

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



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**IMPORTANT NOTICE – PLEASE READ CAREFULLY**

June 18, 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  
Recertification Survey completed 06/04/2015  
Conditions of Participation Not Met - QAPI  
Termination Action Continues**

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 12, 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 June 4, 2015, the Idaho Bureau of Facility Standards (State survey agency) completed a recertification survey at your facility and found that your agency is not in compliance with Condition of Participation **42 CFR 418.58 Quality Assessment and Performance Improvement (QAPI)**. We agree with the State survey agency's findings that the above Conditions of Participation was not met. This deficiency limits the capacity of Intermountain Homecare Hospice - Cassia to furnish services of

Page 3 -- Ms. Lane

an adequate level and quality. The Statement of Deficiencies (Form CMS-2567) reflecting this deficient practice is enclosed for your reference.

#### **PUBLIC NOTICE OF TERMINATION**

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

#### **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:

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

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](mailto: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

July 8<sup>th</sup>, 2015

*Via facsimile (208-364-1888)*

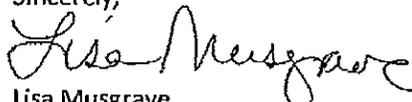
Hospice Survey Team  
Idaho Department of Health and Welfare  
Bureau of Facility Standards  
3232 Elder Street  
Boise, Idaho 83705

**Re: Intermountain Homecare Hospice – Cassia  
Provider # 131542  
Plan of Correction**

Attached for your review is the Plan of Correction on behalf of Intermountain Hospice at Cassia. We did finally receive our survey letter in the mail yesterday. Thank you to your team for sending us a scanned copy last week so that we could complete our Plan. I'm sorry we weren't able to connect with someone sooner. I also want to thank you and your team for their continued guidance to our hospice as we work to bring our agency into compliance with all regulatory standards and to provide excellent patient care to the patients and families we serve.

I look forward to your response and any feedback regarding our Plan of Correction and hope to continue to work closely with you and your colleagues in the future.

Sincerely,



Lisa Musgrave  
Hospice Chief Nursing Officer  
Intermountain Homecare & Hospice

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

PRINTED: 06/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  131542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/04/2015
NAME OF PROVIDER OR SUPPLIER  INTERMOUNTAIN HOMECARE HOSPICE - CASSIA			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the Medicare recertification survey of your hospice agency conducted from 6/01/15 through 6/04/15.</p> <p>The surveyors conducting the recertification were:</p> <p>Gary Guiles, RN, HFS, Team Leader Laura Thompson, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ADL - Activities of Daily Living CM - Case Manager CMS - Centers for Medicare and Medicaid Services COPD - Chronic Obstructive Pulmonary Disease EMS - Emergency Medical Services HA - Health Aide IDG - Interdisciplinary Group MD - Medical Doctor PIP - Performance Improvement Project POC - Plan of Care QAPI - Quality Assessment/Performance Improvement RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care</p>	L 000	<p>Handwritten revisions at 559 + 589 made per conversations with Lisa Musgrave, CNO, 7/10/15 Sylvia Greenwell</p> <p>The Chief Nursing Officer is responsible for Completion of the 2567 Plan of Correction.</p> <p><b>RECEIVED</b> JUL 08 2015 <b>FACILITY STANDARDS</b></p>	
L 524	<p><b>418.54(c) CONTENT OF COMPREHENSIVE ASSESSMENT</b></p> <p>The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.</p>	L 524	<p>IDT structure will include review of patient assessment to assure complete documentation for physical, emotional, spiritual and psychosocial needs at admission and ongoing. Begun June 15, 2015</p>	June 15, 2015-ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Lisa Musgrave RN* TITLE: *CNO* (X6) DATE: *7/8/2015*

