's "Event Reporting Policy," stated "Risk Management, Quality, Patient Safety and Clinical Operations work together to facilitate appropriate process changes warranted to reduce the risk of reoccurrence." The corporate "Event Reporting Policy," included the following definitions of events: - Event: "Any unexpected occurrence or process variance that impacts or may impact the quality of patient care, patient or visitor safety or which poses an operational risk (i.e. an accident, complication, lab error, coding/charging errors, improper informed consent, IS business interruption, medication error, significant billing complaint, improper business practices, regulatory breach, ethical issues fall [sic], equipment failure or theft, etc.). Events may be discovered during routine delivery of care or business operations. Additionally they may be identified by way of a patient/family complaint or grievance." - Adverse Event: "An undesirable and unanticipated outcome that was caused by a clinical mistake, misjudgment or oversight, which results in temporary or permanent injury, damage or harm to the patient." - Reportable Event: "A specific subset of Events that, due to their more serious nature, must be reported within 24 hours of discovery to the Clinical Risk Manager at the Central Office." - Sentinel Event: "A serious event that meets criteria set forth by the Joint Commission and/or the Utah Department of Health. A Root Cause Analysis is completed for all Sentinel Events."	L 500		

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L 500	Continued From page 4 - Serious Safety Event (SSE): "A deviation from generally accepted practice standards (GAPS) and reaches the patient and causes moderate to severe harm or death in any healthcare setting." The policy also stated in the "Event Reporting Administrative Requirements" section that "Business Operations (includes Regions/Facilities)" were to "Assure that clinical staff and other appropriate staff have been trained on how to identify and report an Event, Near Miss or Activity." The policy defined "Business Operations" as "Recurring clinical and customer services that provide value to the communities and patients served by Intermountain Healthcare. Business Operations include Regions, Hospitals, Clinics, Homecare, other facilities [sic] administrative operations, Lab, Pharmacy, Information Systems (IS), Compliance, Risk Management, Quality/Patient Safety and so forth." The policy did not include information regarding how the agency was to "Assure that clinical staff and other appropriate staff have been trained on how to identify and report an Event, Near Miss or Activity" given the policy's definition of "Business Operations." The policy further stated "Business Operations (includes Regions/Facilities)" were to "Designate an individual to oversee the ongoing compliance with all Event Reporting policies and procedures." The policy did not include information regarding how the individual was to be designated or which entity or person within the "Business Operations"	L 500		

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L 500	Continued From page 5 definition would be responsible for the designation. The agency failed to ensure policies and procedures for the detection and prevention of abuse, neglect, mistreatment, injuries of an unknown source or misappropriation of patient property, were sufficiently developed, implemented and monitored necessary to ensure facility staff were able to consistently identify and immediately report all potential violations to the Administrator. This failure resulted in injuries of unknown origin and potential neglect to be unidentified and unreported. Therefore, investigations into the potential violations were not completed and appropriate corrective actions were not taken. a. Refer to L508 as it relates to the agency's failure to ensure policies and procedures were sufficiently developed, implemented and monitored to ensure all allegations of abuse, neglect, mistreatment, injuries of an unknown source or misappropriation of patient property, were immediately reported to the Administrator. b. Refer to L509 as it relates to the agency's failure to ensure policies and procedures were sufficiently developed, implemented and monitored to ensure all allegations of abuse, neglect, mistreatment, injuries of an unknown source or misappropriation of patient property, were immediately investigated and that immediate action was taken to protect patients during the course of investigations. c. Refer to L510 as it relates to the agency's failure to ensure policies and procedures were sufficiently developed, implemented and	L 500		

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INTERMOUNTAIN HOMECARE HOSPICE - CASSIA	1031 EAST MAIN STREET BURLEY, ID 83318

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L 500	Continued From page 6 monitored to ensure appropriate, timely corrective action was taken in response to all allegations of abuse, neglect, mistreatment, injuries of an unknown source or misappropriation of patient property. d. Refer to L511 as it relates to the agency's failure to ensure policies and procedures were sufficiently developed, implemented and monitored to ensure all allegation of abuse, neglect, mistreatment, or misappropriation of patient property, were reported in accordance with State Law. The cumulative effect of these systemic deficient practices placed patients in immediate jeopardy of experiencing serious harm, impairment and/or death due to ongoing neglect. The agency was notified of the immediate jeopardy verbally on 4/23/15 at 1:30 PM and were not able to submit an acceptable immediate plan.	L 500		
L 501	418.52 PATIENTS' RIGHTS The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure patients were fully informed of their rights and that those rights were upheld for 2 of 6 patients (Patient #3 and #6) whose records were reviewed and had the potential to impact 6 of 6 patients (#4 - #9) receiving services at the agency at the time of the survey. This resulted in a potential for patients to be uninformed of their right to choose an attending physician. The findings include:	L 501		4/28/15

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L 501	Continued From page 7 1. Patient #6's records included a "Rights and Responsibilities" form, signed by her guardian on 6/20/13. The form listed multiple patient rights, but did not include the right to choose an attending physician. The "Rights and Responsibilities" form in Patient #6's record included an issue/revised date of 5/08. However, other patients whose records were reviewed included an updated version of the form, dated 2/11, which stated patients have the right "To choose your attending physician." During an interview on 4/22/15 at 2:40 PM, the Interim Nurse Manager reviewed the record and confirmed the "Rights and Responsibilities" form was signed on 6/20/13. She confirmed the form had been updated and the new form was not given to Patient #6's guardian for signature upon admission. The agency failed to inform Patient #6 and/or her guardian of the right to choose her attending physician. 2. Refer to L515 as it relates to the agency's failure to ensure each patient's right to choose an attending physician was upheld.	L 501		
L 508	418.52(b)(4)(i) EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON The hospice must: (i) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the	L 508		5/9/15

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L 508	Continued From page 8 hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator; This STANDARD is not met as evidenced by: Based on policy review, record review and staff interviews, it was determined the agency failed to ensure policies and procedures were sufficiently developed, implemented and monitored to ensure all allegations of abuse, neglect, mistreatment, injuries of an unknown source or misappropriation of patient property, were identified and immediately reported to the Administrator. This failure directly impacted 3 of 6 patients (Patients #1 - #3) whose records were reviewed and had the potential to impact 6 of 6 patients (#4 - #9) receiving services at the agency at the time of the survey. This failure of agency staff to recognize and immediately report allegations resulted in a lack of investigation and a lack of appropriate corrective action being implemented necessary to protect patients from serious and immediate harm, impairment, and/or death due to ongoing neglect. The findings include: 1. The agency's "Abuse Policy," effective October 2008, was a corporate policy. The "Scope" of the policy included hospitals, the medical group, homecare, and ambulatory surgical centers. The policy did not include information specific to the operations of the hospice agency. The policy stated "Whenever any person has reason to believe that a patient has been subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse,	L 508		

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L 508	Continued From page 9 domestic violence, or neglect or who observes a patient being subjected to such conditions or circumstances are required by law to report" and "All suspected cases of abuse, neglect, and exploitation will be immediately reported." However, the policy did not include information regarding who hospice agency staff were to report the allegations to or how the report was to be made (verbally, in writing, etc.). During a telephone interview, on 4/23/15 at 11:30 AM, the Corporate Compliance Director stated all incidents were to be documented on an "Event Report." The agency provided multiple "Event" policies and procedures which included an "Event Reporting Policy," a "Reportable Events Procedure," and a "Risk Event Management Procedure." The policy and procedures documented they were all effective March 2014. The agency also provided a "Patient Grievance Policy" which was also effective March 2014 and a "Patient Grievance Procedure," which was effective October 2014. All of the submitted policies and procedures were related to corporate process. The policies and procedures included information related to corporate operations in both Utah and Idaho and were applicable to various types of healthcare facilities such as hospitals, homecare agencies, etc. The corporate policies and procedures did not include information specific to the operations of the hospice agency. None of the corporate policies and procedures described the hospice agency's systems for immediately reporting all allegations of abuse,	L 508		

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L 508	Continued From page 10 neglect, mistreatment, or misappropriation of patient property to the hospice agency's Administrator and information related to injuries of an unknown source was not present in the policies or procedures. Patient records were reviewed and documented injuries of unknown origin and ongoing potential neglect and which had not been immediately reported to the hospice agency Administrator, as follows: a. The corporate "Abuse Policy," defined "Neglect" as "The passive or active withholding of medicine, food, clothing, treatments, basic hygiene and emotional support by a parent, spouse, child, family member, legal guardian or caregiver." i. Patient #1 was a 90 year old female who had been admitted to hospice on 3/11/14, with a terminal diagnosis of heart disease. Additional diagnoses included pulmonary hypertension and venous insufficiency. She resided at an ALF. A signed copy Patient #1's POC for the certification period 3/05/15 to 5/04/15 was provided to the survey team on 4/21/15 at 4:30 PM. The POC was signed by the Medical Director on 4/21/15, 7 hours after the surveyors requested her record. The Medical Director included a hand written narrative of clinical findings to support her recertification to hospice services which stated "90 year old female [with] end stage heart failure showing continual decline. She is intolerant of Coumadin in she develops coagulopathy and 'Stevens-Johnson' type pupura. Has progressive muscle mass loss and continual mental decline."	L 508		

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L 508	Continued From page 11 During an interview on 4/23/14 beginning at 7:30 AM, the hospice Medical Director reviewed Patient #1's record and confirmed he signed the POC for Patient #1 on 4/21/15. He stated he completed the narrative, and signed the POC after the hospice notified him that the "State Auditors" were at the agency. He reviewed the narrative section that he completed and stated he was in error by writing Patient #1 had "Coumadin Intolerance." He stated he should have put that she was intolerant to Lasix. The Hospice Medical Director stated he reviewed the medical record and must have made an error in the narrative. Patient #1's POC included orders for SN visits twice weekly, and 2 additional visits as needed. Additionally, she had orders for aide visits 7 times weekly, with 2 additional visits as needed. Patient #1's POC also included information regarding her medications, which were provided by the ALF, and which were provided by the hospice agency. One medication that the hospice provided was Coumadin 2 mg, 1 tablet daily. The POC included instructions of "Do not assess PT/INR levels at this time until further notification by [name of hospice Medical Director]." Her record included documentation the most recent PT/INR was performed on 9/25/14, with a result of 25.1 and 2.1 that indicated it was therapeutic. According to the National Library of Medicine website: "Prothrombin time is measured in seconds. Most of the time, results are given as what is called INR (or international normalized ratio). If taking blood thinning medicines such as warfarin, the normal range for PT results is 11 - 13.5 seconds, or INR of 0.8 - 1.1. If taking	L 508		

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L 508	Continued From page 12 warfarin to prevent blood clots, the doctor will most likely choose to keep the INR between 2.0 and 3.0. The risks of bleeding and hematoma in these patients are greater than for people without bleeding problems." The POC noted Patient #1 was to be assisted with the application of CircAid wraps to both lower legs during visits. (CircAid wraps are compression wraps to aid in the reduction of edema in the legs). The POC did not specify who was to assist Patient #1 with the application of the wraps, or the frequency and duration the wraps were to be applied. Patient #1's recertification assessment, performed by an RN, dated 3/05/15, included a Braden Scale (According to the website bradenscale.com, accessed 4/24/15, the Braden Scale is a special scoring system to evaluate a patient's risk of developing a pressure ulcer, "The Braden Scale for Predicting Pressure Sore Risk." It consists of six categories: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. The total score can range from 6 to 23 with a lower score indicating a higher risk. The level of risk indicates the intervention strategies that should be used). Patient #1's scale included information that she was chairfast, her skin was often moist, her mobility was very limited, and she had inadequate intake. Her total score was 12, which indicated she was "High Risk." Her recertification assessment also included documentation she had bruising and excessively dry and scaly skin. However, the areas of bruising were not identified in the assessment. There was no determination of the cause of the bruising noted on Patient #1.	L 508		

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L 508	Continued From page 13 An Event Report for the cause unknown injury could not be found and there was no documentation indicating the injury had been immediately reported to the Administrator. In an RN Visit Note, dated 4/07/15, the RN noted Patient #1 had bruising, but the location of bruising was not identified. Additionally, the note documented Patient #1 had 3+ edema in her right and left lower legs. There was no determination of the cause of the bruising noted on Patient #1. The nursing note did not include documentation the CircAid wraps were either applied or removed. An Event Report for the cause unknown injury could not be found and there was no documentation indicating the injury had been immediately reported to the Administrator. In an RN Visit Note, dated 4/09/15 from 8:23 AM to 10:37 AM, the RN noted Patient #1 had a large developing hematoma on her left lower leg. Her pain was described as a 10 on a pain scale of 1-10, "worst possible imaginable." The note included descriptions of her pain as aching, crushing, shooting, stabbing, and tender, with intermittent spasms. The RN further documented Patient #1 was in severe discomfort, frequently calling out, grabbing her leg, complained of leg spasms approximately every 25-45 seconds, and stated her pain was "unbearable." In the section "Emotional Status" the RN documented "Patient currently exceedingly agitated due to pain in left leg." The RN wrote in the note that there were no falls reported and the patient reported she did not know what happened to her leg. The RN documented "Following 10 doses of	L 508		

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L 508	Continued From page 14 Morphine 1 ml (20 mg) at 15 minute intervals, patient reported she felt the pain in her leg was subsiding adequately." Ten doses of 20 mg of morphine every 15 minutes would be the equivalent of 200 mg Morphine over a 2.5 hour period. She noted Patient #1's Lorazepam was increased to .5 to 1 mg every hour for anxiety and spasms in the left leg. The visit note included a wound assessment sheet with 2 photos of the hematoma. One photo showed erythema and swelling just below the left knee. The second photo showed a much larger hematoma, with a large pocket of fluid noted on the inner aspect. The leg was noted to be more edematous in the second photo. There were no measurements to indicate the actual size of the hematoma. The RN documented that Patient #1 was in a recliner and refused to be transferred to a hospital bed, as it would cause more discomfort. The RN noted that after discussion, Patient #1 agreed to be transferred to the hospital bed. The visit note documented the hospice Medical Director was notified of the hematoma and orders were received to draw a PT/INR, as well as, other labs. The RN noted she reviewed with the ALF nurse and multiple staff members that Patient #1's skin would likely rupture and pooled blood under her skin would drain copiously. She noted the leg was to have disposable pads underneath to manage drainage if the hematoma ruptured. The visit note did not include documentation of discussion with Patient #1 or her family regarding options for treatment of the hematoma, including pursuing evaluation and treatment at the hospital.	L 508		

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L 508	Continued From page 15 Additionally, the note did not include documentation that Patient #1's Coumadin therapy was reevaluated and discussed given her change in status. An Event Report for the cause unknown injury could not be found in the agency's records and there was no documentation indicating the injury of unknown cause had been immediately reported to the Administrator in order to initiate an immediate investigation and to ensure Patient #1 was immediately protected from ongoing physical harm and mental anguish. In an RN Visit note dated 4/09/15 from 2:17 PM to 6:20 PM, the RN documented Patient #1's pain continued at a level of 10 out of 10, with aching, cramping, crushing, shooting, stabbing, and spasms. Additionally, her emotional status was described as "anxious, apprehensive, distraught, irritable, labile, restless, and tearful." The RN noted Patient #1 was not able to eat, and was only able to tolerate fluids. A description of the hematoma on Patient #1's left leg was documented as "swelling and blood pooling to left lower leg appears to be worsening, continued. Patient's hospital bed is assembled and in working order. Patient tolerated [transfer to the bed] with moderate discomfort. Patient required several doses of Morphine every 15 minutes as ordered, and Lorazepam 1 mg every hour as ordered to manage pain symptoms." The RN documented an evaluation of the effectiveness of comfort measures as "Patient reports pain poorly managed during the day today. Ongoing spasms in left leg and persistent	L 508		

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L 508	Continued From page 16 discomfort." The visit note included a wound assessment sheet with a photo of the hematoma. The photo included a measuring guide, which indicated the area of discoloration and swelling of the hematoma was greater than 10 cm (4 inches) wide by 6 cm (2 1/2 inches) long. The height of the hematoma appeared to be approximately 3 cm (1 1/4 inches) high. The RN documented she reviewed teaching with the ALF staff regarding pain management, prevention of further injury to the left leg, prevention of skin breakdown, and the need to keep the leg on disposable pads. She also documented that she reviewed, with the ALF staff, the need to keep Patient #1's leg elevated with pillows, as much as possible, to manage edema and bleeding. The visit note did not indicate Patient #1's physician was notified of the increase in size of the hematoma from the visit 4 hours earlier or of Patient #1's inability to eat. Documentation of discussion with Patient #1 or her family regarding options for treatment of the hematoma, including pursuing evaluation and treatment at the hospital, was not present. Additionally, despite Patient #1's worsening symptoms, the hospice agency's record did not include documentation that the injury of unknown cause on Patient #1's left leg had been reported to the Administrator in order to initiate an immediate investigation and to ensure Patient #1 was immediately protected from ongoing physical harm and mental anguish.	L 508		

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L 508	Continued From page 17 In a visit note dated 4/10/15 from 2:40 AM to 4:15 AM, the RN documented Patient #1's pain was estimated at 6/10, and she was moaning. Additionally, the RN noted Patient #1 was non-responsive, and only responded once during the 2 hour visit. The RN documented the appearance of the hematoma as "left leg with a 10 cm hematoma/blood blister to left calf just below the knee." A wound assessment sheet included photos of the hematoma, which had split open, and the RN documented copious amounts of red bloody drainage. The results of the PT/INR were in the visit note and documented as 28.3 and 2.7, which was above the therapeutic range. The RN documented she reviewed wound care with the ALF staff, and instructed them to not touch the dressing on Patient #1's leg, to only replace the pad under the dressing if it should become soiled. The record did not include documentation that Patient #1's physician was notified of the rupture of the hematoma and amount of drainage, or that Patient #1 was un-responsive. It was not documented if the physician was informed of the result of the PT/INR or that Patient #1's Coumadin therapy was reevaluated and discussed given her status. In a visit note dated 4/10/15 from 11:51 AM to 12:40 PM, the RN documented ALF staff estimated Patient #1's pain rating to be 5 out of 10. The RN documented Patient #1 responded to tactile stimulation only. Patient #1's temperature was noted to be elevated at 99.6, her blood pressure measured 118/64, and her pulse was	L 508		

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L 508	Continued From page 18 elevated at 108/minute. The RN documented "Patient minimally responsive during visit, hands and feet cold to touch, intermittent breathing pattern changes. Staff at facility report they have been unable to administer medications to patient all day today due to unresponsiveness. Patient has not eaten anything today, has had only sips of fluids." The wound assessment for the visit stated "...large hematoma on left lower leg. Large area of blood pooling has ruptured, heavy amount of bloody drainage noted." Additionally, she was noted to have edema around the wound. The RN documented she applied silvadene cream to the open wound and a nonstick pad was placed over the hematoma. The leg was wrapped in an Attends (adult diaper), and disposable absorbent pad. Patient #1's record did not include documentation of orders for the silvadene cream or wound care instructions for the ruptured hematoma on her leg. The record did not include documentation that Patient #1's physician was notified of the continued drainage and her continued inability to eat or of her deteriorating status as evidenced by Patient #1's abnormal vital signs and her inability to take medications. In a visit note dated 4/11/15 from 1:35 PM to 3:30 PM, the RN noted Patient #1 was minimally responsive, could answer yes or no, and moaned. Her temperature was elevated at 99.0. Patient #1's pain was assessed at 5 as evidenced by the crying, moaning, and grimacing noted by the RN.	L 508		

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L 508	Continued From page 19 The RN documented she spoke with the ALF staff to schedule Patient #1's Morphine every 2 hours. The RN noted Patient #1 had noisy respirations, and diminished lung sounds. She documented her skin was discolored with cyanosis. In the section of the note for description of skin, the RN documented Patient #1 had inflammation or cellulitis, open wounds, and bruising. The visit note documented Patient #1 had no food intake, and only sips of fluids. Additionally, the RN stated she had difficulty controlling liquid in her mouth. The RN documented Patient #1 was showing evidence of active dying, and her family was present. The family was noted as stating "We just want her comfortable." The record did not include documentation that Patient #1's physician was notified of the continued drainage, her continued inability to eat, or of her continued abnormal vital signs. Further, the record did not include documentation that Patient #1's physician was notified of the deteriorating status as evidenced by Patient #1's noisy respirations, decreased lung sounds, discolored skin with cyanosis and difficulty with liquids. Additionally, despite Patient #1's worsening symptoms, the hospice agency's record did not include documentation that the injury of unknown cause on Patient #1's left leg had been reported to the Administrator in order to initiate an immediate investigation and to ensure Patient #1 was immediately protected from ongoing physical harm and mental anguish.	L 508		