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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NAME OF PROVIDER OR SUPPLIER  INTERMOUNTAIN HOMECARE HOSPICE - CASSIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1031 EAST MAIN STREET BURLEY, ID 83316	
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L 524	Continued From page 1  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the comprehensive assessment identified the physical and psychosocial needs for 1 of 11 patients (#10) whose records were reviewed. This had the potential to result in inadequate care and treatment being provided to a patient. Findings include:  Patient #10 was a 77 year old female admitted to the hospice on 1/13/15, for a diagnosis of traumatic brain injury. Her POC and record were reviewed, including the certification period of 1/13/15 to 4/12/15.  The SOC visit dated 1/13/15 and signed by the RN, documented a full assessment was performed on admission of Patient #10. However, the visit note documented areas which were not assessed during the SOC visit. Examples included but are not limited to the following:  - Patient #10's abdominal girth and mid-arm circumference were not assessed. Patient #10 was receiving enteral feedings and was not taking food or fluids by mouth. Additionally, the RN documented Patient #10's recent decline during the last month was related to weight loss.  - The SOC visit documented no pain was observed during the visit. Patient #10's spouse stated she did not have to take her prescribed medication for pain for "some time." However, the RN documented no standardized pain tool was used to assess Patient #10's pain level	L 524	Quality Consultants will review 100% of all hospice patients on service a minimum of once monthly to verify POC reflects physical, spiritual, emotional, and psychosocial needs.  Staff educated regarding individual development of POC at start of care and recertification to assure care and documentation captures all elements of physical, spiritual, emotional, and psychosocial needs. Staff educated to include assessment of co-morbid conditions at SOC. Oversight for complete POC documentation will occur through clinical auditors and quality consultants. 100% records reviewed Monthly for 6 months. In progress.  Interventions in the Horizon patient folder will be created by problem category to further prompt clinicians to add documentation that reflects complete needs of patient. Business Analyst/Staff workgroup initiated July 1st, 2015.	July 10, 2015  Education Completed by July 1st 2015. Record review monthly for 6 months.  August 15, 2015

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L 524	Continued From page 2 during the visit.  - Patient #10's lung sounds were not assessed during the SOC visit. Patient #10 was recently hospitalized with aspiration pneumonia on 12/13/14. Patient #10 was documented as experiencing shortness of breath when walking short distances or during dressing herself per her spouse.  Additionally, the RN documented no treatment was initiated for her shortness of breath because it was declined by Patient #10. However, the RN documented Patient #10 had severe cognitive impairment with a loss of speech and/or comprehension and she was non-responsive and non-verbal.  During an interview on 6/03/15 at 2:15 PM, the Interim Nurse Manager reviewed the record and confirmed Patient #10's pain was not comprehensively assessed by the RN. She further confirmed Patient #10's respiratory status and nutritional status were not comprehensively assessed at the SOC visit.  Patient #10 did not have a comprehensive assessment of her needs.	L 524	(cont)  Staff educated on appropriate response to changes in condition including modification to patient plan of care, physician communication, event reporting, and care coordination. Staff educated that the comprehensive assessment must be updated at least every 16 days and which data elements must be included for comprehensive care planning, coordination of services and QAPI. 100% of documentation alerts in SHP will be monitored and reviewed with clinicians for dyspnea and pain by clinical auditors and quality consultants.  Education will be provided on individualizing a Plan of Care, completing a comprehensive assessment including physical, emotional, spiritual, and psychosocial assessment, developing a complete a problem list based on assessment, implementing interventions that are appropriate based on the assessment problem list, and how to document interventions appropriately including use of the Plan for Next Visit as the Clinical Handoff. Case studies will be used to demonstrate appropriate documentation.	Education complete d June 25th. Alert auditing July 14th, 2015 ongoing  Complete d June 25, 2015, and ongoing.	
L 538	418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES  The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.  This STANDARD is not met as evidenced by:	L 538	Focused documentation review will be performed by quality consultants to assure all IDG, Care planning and coordination are present. Minimum of 4 charts monthly will be reviewed and discussed with individual staff members.  Education to staff on addressing all elements in documentation of physical assessment will be provided by clinical auditors, education coordinators, and quality consultants based on review findings immediately and group trends will be responded to ongoing on an as needed basis.	July 14, 2015  June 18, 2015 and ongoing	

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L 538	<p>Continued From page 3</p> <p>Based on staff interview and review of medical records, it was determined the agency failed to ensure POCs specified the care and services necessary to meet patient-specific needs identified in the comprehensive assessment for 4 of 11 patients (#3, #4, #7, and #10) whose records were reviewed. The lack of specific personalized POCs interfered with the hospice's ability to direct patient care. Findings include:</p> <p>1. Patient #3 was a 91 year old female who was admitted for hospice services on 7/25/14 and discharged on 9/05/14. Her diagnoses included dementia and Type II Diabetes.</p> <p>Patient #3's comprehensive RN assessment, dated 7/25/14 at 7:38 PM, stated she took Methadone, a powerful narcotic, for generalized pain and she took insulin for her diabetes. The assessment also stated she had diabetic ulcers on her right foot.</p> <p>Patient #3's POC for the certification period 7/25/14 -10/22/14 stated the nurse was to visit once the first week and 2 times a week after that "...to assess overall patient status, pain and symptom control, medication compliance, patient/family/caregiver concerns, and environmental safety. SN to instruct on disease progression, pain and symptom management, medications, signs and symptoms of dying, comfort measures, and home safety." The POC did not specifically address Patient #3's pain, diabetes, or foot ulcers.</p> <p>The Hospice Nurse Administrator was interviewed on 6/02/15 beginning at 9:30 AM. She stated Patient #3's POC did not specifically address pain, diabetes, or foot ulcers.</p>	L 538	<p>(cont from above)</p> <p>Quality Consultants will review 100% of all hospice patients on service a minimum of once monthly to verify POC reflects physical, spiritual, emotional, and psychosocial needs.</p> <p>Staff will be educated regarding individual development of POC at start of care and recertification to assure care and documentation captures all elements of physical, spiritual, emotional, and psychosocial needs. Oversight for complete POC documentation will occur through clinical auditors and quality consultants. 100% records reviewed Monthly for 6 months. In progress.</p> <p>Staff educated on the purpose of the interdisciplinary team and appropriate content of IDT. Hospice administrator attending IDT meetings one -two times monthly to mentor staff in IDT discussions.</p>	<p>July 10, 2015</p> <p>Educational Completed by July 1st 2015. Record review monthly for 6 months.</p> <p>Completed June 11, 2015</p>	

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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 538	<p>Continued From page 4</p> <p>2. Patient #7 was an 85 year old female who was admitted for hospice services on 3/13/15. She died on 5/11/15. Her diagnoses included lung cancer and debility.</p> <p>Patient #7's comprehensive RN assessment, dated 3/13/15 at 7:38 PM, stated she had a right pleural effusion, a build up of fluid between the lung and the chest wall, which was drained in 12/14. The assessment stated Patient #7 hoped to get it drained again for comfort. The assessment stated Patient #7 used a narcotic pain patch and took another narcotic pain medication on a regular basis. The assessment stated Patient #7 complained of nausea and vomiting. The assessment stated Patient #7 had a loss of appetite and weight. The assessment stated Patient #7 had a cough and shortness of breath. Her oxygen saturation level was 89%. (The Mayo Clinic web site, queried on 6/10/15, stated normal oxygen saturation levels were from 95 to 100%. The site stated levels below 90% were considered low).</p> <p>Patient #7's POC for the certification period 3/13/15 to 6/10/15 stated the nurse was to assess overall patient status, pain and symptom control, medication compliance, patient/family/caregiver concerns, and environmental safety. The POC stated the nurse would also instruct the patient on disease progression, pain and symptom management, medications, signs and symptoms of dying, comfort measures, and home safety. The POC did not specifically address Patient #7's pain, shortness of breath, nausea and vomiting, and nutritional needs.</p> <p>The Hospice Nurse Administrator was interviewed</p>	L 538	(cont.)	