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	131542		C 04/23/2015

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L 508	Continued From page 20 In a RN Visit note dated 4/12/15 from 11:25 AM to 12:25 AM, the RN documented Patient #1's blood pressure was 130/50, her temperature was 99.0, and her pulse was 72/minute. Her oxygen saturations were noted at 85%. Patient #1 was noted to be unresponsive, and her pain was estimated at 2. The RN documented Patient #1's left leg dressing had copious red drainage. The dressing was removed and silvadene cream was applied. A nonstick dressing was placed over the cream, and the leg was wrapped in absorbent pad and placed in an Attends to help with drainage. The record did not include documentation that Patient #1's physician was notified of the continued drainage or her continued deteriorating status. In an RN Visit note dated 4/13/15 from 11:20 AM to 12:18 PM, the RN documented Patient #1's pain was estimated at 7 "severe," and she was intermittently responsive. The RN noted Patient #1 was unable to tolerate any food or drink of any significant amount. Her skin was documented as cyanotic, and her temperature was 99.1. Her breath sounds were diminished, she had shortness of breath, and noisy respirations. The wound assessment sheet for the visit noted Patient #1 had a heavy amount of red drainage from her left leg wound, there was edema, and warmth to the area, as well as, discoloration. The wound care note documented Patient #1's pain	L 508		

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L 508	Continued From page 21 intensity of 10, and intermittent, which differed from the assessment section of the visit note, which described her pain level as 7. Wound care was not documented in the visit note. The record did not include documentation that Patient #1's physician was notified of the continued drainage or of her increase in pain. Further, the record did not include evidence that interventions were adjust to better manage Patient #1's pain. Additionally, despite Patient #1's worsening symptoms, the hospice agency's record did not include documentation that the injury of unknown cause on Patient #1's left leg had been reported to the Administrator in order to initiate an immediate investigation and to ensure Patient #1 was immediately protected from ongoing physical harm and mental anguish. An RN Visit note dated 4/14/15 from 11:30 AM to 1:48 PM, which indicated Patient #1 had died. It did not indicate the time of death. However, an ALF "Charting Note" indicated Patient #1 died at 12:03 PM. During an interview on 4/23/15 at 8:30 AM, the Executive Director of the ALF discussed Patient #1's final few days. He stated Patient #1 was a "non-touch" patient, meaning the ALF staff took care of all of her needs except to touch her. He stated the ALF would bring her meals, empty the trash, clean, do her laundry, and empty her foley bag. He stated the hospice would provide direct care and bathe her. He stated she "lived" in her recliner chair. The Executive Director stated the ALF staff was instructed by the hospice RN not to provide care for the wound on Patient #1's leg,	L 508		

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L 508	Continued From page 22 and that the hospice staff would manage the wound care. He stated the wound was covered, and the ALF staff was instructed to change the absorbent pad under the leg if it became saturated. During an interview on 4/22/15 beginning at 10:15 AM, the hospice Interim Nurse Manager reviewed Patient #1's record. The Interim Nurse Manager stated she was the primary nurse for Patient #1, as she took care of her when she was on home health, before hospice. She stated Patient #1 essentially lived in her recliner chair. The Interim Nurse Manager stated she provided SN visits to Patient #1 twice weekly, and at that time she would remove the CircAid wraps from her legs, provide skin care, and reapply the wraps. She stated the aide would come on a daily basis to sponge bathe Patient #1, but she (the Interim Nurse Manager) was the only one that would unwrap her legs. She stated she was called by Patient #1 to evaluate her left leg as she had severe pain. She stated when she arrived at the ALF, she removed the CircAid wrap from her left leg and noted edema with a hematoma. She stated she took a photo of the hematoma, and another photo 40 minutes later, as the blood was accumulating rapidly. The Interim Nurse Manager stated she e-mailed the photos to the hospice Medical Director and he reviewed them. She stated the Medical Director did not come to the facility to evaluate Patient #1's leg. She stated he ordered lab work, and told her to elevate the leg and apply ice. She stated Patient #1 did not tolerate the ice to her leg and refused it. The Interim Nurse Manager stated she did not question if Patient #1's Coumadin should be discontinued and did not	L 508		

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L 508	Continued From page 23 suggest more aggressive treatment such as having the hematoma evaluated at the hospital. The Interim Nurse Manager stated it was an injury of unknown origin, and stated she questioned the facility staff, who denied injury or falls. The Interim Nurse Manager confirmed she did not initiate an Event Report or any further investigation. She stated she was aware that Patient #1's body underwent an autopsy and an investigation was conducted by the coroner. She stated the coroner came to the agency for further information. When questioned about the coroner visit, the Interim Nurse Manager was asked if an internal investigation was initiated. She stated she did not start an investigation, and did not notify her supervisor at the corporate level. The Interim Nurse Manager stated Patient #1 was in a large amount of pain, but the pain seemed to be managed by administration of Morphine every 15 minutes, as well as the Lorazapam that was administered on an hourly basis. She stated the Morphine was scheduled to be administered every 2 hours even if Patient #1 did not request it, in order to keep her comfortable. The Interim Nurse Manager confirmed the hematoma ruptured, and continued to produce large amounts of bloody drainage, she stated the hospice Medical Director was aware, but he did not come to evaluate Patient #1. She stated she was not sure if he was aware of the results of the PT/INR, and did not talk to him about discontinuing the Coumadin that was ordered. During the interview with the Interim Nurse Manager, she repeatedly stated "There is nothing	L 508		

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L 508	Continued From page 24 that could be done, there would be no reason to take Patient #1 to the hospital, she was dying." However, she did confirm the hematoma was not part of Patient #1's terminal diagnosis. During an interview on 4/23/14 beginning at 7:30 AM, the Hospice Medical Director was asked why a hospice patient was on Coumadin, and was not able to explain why Patient #1 was on Coumadin. He stated it is a controversy whether to keep hospice patients on medications like Coumadin. He stated if it was to prevent from blood clots and stroke for a patient with an unrelated diagnosis, then Coumadin would be indicated. He stated he was unsure if Patient #1 had cardiomegaly or another diagnosis that would indicate she needed Coumadin. When the Hospice Medical Director was asked about the rupture of the hematoma, and the amount of bleeding from the leg, he responded that he was alerted when the hematoma burst. He stated he did not come to evaluate the wound, and was not aware of the amount of drainage. He stated he was aware the results of Patient #1's PT/INR was "Hyper therapeutic," and did not consider discontinuing the Coumadin at that time. Patient #1 sustained an injury to her lower left leg on 4/9/15, cause unknown. The injury developed into a hematoma causing Patient #1 "unbearable," severe pain and she was unable to eat. On 4/10/15 the hematoma had ruptured and had "copious amounts of red bloody drainage." Patient #1 was unresponsive, her vital signs were abnormal, and she was not able to take her medications. On 4/11/15, 4/12/15, and 4/13/15 Patient #1's condition continued to deteriorate and she was showing signs of active dying. She	L 508		

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L 508	Continued From page 25 was not responsive, continued being unable to eat, had difficultly drinking, her vital signs continued to be abnormal, and the left leg wound continued to have a "heavy amount of red drainage." However, during the 6 day period, from 4/9/14 when the injury was sustained to her death on 4/14/15, no Event Reports were completed for Patient #1, the Administrator was not contacted to report Patient #1's injury and an investigation was not initiated in order to ensure she was protected from ongoing physical harm and mental anguish. Further, a "Coroner's Office Death Investigation Report," dated 4/14/15, stated the Coroner had been contacted by the owner of the funeral home that Patient #1 had been taken to. The Coroner documented the home health nurse had asked the owner of the funeral home to contact the Coroner to "check on the decedent." The report stated "He [the owner of the funeral home] stated the home health [and hospice] nurse was afraid that there had been possible negligence from the nursing home [ALF]." An Event Report documenting the possible negligence from the ALF was not present in the hospice agency's records and there was no documentation indicating the possible negligence had been immediately reported to the Administrator. The "Coroner's Office Death Investigation Report" also stated the Coroner "...spoke with home health they advised that last Thursday, April 9, they found the decedent with a bruise on the left calf. Been [sic] found at approximately 0830 hrs. They stated that over the next 20 minutes the area increased in size almost doubled [sic]. I	L 508		

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L 508	Continued From page 26 obtained pictures that were taken at the extended care facility at that time. There were also pictures that were taken at the extended care facility over the next two or three days that showed the wound getting larger and the skin splitting open. Home Health contacted [hospice Medical Director's name] who advised that they do nothing accept [sic] icepack the area to see if they could stop the bleeding down [sic]...Home health also advised me that when I checked the leg on April 9 the decedent stated that is was hurting her. She had a blood clot 2 to 3 years ago in the same area and at that time nothing was done for it..." The report stated an autopsy had been conducted and "...showed that the decedent died of heart failure. [Physician's name who performed the autopsy] was unable to say if the wound on the left leg hastened the decedent's death or not..." An Event Report documenting the Coroner's contact with the hospice agency regarding potential concern in Patient #1's care was not present in the hospice agency's records and there was no documentation indicating the Administrator had been notified. During a telephone interview on 4/23/15 beginning at 12:00 PM, the Corporate Compliance Officer stated he was not aware of Patient #1's hematoma, death, and coroner investigation. He stated he would have expected an Event report for the injury of unknown cause, as well as, the coroner investigation. He stated the hospice agency did not contact the corporate level Hospice Administrator. The agency failed to ensure the injury of unknown cause on Patient #1's left leg had been reported to the Administrator in order to initiate an	L 508		

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L 508	Continued From page 27 immediate investigation and to ensure Patient #1 was immediately protected from ongoing physical harm and mental anguish. ii. Patient #3 was an 80 year old female who was hospice services from 2/19/15 until her death on 3/16/15, with a terminal diagnosis of renal failure. Additional diagnoses included CHF, kidney disease, and memory loss. She resided at an ALF. A signed copy of Patient #3's POC for the certification period 2/19/15 to 5/19/15 was provided to the survey team on 4/21/15 at 4:30 PM. The POC was signed by the Medical Director on 4/21/15, 7 hours after the surveyors requested her record. The Medical Director included a hand written narrative of clinical findings to support her admission to hospice services which stated "81 year old [female] with a history of dementia has recently been deteriorating with increase in hallucinations, neglect, and at times combativeness. She also has had increased edema to the point of weeping from her legs. Echocardiogram showed normal EF [ejection fraction] 73%, but had moderate aortic stenosis [with] calcification. She also has progressive CKD. After discussion with family, the PCP opts to place her on hospice. She has been on Coumadin for chronic DVT." During an interview with the Hospice Medical Director on 4/23/15 at 7:30 AM, he reviewed Patient #3's record and confirmed he signed the POC for Patient #3 on 4/21/15. He stated he completed the narrative, and signed the POC after the hospice notified him that the "State Auditors" were at the agency. He reviewed the narrative section that he completed and stated he	L 508		

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L 508	Continued From page 28	L 508		

was in error by writing Patient #3 had increased edema and weeping legs. He stated he reviewed Patient #3's history and physical, and brought the information related to her edema and weeping legs to the narrative from that information. He stated he did not actually evaluate Patient #3 in person.

Patient #3's POC included orders for SN visits 3 times weekly, and aide visits 7 days a week to provide bathing and assistance with ADLs. Her POC included information regarding her medications, which were provided by the hospice agency. One medication that the hospice provided was Coumadin 2.5 mg, 1 tablet daily.

Patient #3's admission assessment, dated 2/19/15, and performed by an RN, noted she had 1+ edema in her right and left lower extremities. Her skin assessment noted "No signs or symptoms." No areas of skin breakdown or potential areas were noted.

Patient #3's record indicated her medication was not administered as ordered, and the hospice agency did not ensure communication regarding physician orders, which resulted in medication errors and adverse outcomes, as follows:

Patient #3's record included records from her care that was provided by the home health agency prior to her admission to hospice. A Physician's Order, dated 2/12/15, noted "PT-40.3, INR-4.6, Hold Coumadin X 3 days, recheck PT/INR on 2/15/15 call Dr. [name] [with] results."

A Physician's Order, dated 2/16/15, noted "Spoke [with] nurse, explained no lab on 2/15/15 d/t weekend [and] no home health orders. MD

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L 508	Continued From page 29 agreed to draw INR 2/17/15 AM." A Home Health Nurse's Note on 2/17/15, documented "INR was redrawn this AM and was 10.3. MD ordered to give Vitamin K 5 mg and redraw tomorrow." A Physician's order, dated 2/17/15, noted "Vitamin K 5 mg today and repeat PT on 2/18/15." A Charting Note from the ALF, dated 2/17/15, stated "INR was redrawn this AM, and it was 10.3. MD ordered to give Vitamin K 5 mg and draw tomorrow. He also ordered stat CBC and CMP." A Charting Note from the ALF, dated 2/19/15, stated "INR, redrawn yesterday morning and was 2.5. Resident was admitted to hospice. MD reported to resume Coumadin and recheck INR 2/20/15. On 2/17/15 her MD wanted her to be direct admit to the hospital and resident declined to EMT's. She will now be on Hospice for comfort and end of life care." A copy of the Physician's Order dated 2/18/15, stated "Restart Coumadin tonight, repeat PT/INR on 2/20/15." The order was signed by the physician. Beside the order, handwritten and signed by the Medication Nurse at the ALF, was the note "Med Error, Order was never processed by Pharmacy, MD notified 2/24/15." The note did not indicate if the hospice was notified of the medication error. A Charting Note from the ALF, dated 2/24/15, stated "Coumadin dose changed to 2.5 mg daily, recheck INR next week. Todays [sic] INR is 2.2."	L 508		

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L 508	Continued From page 30 An "Outside Agency Visit Note," dated 3/03/15, signed by the hospice RN and left at the ALF, noted "Patient refused PT/INR. Does not want nursing to assess her, very agitated when woken up." A hospice Case Communication note, dated 3/06/15, stated "Patient has not had Coumadin X 4 days, patient refused. PT/INR 4.9/59.0." An "Outside Agency Visit Note," dated 3/06/15, signed by the hospice RN and left at the ALF, noted "PT/INR 4.9/59.0. Dr. [name] notified." The note included a notation by the ALF medication nurse "MD ordered Vit K 10 mg then DC'd. No further instruction- family notified." The notation was signed by the ALF medication nurse, dated 3/10/15. However, her record did not include verbal or written orders to discontinue the Vitamin K. A hospice Case Communication note, entered by the RN and dated 3/09/15, noted "PT/INR 3.5/34.9, Patient has refused Coumadin X 7 days." A hospice Case Communication note, dated 3/12/15 at 5:17 PM, and entered by the MSW, noted during an IDT at the ALF, "RN states that patients foley drainage is 'pure blood' r/t [related to] clotting issues d/t [due to] recent adjustments, trouble monitoring clotting. [Hospice RN] inquired about orders to DC all meds except for comfort meds, [ALF medication nurse] stated the facility had not received orders, specifying DC Coumadin, Vit K, all labs, all meds except for comfort." The hospice RN was aware Patient #3's PT/INR	L 508		

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L 508	Continued From page 31 was above therapeutic levels and the ALF did not have the orders to discontinue the medications. However, action taken to resolve the issues were not documented in Patient#3's record. A hospice RN Visit note dated 3/13/15, stated "PT/INR done per physician r/t recent blood tinged urine. INR 2.2, PT 26.2." A hospice RN Visit note dated 3/14/15 from 8:21 PM to 9:30 PM, noted "SN visit today due to report of redness and swelling to R [right] side of face near jaw line. Lump observed, that is red and warm to the touch. Dr. [name] notified, could possibly be a tooth abcess [sic]. Vitals are stable this visit, but heart rate is running 120/126/minute. Patient is diaphoretic." The section of the assessment for the visit note documented Patient #3's respiratory rate was 24-28/ minute, her heart rate was 124, and her oxygen saturations were 91% on room air. Patient #3's blood pressure was not assessed. Her pain was estimated by the RN as 3/10 as determined by Patient #3's moaning. An "Outside Agency Visit Note," dated 3/14/15 at 9:25 PM, signed by the hospice RN and left at the ALF, noted "Morphine scheduled 0.25 ml every 4 hours." A Physician Order, dated 3/14/15 at 8:00 PM, and signed by Patient #3's physician, noted Morphine 0.25 ml was to be administered orally every 4 hours. A hospice RN Visit note dated 3/15/15 from 12:18 PM to 12:55 PM, noted Patient #3's blood pressure was 90/52, her heart rate was	L 508		

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INTERMOUNTAIN HOMECARE HOSPICE - CASSIA	1031 EAST MAIN STREET BURLEY, ID 83318

(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 508	Continued From page 32 108/minute, oxygen saturation was 90% on room air, and her temperature was 96.9. She continued to have swelling on her right jaw area, and pain was assessed by the RN at 3/10. Patient #3 died on 3/16/15. The ALF MAR documented Patient #3 refused to take Coumadin as ordered from 3/02/15 - 3/06/15 and from 3/08/15 - 3/10/15. The ALF MAR indicated Patient #3 also refused her Vitamin K on 3/11/15. The hospice RN was aware the ALF had not administered the scheduled doses of Coumadin and Vitamin K and reported Patient #3's "...foley drainage is 'pure blood' r/t clotting issues d/t recent adjustments, trouble monitoring clotting" as documented in the MSW's Case Communication note, dated 3/12/15 at 5:17 PM. However, Event Reports documenting the medication omissions, elevated PT/INR levels, and bleeding concerns were not found. During an interview on 4/23/15 at 9:30 AM, the Interim Nurse Manager confirmed Event Reports were not completed for the incidents of abnormal lab values, bloody urine, and medication errors and the Administrator was not notified. Further, the narrative section of the hospice RN Visit note dated 3/15/15 from 12:18 PM to 12:55 PM, documented the ALF medication aide on duty stated the ALF did not receive an order for scheduled morphine, so Patient #3 was not receiving medications as they were ordered. The ALF MAR indicated Patient #3 did not receive	L 508		

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L 508	Continued From page 33 routine Morphine every 4 hours as ordered. It remained as a PRN medication on the MAR, and she received PRN doses once on 3/02/15, 3/03/15, and at 9:38 PM on 3/14/15. During an interview on 4/23/15 at 9:30 AM, the Interim Nurse Manager reviewed Patient #3's record and confirmed she was aware of the medication omissions. She stated she met on several occasions with the staff of the ALF, as the hospice representative to discuss patient compliance as well as, staff compliance with medication administration. She stated a problem she had noted was the physician did not always fax the order to the ALF when the order was faxed to the hospice. The Interim Nurse Manager described the process of medication and order changes. She stated an order is faxed from the physician to the Corporate office, the order is transcribed to the electronic medical record (EMR), and then a scanned copy of the order is placed in the record. Once the order has been entered into the EMR, a communication note is placed in the agency and patient record. The agency and RN is alerted about the order, and it is then part of the record, and the patient care should at that point reflect the new order. She stated her staff assumes the ALF is alerted of the orders by the physician generated fax, but if the ALF does not get the order, there is a breakdown in the system. The Interim Nurse Manager stated the hospice nursing staff does not confirm each order with the facilities the patients are in. However, an Event Report documenting the Interim Nurse Manager's concerns with the agency's physician order system was not found.	L 508		

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L 508	Continued From page 34 Further, there was no indication the Administrator had been immediately notified of the physician order system problems and the resulting potential neglect of Patient #3's needs, as defined in the corporate "Abuse Policy," as "The passive or active withholding of medicine...[and] treatments...by a...caregiver." During an interview on 4/23/15 at 9:30 AM, the Interim Nurse Manager confirmed Event Reports were not completed for the identified medication errors and the Administrator was not notified of the system problems. The agency failed to ensure that medication system errors were immediately reported to the Administrator in order to initiate an immediate investigation and to ensure Patient #3's medical needs were not neglected. iii. Patient #2 was an 89 year old male who had been admitted to hospice on 8/17/14 with a diagnosis of malignant neoplasm of the prostate with probable metastasis to the bone. Patient #2's initial physical evaluation, dated 8/17/14, documented mid arm measurements bilaterally as 25 cm. No lower extremity measurements were documented, trace edema was noted in both feet, lung sounds were noted to be clear in all fields, and Patient #2 reported shortness of breath when walking 20 feet or less. During the certification period from 12/15/14 to 2/12/15, symptoms of increasing systemic edema and shortness of breath were noted during SN visits, without medical intervention, as follows: 12/12/14 - Edema in both feet was documented	L 508		

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L 508	Continued From page 35 as 1+ (trace) and wheezes were noted in both lungs. No upper or lower extremity measurements were documented. Patient #2 was noted to be short of breath "while talking or eating or performing other ADLs." 12/14/14 - Edema in both feet was documented as "non-pitting," wheezing and crackles were noted in both lungs, and mid arm circumference was measured at 26 cm bilaterally with no lower extremity measurements documented. Shortness of breath was noted "while talking or eating or performing other ADLs." 12/15/14 - Edema was documented as 2+, shiny, and hard in both lower extremities. No extremity measurements were documented. Rales were documented in all lung fields. Patient #2's shortness of breath was present while he was "at rest." 12/16/14 - No upper or lower extremity measurements were documented. Rales were noted in all lung fields, and Patient #2's right lower leg was noted to have "redness with blister that is beginning to weep." Patient #2 continued with shortness of breath "at rest." 12/17/14 - Upper and lower extremity measurements were not assessed. Edema was documented as 3+, hard, shiny, with red areas in both lower extremities. Patient #2 was noted to have "severe with [sic] shortness of breath with exertion." 12/19/14 - No extremity measurements were documented, and no lung sounds were obtained. Edema was noted to be 3+ in both lower extremities. Shortness of breath "at rest" was	L 508		

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L 508	Continued From page 36 documented. 12/22/14 - Edema was noted to be 3+ in bilateral lower extremities. While lung sounds were documented as clear, Patient #2 reported he was short of breath. Oxygen saturation level was documented at 92% on room air and Patient #2's respiratory rate was 20/min. Upper and lower extremity measurements were not assessed. The social worker's visit note on this date stated Patient #2 "becomes SOB [short of breath] with conversation." 12/26/14 - Edema was noted to be 4+ in both lower extremities with "blistering ulcer on right anterior lower leg." Lung sounds were diminished in the left lung and the right upper lung. Rales were heard in the right lower lung. Respiratory rate had increased to 30/min with oxygen saturation measured at 84% on room air. Nursing notes stated "In obvious respiratory distress..." 12/29/14 - Edema was documented as 4+ with "red weeping blistered area on right lower leg." No upper or lower extremity measurements were documented. Rales were noted in both lung bases and lung sounds were diminished in the middle and upper areas of both lungs. Shortness of breath was noted while Patient #2 was "at rest." The 12/29/14 SN note included documentation the Medical Director was contacted and Lasix (a diuretic medication) was requested for Patient #2. However, the SN note dated 1/02/14, documented the Lasix was started, 4 days after the medication was initially requested.	L 508		

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L 508	Continued From page 37	L 508		

During the 18 day period, from 12/12/14 to 12/29/14, Patient #2 exhibited increasing symptoms of systemic edema as noted in SN visit notes. There was no documentation Patient #2's physician was informed of his increasing systemic edema until 12/29/14 and pharmaceutical treatment was not initiated for 4 more days, on 1/2/15. Treatment for dyspnea was not initiated at any time from 12/12/14 until Patient #2's death on 1/9/15.

However, the agency's records did not include Event Reports or other documentation which indicated the Administrator was aware of the potential neglect of Patient #2's medical needs as defined in the corporate "Abuse Policy," as "The passive or active withholding of medicine...[and] treatments...by a...caregiver."

When asked about Patient #2, during an interview on 4/22/15 at 11:05 AM, the Interim Nurse Manager did not have an explanation for why the Medical Director was not contacted or informed prior to 12/29/14, regarding Patient #2's worsening lower extremity edema and increasing shortness of breath. She further confirmed no interventions were implemented for his shortness of breath and was unable to give an explanation why the RN did not perform interventions.

The agency failed to ensure that Patient #2's worsening dyspnea and increasing edema was immediately reported to the Administrator in order to initiate an immediate investigation and to ensure Patient #2's medical needs were not neglected.

The agency failed to ensure agency staff recognized and immediately reported cause

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L 508	Continued From page 38 unknown injuries and allegations of potential neglect to the agency Administrator. This resulted in a lack of immediate investigation and protection of patients, which placed them at risk of serious and immediate harm, impairment, and/or death due to ongoing neglect. The agency was notified of the immediate jeopardy verbally on 4/23/15 at 1:30 PM and were not able to submit an acceptable immediate plan.	L 508		
L 509	418.52(b)(4)(ii) EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON [The hospice must:] (ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures; This STANDARD is not met as evidenced by: Based on review of agency policies and procedures, record review and interview, it was determined the agency failed to ensure policies and procedures were sufficiently developed, implemented and monitored to ensure investigations were conducted for all allegations of abuse, neglect, mistreatment, injuries of an unknown source or misappropriation of patient property, and that patients were protected during the course of such investigations for 6 of 6 patients (Patients #4 - #9) receiving services at the agency at the time of the survey. Failure to	L 509		5/9/15

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L 509	Continued From page 39 ensure all alleged incidents were properly investigated had the potential to result in patients being subjected to ongoing abuse, neglect, mistreatment, and exploitation and/or continuing to be exposed to unidentified injury causing hazards. The findings include: 1. The agency's "Abuse Policy," effective October 2008, was a corporate policy. The "Scope" of the policy included hospitals, the medical group, homecare, and ambulatory surgical centers. The policy did not include information specific to the operations of the hospice agency. The policy included definitions which included abuse, physical abuse, domestic abuse, sexual abuse, rape, neglect and exploitation. However, the policy did not include information related to injuries of unknown source. Further, the policy did not include information related to investigating any alleged violations or protecting patients during the course of such investigations. 2. During a telephone interview, on 4/23/15 at 11:30 AM, the Corporate Compliance Director stated all incidents were to be documented on an "Event Report." The agency provided multiple "Event" policies and procedures which included an "Event Reporting Policy," a "Reportable Events Procedure," and a "Risk Event Management Procedure." The policy and procedures documented they were all effective March 2014. The agency also provided a "Patient Grievance Policy" which was also effective March 2014 and a "Patient Grievance Procedure," which was effective October 2014.	L 509		

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L 509	Continued From page 40 All of the submitted policies and procedures were related to corporate process. The policies and procedures included information related to corporate operations in both Utah and Idaho and were applicable to various types of healthcare facilities. The corporate policies and procedures did not include information specific to the operations of the hospice agency, clear provisions for the immediate investigation of violations, or information related to how the agency protected patients during the course of the investigations, as follows: a. The corporation's "Event Reporting Policy," included multiple definitions of events, which included the following: - Event: "Any unexpected occurrence or process variance that impacts or may impact the quality of patient care, patient or visitor safety or which poses an operational risk (i.e. an accident, complication, lab error, coding/charging errors, improper informed consent, IS business interruption, medication error, significant billing complaint, improper business practices, regulatory breach, ethical issues fall [sic], equipment failure or theft, etc.). Events may be discovered during routine delivery of care or business operations. Additionally they may be identified by way of a patient/family complaint or grievance." - Adverse Event: "An undesirable and unanticipated outcome that was caused by a clinical mistake, misjudgment or oversight, which results in temporary or permanent injury, damage or harm to the patient."	L 509		

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L 509	Continued From page 41 - Sentinel Event: "A serious event that meets criteria set forth by the Joint Commission and/or the Utah Department of Health. A Root Cause Analysis is completed for all Sentinel Events." - Serious Safety Event (SSE): "A deviation from generally accepted practice standards (GAPS) and reaches the patient and causes moderate to severe harm or death in any healthcare setting." The agency's corresponding "Reportable Events Procedure," effective March 2014 included definitions for "Event," "Adverse Event," "Reportable Event," and "Sentinel Event" which matched the definitions given in the agency's "Event Reporting Policy," stated above. However, the procedure did not include information related the "Serious Safety Event (SSE)" defined in the agency's "Event Reporting Policy." Information regarding how the "Serious Safety Event (SSE)" events were to be investigated was not present in the procedure. The agency failed to ensure the procedure was sufficiently developed to address the investigation of "Serious Safety Events." b. The "Reportable Events Procedure," stated the "Region/Facility" was to "Initiate a Risk/Quality investigation...to determine appropriate actions" for all non-sentinel and sentinel events. The policy did not include information regarding who was responsible for initiating investigations for the hospice agency. c. The "Event Reporting Policy," effective March 2014 defined a "Reportable Event" as "A specific	L 509		

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L 509	Continued From page 42 subset of Events that, due to their more serious nature, must be reported within 24 hours of discovery to the Clinical Risk Manager at the Central Office." The corresponding "Reportable Events Procedure," effective March 2014, stated "Each facility must implement training and education for staff to notify Risk Management of events that meet Reportable Event Criteria...This also applies to Events for which notification occurs by way of patient complaint and legal notice of intent to commence litigation...Events are evaluated by the Risk/Quality Management...If there is any question whether an Event qualifies as a Reportable Event, Risk/Quality Management should consult with the Corporate Clinical Risk Manager..." The corresponding "Risk Event Management Procedure," effective March 2014, stated Events were to be "...triaged within 24 hours for Reportable Events, and within seven (7) days for all other events." The procedure stated the "Triager shall determine if the event meets the definition of Reportable Event or Complaint/Grievance and implement the corresponding procedure." i. The "Risk Event Management Procedure," stated the "Triager determines what follow-up action is required for the event." The procedure stated the following: - "If the event meets Initial Assessment Criteria...it shall be forwarded to the individual accountable for the investigation and follow-up (Risk Management, Quality, Medical Director, CMO, etc.). The Initial Assessment Criteria includes	L 509		

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L 509	Continued From page 43 whether the event is a Reportable Event, a Near Miss Event, and whether it meets thresholds for severity of harm and compensability." - "The event shall be forwarded to the department leader where the event occurred for the investigation and corrective action(s). If the Triager expects a response on follow-up form [sic] the department head, it should be specifically requested when the event is assigned." The "Risk Event Management Procedure" did not include information specific to the hospice agency or provide for the immediate investigation of abuse, neglect, and mistreatment, injuries of an unknown source or misappropriation of patient property. Further, the policy did not include information related to the protection of patients during the course of investigations. ii. The "Patient Grievance Policy," effective March 2014 defined "Grievance" as "A written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the compliant by staff present) by a patient, or the patient's representative, regarding the patient's care, abuse or neglect, issues related to the hospital's compliance with CMS Hospital Conditions of Participation (CoP), or a Medicare beneficiary billing complaint related to rights and limitations..." The "Patient Grievance Policy" stated "The facilities' Governing Board must review and resolve grievances (complaints), unless it delegated this responsibility, in writing, to a Grievance Committee under the direction of Risk Management." The policy also stated, in the "Risk Management or Other Response to	L 509		

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L 509	Continued From page 44 Grievance/Complaints" section that "Assigned staff identify, investigate, and respond to the grievance in a reasonable time frame given the seriousness of the allegations and the potential for harm to patients, as outlined in the Patient Grievance Procedure." The policy did not include information specifically related to the hospice agency or provide for the immediate investigation of abuse, neglect, and mistreatment, injuries of an unknown source or misappropriation of patient property. Further, the policy did not include information related to the protection of patients during the course of investigations. iii. The "Patient Grievance Procedure" stated "Risk Management/Patient Relations reviews complaints, and designates them as grievances in the Event System if criteria is met...Risk Management/Patient Relations representatives or others designated coordinate the investigation and evaluation of all complaints and grievances, including the coordination of corrective action by the appropriate department or medical director, as required by Risk Management Procedure." The policy did not include information specifically related to the hospice agency or provide for the immediate investigation of abuse, neglect, and mistreatment, injuries of an unknown source or misappropriation of patient property. Further, the policy did not include information related to the protection of patients during the course of investigations. During an interview on 4/22/15 at 3:30 PM, the Interim Nurse Manager was asked about policies and procedures specific to the hospice agency.	L 509		

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L 509	Continued From page 45 She stated the policies were not specific to Hospice, and the agency did not have their own individual policies. She stated the policies were online, and maintained at the corporate level. She stated the policies were available to be reviewed online, but to obtain a copy would require a release from the IT department. She stated incidents, complaints, and grievances would be investigated through the corporate office, and she would receive instruction from them if further action from her was required. The agency failed to sufficiently develop, implement, and monitor hospice policies and procedures necessary to ensure all allegations of abuse, neglect, mistreatment, injuries of an unknown source or misappropriation of patient property, were immediately investigated and that patients were protected during the course of such investigations.	L 509		
L 510	418.52(b)(4)(iii) EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON [The hospice must:] (iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; This STANDARD is not met as evidenced by: Based on review of agency policies and procedures, record review and interview, it was determined the agency failed to ensure policies and procedures were sufficiently developed, implemented and monitored to ensure appropriate, timely corrective action was taken in	L 510		5/18/15

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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
L 510	Continued From page 46	L 510		

response to all allegations of abuse, neglect, mistreatment, injuries of an unknown source or misappropriation of patient property for 6 of 6 patients (Patients #4 - #9) receiving services at the agency at the time of the survey. This resulted in the potential for patients being subjected to ongoing abuse, neglect, mistreatment, exploitation and/or continuing to be exposed to injury causing hazards. The findings include:

1. The agency's "Abuse Policy," effective October 2008, was a corporate policy. The "Scope" of the policy included hospitals, the medical group, homecare, and ambulatory surgical centers. The policy did not include information specific to the operations of the hospice agency.

The policy included definitions which included abuse, physical abuse, domestic abuse, sexual abuse, rape, neglect and exploitation. However, the policy did not include information related to injuries of unknown source. Further, the policy did not include information related to the implementation of appropriate corrective in response to such incidents.

2. During a telephone interview, on 4/23/15 at 11:30 AM, the Corporate Compliance Director stated all incidents were to be documented on an "Event Report."

The agency provided multiple "Event" policies and procedures which included an "Event Reporting Policy," a "Reportable Events Procedure," and a "Risk Event Management Procedure." The policy and procedures documented they were all effective March 2014. The agency also provided a "Patient Grievance

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L 510	Continued From page 47 Policy" which was also effective March 2014 and a "Patient Grievance Procedure," which was effective October 2014. All of the submitted policies and procedures were related to corporate process. The policies and procedures included information related to corporate operations in both Utah and Idaho and were applicable to various types of healthcare facilities. The corporate policies and procedures did not include information specific to the operations of the hospice agency or clear provisions for timely, appropriate corrective actions to be taken in response substantiated violations, as follows: a. The corporation's "Event Reporting Policy," included multiple definitions of events, which included the following: - Event: "Any unexpected occurrence or process variance that impacts or may impact the quality of patient care, patient or visitor safety or which poses an operational risk (i.e. an accident, complication, lab error, coding/charging errors, improper informed consent, IS business interruption, medication error, significant billing complaint, improper business practices, regulatory breach, ethical issues fall [sic], equipment failure or theft, etc.). Events may be discovered during routine delivery of care or business operations. Additionally they may be identified by way of a patient/family complaint or grievance." - Adverse Event: "An undesirable and unanticipated outcome that was caused by a clinical mistake, misjudgment or oversight, which	L 510		

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L 510	Continued From page 48 results in temporary or permanent injury, damage or harm to the patient." - Sentinel Event: "A serious event that meets criteria set forth by the Joint Commission and/or the Utah Department of Health. A Root Cause Analysis is completed for all Sentinel Events." - Serious Safety Event (SSE): "A deviation from generally accepted practice standards (GAPS) and reaches the patient and causes moderate to severe harm or death in any healthcare setting." The "Reportable Events Procedure," stated the "Region/Facility" was to "Initiate a Risk/Quality investigation (RCA, SCA, Interviews, Medical Record Review, and/or performance review) to determine appropriate actions" for all non-sentinel and sentinel events. The procedure stated the following: - The "Non-Sentinel Reportable Events (Patient Event Investigation and Action Plan Process)" section that identified actions "required for process improvement" were to be documented within 90 days. The procedure did not include timeframes for the actions to be implemented. - The procedure stated in the "Sentinel Events" section that a "...final report and action plan required by the State is submitted within 45 days of the State notification." The procedure did not specify which State(s) the reporting requirements referred to and did not include timeframes for the actions to be implemented.	L 510		

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L 510	Continued From page 49 b. The agency's "Event Reporting Policy," effective March 2014 defined a "Reportable Event" as "A specific subset of Events that, due to their more serious nature, must be reported within 24 hours of discovery to the Clinical Risk Manager at the Central Office." The agency's corresponding "Reportable Events Procedure," effective March 2014, stated "Each facility must implement training and education for staff to notify Risk Management of events that meet Reportable Event Criteria...This also applies to Events for which notification occurs by way of patient complaint and legal notice of intent to commence litigation...Events are evaluated by the Risk/Quality Management...If there is any question whether an Event qualifies as a Reportable Event, Risk/Quality Management should consult with the Corporate Clinical Risk Manager..." The agency's corresponding "Risk Event Management Procedure," effective March 2014, stated Events were to be "...triaged within 24 hours for Reportable Events, and within seven (7) days for all other events." The procedure stated the "Triager shall determine if the event meets the definition of Reportable Event or Complaint/Grievance and implement the corresponding procedure." i. The "Risk Event Management Procedure," stated the "Triager determines what follow-up action is required for the event." The procedure stated the following: - "If the event meets Initial Assessment Criteria...it shall be forwarded to the individual accountable	L 510		

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L 510	Continued From page 50 for the investigation and follow-up (Risk Management, Quality, Medical Director, CMO, etc.). The Initial Assessment Criteria includes whether the event is a Reportable Event, a Near Miss Event, and whether it meets thresholds for severity of harm and compensability." - "The event shall be forwarded to the department leader where the event occurred for the investigation and corrective action(s). If the Triager expects a response on follow-up form [sic] the department head, it should be specifically requested when the event is assigned." The "Risk Event Management Procedure" did not include information specifically related to the hospice agency or establish timeframes for when appropriate actions was to be taken. ii. The "Patient Grievance Policy," effective March 2014 defined "Grievance" as "A written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the compliant by staff present) by a patient, or the patient's representative, regarding the patient's care, abuse or neglect, issues related to the hospital's compliance with CMS Hospital Conditions of Participation (CoP), or a Medicare beneficiary billing complaint related to rights and limitations..." The "Patient Grievance Policy" stated "The facilities' Governing Board must review and resolve grievances (complaints), unless it delegated this responsibility, in writing, to a Grievance Committee under the direction of Risk Management." The policy also stated, in the "Risk Management or Other Response to Grievance/Complaints" section that "Assigned	L 510		

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L 510	Continued From page 51 staff identify, investigate, and respond to the grievance in a reasonable time frame given the seriousness of the allegations and the potential for harm to patients, as outlined in the Patient Grievance Procedure." The "Risk Event Management Procedure" did not include information specifically related to the hospice agency or provide a timeframe for when appropriate actions was to be taken. iii. The "Patient Grievance Procedure" stated "Risk Management/Patient Relations reviews complaints, and designates them as grievances in the Event System if criteria is met...Risk Management/Patient Relations representatives or others designated coordinate the investigation and evaluation of all complaints and grievances, including the coordination of corrective action by the appropriate department or medical director, as required by Risk Management Procedure." The "Risk Event Management Procedure" did not include information specifically related to the hospice agency or establish timeframes for when appropriate actions was to be taken. During an interview on 4/23/15 at 9:30 AM, the Interim Nurse Manager and Corporate Risk Manager were asked about policies and procedures specific to the hospice agency. The Interim Nurse Manager stated the policies were maintained at the corporate level. She stated she was not involved with the investigation and resolution of investigations, the Risk Management and Corporate Compliance staff would take care of issues. She stated she was not aware of the outcome of investigations, corrective actions, and time frames.	L 510		