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NAME OF PROVIDER OR SUPPLIER  INTERMOUNTAIN HOMECARE HOSPICE - CASSIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1031 EAST MAIN STREET BURLEY, ID 83318		
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L 538	<p>Continued From page 5</p> <p>on 6/03/15 beginning at 9:40 AM. She stated Patient #7's POC did not specifically address pain, shortness of breath, nausea and vomiting, and nutritional needs.</p> <p>3. Patient #10 was a 77 year old female admitted to the hospice on 1/13/15 for a diagnosis of traumatic brain injury. Her POC and record were reviewed for the certification period of 1/13/15 to 4/12/15.</p> <p>Patient #10's SOC visit was completed on 1/13/15 by the RN. Patient #10 was documented as experiencing shortness of breath with dressing, toileting, and ambulating short distances. The RN documented no interventions were initiated due to Patient 10's refusal. However, Patient #10 was documented as non-responsive and non-verbal.</p> <p>Patient #10's enteral feedings were documented as a source of stress for the primary caregiver, Patient #10's spouse. The RN documented Patient #10's spouse was worried he had made the wrong decision regarding enteral feedings and felt guilty for starting the feedings. The RN documented Patient #10's spouse was having difficulty deciding whether to stop the enteral feedings. However, there was no documentation the RN had discussed the spouse's concerns with the spouse or with other members of the IDG.</p> <p>Patient #10's neurological status was assessed by the RN, related to her diagnosis of traumatic brain injury. The RN documented Patient #10 had short and long term memory impairment, confusion, and severe cognitive impairment with loss of speech.</p>	L 538	(cont.)		

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NAME OF PROVIDER OR SUPPLIER  INTERMOUNTAIN HOME CARE HOSPICE - CASSIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1031 EAST MAIN STREET BURLEY, ID 83318		
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L 538	<p>Continued From page 6</p> <p>The POC ordered the "SN to assess overall patient status, pain and symptom management, medications, signs and symptoms of dying, comfort measures, and environmental safety." There was no documentation of specific interventions related to Patient #10's terminal diagnosis of a traumatic brain injury or the family's needs which were identified during the comprehensive assessment. Additionally, the POC did not include interventions or orders for who was responsible for managing or monitoring her enteral feedings.</p> <p>During an interview on 6/03/15 at 2:15 PM, the Interim Nurse Manager reviewed the record and confirmed the POC did not include specific interventions related to Patient #10's initial comprehensive assessment.</p> <p>4. Patient #4 was an 82 year old male admitted to the hospice on 5/19/15 for a diagnosis of Non-Hodgkin's Lymphoma. His record, including the POC, was reviewed for the certification period of 5/19/15 to 8/16/15.</p> <p>Patient #4's SOC visit was completed on 5/19/15 by the RN. Patient #4 had a PleurX drainage system (used to drain excessive fluid to the chest or abdomen) to his right lower abdomen upon admission to the hospice. Patient #4 had a wound to his right abdomen where the drain tube entered his body.</p> <p>The visit note stated the wound and drainage system were assessed and Patient #4's wife was trained and caring for the wound and the drainage system.</p> <p>The POC orders stated "Patient and family may</p>	L 538	(cont.)		

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L 538	Continued From page 7 use the PleurX drainage system as needed for relief of pressure to abdomen." The POC did not include parameters regarding the use of the drainage system to manage excess fluid. Additionally, there were no interventions or orders related to the management of the PleurX drainage system.  The POC did not include wound orders for monitoring or management of Patient #4's wound to his abdomen.  During an interview on 6/03/15 at 9:55 AM, the RN reviewed the record and confirmed the POC did not include orders or interventions related to Patient #4's drainage system or his abdominal wound. She stated Patient #4's wife was trained how to use the drainage system and was caring for his abdominal wound.  The POCs did not include all the services or interventions necessary to meet the identified needs of the patients.	L 538	(cont.)	
L 543	418.56(b) PLAN OF CARE  All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure	L 543	Hospice leadership will utilize open visit report to monitor scheduled visits for oversight. Any visit that is scheduled and not performed will be followed up weekly to determine if patient canceled or visit needs to occur. Manager to follow-up on appropriate documentation to be completed; either missed visit or visit completed before Thursday of each week.  Educate staff when a visit is canceled at the patient's request the medical record needs to reflect a canceled visit and the supporting documentation must be in the patient's medical record. June 2015 complete.	June 8, 2015, ongoing  June 8, 2015 complete