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L 510	Continued From page 52 The agency failed to sufficiently develop, implement and monitor hospice policies and procedures necessary to ensure appropriate, timely corrective action was taken in response to all allegations of abuse, neglect, and mistreatment, injuries of an unknown source or misappropriation of patient property.	L 510		
L 511	418.52(b)(4)(iv) EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON [The hospice must:] (iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation. This STANDARD is not met as evidenced by: Based on policy review, record review and staff interviews, it was determined the agency failed to ensure policies and procedures were sufficiently developed, implemented and monitored to ensure all allegation of abuse, neglect, mistreatment, or misappropriation of patient property, were reported in accordance with State Law. This failure directly impacted 1 of 2 patients (Patient #10) reviewed, for whom Event Notes were completed and had the potential to impact 6 of 6 patients (Patients #4 - #9) who were receiving agency services at the time of the survey. This resulted in a potential lack of protection and advocacy for patients. The findings include: 1. Idaho law requires reporting abuse, exploitation, and neglect for children and vulnerable adults, as follows:	L 511		4/28/15

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L 511	Continued From page 53 a. Idaho statute 16-1605 states "Reporting of abuse, abandonment or neglect. (1) Any physician...nurse...social worker, or other person having reason to believe that a child under the age of eighteen (18) years has been abused, abandoned or neglected or who observes the child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment or neglect shall report or cause to be reported within twenty-four (24) hours such conditions or circumstances to the proper law enforcement agency or the department. The department shall be informed by law enforcement of any report made directly to it. When the attendance of a physician, resident, intern, nurse, day care worker, or social worker is pursuant to the performance of services as a member of the staff of a hospital or similar institution, he shall notify the person in charge of the institution or his designated delegate who shall make the necessary reports." b. Idaho statute 39-5303 states "Duty to report cases of abuse, neglect or exploitation of vulnerable adults. (1) Any physician, nurse, employee of a public or private health facility...social worker...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 [Idaho commission on aging]...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	L 511		

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L 511	Continued From page 54 to the appropriate law enforcement agency." The agency's "Abuse Policy," effective October 2008, was a corporate policy. The "Scope" of the policy included hospitals, the medical group, homecare, and ambulatory surgical centers. The policy did not include information specific to the operations of the hospice agency. The policy stated "Intermountain Healthcare will assess patients, adult and pediatric, for suspected abuse and provide suspected victims of abuse, neglect, or exploitation with the appropriate medical treatment and supportive care, as well as notify appropriate authorities of suspected abuse, neglect, exploitation [sic] in accordance with state law." The policy included a "Primary Source" section which included "Idaho Code 16-1619, 39-5303, 9-203." However, no other information such as which Idaho agencies were to be reported to and the timeframes for reporting was present in the policy. Additionally, the policy did not state which person at the hospice agency was responsible to ensure reporting occurred or how the reporting was to take place. During a telephone interview, on 4/23/15 at 11:30 AM, the Corporate Compliance Director stated all incidents were to be documented on an "Event Report." The agency's Event Report summary from 1/1/14 through 4/23/15 was reviewed and documented 6 total events (1 event related to an increase in pain medication, 4 events related to falls and 1 event related to an allegation of abuse). The summary documented on 4/28/14 a patient reported a "facility aide bruised her arms by forcing her to	L 511		

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L 511	Continued From page 55 get dressed." The corresponding Event Notes stated the following: 5/15/14 at 3:26:52 PM: The RN documented that during her visit on 5/14/14, Patient #10 reported she was "forced to get dressed" on the morning of 4/28/14 by a facility aide. The RN documented the aide held Patient #10's "arms down causing bilateral bruising to arms/wrists and the left wrists [sic] skin was broke open and a steri strip was applied." The RN documented the Patient #10's daughter was present and the RN "encouraged her" to notify the Administrator of the ALF. The RN documented the ALF Administrator "did come to me prior to leaving the facility and asked if I had seem [sic] bruises to her arms. I let him know that I had. I also received a call later that after noon [sic] from the facility staff nurse regarding the situation. She states that the aide said that [Patient #10] wanted to take a shower and she did not have time to help her since she had four other patients to watch at that time. She said that she redirected her and then noticed that she must have bumped her arm when she came out for breakfast." The RN documented she "mentioned to the nurse that the patient had bilateral matching marks to both arms and that I find it hard to believe that she bumped them too hard. I suggested to her the next time they have difficulty with getting her dressed to either contact [name] her daughter who comes to see daily [sic] or notify our staff and we can help them." A second note, also dated 5/15/14 and timed 3:26:52 PM documented the RN had contacted the ALF Administrator, the hospice office manager, and Patient #10's physician. The Event Note did not include documentation	L 511		

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L 511	Continued From page 56 that the incident had been reported to the Idaho commission on aging. When asked, during an interview on 4/23/15 at 11:35 AM, the RN that signed the Event Report stated she had held many conversations with the ALF staff regarding not forcing Patient #10 to get up early and shower. She instructed the ALF staff to call her if they were experiencing problems with Patient #10. She stated she had not notified adult protective services (Idaho commission on aging) and did not believe the ALF staff had made the notification either. The facility failed to ensure potential abuse was reported in accordance with Idaho State Law.	L 511		
L 515	418.52(c)(4) RIGHTS OF THE PATIENT [The patient has a right to the following:] (4) Choose his or her attending physician; This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure each patient's right to choose an attending physician was upheld. This failure directly impacted 1 of 6 patients (Patient #3) whose records were reviewed and had the potential to impact 6 of 6 patients (#4 - #9) receiving services at the agency at the time of the survey. This resulted in a violation of patient rights. The findings include: 1. Patient #3 was an 80 year old female who was hospice services from 2/19/15 until her death on 3/16/15, with a terminal diagnosis of renal failure. Additional diagnoses included CHF, kidney disease, and memory loss.	L 515		4/28/15

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L 515	Continued From page 57 Patient #3's records included a "Rights and Responsibilities" form, signed by her Guardian on 2/19/15. The form listed multiple patient rights, including the right "To choose you attending physician." However, her right was not upheld as follows: A signed copy of Patient #3's POC was provided to the survey team on 4/21/15 at 4:30 PM. The POC was signed by the Medical Director on 4/21/15; 7 hours after the surveyors requested her record. The Medical Director included a hand written narrative of clinical findings to support her admission to hospice services. The narrative stated "...She has been on Coumadin for chronic DVT." During an interview with the hospice Medical Director on 4/23/15 at 7:30 AM, he reviewed Patient #3's record, and confirmed he signed the POC for Patient #3 on 4/21/15. He was asked why a hospice patient was on Coumadin, and was not able to explain why Patient #3 was on Coumadin. He stated it is a controversy whether to keep hospice patients on medications like Coumadin. He stated if it was to prevent from blood clots and stroke for a patient with an unrelated diagnosis, then Coumadin would be indicated. He stated Patient #3's primary physician wanted her to continue on the Coumadin, as well as, the Namenda, Donepezil, and Pramipexole, that she took for dementia. He stated he did not think that a hospice patient should be continued on dementia medications, but he deferred to the attending physician on that matter. However, involvement of Patient #3's attending	L 515		

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L 515	Continued From page 58 physician was not evident on her POC. During an interview with the hospice Medical Director on 4/23/15 at 7:30 AM, he stated Patient #3 did have an attending physician, but the attending physician was not included on the POC. The hospice Medical Director stated the hospice Corporation instructed him that he (the hospice Medical Director) was to be included on all hospice patients as the attending and Medical Director. He stated he was not comfortable with that, as he was an Oncologist, and he wanted to continue as the attending physician for some of his oncology patients that were cared for by other hospice agencies. He stated he was told that was not possible by the Corporation, as that would be a conflict in interest, on the "Non-Compete Clause" on his contract. The agency failed to ensure each patient's right to choose an attending physician was upheld.	L 515		
L 552	418.56(d) REVIEW OF THE PLAN OF CARE The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure POCs were updated as needed for 5 of 6 patients (Patients #1 - #4 and #6) whose records were reviewed. This resulted in a lack of interventions being provided to meet patient	L 552		

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L 552	Continued From page 59 needs. The findings include: 1. Patient #1 was a 90 year old female who had been admitted to hospice on 3/11/14, with a terminal diagnosis of heart disease. Additional diagnoses included pulmonary hypertension and venous insufficiency. She resided at an ALF. Patient #1's POC for the certification period 3/05/15 to 5/04/15 included orders for SN visits twice weekly, and 2 additional visits as needed. Additionally, she had orders for aide visits 7 times weekly, with 2 additional visits as needed. a. Patient #1's POC also included information regarding her medications, which were provided by the ALF, and which were provided by the hospice agency. One medication that the hospice provided was Coumadin 2 mg, 1 tablet daily. The POC included instructions of "Do not assess PT/INR levels at this time until further notification by [name of hospice Medical Director]." Her record included documentation the most recent PT/INR was performed on 9/25/14, with a result of 25.1 and 2.1 that indicated it was therapeutic. According to the National Library of Medicine website: "Prothrombin time is measured in seconds. Most of the time, results are given as what is called INR (or international normalized ratio). If taking blood thinning medicines such as warfarin, the normal range for PT results is 11 - 13.5 seconds, or INR of 0.8 - 1.1. If taking warfarin to prevent blood clots, the doctor will most likely choose to keep the INR between 2.0 and 3.0. The risks of bleeding and hematoma in these patients are greater than for people without bleeding problems."	L 552		

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INTERMOUNTAIN HOMECARE HOSPICE - CASSIA	1031 EAST MAIN STREET BURLEY, ID 83318

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L 552	Continued From page 60 Patient #1's recertification assessment, performed by an RN, dated 3/05/15, included documentation she had bruising and excessively dry and scaly skin. However, the areas of bruising were not identified in the assessment. There was no determination of the cause of the bruising noted on Patient #1. Further, Patient #1's POC stated she was to be assisted with the application of CircAid wraps to both lower legs during visits. (CircAid wraps are compression wraps to aid in the reduction of edema in the legs). The POC did not specify who was to assist Patient #1 with the application of the wraps, or the frequency and duration the wraps were to be applied. In an RN Visit Note, dated 4/07/15, the RN noted Patient #1 had bruising, but the location of bruising was not identified. Additionally, the note documented Patient #1 had 3+ edema in her right and left lower legs. There was no determination of the cause of the bruising noted on Patient #1. The nursing note did not include documentation the CircAid wraps were either applied or removed. In an RN Visit Note, dated 4/09/15 from 8:23 AM to 10:37 AM, the RN noted Patient #1 had a large developing hematoma on her left lower leg. Her pain was described as a 10 on a pain scale of 1-10, "worst possible imaginable." The note included descriptions of her pain as aching, crushing, shooting, stabbing, and tender, with intermittent spasms. The RN further documented Patient #1 was in severe discomfort, frequently calling out, grabbing her leg, complained of leg spasms approximately every 25-45 seconds, and stated her pain was "unbearable." In the section	L 552		

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L 552	Continued From page 61 "Emotional Status" the RN documented "Patient currently exceedingly agitated due to pain in left leg." The RN wrote in the note that there were no falls reported and the patient reported she did not know what happened to her leg. The RN documented "Following 10 doses of Morphine 1 ml (20 mg) at 15 minute intervals, patient reported she felt the pain in her leg was subsiding adequately." Ten doses of 20 mg of morphine every 15 minutes would be the equivalent of 200 mg Morphine over a 2.5 hour period. She noted Patient #1's Lorazepam was increased to .5 to 1 mg every hour for anxiety and spasms in the left leg. The visit note included a wound assessment sheet with 2 photos of the hematoma. One photo showed erythema and swelling just below the left knee. The second photo showed a much larger hematoma, with a large pocket of fluid noted on the inner aspect. The leg was noted to be more edematous in the second photo. There were no measurements to indicate the actual size of the hematoma. The RN documented that Patient #1 was in a recliner and refused to be transferred to a hospital bed, as it would cause more discomfort. The RN noted that after discussion, Patient #1 agreed to be transferred to the hospital bed. The visit note documented the hospice Medical Director was notified of the hematoma and orders were received to draw a PT/INR, as well as, other labs. The RN noted she reviewed with the ALF nurse and multiple staff members that Patient #1's skin would likely rupture and pooled blood under her skin would drain copiously. She noted	L 552		

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L 552	Continued From page 62 the leg was to have disposable pads underneath to manage drainage if the hematoma ruptured. The visit note did not include documentation of discussion with Patient #1 or her family regarding options for treatment of the hematoma, including pursuing evaluation and treatment at the hospital. Additionally, the note did not include documentation that Patient #1's Coumadin therapy or the use of the CircAid wraps was reevaluated and discussed given her change in status. In an RN Visit note dated 4/09/15 from 2:17 PM to 6:20 PM, the RN documented Patient #1's pain continued at a level of 10 out of 10, with aching, cramping, crushing, shooting, stabbing, and spasms. Additionally, her emotional status was described as "anxious, apprehensive, distraught, irritable, labile, restless, and tearful." The RN noted Patient #1 was not able to eat, and was only able to tolerate fluids. A description of the hematoma on Patient #1's left leg was documented as "swelling and blood pooling to left lower leg appears to be worsening, continued. Patient's hospital bed is assembled and in working order. Patient tolerated [transfer to the bed] with moderate discomfort. Patient required several doses of Morphine every 15 minutes as ordered, and Lorazepam 1 mg every hour as ordered to manage pain symptoms." The RN documented an evaluation of the effectiveness of comfort measures as "Patient reports pain poorly managed during the day today. Ongoing spasms in left leg and persistent discomfort."	L 552		

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L 552	Continued From page 63 The visit note included a wound assessment sheet with a photo of the hematoma. The photo included a measuring guide, which indicated the area of discoloration and swelling of the hematoma was greater than 10 cm (4 inches) wide by 6 cm (2 1/2 inches) long. The height of the hematoma appeared to be approximately 3 cm (1 1/4 inches) high. The RN documented she reviewed teaching with the ALF staff regarding pain management, prevention of further injury to the left leg, prevention of skin breakdown, and the need to keep the leg on disposable pads. She also documented that she reviewed, with the ALF staff, the need to keep Patient #1's leg elevated with pillows, as much as possible, to manage edema and bleeding. The visit note did not indicate Patient #1's physician was notified of the increase in size of the hematoma from the visit 4 hours earlier or of Patient #1's inability to eat. Documentation of discussion with Patient #1 or her family regarding options for treatment of the hematoma, including pursuing evaluation and treatment at the hospital, was not present. In a visit note dated 4/10/15 from 2:40 AM to 4:15 AM, the RN documented Patient #1's pain was estimated at 6/10, and she was moaning. Additionally, the RN noted Patient #1 was non-responsive, and only responded once during the 2 hour visit. The RN documented the appearance of the hematoma as "left leg with a 10 cm hematoma/blood blister to left calf just below the	L 552		

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L 552	Continued From page 64 knee." A wound assessment sheet included photos of the hematoma, which had split open, and the RN documented copious amounts of red bloody drainage. The results of the PT/INR were in the visit note and documented as 28.3 and 2.7, which was above the therapeutic range. The RN documented she reviewed wound care with the ALF staff, and instructed them to not touch the dressing on Patient #1's leg, to only replace the pad under the dressing if it should become soiled. The record did not include documentation that Patient #1's physician was notified of the rupture of the hematoma and amount of drainage, or that Patient #1 was un-responsive. It was not documented if the physician was informed of the result of the PT/INR or that Patient #1's Coumadin therapy and CircAid wrap use was reevaluated and discussed given her status. In a visit note dated 4/10/15 from 11:51 AM to 12:40 PM, the RN documented ALF staff estimated Patient #1's pain rating to be 5 out of 10. The RN documented Patient #1 responded to tactile stimulation only. Patient #1's temperature was noted to be elevated at 99.6, her blood pressure measured 118/64, and her pulse was elevated at 108/minute. The RN documented "Patient minimally responsive during visit, hands and feet cold to touch, intermittent breathing pattern changes. Staff at facility report they have been unable to administer medications to patient all day today due to unresponsiveness. Patient has not eaten anything today, has had only sips of fluids."	L 552		

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L 552	Continued From page 65 The wound assessment for the visit stated "...large hematoma on left lower leg. Large area of blood pooling has ruptured, heavy amount of bloody drainage noted." Additionally, she was noted to have edema around the wound. The RN documented she applied silvadene cream to the open wound and a nonstick pad was placed over the hematoma. The leg was wrapped in an Attends (adult diaper), and a disposable absorbent pad. Patient #1's record did not include documentation of orders for the silvadene cream or wound care instructions for the ruptured hematoma on her leg. The record did not include documentation that Patient #1's physician was notified of the continued drainage and her continued inability to eat or of her deteriorating status as evidenced by Patient #1's abnormal vital signs and her inability to take medications. In a visit note dated 4/11/15 from 1:35 PM to 3:30 PM, the RN noted Patient #1 was minimally responsive, could answer yes or no, and moaned. Her temperature was elevated at 99.0. Patient #1's pain was assessed at 5 as evidenced by the crying, moaning, and grimacing noted by the RN. The RN documented she spoke with the ALF staff to schedule Patient #1's Morphine every 2 hours. The RN noted Patient #1 had noisy respirations, and diminished lung sounds. She documented her skin was discolored with cyanosis. In the section of the note for description of skin, the RN documented Patient #1 had inflammation or cellulitis, open wounds, and bruising.	L 552		

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L 552	Continued From page 66 The visit note documented Patient #1 had no food intake, and only sips of fluids. Additionally, the RN stated she had difficulty controlling liquid in her mouth. The RN documented Patient #1 was showing evidence of active dying, and her family was present. The family was noted as stating "We just want her comfortable." The record did not include documentation that Patient #1's physician was notified of the continued drainage, her continued inability to eat, or of her continued abnormal vital signs. Further, the record did not include documentation that Patient #1's physician was notified of the deteriorating status as evidenced by Patient #1's noisy respirations, decreased lung sounds, discolored skin with cyanosis and difficulty with liquids. In a RN Visit note dated 4/12/15 from 11:25 AM to 12:25 AM, the RN documented Patient #1's blood pressure was 130/50, her temperature was 99.0, and her pulse was 72/minute. Her oxygen saturations were noted at 85%. Patient #1 was noted to be unresponsive, and her pain was estimated at 2. The RN documented Patient #1's left leg dressing had copious red drainage. The dressing was removed and silvadene cream was applied. A nonstick dressing was placed over the cream, and the leg was wrapped in an absorbent pad and placed in an Attends to help with drainage. The record did not include documentation that Patient #1's physician was notified of the	L 552		

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L 552	Continued From page 67 continued drainage or her continued deteriorating status. In an RN Visit note dated 4/13/15 from 11:20 AM to 12:18 PM, the RN documented Patient #1's pain was estimated at 7 "severe," and she was intermittently responsive. The RN noted Patient #1 was unable to tolerate any food or drink of any significant amount. Her skin was documented as cyanotic, and her temperature was 99.1. Her breath sounds were diminished, she had shortness of breath, and noisy respirations. The wound assessment sheet for the visit noted Patient #1 had a heavy amount of red drainage from her left leg wound, there was edema, and warmth to the area, as well as, discoloration. The wound care note documented Patient #1's pain intensity of 10, and intermittent, which differed from the assessment section of the visit note, which described her pain level as 7. Wound care was not documented in the visit note. The record did not include documentation that Patient #1's physician was notified of the continued drainage or of her increase in pain. Further, the record did not include evidence that interventions were adjust to better manage Patient #1's pain. An RN Visit note dated 4/14/15 from 11:30 AM to 1:48 PM, which indicated Patient #1 had died. It did not indicate the time of death. However, an ALF "Charting Note" indicated Patient #1 died at 12:03 PM. During an interview on 4/22/15 beginning at 10:15	L 552		

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L 552	Continued From page 68 AM, the hospice Interim Nurse Manager reviewed Patient #1's record. The Interim Nurse Manager stated she was the primary nurse for Patient #1, as she took care of her when she was on home health, before hospice. She stated Patient #1 essentially lived in her recliner chair. The Interim Nurse Manager stated she provided SN visits to Patient #1 twice weekly, and at that time she would remove the CircAid wraps from her legs, provide skin care, and reapply the wraps. She stated the aide would come on a daily basis to sponge bathe Patient #1, but she (the Interim Nurse Manager) was the only one that would unwrap her legs. She stated she was called by Patient #1 to evaluate her left leg as she had severe pain. She stated when she arrived at the ALF, she removed the CircAid wrap from her left leg and noted edema with a hematoma. She stated she took a photo of the hematoma, and another photo 40 minutes later, as the blood was accumulating rapidly. The Interim Nurse Manager stated she e-mailed the photos to the hospice Medical Director and he reviewed them. She stated the Medical Director did not come to the facility to evaluate Patient #1's leg. She stated he ordered lab work, and told her to elevate the leg and apply ice. She stated Patient #1 did not tolerate the ice to her leg and refused it. The Interim Nurse Manager stated she did not question if Patient #1's Coumadin should be discontinued and did not suggest more aggressive treatment such as having the hematoma evaluated at the hospital. The Interim Nurse Manager stated it was an injury of unknown origin, and stated she questioned the facility staff, who denied injury or falls.	L 552		

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L 552	Continued From page 69 The Interim Nurse Manager stated Patient #1 was in a large amount of pain, but the pain seemed to be managed by administration of Morphine every 15 minutes, as well as the Lorazapam that was administered on an hourly basis. She stated the Morphine was scheduled to be administered every 2 hours even if Patient #1 did not request it, in order to keep her comfortable. The Interim Nurse Manager confirmed the hematoma ruptured, and continued to produce large amounts of bloody drainage, she stated the hospice Medical Director was aware, but he did not come to evaluate Patient #1. She stated she was not sure if he was aware of the results of the PT/INR, and did not talk to him about discontinuing the Coumadin that was ordered. During an interview on 4/23/14 beginning at 7:30 AM, the hospice Medical Director was asked why a hospice patient was on Coumadin, and was not able to explain why Patient #1 was on Coumadin. He stated it is a controversy whether to keep hospice patients on medications like Coumadin. He stated if it was to prevent from blood clots and stroke for a patient with an unrelated diagnosis, then Coumadin would be indicated. He stated he was unsure if Patient #1 had cardiomegaly or another diagnosis that would indicate she needed Coumadin. When the hospice Medical Director was asked about the rupture of the hematoma, and the amount of bleeding from the leg, he responded that he was alerted when the hematoma burst. He stated he did not come to evaluate the wound, and was not aware of the amount of drainage. He stated he was aware the results of Patient #1's PT/INR was "Hyper therapeutic," and did not	L 552		

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L 552	Continued From page 70 consider discontinuing the Coumadin at that time. Patient #1 experienced an injury of unknown origin resulting in a subsequent significant change in status. However, her record did not include documentation that the Interdisciplinary Group, including the Medical Director, had been notified of her change in status and an update to her POC was not present. During an interview on 4/22/15 beginning at 7:30 AM, the hospice Medical Director stated Patient #1 was briefly discussed during the weekly IDT meeting on 4/09/15, when they discussed the hematoma. He stated he told the hospice staff the hematoma would eventually rupture and drain. The Medical Director did not know if updates to her POC were implemented with her change in status. 2. Patient #3 was an 80 year old female who was hospice services from 2/19/15 until her death on 3/16/15, with a terminal diagnosis of renal failure. Additional diagnoses included CHF, kidney disease, and memory loss. She resided at an ALF. Patient #3's POC for the certification period 2/19/15 to 5/19/15 included orders for SN visits 3 times weekly, and aide visits 7 days a week to provide bathing and assistance with ADLs. Her POC included information regarding her medications, which were provided by the hospice agency. One medication that the hospice provided was Coumadin 2.5 mg, 1 tablet daily. Patient #3's admission assessment, dated 2/19/15, and performed by an RN, noted she had 1+ edema in her right and left lower extremities.	L 552		

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L 552	Continued From page 71 Her skin assessment noted "No signs or symptoms." No areas of skin breakdown or potential areas were noted. Patient #3's record indicated her medication was not administered as ordered, and the hospice agency did not ensure communication regarding physician orders, which resulted in medication errors and adverse outcomes, as follows: Patient #3's record included information from her care that was provided by the home health agency prior to her admission to hospice. The records, from 2/12/15 to 2/19/15 included multiple adjustments to her Coumadin orders and administration of Vitamin K as a result of her PT/INR lab test results. A Charting Note from the ALF, dated 2/19/15, stated "INR, redrawn yesterday morning and was 2.5. Resident was admitted to hospice. MD reported to resume Coumadin and recheck INR 2/20/15. On 2/17/15 her MD wanted her to be direct admit to the hospital and resident declined to EMT's. She will now be on Hospice for comfort and end of life care." A copy of the Physician's Order dated 2/18/15, stated "Restart Coumadin tonight, repeat PT/INR on 2/20/15." The order was signed by the physician. Beside the order, handwritten and signed by the Medication Nurse at the ALF, was the note "Med Error, Order was never processed by Pharmacy, MD notified 2/24/15." The note did not indicate if the hospice was notified of the medication error. A Charting Note from the ALF, dated 2/24/15, stated "Coumadin dose changed to 2.5 mg daily,	L 552		

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L 552	Continued From page 72 recheck INR next week. Todays [sic] INR is 2.2." An "Outside Agency Visit Note," dated 3/03/15, signed by the hospice RN and left at the ALF, noted "Patient refused PT/INR. Does not want nursing to assess her, very agitated when woken up." A hospice Case Communication note, dated 3/06/15, stated "Patient has not had Coumadin X 4 days, patient refused. PT/INR 4.9/59.0." An "Outside Agency Visit Note," dated 3/06/15, signed by the hospice RN and left at the ALF, noted "PT/INR 4.9/59.0. Dr. [name] notified." The note included a notation by the ALF medication nurse "MD ordered Vit K 10 mg then DC'd. No further instruction- family notified." The notation was signed by the ALF medication nurse, dated 3/10/15. However, her record did not include verbal or written orders to discontinue the Vitamin K. A hospice Case Communication note, entered by the RN and dated 3/09/15, noted "PT/INR 3.5/34.9, Patient has refused Coumadin X 7 days." A hospice Case Communication note, dated 3/12/15 at 5:17 PM, and entered by the MSW, noted during an IDT at the ALF, "RN states that patients foley drainage is 'pure blood' r/t [related to] clotting issues d/t [due to] recent adjustments, trouble monitoring clotting. [Hospice RN] inquired about orders to DC all meds except for comfort meds, [ALF medication nurse] stated the facility had not received orders, specifying DC Coumadin, Vit K, all labs, all meds except for comfort."	L 552		

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L 552	Continued From page 73 The hospice RN was aware Patient #3's PT/INR was above therapeutic levels and the ALF did not have the orders to discontinue the medications. However, action taken to resolve the issues were not documented in Patient#3's record. A hospice RN Visit note dated 3/13/15, stated "PT/INR done per physician r/t recent blood tinged urine. INR 2.2, PT 26.2." A hospice RN Visit note dated 3/14/15 from 8:21 PM to 9:30 PM, noted "SN visit today due to report of redness and swelling to R [right] side of face near jaw line. Lump observed, that is red and warm to the touch. Dr. [name] notified, could possibly be a tooth abcess [sic]. Vitals are stable this visit, but heart rate is running 120/126/minute. Patient is diaphoretic." The section of the assessment for the visit note documented Patient #3's respiratory rate was 24-28/ minute, her heart rate was 124, and her oxygen saturations were 91% on room air. Patient #3's blood pressure was not assessed. Her pain was estimated by the RN as 3/10 as determined by Patient #3's moaning. An "Outside Agency Visit Note," dated 3/14/15 at 9:25 PM, signed by the hospice RN and left at the ALF, noted "Morphine scheduled 0.25 ml every 4 hours." A Physician Order, dated 3/14/15 at 8:00 PM, and signed by Patient #3's physician, noted Morphine 0.25 ml was to be administered orally every 4 hours. A hospice RN Visit note dated 3/15/15 from 12:18	L 552		

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L 552	Continued From page 74 PM to 12:55 PM, noted Patient #3's blood pressure was 90/52, her heart rate was 108/minute, oxygen saturation was 90% on room air, and her temperature was 96.9. She continued to have swelling on her right jaw area, and pain was assessed by the RN at 3/10. Patient #3 died on 3/16/15. The ALF MAR documented Patient #3 refused to take Coumadin as ordered from 3/02/15 - 3/06/15 and from 3/08/15 - 3/10/15. The ALF MAR indicated Patient #3 also refused her Vitamin K on 3/11/15. The hospice RN was aware the ALF had not administered the scheduled doses of Coumadin and Vitamin K and reported Patient #3's "...foley drainage is 'pure blood' r/t clotting issues d/t recent adjustments, trouble monitoring clotting" as documented in the MSW's Case Communication note, dated 3/12/15 at 5:17 PM. Further, the narrative section of the hospice RN Visit note dated 3/15/15 from 12:18 PM to 12:55 PM, documented the ALF medication aide on duty stated the ALF did not receive an order for scheduled morphine, so Patient #3 was not receiving medications as they were ordered. The ALF MAR indicated Patient #3 did not receive routine Morphine every 4 hours as ordered. It remained as a PRN medication on the MAR, and she received PRN doses once on 3/02/15, 3/03/15, and at 9:38 PM on 3/14/15. Patient #3's records documented a significant change in status as evidence by abnormal lab values and bloody urine due to medication errors	L 552		

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L 552	Continued From page 75 and her refusal to take medications. However, her record did not include documentation that the Interdisciplinary Group, including the Medical Director, had updated her POC. During an interview on 4/23/15 at 9:30 AM, the Interim Nurse Manager reviewed Patient #3's record and confirmed she was aware of the abnormal lab values, bloody urine, and medication errors. She stated the abnormal lab values, medication errors, and non-compliance were not discussed during the Interdisciplinary Group meetings, and her POC was not updated to reflect those concerns. 3. Patient #4 was an 85 year old male with a terminal diagnosis of COPD who had been admitted to hospice on 3/25/14. He resided at an ALF. Patient #4's Case Communication Report notes documented he had experienced falls as follows: 3/25/15 - The report documented "...reoccurant falls...PT had a fall this am [sic] 3-25-15 and hit his head pretty hard has [sic] a hematoma on top of his head and several small skin tears to his elbow..." 4/7/15 - The report documented the physician was contacted due to Patient #4 falling. No new injuries were identified on the report. 4/19/15 - The report documented ALF staff had found Patient #4 on the floor. A corresponding RN Visit note documented the RN "attempted to educate patient on calling aides for help, but patient is confused and confusion is getting worse, patient fell this am [sic] and aide at facility	L 552		

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L 552	Continued From page 76 called SN and SN responded..." Patient #4's record did not include documentation that the physician had been notified of the fall. When asked on 4/22/15 at 3:30 PM, the Interim Nurse Manager stated the fall had not been reported to the physician. Patient #4 experienced 3 falls in less than a 5 week period. However, his record did not include documentation that the Interdisciplinary Group, including the Medical Director, had updated his POC to address his falls. During an interview on 4/22/15 at 3:30 PM, the Interim Nurse Manager stated she was aware of Patient #4's falls. She confirmed the agency did not implement interventions to reduce his risk of falls and his POC was not updated. 4. Patient #2 was an 89 year old male who had been admitted to hospice on 8/17/14 with a diagnosis of malignant neoplasm of the prostate with probable metastasis to the bone. Patient #2's initial physical evaluation, dated 8/17/14, documented mid arm measurements bilaterally as 25 cm. No lower extremity measurements were documented, trace edema was noted in both feet, lung sounds were noted to be clear in all fields, and Patient #2 reported shortness of breath when walking 20 feet or less. During the certification period from 12/15/14 to 2/12/15, symptoms of increasing systemic edema and shortness of breath were noted during SN visits, without medical intervention, as follows: 12/12/14 - Edema in both feet was documented as 1+ (trace) and wheezes were noted in both	L 552		

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L 552	Continued From page 77 lungs. No upper or lower extremity measurements were documented. Patient #2 was noted to be short of breath "while talking or eating or performing other ADLs." 12/14/14 - Edema in both feet was documented as "non-pitting," wheezing and crackles were noted in both lungs, and mid arm circumference was measured at 26 cm bilaterally with no lower extremity measurements documented. Shortness of breath was noted "while talking or eating or performing other ADLs." 12/15/14 - Edema was documented as 2+, shiny, and hard in both lower extremities. No extremity measurements were documented. Rales were documented in all lung fields. Patient #2's shortness of breath was present while he was "at rest." 12/16/14 - No upper or lower extremity measurements were documented. Rales were noted in all lung fields, and Patient #2's right lower leg was noted to have "redness with blister that is beginning to weep." Patient #2 continued with shortness of breath "at rest." 12/17/14 - Upper and lower extremity measurements were not assessed. Edema was documented as 3+, hard, shiny, with red areas in both lower extremities. Patient #2 was noted to have "severe with [sic] shortness of breath with exertion." 12/19/14 - No extremity measurements were documented, and no lung sounds were obtained. Edema was noted to be 3+ in both lower extremities. Shortness of breath "at rest" was documented.	L 552		

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L 552	Continued From page 78 12/22/14 - Edema was noted to be 3+ in bilateral lower extremities. While lung sounds were documented as clear, Patient #2 reported he was short of breath. Oxygen saturation level was documented at 92% on room air and Patient #2's respiratory rate was 20/min. Upper and lower extremity measurements were not assessed. The social worker's visit note on this date stated Patient #2 "becomes SOB [short of breath] with conversation." 12/26/14 - Edema was noted to be 4+ in both lower extremities with "blistering ulcer on right anterior lower leg." Lung sounds were diminished in the left lung and the right upper lung. Rales were heard in the right lower lung. Respiratory rate had increased to 30/min with oxygen saturation measured at 84% on room air. Nursing notes stated "In obvious respiratory distress..." 12/29/14 - Edema was documented as 4+ with "red weeping blistered area on right lower leg." No upper or lower extremity measurements were documented. Rales were noted in both lung bases and lung sounds were diminished in the middle and upper areas of both lungs. Shortness of breath was noted while Patient #2 was "at rest." The 12/29/14 SN note included documentation the Medical Director was contacted and Lasix (a diuretic medication) was requested for Patient #2. However, the SN note dated 1/02/14, documented the Lasix was started, 4 days after the medication was initially requested. During the 18 day period, from 12/12/14 to	L 552		

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L 552	Continued From page 79 12/29/14, Patient #2 exhibited increasing symptoms of systemic edema as noted in SN visit notes. There was no documentation Patient #2's physician was informed of his increasing systemic edema until 12/29/14 and pharmaceutical treatment was not initiated for 4 more days, on 1/2/15. Treatment for dyspnea was not initiated at any time from 12/12/14 until Patient #2's death on 1/9/15. Patient #2's records documented a significant change in status. However, his record did not include documentation that the Interdisciplinary Group, including the Medical Director, had updated his POC to address his edema and dyspnea. When asked during an interview on 4/22/15 at 11:05 AM, the Interim Nurse Manager did not have an explanation for why the Medical Director was not contacted or informed regarding of Patient #2's worsening lower extremity edema prior to 12/29/14. She also confirmed no interventions were implemented for his shortness of breath, but was unable to explain way. Patient #2's POC was not updated to include interventions for a significant change in status. 5. Patient #6 was an 87 year old female who had been admitted to hospice on 6/20/13 with a diagnosis of senile degeneration and debility. Her POC for the recertification period of 2/10/15 to 4/10/15 documented SN visits were being increased to 2 times per week due to increased confusion and agitation. Her POC stated "SN to assess overall patient status, pain and symptom control, medication compliance,	L 552		

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L 552	Continued From page 80 patient/family/caregiver concerns, and environment safety." Information related to a current recertification (from 4/10/15 forward) was not present in her record at the time of the survey. Further, an RN Visit note, dated 4/17/15 stated the RN was concerned about Patient #3's spouse, who was Patient #3's primary caregiver. The note stated Patient #3's husband had complaints of headaches and blurred vision. The note stated Patient #3's husband was scheduling an appointment with a physician and was hoping to be placed on home health services if needed. Patient #6's record did not include an updated POC which addressed the RN's concerns related to her current recertification period. When asked about Patient #6 on 4/21/15 at 4:30 PM the Interim Nurse Manager stated the spouse was receiving Meals on Wheels a couple of times a week and had a family member living close by. She did not have an explanation regarding why the POC was not updated. The agency failed to ensure patient POCs were updated as needed.	L 552		
L 648	418.100 ORGANIZATIONAL ENVIRONMENT This CONDITION is not met as evidenced by: Based on review of policies and procedures, Event Reports, record review and staff interview, it was determined the hospice failed to ensure the organization and administration of services was conducted in a manner which provided direction and oversight of the agency's operations. This	L 648		5/7/15

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L 648	Continued From page 81 resulted in the inability of the agency to ensure patients were protected from harm and that their needs were met. The findings include: 1. Refer to L651 as it relates to the governing body's failure to ensure responsibility was assumed for implementing programs and providing direction to the agency. The governing body's lack of oversight and monitoring resulted in systemic deficient practices placed patients in immediate jeopardy of experiencing serious harm, impairment and/or death due to ongoing neglect. The agency was notified of the immediate jeopardy verbally on 4/23/15 at 1:30 PM and were not able to submit an acceptable immediate plan.	L 648		
L 651	418.100(b) GOVERNING BODY AND ADMINISTRATOR A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body. This STANDARD is not met as evidenced by: Based on review of the organization chart, job descriptions, policies and procedures and staff interview, it was determined the hospice failed to ensure the Governing Body assumed	L 651		5/7/15

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L 651	Continued From page 82 responsibility for the management and operational direction of the hospice agency for all patients recieving services at the agency. This prevented the hospice from being organized along clear lines of authority and from ensuring policies and procedures were sufficiently developed, implemented and monitored. These failures resulted in a lack of clear direction to staff and significantly impeded the agency's ability to meet the patients' health and safety needs. The findings include: 1. The hospice was part of a corporation which included, but was not limited to, hospitals, home health agencies, and hospice agencies. a. The top right hand side of the undated organization chart titled "Intermountain Homecare & Hospice" listed the following in descending order: - "Intermountain Healthcare Governing Board" - "Professional Standards Committee" - "Intermountain Homecare & Hospice Board" The list was not connected to any other part of the organizational chart and it did not include a listing of names or positions which comprised the Governing Board, the Professional Standards Committee or the Intermountain Homecare & Hospice Board. A second organizational chart, dated 9/24/14 and titled "Intermountain Homecare" included the Idaho Cassia location. The chart did not include information related to a Governing Board. The Interim Nurse Manager was asked to provide Governing Board meeting minutes. She stated	L 651		

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L 651	Continued From page 83 they would be requested from the corporate office. When asked about the specific Hospice Agency Governing Board for the Burley location, she was unable to provide information. On 4/23/15 at 1:00 PM, the Corporate Risk Manager provided a copy of the most recent 4 quarters of Intermountain Homecare Board Meeting minutes. The minutes did not include verbiage directly related to the Burley Hospice agency. The Corporate Risk Manager was unable to provide further documentation. b. In the center column of the "Intermountain Homecare & Hospice" organization staff names and titles were listed in descending order, as follows: - "President and CEO Intermountain Healthcare" - "Executive VP Intermountain Healthcare" - "CEO Park City Med. Ctr. RVP Clinical Outreach Serv" - "Administrator/COO Intermountain Homecare & Hospice" Eight staff names and positions were arranged horizontally under the position of "Administrator/COO Intermountain Homecare & Hospice." Areas of responsibility were listed under each position, which included, but were not limited to, the following: - "Operations Officer Home Health/Hospice CNO." Responsibilities listed were home health, patient care management, hospice, pediatrics, quality patient safety and education." - "Risk Management/Compliance Director." Responsibilities listed were risk, contract review,	L 651		

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L 651	Continued From page 84 compliance, and emergency management. - "Medical Director." Responsibilities listed were medical direction, physician liaison, ethics consultation, infection control, and patient quality care. The top of the second organizational chart, titled "Intermountain Homecare" for the Idaho Cassia location, included the names of the "Medical Director" and the CNO which were listed on the corporation's organization chart. The connection between Risk Management and the Cassia location was not evident. However, when asked about the reporting of abuse, neglect and mistreatment, the Interim Nurse Manager stated upon identification of an event, a report would be placed into the computer, and the corporate level of Risk Management would follow from that point. She stated she would be notified by corporate if any further action would be required on her part. c. Three staff names and positions were arranged horizontally under the position of CNO on the "Intermountain Homecare" chart for the Idaho Cassia location, which included the Support Services Director, the Home Health Nurse Administrator, and the Hospice Nurse Administrator. Directly under the Home Health Nurse Administrator positions, was listed a name and the title "Nurse Manager (Interim)." Responsibilities listed under the "Nurse Manager (Interim)" position included Home Health and Hospice. A dotted line connected the Hospice responsibility back to the Hospice Nurse	L 651		