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L 543	<p>Continued From page 8</p> <p>hospice care and services furnished to patients followed individualized written POCs for 2 of 11 patients (#4 and #11) whose records were reviewed. This had the potential to result in unmet patient and family needs. Findings include:</p> <p>1. Patient #4 was an 82 year old admitted to the hospice on 6/19/15 for a diagnosis of Non-Hodgkin's Lymphoma. His record, including the POC, was reviewed for the certification period of 5/19/15 to 8/16/15.</p> <p>Patient #4's POC dated 5/19/15, ordered HA services 4 times a week for 1 week then 3 times a week for 12 weeks, with 3 visits as needed. However, the HA had documented 1 visit the first week dated 5/21/15. There were no missed visit notes documented in Patient #4's record.</p> <p>During an interview on 6/03/15 at 9:55 AM, the RN reviewed the record. She confirmed the HA did not make the ordered visits because Patient #4's wife had been upset and did not want further visits the first week. The RN stated Patient #4's physician was aware but confirmed it was not documented in the record. At 2:05 PM on 6/03/15, the RN presented missed visit notes for 2 of the visits that were missed by the HA the first week. She confirmed 1 of the 4 ordered HA visits was not done.</p> <p>During an interview on 6/03/15 at 10:26 AM, the Interim Nurse Manager reviewed the record and confirmed HA visits were not completed as ordered on the POC.</p> <p>The agency failed to ensure Patient #4 received HA visits as ordered.</p>	L 543	(cont.)		

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NAME OF PROVIDER OR SUPPLIER  INTERMOUNTAIN HOMECARE HOSPICE - CASSIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1031 EAST MAIN STREET BURLEY, ID 83318		
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L 543	Continued From page 9  2. Patient #11 was an 82 year old male admitted to the hospice on 3/05/15 for a diagnosis of metastatic cancer in his right hip. His record, including the POC, was reviewed for the certification period of 3/05/15 to 6/02/15.  Patient #11's POC dated 3/05/15, ordered SN visits 2 times a week for the first week, 3 times a week for 2 weeks, 2 times a week for 7 weeks, and 3 visits as needed for the certification period.  During the first week of the certification period Patient #11 received 3 visits by the SN. On weeks 2 and 3 he received 6 visits by the SN each week. There was no order included in the record for increased SN visits.  During an interview on 6/04/15 at 8:55 AM, the Interim Nurse Manager reviewed the record and confirmed the ordered SN visits and additional visits were made. She stated there was an order to increase the visit frequency per a request by Patient #11's family. The Interim Nurse Manager confirmed the POC was not updated to include the increased frequency for SN visits. She confirmed the family's request to increase SN visits was not documented in the record.  The agency failed to include orders for the increased frequency of SN visits to Patient #11.	L 543	Clinical staff educated to check physicians orders for frequency prior to adding visits. June 8, 2015 complete.  A minimum of 50% of open records or 4 charts, whichever is greater will be audited for Plan of care review to include order frequency and updates when there is a change requiring an increase in visits by any discipline. To begin July 20, 2015 by clinical auditors.	June 8, 2015  July 20, 2015	
L 549	418.56(c)(4) CONTENT OF PLAN OF CARE  [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (4) Drugs and treatment necessary to meet the	L 549	QAPI plan includes monitoring ability of patient and caregiver to safely administer medications. Plan developed and implemented in May, reeducated staff June 30th.	June 30th, 2015	

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L 549	<p>Continued From page 10 needs of the patient.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the POC included all drugs and treatments necessary to meet the needs of 1 of 11 patients (#11) whose records were reviewed. This resulted in inadequate pain management for the patient. Findings include:</p> <p>Patient #11 was an 82 year old male admitted to the hospice on 3/05/15 for a diagnosis of metastatic cancer in his right hip. His record, including the POC, was reviewed for the certification period of 3/05/15 to 6/02/15.</p> <p>Patient #11's record included an SOC visit dated 3/05/15, signed by the RN which documented Patient #11 reported having extreme pain to his right hip. The SOC note stated Patient #11's family agreed with the POC, and were willing and able to be involved with the care of Patient #11.</p> <p>However, the RN documented "Family is a little leary [sic] about giving liquid Morphine and Ativan for patient's breakthrough pain because of the drowsiness and sleepiness that it causes. Continue with pain management and administration teaching with family. Encourage use of medications to keep patient comfortable." Patient #11's family was instructed when to give the oral pain medication and anxiety medication.</p> <p>The POC did not include interventions to meet Patient #11's pain management needs or to address the family's apprehension in administering medications as ordered.</p>	L 549	<p>(cont.)</p> <p>F10 Libraries in McKesson Horizon updated to include in the Orders for Plan of Care, Interventions, and IDG template. Reviewed/ reeducated staff June 30th, 2015</p> <p>Pain management will be monitored by quality consultants ongoing to further assure patients needs are addressed and documented. Data from SHP and chart reviews. Start July 10, 2015 and ongoing.</p> <p>Staff educated on Pain and Symptom management, family involvement in care, social support and care planning during IDT coaching. Completed June 10th, 2015.</p>	<p>June 30, 2015</p> <p>July 10, 2015</p> <p>June 10, 2015</p>	

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L 549	Continued From page 11  During an interview on 6/04/15 at 8:55 AM, the Interim Nurse Manager reviewed the record and confirmed Patient #11's POC did not include interventions to meet the pain needs which were identified at his SOC visit.	L 549	(cont.)  F10 Libraries in McKesson Horizon updated to include in the Orders for Plan of Care, Interventions, and IDG template. Reviewed/reeducated staff June 30th, 2015	June 30, 2015	
L 552	Patient #11 did not receive the treatment necessary to meet his needs. 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 1 of 11 patients (Patient #11) whose records were reviewed. This resulted in a lack of interventions being provided to meet patient needs. The findings include:  Patient #11 was an 82 year old male admitted to the hospice on 3/05/15 for a diagnosis of metastatic cancer in his right hip. His record, including the POC, was reviewed for the certification period of 3/05/15 to 6/02/15.  Patient #11's initial evaluation, dated 3/05/15, documented he had cancer of his hip with a right acetabular (hip) fracture. Patient #11 was bedbound and required maximum assistance with	L 552	Pain management will be monitored by quality consultants ongoing to further assure patients needs are addressed and documented. Data from SHP and chart reviews. Start July 10, 2015 and ongoing.  Staff educated on Pain and Symptom management, family involvement in care, social support and care planning during IDT coaching. Completed June 10th, 2015.	July 10, 2015  June 10, 2015	