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L 651	Continued From page 85 Administrator. However, a direct relationship between the Hospice Administrator and the "Nurse Manager (Interim)" was not evident. During an interview on 4/23/15 at 12:00 PM, the Interim Nurse Manager stated she reported to the Hospice Administrator, whose office was located in a city in another state. The city was approximately 184 miles away from the hospice agency. When asked, the Interim Nurse Manager stated, via email on 4/24/15 at 4:05 PM, that the Administrator was appointed as the "Interim" manager on 3/30/14 and held the position until she was appointed as the permanent Administrator on 6/8/14. However, the Administrator's oversight was not sufficient to ensure policies and procedures were developed, implemented and monitored to meet the specific needs of the hospice agency, necessary to ensure patients were protected from harm and that their needs were met, as follows: i. The agency's "Abuse Policy," effective October 2008, was a corporate policy. The "Scope" of the policy included hospitals, the medical group, homecare, and Ambulatory Surgical Centers. The policy did not include information specific to the operations of the hospice agency. The policy stated "Whenever any person has reason to believe that a patient has been subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, domestic violence, or neglect or who observes a patient being subjected to such conditions or circumstances are required by law to report" and "All suspected cases of abuse, neglect, and exploitation will be immediately reported."	L 651		

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L 651	Continued From page 86 However, the policy did not include information regarding who to report the allegations to or how the report was to be made (verbally, in writing, etc.). During a telephone interview, on 4/23/15 at 11:30 AM, the Corporate Compliance Director stated all incidents were to be documented on an "Event Report." The agency provided multiple "Event" policies and procedures which included an "Event Reporting Policy," a "Reportable Events Procedure," and a "Risk Event Management Procedure." The policy and procedures documented they were all effective March 2014. The agency also provided a "Patient Grievance Policy" which was also effective March 2014 and a "Patient Grievance Procedure," which was effective October 2014. All of the submitted policies and procedures were related to corporate process. The policies and procedures included information related to corporate operations in both Utah and Idaho and were applicable to various types of healthcare facilities. The corporate policies and procedures did not include information specific to the operations of the hospice agency. None of the corporate policies and procedures described the hospice agency's systems for immediately reporting all alleged violations to the hospice agency's Administrator. Additionally, the "Nurse Administrator - Hospice" job description stated the position was "...accountable for providing leadership and implementing strategic direction to Hospice	L 651		

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L 651	Continued From page 87 Services throughout Homecare. This position will work in partnership with the Homecare CNO, Administrator, and leadership to ensure the provision of optimal patient care, attainment of financial goals, and the development of leaders." The job description listed various responsibilities under multiple domains which included Leadership, Operational Effectiveness, Employee Engagement, Clinical Excellence, Service Excellence, Physician Engagement, and Community Stewardship. Information related to the Administrator's role in the prevention and detection of abuse, neglect, mistreatment, or misappropriation of patient property was not evident. ii. The corporate "Event Reporting Policy," effective March 2014 stated "Risk Management, Quality, Patient Safety and Clinical Operations work together to facilitate appropriate process changes warranted to reduce the risk of reoccurrence." The "Event Reporting Policy," included definitions of events, such as Events, Adverse Events, Reportable Events, Sentinel Events, etc. The policy stated "Business Operations (includes Regions/Facilities)" were to "Designate an individual to oversee the ongoing compliance with all Event Reporting policies and procedures." However, the policy defined "Business Operations" as "Recurring clinical and customer services that provide value to the communities and patients served by Intermountain Healthcare. Business Operations include Regions, Hospitals, Clinics, Homecare, other facilities [sic]	L 651		

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L 651	Continued From page 88 administrative operations, Lab, Pharmacy, Information Systems (IS), Compliance, Risk Management, Quality/Patient Safety and so forth." The policy did not include information regarding how the agency was to "Assure that clinical staff and other appropriate staff have been trained on how to identify and report an Event, Near Miss or Activity" given the policy's definition of "Business Operations." The policy did not include information regarding how the hospice agency was to "designate an individual to oversee the ongoing compliance with all Event Reporting policies and procedures" or which entity or person within the "Business Operations" definition would be responsible for the designation. Further, the "Event Reporting Policy," defined an Event as "Any unexpected occurrence or process variance that impacts or may impact the quality of patient care, patient or visitor safety or which poses an operational risk..." The policy listed multiple examples of events which included accidents and falls. Patient #4 was an 85 year old male with a terminal diagnosis of COPD who had been admitted to hospice on 3/25/14. He resided at an ALF. Patient #4's Case Communication Report notes documented he had experienced falls as follows: 3/25/15 - The report documented "...reoccurant falls...PT had a fall this am [sic] 3-25-15 and hit his head pretty hard has [sic] a hematoma on top	L 651		

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L 651	Continued From page 89 of his head and several small skin tears to his elbow..." 4/7/15 - The report documented the physician was contacted due to Patient #4 falling. No new injuries were identified on the report. 4/19/15 - The report documented ALF staff had found Patient #4 on the floor. A corresponding RN Visit note documented the RN "attempted to educate patient on calling aides for help, but patient is confused and confusion is getting worse, patient fell this am [sic] and aide at facility called SN and SN responded..." Patient #4's record did not include documentation that the physician had been notified of the fall. When asked on 4/22/15 at 3:30 PM, the Interim Nurse Manager stated the fall had not been reported to the physician. Additionally, Event Reports related to the falls could be found and the falls were not included in the agency's Event Summary report. During an interview on 4/22/15 at 3:30 PM, the Interim Nurse Manager confirmed Event Reports were not initiated after the reported falls. The Event Reporting Policy was not sufficiently developed, implemented, or monitored necessary to meet the needs of the hospice patients. iii. The "Hospice Interdisciplinary Management Homecare Procedure," effective August 2014, stated the following in the "Reportable Conditions" section: - "Notify physician of pain or symptoms that are not being managed by the current treatment	L 651		

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L 651	Continued From page 90 regimen. Obtain orders to better meet the symptom management needs of the patient." - "Notify physician of significant change in patient condition." However, patient records did not include consistent documentation that the physician had been notified of patients' changing needs. Examples included, but were not limited to, the following: - Patient #1's record documented she had sustained an injury of unknown cause to her lower left leg on 4/9/15. The injury developed into a hematoma causing Patient #1 "unbearable," severe pain and she was unable to eat. On 4/10/15 the hematoma had ruptured and had "copious amounts of red bloody drainage." Patient #1 was unresponsive, her vital signs were abnormal, and she was not able to take her medications. On 4/11/15, 4/12/15, and 4/13/15 Patient #1's condition continued to deteriorate and she was showing signs of active dying. She was not responsive, continued being unable to eat, had difficultly drinking, her vital signs continued to be abnormal, and the left leg wound continued to have a "heavy amount of red drainage." However, Patient #1's record did not document that the physician was notified of her deteriorating status during the 6 day period, from 4/9/14 when the injury was sustained to her death on 4/14/15. Patient #1's record documented the physician was only notified of the injury on 4/9/15. - iii. Patient #2 was an 89 year old male who had been admitted to hospice on 8/17/14 with a	L 651		

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L 651	Continued From page 91 diagnosis of malignant neoplasm of the prostate with probable metastasis to the bone. Patient #2's initial physical evaluation, dated 8/17/14, documented mid arm measurements bilaterally as 25 cm. No lower extremity measurements were documented, trace edema was noted in both feet, lung sounds were noted to be clear in all fields, and Patient #2 reported shortness of breath when walking 20 feet or less. During an 18 day period, from 12/12/14 to 12/29/14, Patient #2 exhibited increasing symptoms of systemic edema as noted in SN visit notes. There was no documentation Patient #2's physician was informed of his increasing systemic edema until 12/29/14 and pharmaceutical treatment was not initiated for 4 more days, on 1/2/15. Treatment for dyspnea was not initiated at any time from 12/12/14 until Patient #2's death on 1/9/15. When asked about Patient #2 the Medical Director, on 4/23/15 at 8:00 AM, stated he was not informed by the RN of his increasing SOB and dyspnea, or his increasing edema to both lower extremities. The SN failed to notify the physician of Patient #2's significant change in condition. The Administrator's oversight of the facility was not sufficient to ensure the physician was notified of patients' significant change in conditions. 2. Refer to L500 Condition of Participation: Patient Rights and associated standard level deficiencies as they relate to the Governing Body's failure to ensure policies and procedures	L 651		

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L 651	Continued From page 92	L 651		
	were sufficiently developed, implemented and monitored necessary to ensure patients' rights were upheld and that they were free from abuse, neglect, and mistreatment. 3. Refer to L664 Condition of Participation: Medical Director and the associated standard level deficiency as they relate to the Governing Body's failure to ensure the Medical Director provided sufficient oversight necessary to ensure patient needs were met. The cumulative effect of these systemic deficient practices placed patients in immediate jeopardy of experiencing serious harm, impairment and/or death due to ongoing neglect. The agency was notified of the immediate jeopardy verbally on 4/23/15 at 1:30 PM and were not able to submit an acceptable immediate plan.			
L 664	418.102 MEDICAL DIRECTOR This CONDITION 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 necessary to ensure patient needs were met. This resulted in the lack of direction to staff to ensure the patient's health and safety needs were met. Findings include: 1. Refer to L669 as it relates to the Medical Director's failure to ensure patient needs were met.	L 664		6/30/15
L 669	418.102(d) MEDICAL DIRECTOR RESPONSIBILITY The medical director or physician designee has	L 669		6/30/15

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L 669	Continued From page 93 responsibility for the medical component of the hospice's patient care program. 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 to meet patient needs. This failure directly impacted 3 of 6 patients (Patients #1, #2, and #4) whose records were reviewed and had the potential to impact 6 of 6 patients (#4 - #9) receiving services at the agency at the time of the survey. This failure resulted in POC that were not accurate and current and a lack of medical intervention necessary to meet patient needs. The findings include: 1. During an interview with the hospice Medical Director on 4/23/15 at 7:30 AM, the hospice Medical Director stated he held the position for about a year. He stated he was primarily an Oncologist, and was hired by the hospital to be the Internal Medicine physician. He stated he was asked to be the Hospice Medical Director, and was happy to take the position, however he had no experience in that role. He stated he commuted to the area, and he was burdened with a very heavy load, and stated he did not have as much time to devote to the role as he wanted. During an interview on 4/23/15 at 7:30 AM, when asked about training and orientation to the hospice agency, the Medical Director stated that when he accepted the position, he was provided with a pamphlet from the corporate office. He stated he leafed through it, but did not have time to read it entirely.	L 669		

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L 669	Continued From page 94 When asked about patient care, the Medical Director stated he did not have computer access to the hospice patients. He stated the corporation had not granted him access, and it was difficult to keep track of the patients without that capability. Patient records were reviewed. The records did not demonstrate the Medical Director provided patients with sufficient oversight, as follows: a. Patients' POCs were not accurate and were not kept current. i. Patient #1 was a 90 year old female who had been admitted to hospice on 3/11/14, with a terminal diagnosis of heart disease. Additional diagnoses included pulmonary hypertension and venous insufficiency. She resided at an ALF. A signed copy Patient #1's POC for the certification period 3/05/15 to 5/04/15 was provided to the survey team on 4/21/15 at 4:30 PM. The POC was signed by the Medical Director on 4/21/15, 7 hours after the surveyors requested her record. The Medical Director included a hand written narrative of clinical findings to support her recertification to hospice services which stated "90 year old female [with] end stage heart failure showing continual decline. She is intolerant of Coumadin in she develops coagulopathy and 'Stevens-Johnson' type purpura. Has progressive muscle mass loss and continual mental decline." During an interview on 4/23/14 beginning at 7:30 AM, the hospice Medical Director reviewed Patient #1's record and confirmed he signed the POC for Patient #1 on 4/21/15. He stated he completed the narrative, and signed the POC	L 669		

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L 669	Continued From page 95 after the hospice notified him that the "State Auditors" were at the agency. He reviewed the narrative section that he completed and stated he was in error by writing Patient #1 had "Coumadin Intolerance." He stated he should have put that she was intolerant to Lasix. The Hospice Medical Director stated he reviewed the medical record, and must have made an error in the narrative. ii. Patient #3 was an 80 year old female who was hospice services from 2/19/15 until her death on 3/16/15, with a terminal diagnosis of renal failure. Additional diagnoses included CHF, kidney disease, and memory loss. She resided at an ALF. Her record documented her medications included Coumadin 2.5 mg, 1 tablet daily, Donepezil 10 mg, 1 tablet daily, Namenda 10 mg, 1 tablet twice daily, and Pramipexole 0.5 mg, 1 tablet twice daily. A signed copy of Patient #3's POC for the certification period 2/19/15 to 5/19/15 was provided to the survey team on 4/21/15 at 4:30 PM. The POC was signed by the Medical Director on 4/21/15, 7 hours after the surveyors requested her record. The Medical Director included a hand written narrative of clinical findings to support her admission to hospice services which stated "81 year old [female] with a history of dementia has recently been deteriorating with increase in hallucinations, neglect, and at times combativeness. She also has had increased edema to the point of weeping from her legs. Echocardiogram showed normal EF [ejection fraction] 73%, but had moderate aortic stenosis [with] calcification. She also has progressive CKD. After discussion with family, the PCP opts to place her on hospice. She has been on Coumadin for chronic DVT."	L 669		

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L 669	Continued From page 96	L 669		
	During an interview with the hospice Medical Director on 4/23/15 at 7:30 AM, he reviewed Patient #3's record, and confirmed he signed the POC for Patient #3 on 4/21/15. He stated he completed the narrative, and signed the POC after the hospice notified him that the "State Auditors" were at the agency. He was asked why a hospice patient was on Coumadin, and was not able to explain why Patient #3 was on Coumadin. He stated it is a controversy whether to keep hospice patients on medications like Coumadin. He stated if it was to prevent from blood clots and stroke for a patient with an unrelated diagnosis, then Coumadin would be indicated. He stated Patient #3's primary physician wanted her to continue on the Coumadin, as well as, the Namenda, Donepezil, and Pramipexole, that she took for dementia. He stated he did not think that a hospice patient should be continued on dementia medications, but he deferred to the attending physician on that matter.			
	He reviewed the narrative section that he completed and stated he was in error by writing Patient #3's increased edema and weeping legs. He stated he reviewed Patient #3's history and physical, and brought the information related to her edema and weeping legs to the narrative from that information. He stated he did not actually evaluate Patient #3 in person.			
	iii. Patient #4 was an 85 year old male with a terminal diagnosis of COPD who had been admitted to hospice on 3/25/14. He resided at an ALF.			
	A signed copy Patient #4's POC for the certification period 3/25/15 to 6/22/15 was			

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L 669	Continued From page 97 provided to the survey team on 4/21/15 at 4:30 PM. The POC was signed by the Medical Director on 4/21/15, 7 hours after the surveyors requested his record. The Medical Director included a hand written narrative of clinical findings to support his certification to hospice services which stated "96 year old male with a history of congestive heart failure (EF [ejection fraction] 56%) [2012] progressive weakness, anasarca, including scrotal edema. His saturation runs in high 80's. Admitted for end of life care." (Anasarca is defined by the National Institutes of Health, as massive generalized edema.) Patient #4's record also contained Hospice Certification of Terminal Illness, also signed by a physician on 4/21/15, which documented a diagnosis of edema. However, the diagnosis of edema was not consistent with the RN's admission assessment which was dated 3/25/15. During an interview with the hospice Medical Director on 4/23/15 at 7:30 AM, he reviewed Patient #4's record, and confirmed he signed the POC for Patient #4 on 4/21/15. He stated he completed the narrative, and signed the POC after the hospice notified him that the "State Auditors" were at the agency. He stated the diagnosis of edema was taken from a History and Physical report and not by direct examination. The Medical Director failed to ensure patient POCs were accurate and were kept current. b. Patient records did not include documentation of sufficient medical care and treatment. Examples included, but were not limited to, the following:	L 669		

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L 669	Continued From page 98 i. Patient #1's POC for the certification period 3/05/15 to 5/04/15 included information regarding her medications. One medication that the hospice provided was Coumadin 2 mg, 1 tablet daily. In an RN Visit Note, dated 4/09/15, documented Patient #1 had a cause unknown injury to her left lower leg and was in pain. The visit note included a wound assessment sheet with 2 photos which showed a hematoma. One photo showed erythema and swelling just below the left knee. The second photo showed a much larger hematoma, with a large pocket of fluid noted on the inner aspect. The leg was noted to be more edematous in the second photo. There were no measurements to indicate the actual size of the hematoma. The visit note documented the hospice Medical Director was notified of the hematoma, and orders were received to draw a PT/INR, as well as, other labs. The RN noted she reviewed with the ALF nurse and multiple staff members that Patient #1's skin would likely rupture and pooled blood under her skin would drain copiously. She noted the leg was to have disposable pads underneath to manage drainage if the hematoma ruptured. The visit note did not include documentation of discussion with the Medical Director regarding options for treatment of the hematoma, including pursuing evaluation and treatment at the hospital. Additionally, the note did not include documentation of Patient #1's Coumadin therapy was reevaluated and discussed given her change in status.	L 669		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	131542		C 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERMOUNTAIN HOMECARE HOSPICE - CASSIA	1031 EAST MAIN STREET BURLEY, ID 83318

(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 99 During an interview on 4/22/15 beginning at 10:15 AM, the hospice Interim Nurse Manager reviewed Patient #1's record. The Interim Nurse Manager stated she was the primary nurse for Patient #1. The Interim Nurse Manager stated she e-mailed the photos to the hospice Medical Director and he reviewed them. She stated the Medical Director did not come to the facility to evaluate Patient #1's leg. She stated he ordered lab work, and told her to elevate the leg and apply ice. She stated Patient #1 did not tolerate the ice to her leg and refused it. The Interim Nurse Manager stated she did not question if Patient #1's Coumadin should be discontinued and did not suggest more aggressive treatment such as having the hematoma evaluated at the hospital. In a visit note dated 4/10/15 from 2:40 AM to 4:15 AM, the RN documented Patient #1's pain was estimated at 6/10, and she was moaning. Additionally, the RN noted Patient #1 was non-responsive, only responded once during the 2 hour visit. The RN documented the appearance of the hematoma as "left leg with a 10 cm hematoma/blood blister to left calf just below the knee." A wound assessment sheet included photos of the hematoma, which had split open, and the RN documented copious amounts of red bloody drainage. The results of the PT/INR were in the visit note and documented as 28.3 and 2.7, which was above the therapeutic range. During an interview on 4/22/15 beginning at 10:15 AM, the hospice Interim Nurse Manager confirmed the hematoma ruptured, and continued to produce large amounts of bloody drainage, she stated the hospice Medical Director was aware, but he did not come to evaluate Patient #1. She	L 669		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
L 669	Continued From page 100 stated she was not sure if the Medical Director was aware of the results of the PT/INR, and did not talk to him about discontinuing the Coumadin that was ordered. During an interview on 4/23/14 beginning at 7:30 AM, the hospice Medical Director was not able to explain why Patient #1 was on Coumadin. He stated he was unsure if Patient #1 had cardiomegaly or another diagnosis that would indicate she needed Coumadin. When the hospice Medical Director was asked about the rupture of the hematoma, and the amount of bleeding from the leg, he responded that he was alerted when the hematoma burst. He stated he did not come to evaluate the wound, and was not aware of the amount of drainage. He stated he was aware the results of Patient #1's PT/INR was "Hyper therapeutic," and did not consider discontinuing the Coumadin at that time. The hospice Medical Director failed to provide medical oversight of hospice patients.	L 669		