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L 552	<p>Continued From page 12</p> <p>ADLs. Patient #11 stated he had severe pain to his right hip.</p> <p>During his certification period of 3/05/15 to 6/02/15, Patient #11 experienced several episodes of poorly controlled pain symptoms and increasing family member apprehension with regard to pain management. Examples included but were not limited to the following:</p> <ul style="list-style-type: none"> <li>- In a visit note dated 3/07/15, the RN documented Patient #11 rated his pain as 6 on a scale of 0 - 10. Patient #11 was documented as crying intermittently and moaning due to pain. The RN documented she administered 3 doses of oral pain medication and 1 dose of oral anti-anxiety medication to relieve Patient #11's pain.</li> <li>- In a visit note dated 3/08/15, the RN documented Patient #11's family members were anxious about his infusion pump running out of pain medication. The RN documented the family was educated. However the documentation did not include details on what Patient #11's family was educated regarding.</li> <li>- In a visit note dated 3/11/15, the RN documented Patient #11 was having "very intense severe" pain. His pain level was documented as 8 out of 10 on a 1 to 10 scale. The RN documented medicating Patient #11 4 times with his prescribed oral medications before he received relief. The family was educated on using distraction and relaxation to assist with Patient #11's pain.</li> <li>- In a visit note dated 3/13/15, documented Patient #11 was having leg spasms which were</li> </ul>	L 552	<p>(cont.)</p> <p>F10 Libraries in McKesson Horizon updated to include in the Orders for Plan of Care, Interventions, and IDG template. Reviewed/ reeducated staff June 30th, 2015</p> <p>Pain management will be monitored by quality consultants ongoing to further assure patients needs are addressed and documented. Data from SHP and chart reviews. Start July 10, 2015 and ongoing.</p> <p>Staff educated on Pain and Symptom management, family involvement in care, social support and care planning during IDT coaching. Completed June 10th, 2015.</p>	<p>June 30, 2015</p> <p>July 10, 2015</p> <p>June 10, 2015</p>

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L 552	<p>Continued From page 13</p> <p>increasing his pain. The RN documented Patient #11's daughter did not want to give him scheduled doses of anti-anxiety medications during the day, as ordered by his physician. Additionally, the RN documented the family of Patient #11 had a meeting and decided they did not want to increase his epidural pain medication as ordered and had decreased his oral pain medication during the day.</p> <p>- In a visit note dated 3/19/15 at 10:20 AM, the RN documented the family members of Patient #11 were encouraged on the use of oral pain medications and anti-anxiety medications for his breakthrough pain. The visit note stated the family was reluctant about using the oral medications.</p> <p>Patient #11 exhibited increasing symptoms of pain as noted in SN visit notes. Patient #11's records documented a significant change in his family's agreement and compliance with his prescribed pain management. There was no documentation Patient #11's physician was informed of his increasing pain or his family's reluctance to administer ordered pain medication to manage his symptoms. Additionally, his record did not include documentation that the IDG, including the Medical Director, had updated his POC to address his family's refusal to give scheduled pain medications or increase his pain medication infusion for his comfort.</p> <p>During an interview on 6/04/15 at 8:55 AM, the Interim Nurse Manager reviewed the record. She confirmed the IDG meetings did not specifically address Patient #11's pain management needs or his family member's apprehension to follow the physician orders. The Interim Nurse Manager</p>	L 552	(cont.)	<p><del>June 30, 2015</del></p> <p><del>July 10, 2015</del></p> <p><del>June 10, 2015</del></p>