CORRECTIVE ACTION PLAN

Site: Intermountain Hospice-Cassia
Date: 5/15/15

Statement of Problem	Steps for Improvement	Point Person	Person Responsible/ Evaluation Date	• Progress Towards Outcome
L000 During the survey it was determined that deficient practices at the following 2 Conditions of Participation placed the health and safety of patients in immediate jeopardy of serious harm, impairment, or death and had the potential to impact all patients receiving services at the agency: 42 CFR 418.52 Patient Rights 42 CFR 418.100 Governing Body			CNO will be responsible for completion of the entire action plan.	An abatement plan, which was acceptable to the Department, has been prepared and executed to abate the immediate jeopardy.
L500 418.52 Patient Rights Agency policy and procedures insufficient to ensure all allegations of abuse neglect, mistreatment, injuries, or misappropriation of patient property are immediately investigated and immediate action taken to protect	• Develop Guideline for timely event identification, reporting and follow-up.	Compliance	4/28/15-CNO (Chief Nursing Officer)	4/28/15 - Guideline developed listing specific responsibilities for all events (attached); **Revisions Completed 5/14/15.**
	• Educate office manager of expectations for follow-up of all reportable events.	Compliance	4/24/15-CNO	Office manager educated regarding specific responsibilities for event monitoring including investigating and follow-up reporting to compliance and applicable state authorities as indicated. **Completed 4/24/15**
	• Event Reporting Policy to be	Compliance	4/24/15-CNO	Policy updated to include Home Health and

CORRECTIVE ACTION PLAN

patients	updated to include Hospice			Hospice service divisions. **Completed 5/9/15 attached.**
	• Procedure developed for reporting injuries of an unknown source and staff education provided.	Hospice administrator	4/24/15-CNO	Hospice administrator (interim) provided in service to all staff on reporting of injuries of unknown origin. **Completed** on 4/24/15 Reviewed with staff for verification of understanding by CNO 5/11/15. Policy updated and approved 5/14/15
	• All clinical staff to have verbal education and coaching by nurse manager before next shift to include: results of the survey, where and when to report abuse / neglect/ maltreatment/ patient complaints to nurse manager and state authorities and phone numbers of where to report. Complete by end of day 4/24/15.	Nurse manager	4/24/15-CNO	4/24/15 - Verbal education and coaching to all staff regarding reporting abuse/ neglect/ maltreatment/ patient complaints and reporting process completed before next scheduled shift. **Complete.**
	• All staff (clinical, office and medical director) to complete on-line training on abuse/ neglect by end of day 4/24/15. Twice daily report of completion of training to be sent to nurse manager from education department to allow manager to complete follow-up. Staff will not be able to work until the education is completed and the education sanction grid will be followed	Nurse manager	Ongoing-CNO	4/24/15 - On-line training on abuse/neglect completed by all staff prior to next scheduled shift. **Complete. See attachment**

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	for mandatory education.			
	• On-line training on abuse/neglect to be completed by all staff annually. Completion of education to be tracked via quarterly education reports.	Education manager	4/24/15-CNO	Mandatory abuse training will be completed during the third quarter annually each year and tracked in the education software for each employee.
	• New employees complete abuse / neglect education including demonstration of event reporting.	Nurse manager	4/24/15-CNO	4/24/15 – Abuse/Neglect policies reviewed by all staff prior to next scheduled shift and as new staff are hired during orientation. **Complete 4/24/15 and ongoing**
	• All Staff to review policies on abuse/neglect and event reporting. Evidenced by initialed printed copy of policies by end of day 4/24/15 Staff will not be able to work until the education is completed and the education sanction grid will be followed for mandatory education.	Nurse manager	4/24/15-CNO	**Completed 4/24/15**
	• All Staff to be provided with phone numbers for reporting suspected abuse/neglect/maltreatment to appropriate agencies and educated in process of reporting suspected abuse/neglect/maltreatment to appropriate authorities and nurse manager by end of day 4/24/15.	Nurse manager	4/30/15-CNO	4/24/15 – Staff provided with laminated copy of Idaho state phone numbers for Adult Protective Services and Child Protective Services and educated in process of reporting suspected abuse/neglect to appropriate authorities and nurse manager. **Completed.**
	• All staff to complete education	Nurse manager	5/1/15-CNO	4/30/15 – Education complete for all staff on use of on-line event reporting system.

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	on use of on-line event reporting system.			**Completed.** CNO verified understanding in staff meeting 5/11/15.
	• Manager to round daily for 3 weeks to discuss any suspected abuse/neglect/maltreatment /injuries of an unknown source/adverse events, including falls and assure event report is completed appropriately until staff demonstrates understanding of appropriate reporting behavior.	Nurse manager		Daily rounding by manager to discuss any suspected abuse/neglect / maltreatment/ adverse events and assure event report is completed appropriately. Began 4/27/15 and completed 5/15/15. **Completed**
	• ID Adult Protective Services Agency provided on-site education to staff on reporting topics.	Adult Protective Services (APS)	May 2015-CNO	Staff attended presentation by APS on 5/5/15 and CPS on 5/7/15 to review, discuss and ask questions regarding reporting. **Completed**
	• Education provided to clinical staff on discussing treatment options including hospitalization with patient and family when hospice patients have a significant decline or change in condition.	Hospice administrator / Education manager	May 2015-CNO	Staff review of clinical care process and procedure for treatment options during staff meeting on 5/11/15. Verbalized understanding. **Completed.**
L501 418.52 Patient Rights Patient not informed of their right to choose an attending physician due to use of an outdated Patient Rights form	• Assure all patients admitted receive updated patient rights form that includes information regarding the right to choose an attending physician by checking forms as they are put in admission packets and checking form prior to patient signing.	Nurse manager/ Admitting clinician	4/28/15-CNO	4/28/15 – All admission packets checked for correct patient rights information. All staff educated to check for correct form before patient signing. **Completed.**
	• Review all 7 active hospice	Compliance	4/28/15-CNO	4/28/15 – Upon 100% medical record review

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	patients and validate the correct form has been signed. • Any patient found to have an incorrect form signed to be given an updated form and notified of the right to choose an attending physician.	Nurse manager	4/28/15-CNO	one patient found to have an outdated form. New information regarding right to choose an attending physician given to patient with incorrect form. **Completed 4/28/15** Billing department will continue 100% audit of all records for use of correct forms ongoing.
L508 418.52(b)(4)(i) Exercise of Rights/Respect for Property/Person Policies and procedures insufficiently developed, implemented and monitored to ensure all allegations of abuse, neglect, mistreatment, injuries of an unknown source or misappropriation of patient property were identified an immediately reported to the administrator	• Develop Guideline for event follow-up • Educate office manager of expectations for follow-up of events. • Abuse Policy to be updated to include Hospice. • All staff to have verbal education and coaching by nurse manager before next shift to include: results of the survey, reporting abuse/neglect/maltreatment/patient complaints immediately to nurse manager and state authorities and numbers of where to report. Complete by end of day 4/24/15. • All staff to complete on-line training on abuse/ neglect by end of day 4/24/15. Twice daily report of completion of training to be sent to nurse manager from education department to allow manager to complete follow-up. Staff will not be able to work	Compliance Compliance Compliance Nursing manger Nurse manager	4/28/15-CNO 4/24/15-CNO 4/24/15-CNO	4/28/15 – Guideline developed listing specific responsibilities for follow-up of all events, office manager educated regarding specific responsibilities for event follow-up including investigating and follow-up reporting to compliance and applicable state authorities as indicated. Abuse Policy updated to include Home Health and Hospice service divisions. **Completed 5/9/15 attached.** 4/24/15 - Verbal education and coaching to all staff regarding reporting abuse/neglect/maltreatment/patient complaints and reporting process completed before next scheduled shift. **Completed.** 4/24/15 - On-line training on abuse/neglect completed by all staff prior to next scheduled shift. **Completed.**

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	until the education is completed and the education sanction grid will be followed for mandatory education. • On-line training on abuse/neglect to be completed by all staff annually. Completion of education to be tracked via quarterly education reports.	Education Department	Ongoing-CNO	Mandatory abuse training will be completed during the third quarter annually each year and tracked in the education software for each employee.
	• All Staff to review policies on abuse/neglect and event reporting. Evidenced by initialed printed copy of policies by end of day 4/24/15 Staff will not be able to work until the education is completed and the education sanction grid will be followed for mandatory education.	Nurse manager	4/24/15-CNO	4/24/15 – Abuse/Neglect policies reviewed by all staff prior to next scheduled shift. **Completed.**
	• All Staff to be provided with and phone numbers for reporting suspected abuse/neglect/maltreatment to appropriate agencies and educated in process of reporting suspected abuse/neglect/maltreatment to appropriate authorities and nurse manager by end of day 4/24/15. • All staff to complete on-line education on use of on-line event reporting system.	Nurse manager	4/24/15-CNO	4/24/15 – Staff provided with laminated copy of Idaho state phone numbers for Adult Protective Services and Child Protective Services and educated in process of reporting suspected abuse/neglect to appropriate authorities and nurse manager. Stickers with phone numbers for Adult Protective Services and Child Protective Services also given to staff to apply to laptops for ready access to phone numbers. **Completed.**

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	• Corporation Operations team including Quality Director, Hospice Administrator, Home Health Administrator and CNO to review events related to abuse /neglect / maltreatment / falls and other serious patient safety concerns monthly for trends, numbers of reports, decline in event reporting, concern with appropriate follow-though. • Quality team to review a minimum of 50% or 3 open hospice patient records per month, whichever is greater for potential unreported abuse/ neglect/ maltreatment / falls or other serious patient safety events.	Nurse manager Nurse Manager Nurse Manager	4/30/15-CNO 5/15/15-CNO 5/15/15-CNO	4/30/15 – Education completed on use of on-line event reporting system by all staff. **Completed.** 5/15/15 To become standing monthly Operations agenda item in May meeting. 5/15/15- Audit results to be presented at team huddles and at staff meetings monthly and shared at monthly Corporate HHH Managers meeting.
L509 418.52(b)(4)(ii) Exercise of Rights/Respect for Property/Person Failure to immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified.	• Develop Guideline for event reporting to include specific timeframe for completion of follow-up. • Educate office manager of expectations for follow-up of events. • Abuse policy to be updated to specify Hospice in the scope and events guideline updated to address "Injuries of an unknown source."	Compliance Compliance Hospice administrator/ Compliance	4/28/15-CNO	4/28/15 – Guideline developed listing specific responsibilities for follow-up of all events, office manager educated regarding specific responsibilities for event follow-up including investigating and follow-up reporting to compliance and applicable state authorities as indicated. **Completed.** Abuse Policy updated to include Home Health and Hospice service divisions. **Completed 5/9/15 attached.** Daily rounding by manager to discuss any suspected abuse/neglect / maltreatment/ adverse events and assure event report is

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				completed appropriately. Began 4/27/15 and completed 5/15/15. **Completed** 5/18/15 Quality team to review a minimum of 50% or 3 open hospice patient records per month, whichever is greater for potential unreported abuse/ neglect/ maltreatment / falls or other serious patient safety events, for appropriate use of event reporting and for timely and appropriate communication of events to agency and hospice administrator and outside governing body. Audit results to be presented at team huddles and at site staff meetings monthly and trends shared at monthly Corporate HHH Managers meeting. Reeducation, coaching and discipline to occur to address audit results as needed.
L510 418.52(b)(4)(iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency	• Develop Guideline for event reporting to include specific timeframe for completion of follow-up. • Educate office manager of expectations for follow-up of events	Compliance	4/28/15-CNO	4/28/15 – Guideline developed listing specific responsibilities for follow-up of all events, office manager educated regarding specific responsibilities for event follow-up including investigating and follow-up reporting to compliance and applicable state authorities as indicated. Suspected events are reviewed immediately with Hospice administrator including resulting actions when necessary. **Completed.** Daily rounding by manager to discuss any suspected abuse/neglect / maltreatment/ adverse events and assure event report is completed appropriately. Began 4/27/15 and completed 5/15/15. **Completed** 5/18/15 Quality team to review a minimum of 50% or 3 open hospice patient records per

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				month, whichever is greater for potential unreported abuse/ neglect/ maltreatment / falls or other serious patient safety events, for appropriate use of event reporting and for timely and appropriate communication of events to agency and hospice administrator and outside governing body. Audit results to be presented at team huddles and at site staff meetings monthly and trends shared at monthly Corporate HHH Managers meeting. Reeducation, coaching and discipline to occur to address audit results as needed.
L511 418.529b)(4)(iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State Survey and Certification Agency) within 5 working days of becoming aware of the violation.	• Develop Guideline for event reporting to include specific timeframe for completion of follow-up. • Educate office manager of expectations for follow-up of events. • All staff to have verbal education and coaching by nurse manager before next shift to include: results of the survey, reporting abuse/neglect/maltreatment/patient complaints immediately to nurse manager and state authorities and numbers of where to report. Complete by end of day 4/24/15. • All staff to complete on-line training on abuse/ neglect by end of day 4/24/15. Twice daily	Compliance Compliance Nurse manager Nurse manager	4/28/15-CNO 4/28/15-CNO 4/24/15-CNO 4/24/15-CNO	4/28/15 – Guideline developed listing specific responsibilities for follow-up of all events, office manager educated regarding specific responsibilities for event follow-up including investigating and follow-up reporting to compliance and applicable state authorities as indicated. **Completed.** 4/24/15 - Verbal education and coaching to all staff regarding reporting abuse/neglect/maltreatment/patient complaints and reporting process completed before next scheduled shift. **Completed.** 4/24/15 - On-line training on abuse/neglect completed by all staff prior to next scheduled shift. **Completed.**

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	report of completion of training to be sent to nurse manager from education department to allow manager to complete follow-up. Staff will not be able to work until the education is completed and the employee sanction grid will be followed for mandatory education.			
	• On-line training on abuse/neglect to be completed by all staff annually. Completion of education to be tracked via quarterly education reports.	Nurse manager	4/24/15-CNO	4/24/15 - On-line training on abuse/neglect completed by all staff prior to next scheduled shift. **Completed.**
	• All Staff to review policies on abuse/neglect and event reporting. Evidenced by initialed printed copy of policies by end of day 4/24/15 Staff will not be able to work until the education is completed and the education sanction grid will be followed for mandatory education.	Nurse manager	4/24/15-CNO	4/24/15 – Abuse/Neglect policies reviewed by all staff prior to next scheduled shift. **Completed.**
	• All Staff to be provided with and phone numbers for reporting suspected abuse/neglect/maltreatment to appropriate agencies and educated in process of reporting suspected abuse/neglect/maltreatment to	Nurse manager	4/24/15-CNO	4/24/15 – Staff provided with laminated copy of Idaho state phone numbers for Adult Protective Services and Child Protective Services and educated in process of reporting suspected abuse/neglect to appropriate authorities and nurse manager. Stickers with phone numbers for Adult Protective Services and Child Protective Services also given to

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	appropriate authorities and nurse manager by end of day 4/24/15.			staff to apply to laptops for ready access to phone numbers. **Completed.** Hospice nurse administrator to review all suspected and reported situations as part of event reporting process. **Completed.**
L515 418.52(c)(4) The patient has the right to choose his or her attending physician	• Assure patient's chosen attending physician is included on the Hospice plan of care. Health Information Management to verify attending physician chosen by patient and listed on the Hospice Notice of Election is included on the Hospice Plan of Care. Nurse Manager to be notified of any patient whose chosen attending physician is not listed on the Hospice Plan of Care to have the Hospice Plan of Care updated with the correct attending physician.	Health Information Management/ Nurse manager/ Case manager	4/28/15 – ongoing CNO	4/28/15 Audit of all current Hospice patients completed to verify attending physician listed on Hospice Notice of Election (NOE) is listed on current Hospice Plan of Care (POC). Health Information Management to continue ongoing audit for all new Hospice patients. Any NOE that does not match the POC will be referred immediately to the hospice manager/case manager for verification and correction. **Completed.**
L552 418.56(d) Review of the plan of care	• Interim Administrator to educate the field staff regarding the purpose and documentation requirement of the Plan of Care and when a change of condition necessitates revision. • Interim Administrator to	Interim Administrator Hospice Administrator	5/14/15-CNO	5/04/15 Staff educated by CNO and Interim administrator on physician communication regarding patient events and concerns. **Completed 5/4/15** 5/08/15 Staff educated by Interim Administrator on Plan of Care requirements regarding documentation and communication. Staff educated on need to have a physician

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	educate staff regarding need to communicate with physician and obtain an order for every change in medication, wound care protocol, visit frequency or any change in treatment. • Interim Administrator and CNO to educate hospice staff on how/what and when to communicate changes in condition, patient safety events and/or potential concerns to the patients attending physician and/or medical director, • Hospice Administrator to educate staff at IDT regarding appropriate documentation of measurable decline, what to share at IDT, when to notify the physician.			order for any changes in treatment. **Completed 5/08/15** 5/14/15 Hospice Administrator educated staff on how to document measurable decline, when to notify physician and what to discuss during IDT. **Completed 5/14/15** 5/12/15 100% chart audit performed on all notes documented between 5/8/15 and 5/12/15 to review for a contact note to attending physician and case-manager if the visit note contained a change in condition. 4/30/15 to current chart audits performed on all open hospice records to audit for object measurements of patient decline. Results will be discussed with staff during staff meetings and IDT meetings. 5/15/15 100% chart audit to be performed on all hospice records for presence of interim orders to update the Plan of Care for any changes in treatment or condition.
L648 418.100 Organizational Environment	• Update organizational charts to reflect Cassia Hospice oversight • Information for Cassia Hospice to be clearly identified in minutes for governing board meetings • Develop process for oversight of Cassia Hospice. Oversight will occur through email, phone, and face to face rounding. • Nursing manager will send	Compliance Hospice Leadership Hospice Administrator Hospice	4/28/15-CNO Ongoing-CNO 4/24/15-CNO 5/7/15-CNO	4/28/15 – Cassia Hospice organizational chart updated to reflect corporate and governing body oversight. **Completed.** Ongoing 4/24/15 – Cassia Hospice oversight process developed and implemented. **Completed and ongoing.** 5/7/15- Hospice management consultant(s) to

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	update emails to the Hospice administrator for review at least 3 times a week for one month, email communication to include: Date Current census # of patients at home # of patients in SNF # of patients in ALF Patients without advance directives and actions to resolve Patient care issues Any staffing level concerns Any staff performance issues Other problems or concerns	Leadership		be on-site for direct oversight weekly for three weeks then monthly or until Administrator deems operations are meeting all expectations. **Completed and ongoing.**
	• Administrator will talk with site manager at least weekly to review status of the program including census, patient care concerns, staffing issues and follow up on quality audits.	Hospice Administrator	4/24/15-CNO	Process instituted.
	• Administrator and site manager will teleconference at least monthly to review agency financials and operational concerns.	Hospice Administrator	4/24/15-CNO	Process instituted.
	• Administrator and site manager will meet at least monthly to review practice concerns and changes, operational issues and expectations as well as updates to education and policy.	Hospice Administrator	4/24/15-CNO	Process instituted.
L651	• Update organizational charts to	Compliance	4/28/15-CNO	4/28/15 – Cassia Hospice organizational chart

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418.100(b) A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.	reflect Cassia Hospice oversight • Information for Cassia Hospice to be clearly identified in minutes for governing board meetings • Develop process for oversight of Cassia Hospice. Oversight will occur through email, phone, and face to face rounding. • Nursing manager will send update emails to the Hospice administrator for review at least 3 times a week for one month, email communication to include: Date Current census # of patients at home # of patients in SNF # of patients in ALF Patients without advance directives and actions to resolve Patient care issues Any staffing level concerns Any staff performance issues Other problems or concerns • Administrator will talk with site manager at least weekly to review status of the program including census, patient care concerns, staffing issues and follow up on quality audits. • Administrator and site manager	Hospice administrator Hospice administrator Hospice administrator Hospice administrator Hospice administrator	Ongoing-CNO 4/24/15-CNO 5/7/15-CNO 4/30/15-CNO 4/30/15-CNO	updated to reflect corporate and governing body oversight. 4/24/15 – Cassia Hospice oversight process developed and implemented 5/7/15- Hospice management consultant(s) to be on-site for direct oversight weekly for three weeks then monthly or until Administrator deems operations are meeting all expectations. **Completed and ongoing.** 5/7/15 -New hospice interim management structure; nurse manager role will be elevated to hospice administrator for ID. Position will be on-site to oversee daily operations. 4/30/15 meetings instituted.

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	will meet at least monthly to review agency financials and operational concerns. • Administrator and site manager will meet at least monthly to review practice concerns and changes, operational issues and expectations as well as updates to education and policy. • Medication reconciliation in-service to be provide to clinicians including review of process and documentation. • Pain management in-service to be conducted to include pain goals, pain management for breakthrough and pre-medication for pain	Hospice administrator Education manager/ Quality consultants Education manager/ Quality consultants	4/30/15-CNO 5/1/15-CNO 5/1/15-CNO	4/30/15 meetings instituted. 5/1/15 Quality team to review a minimum of 50% or 3 open hospice patient records per month for medication reconciliation and medication education to ensure it meets policy and guideline standards. Results will be reviewed at least monthly with clinical staff in staff meetings and staff huddles. 5/1/15 Quality team to review a minimum of 50% or 3 open hospice patient records per month for pain management and pain documentation to ensure it meets policy and guideline standards. Results will be reviewed at least monthly with clinical staff in staff meetings and staff huddles.
L664 418.102 Condition of Participation: Medical director.	• Assure Hospice Medical Director has access to electronic medical record • Training for Hospice Medical Director on process for accessing patient electronic medical record • Review orientation and education completed by Hospice Medical Director • Ensure that Hospice Medical Director has access to quarterly	Nurse manager Nurse manager Education department	4/28/15-CNO 5/7/15-CNO 5/11/15-CNO	4/28/15 – Verified with IT department that Hospice Medical Director does have access to electronic medical record. **Completed.** Medical Director will receive basic electronic record education from education coordinator. Began on 5/7/15 and ongoing. Orientation checklist and role responsibilities reviewed. New orientation plan created. **Completed 5/11/15** Implement new orientation and mentoring for

CORRECTIVE ACTION PLAN

	education and is completing required and mandatory education as specified in the education accountability grid. (include the education accountability grid) • Confirm Medical Director understands roles and responsibilities of position.	Nurse manager/ Education department Hospice Leadership	5/15/15-CNO 6/30/15-CNO	Hospice Medical Director starting 5/15/15 and ongoing. 6/30/15- Will partner experienced hospice system Medical Director's with Cassia Medical Director to work in a peer to peer relationship for thirty (30) days to confirm Director understands roles and responsibilities of this position and can consult as needed. Competency will be performed at the end of sixty days to confirm knowledge.
L669 418.102(d) Standard: Medical director responsibility. The medical director or physician designee has responsibility for the medical component of the hospice's patient care program.	• Assure Hospice Medical Director has access to electronic medical record • Training for Hospice Medical Director on process for accessing patient electronic medical record • Review orientation and education completed by Hospice Medical Director • Ensure that Hospice Medical Director has access to quarterly education and is completing required and mandatory education as specified in the education accountability grid. (include the education accountability grid)	Nurse manager/ Hospice administrator Nurse manager/ Hospice administrator Nurse manager Nurse manager / Education department Nurse manager	4/28/15-CNO 5/7/15-CNO 5/11/15-CNO 5/15/15-CNO 6/30/15-CNO	4/28/15 – Verified with IT department that Hospice Medical Director does have access to electronic medical record. **Completed.** Medical Director will receive basic electronic record education from education coordinator. Began on 5/7/15 and ongoing. Orientation checklist and role responsibilities reviewed. New orientation plan created. **Completed 5/11/15** Implement new orientation and mentoring for Hospice Medical Director starting 5/15/15 and ongoing. 6/30/15- Will partner experienced hospice

CORRECTIVE ACTION PLAN

	• Confirm Medical Director understands roles and responsibilities of position.	/Hospice administrator		system Medical Director's with Cassia Medical Director to work in a peer to peer relationship for thirty (30) days to confirm Director understands roles and responsibilities of this position and can consult as needed. Competency will be performed at the end of sixty days to confirm knowledge.
	• Educate staff regarding notification of physician for patient changes suggestive of a need to alter the plan of care. • If there were changes in patient's condition, physician is notified and outcome documented in the medical record. Audit indicators to be collected on 100% of patients discussed in weekly interdisciplinary team meeting. Audit to begin 4/30/15. Audit results to be at 90% compliance by 5/14/15.	Quality Consultants/ Hospice administration	5/08/15-CNO	Staff education provided. Quality consultant performed 100% review to confirm understanding by clinicians. 5/08/15 started and ongoing. Education of the expectation and documentation requirements reviewed with staff. Audit performed and feedback provided immediately to clinician(s). Results summary to be presented weekly for follow up actions if necessary.

CORRECTIVE ACTION PLAN

The Administrator signing and dating this form is indicating their approval of the plan of correction being submitted above.

Lisa Musgrave RN Date 5/15/15

Lisa Musgrave, Chief Nursing Officer
Intermountain Homecare & Hospice

Attachments:

Guidelines for reporting events
- Education sanction grid
- Module for Abuse (online education)
- Medical Director Education and Orientation Grid
- Home Health and Hospice Event Reporting Policy

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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May 5, 2015

Kim Lane, Administrator
Intermountain Homecare Hospice - Cassia
1031 East Main Street
Burley, ID 83318-2029

Provider #131542

Dear Ms. Lane:

An unannounced on-site complaint investigation was conducted from April 21, 2015 to April 23, 2015 at Intermountain Homecare Hospice - Cassia. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006957

Allegation: Patients are not provided with appropriate medical care after sustaining injuries of an unknown origin.

Findings: During the investigation, policies and procedures, Event Reports and patient records were reviewed and staff were interviewed.

During a telephone interview, on 4/23/15 at 11:30 AM, the Corporate Compliance Director stated all incidents were to be documented on an "Event Report."

The agency provided multiple "Event" policies and procedures which included an "Event Reporting Policy," a "Reportable Events Procedure," and a "Risk Event Management Procedure." The policy and procedures documented they were all effective March 2014. The agency also provided a "Patient Grievance Policy" which was also effective March 2014, a "Patient Grievance Procedure," which was effective October 2014, and an "Abuse Policy," which was effective October 2008.

None of the policies and procedures included information related the hospice agency's systems for immediately reporting and investigating injuries of an unknown source.

The agency's Event Reporting Summary from 1/1/14 to 4/23/15 was reviewed. The summary included a total of 6 incidents which had occurred in that time period (4 related to falls, one related to an allegation of abuse, and one related to a patient's request for an increase in pain medication). The summary did not include documentation that Event Report(s) had been completed related to injuries of an unknown source.

The medical records of 6 patients were reviewed. One of the 6 records documented the Registered Nurse (RN) had noted the patient had bruising on 3/05/15, 4/07/15 and 4/09/15. The patient's record did not include a determination regarding the cause of the bruising and corresponding Event Reports were not present in the hospice agency's records.

Further, the patient's record did not include documentation that she received adequate medical care for the injury of unknown origin that she sustained on 4/09/15, as follows:

The patient's Plan of Care (POC) for the certification period 3/05/15 to 5/04/15 documented she received Coumadin 2 mg, 1 tablet daily. The POC included instructions of "Do not assess PT/INR levels at this time until further notification by the hospice Medical Director." Her record included documentation the most recent PT/INR was performed on 9/25/14, with a result of 25.1 and 2.1 that indicated it was therapeutic.

According to the National Library of Medicine website: "Prothrombin time is measured in seconds. Most of the time, results are given as what is called INR (or international normalized ratio). If taking blood thinning medicines such as warfarin, the normal range for PT results is 11 - 13.5 seconds, or INR of 0.8 - 1.1. If taking warfarin to prevent blood clots, the doctor will most likely choose to keep the INR between 2.0 and 3.0. The risks of bleeding and hematoma in these patients are greater than for people without bleeding problems."

In an RN Visit Note, dated 4/09/15 from 8:23 AM to 10:37 AM, the RN noted the patient had a large developing hematoma on her left lower leg. Her pain was described as a 10 on a pain scale of 1-10, "worst possible imaginable." The note included descriptions of her pain as aching, crushing, shooting, stabbing, and tender, with intermittent spasms. The RN further documented the patient was in severe discomfort, frequently calling out, grabbing her leg, complained of leg spasms approximately every 25-45 seconds, and stated her pain was "unbearable." In the section "Emotional Status" the RN documented "Patient currently exceedingly agitated due to pain in left leg." The RN wrote in the note that there were no falls reported and the patient reported she did not know what happened to her leg.

The RN documented "Following 10 doses of Morphine 1 ml (20 mg) at 15 minute intervals, patient reported she felt the pain in her leg was subsiding adequately." Ten doses of 20 mg of morphine every 15 minutes would be the equivalent of 200 mg Morphine over a 2.5 hour period. She noted the patient's Lorazepam was increased to .5 to 1 mg every hour for anxiety and spasms in the left leg.

The visit note included a wound assessment sheet with 2 photos of the hematoma. One photo showed erythema and swelling just below the left knee. The second photo showed a much larger hematoma, with a large pocket of fluid noted on the inner aspect. The leg was noted to be more edematous in the second photo. There were no measurements to indicate the actual size of the hematoma.

The visit note documented the hospice Medical Director was notified of the hematoma and orders were received to draw a PT/INR, as well as, other labs. The RN noted that she told the patient's caregivers that the patient's skin would likely rupture and pooled blood under her skin would drain copiously. She noted the leg was to have disposable pads underneath to manage drainage if the hematoma ruptured.

The visit note did not include documentation of discussion with the patient or her family regarding options for treatment of the hematoma, including pursuing evaluation and treatment at the hospital. Additionally, the note did not include documentation that the patient's Coumadin therapy was reevaluated and discussed given her change in status.

In an RN Visit note dated 4/09/15 from 2:17 PM to 6:20 PM, the RN documented the patient's pain continued at a level of 10 out of 10, with aching, cramping, crushing, shooting, stabbing, and spasms. Additionally, her emotional status was described as "anxious, apprehensive, distraught, irritable, labile, restless, and tearful." The RN noted the patient was not able to eat, and was only able to tolerate fluids.

A description of the hematoma on the patient's left leg was documented as "swelling and blood pooling to left lower leg appears to be worsening, continued. Patient's hospital bed is assembled and in working order. Patient tolerated transfer to the bed with moderate discomfort. Patient required several doses of Morphine every 15 minutes as ordered, and Lorazepam 1 mg every hour as ordered to manage pain symptoms."

The RN documented an evaluation of the effectiveness of comfort measures as "Patient reports pain poorly managed during the day today. Ongoing spasms in left leg and persistent discomfort."

The visit note included a wound assessment sheet with a photo of the hematoma. The photo included a measuring guide, which indicated the area of discoloration and swelling of the hematoma was greater than 10 cm (4 inches) wide by 6 cm (2 1/2 inches) long. The height of the hematoma appeared to be approximately 3 cm (1 1/4 inches) high.

The RN documented she reviewed teaching with the patient's caregivers regarding pain management, prevention of further injury to the left leg, prevention of skin breakdown, and the need to keep the leg on disposable pads. She also documented that she reviewed the need to keep the patient's leg elevated with pillows, as much as possible, to manage edema and bleeding.

The visit note did not indicate the patient's physician was notified of the increase in size of the hematoma from the visit 4 hours earlier or of the patient's inability to eat. Documentation of discussion with the patient or her family regarding options for treatment of the hematoma, including pursuing evaluation and treatment at the hospital, was not present.

In a visit note dated 4/10/15 from 2:40 AM to 4:15 AM, the RN documented the patient's pain was estimated at 6/10, and she was moaning. Additionally, the RN noted the patient was non-responsive, and only responded once during the 2 hour visit.

The RN documented the appearance of the hematoma as "left leg with a 10 cm hematoma/blood blister to left calf just below the knee." A wound assessment sheet included photos of the hematoma, which had split open, and the RN documented copious amounts of red bloody drainage.

The results of the PT/INR were in the visit note and documented as 28.3 and 2.7, which was above the therapeutic range. The RN documented she reviewed wound care with the patient's caregivers and instructed them to not touch the dressing on the patient's leg, to only replace the pad under the dressing if it should become soiled.

The record did not include documentation that the patient's physician was notified of the rupture of the hematoma and amount of drainage, or that the patient was un-responsive. It was not documented if the physician was informed of the result of the PT/INR or that the patient's Coumadin therapy was reevaluated and discussed given her status.

In a visit note dated 4/10/15 from 11:51 AM to 12:40 PM, the RN documented the patient's caregivers estimated her pain rating to be 5 out of 10. The RN documented the patient responded to tactile stimulation only. The patient's temperature was noted to be elevated at 99.6, her blood pressure measured 118/64, and her pulse was elevated at 108/minute.

The RN documented "Patient minimally responsive during visit, hands and feet cold to touch, intermittent breathing pattern changes. Staff at facility report they have been unable to administer medications to patient all day today due to unresponsiveness. Patient has not eaten anything today, has had only sips of fluids."

The wound assessment for the visit stated "...large hematoma on left lower leg. Large area of blood pooling has ruptured, heavy amount of bloody drainage noted." Additionally, she was noted to have edema around the wound. The RN documented she applied silvadene cream to the open wound and a nonstick pad was placed over the hematoma. The leg was wrapped in an Attends (adult diaper), and a disposable absorbent pad.

However, the patient's record did not include documentation of orders for the silvadene cream or wound care instructions for the ruptured hematoma on her leg. Further, the records did not include documentation that the patient's physician was notified of the continued drainage and her continued inability to eat or of her deteriorating status as evidenced by the patient's abnormal vital signs and her inability to take medications.

In a visit note dated 4/11/15 from 1:35 PM to 3:30 PM, the RN noted the patient was minimally responsive, could answer yes or no, and moaned. Her temperature was elevated at 99.0. The patient's pain was assessed at 5 as evidenced by the crying, moaning, and grimacing noted by the RN. The RN documented she spoke with the the patient's caregivers to schedule the patient's Morphine every 2 hours.

The RN noted the patient had noisy respirations, and diminished lung sounds. She documented her skin was discolored with cyanosis. In the section of the note for description of skin, the RN documented the patient had inflammation or cellulitis, open wounds, and bruising.

The visit note documented the patient had no food intake, and only sips of fluids. Additionally, the RN stated she had difficulty controlling liquid in her mouth. The RN documented the patient was showing evidence of active dying, and her family was present. The family was noted as stating "We just want her comfortable."

The record did not include documentation that the patient's physician was notified of the continued drainage, her continued inability to eat, or of her continued abnormal vital signs. Further, the record did not include documentation that the patient's physician was notified of the deteriorating status as evidenced by the patient's noisy respirations, decreased lung sounds, discolored skin with cyanosis and difficulty with liquids.

In a RN Visit note dated 4/12/15 from 11:25 AM to 12:25 AM, the RN documented the patient's blood pressure was 130/50, her temperature was 99.0, and her pulse was 72/minute. Her oxygen saturations were noted at 85%. The patient was noted to be unresponsive, and her pain was estimated at 2.

The RN documented the patient's left leg dressing had copious red drainage. The dressing was removed and silvadene cream was applied. A nonstick dressing was placed over the cream, and the leg was wrapped in an absorbent pad and placed in an Attends to help with drainage.

The record did not include documentation that the patient's physician was notified of the continued drainage or her continued deteriorating status.

In an RN Visit note dated 4/13/15 from 11:20 AM to 12:18 PM, the RN documented the patient's pain was estimated at 7 "severe," and she was intermittently responsive. The RN noted the patient was unable to tolerate any food or drink of any significant amount. Her skin was documented as cyanotic, and her temperature was 99.1. Her breath sounds were diminished, she had shortness of breath, and noisy respirations.

The wound assessment sheet for the visit noted the patient had a heavy amount of red drainage from her left leg wound, there was edema, and warmth to the area, as well as, discoloration. The wound care note documented the patient's pain intensity of 10, and intermittent, which differed from the assessment section of the visit note, which described her pain level as 7. Wound care was not documented in the visit note.

The record did not include documentation that the patient's physician was notified of the continued drainage or of her increase in pain. Further, the record did not include evidence that interventions were adjusted to better manage the patient's pain.

An RN Visit note dated 4/14/15 from 11:30 AM to 1:48 PM, indicated the patient had died.

During an interview on 4/22/15 beginning at 10:15 AM, the hospice Interim Nurse Manager reviewed the patient's record. The Interim Nurse Manager stated she was the primary nurse for the patient. She stated that at 8:00 AM on 4/09/15, she was called by the patient to evaluate her left leg as she had severe pain. She stated when she arrived she observed the patient's left leg and noted edema with a hematoma. She stated she took a photo of the hematoma, and another photo 40 minutes later, as the blood was accumulating rapidly.

The Interim Nurse Manager stated she e-mailed the photos to the hospice Medical Director and he reviewed them. She stated the Medical Director did not come to the facility to evaluate the patient's leg. She stated he ordered lab work, and told her to elevate the leg and apply ice. She stated the patient did not tolerate the ice to her leg and refused it. The Interim Nurse Manager stated she did not question if the patient's Coumadin should be discontinued and did not suggest more aggressive treatment such as having the hematoma evaluated at the hospital. The Interim Nurse Manager stated it was an injury of unknown origin, and stated she questioned the patient's caregivers, who denied injury or falls. The Interim Nurse Manager confirmed she did not initiate an Event Report or any further investigation into the patient's injury.

The Interim Nurse Manager stated the patient was in a large amount of pain, but the pain seemed to be managed by administration of Morphine every 15 minutes, as well as the Lorazapam that was administered on an hourly basis. She stated the Morphine was scheduled to be administered every 2 hours even if the patient did not request it, in order to keep her comfortable.

The Interim Nurse Manager confirmed the hematoma ruptured and continued to produce large amounts of bloody drainage. She stated the hospice Medical Director was aware, but he did not come to evaluate the patient. She stated she was not sure if the Medical Director was aware of the results of the PT/INR, and did not talk to him about discontinuing the Coumadin that was ordered.

During an interview on 4/23/14 beginning at 7:30 AM, the hospice Medical Director was not able to explain why the patient was on Coumadin. He stated it is a controversy whether to keep hospice patients on medications like Coumadin. He stated if it was to prevent from blood clots and stroke for a patient with an unrelated diagnosis, then Coumadin would be indicated. He stated he was unsure if the patient had cardiomegaly or another diagnosis that would indicate she needed Coumadin.

When the hospice Medical Director was asked about the rupture of the hematoma and the amount of bleeding from the leg, he responded that he was alerted when the hematoma burst. He stated he did not come to evaluate the wound and was not aware of the amount of drainage. He stated he was aware the results of the patient's PT/INR was "Hyper therapeutic," and did not consider discontinuing the Coumadin at that time.

The patient sustained an injury of unknown source to her lower left leg on 4/9/15. The injury developed into a hematoma causing the patient "unbearable," severe pain and she was unable to eat. On 4/10/15 the hematoma ruptured and had "copious amounts of red bloody drainage." The patient was unresponsive, her vital signs were abnormal, and she was not able to take her medications. On 4/11/15, 4/12/15, and 4/13/15 the patient's condition continued to deteriorate and she was showing signs of active dying. She was not responsive, continued being unable to eat, had difficultly drinking, her vital signs continued to be abnormal, and the left leg wound continued to have a "heavy amount of red drainage."

However, during the 6 day period, from 4/9/14 when the injury was sustained until her death on 4/14/15, no Event Reports were completed for the patient and an investigation was not initiated in order to ensure she was protected from ongoing physical harm.

During a telephone interview on 4/23/15 beginning at 12:00 PM, the Corporate Compliance Officer stated he was not aware of the patient's hematoma or death. He stated he would have expected an Event Report for the injury of unknown cause. He stated the hospice agency had not contacted the corporate level Hospice Administrator regarding the injury.

The agency failed to ensure and Event Report and an investigation had been completed and for the injury of unknown cause on the patient's left leg. Further, the hospice agency did not ensure the Medical Director was kept informed of the patient's status or that appropriate medical was provided to the patient.

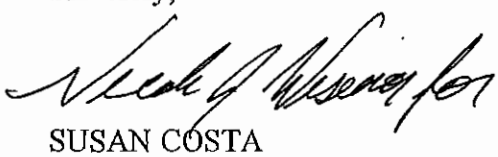
Therefore, the allegation was substantiated and federal deficiencies related to the allegation were cited.

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.

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,



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