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L 552	Continued From page 14 confirmed his POC was not updated to meet his needs.	L 552	(cont.)	
L 559	<p>Patient #11's POC was not updated to include interventions for a significant change in status.</p> <p>418.58 QUALITY ASSESSMENT &amp; PERFORMANCE IMPROVEMENT</p> <p>This CONDITION is not met as evidenced by: Based on staff interviews and review of QAPI plans, QAPI documents, adverse event documents, and meeting minutes, it was determined the hospice failed to ensure a QAPI program was developed, implemented, and maintained. This resulted in the hospice's inability to monitor services and improve the quality of patient care based on relevant data and actions taken. Findings include:</p> <ol style="list-style-type: none"> <li>1. Refer to L560 as it relates to the hospice's failure to ensure an effective, ongoing, hospice-wide, data-driven QAPI program was developed and implemented.</li> <li>2. Refer to L562 as it relates to hospice's failure to ensure the QAPI program measured and analyzed quality indicators, including adverse patient events.</li> <li>3. Refer to L564 as it relates to hospice's failure to ensure the QAPI program used data to monitor the effectiveness of its services and to identify opportunities and priorities for improvement.</li> <li>4. Refer to L565 as it relates to the hospice's</li> </ol>	L 559	<p>Intermountain Hospice- Cassia Quality Plan developed and approved. A fully integrated QAPI plan is developed from assessment of needs specific to this location that is based on complexity and service. Complete June 24, 2015</p> <p>Governing Board QAPI Goal that includes frequency and data collection methodology is developed, reviewed and approved. Governing board reviewed and approved QAPI plan. Complete July 10, 2015</p> <p>Quality Committee consisting of all Home Health and Hospice leadership met June 24, 2015. Quality coordinator was voted in, plan reviewed and approved. Minutes from the Quality Committee recorded. Complete.</p> <p>Quality indicators were identified, metrics developed, and frequency established in the QAPI. Complete.</p> <p>Hospice staff provided education on requirements of QAPI elements for Safe Medication Administration. Begin May 2015, refresher July 2, 2015 - ongoing as needed.</p> <p>QAPI plan was reviewed with all Hospice staff during team meeting. Complete July 2, 2015</p> <p>PDSA was completed and performance monitoring and measurement began. Begin June 25, 2015-ongoing.</p>	<p>June 24, 2015</p> <p>July 10, 2015</p> <p>June 24, 2015</p> <p>June 24, 2015</p> <p>May 15, 2015, review July 2, 2015</p> <p>June 25, 2015</p>

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NAME OF PROVIDER OR SUPPLIER  INTERMOUNTAIN HOMECARE HOSPICE - CASSIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1031 EAST MAIN STREET BURLEY, ID 83316		
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L 559	Continued From page 15 failure to ensure the frequency and detail of data collection was developed and approved by the hospice's Governing Board. .  5. Refer to L566 as it relates to the hospice's failure to ensure the QAPI program focused on high-risk, high volume, or problem prone areas.  6. Refer to L569 as it relates to the hospice's failure to ensure adverse patient events were tracked and their causes were analyzed.  7. Refer to L571 as it relates to the hospice's failure to ensure PIPs were developed and implemented.  9. Refer to L574 as it relates to the failure of the Governing Board to assume responsibility for developing, implementing, and maintaining the QAPI program.  The cumulative effect of these systemic failures seriously impeded the ability of the agency to assess, monitor, and improve the quality of its services.	L 559 (cont)	Clinical Operations team to update job description for the COO, Medical Director, Quality Director, and Quality consultants to include their role in the Quality Program. Completed  Human Resources to update job description of COO, Medical Director, Quality Director, and Quality consultants when updated by Clinical Operations Team.	July 7, 2015  July 18, 2015 <sup>03</sup> <i>sc</i>	
L 560	418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT  The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative	L 560	Intermountain Hospice- Cassia Quality Plan developed and approved. A fully integrated QAPI plan is developed from assessment of needs specific to this location that is based on complexity and service.  Governing board reviewed and approved QAPI plan. Governing Board QAPI Goal that includes frequency and data collection methodology is developed, reviewed and approved.	June 24, 2015  July 10th, 2015	

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L 560	Continued From page 16 outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.  This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents and meeting minutes, it was determined the agency failed to ensure an effective, ongoing, hospice-wide data-driven, QAPI program was developed and implemented. This resulted in a lack of direction to staff responsible for maintaining the QAPI program. Findings include:  1. A document titled "Quality & Patient Safety Plan, Draft" dated February 2015, included broad categories, such as a mission statement and guiding principles. However, the document did not include specific quality indicators, goals, or guidance to staff regarding how the quality of care and services would be evaluated. In addition, the document addressed both home health and hospice agencies throughout the Intermountain Homecare system which included 8 different locations in Utah and Idaho. Finally, no documentation was present indicating the "draft" plan had been approved by the Governing Board. No plan specific to the Burley, Idaho hospice was documented.  The Chief Nursing Officer was interviewed on 6/11/15 beginning at 9:00 AM. She confirmed the "Quality & Patient Safety Plan, Draft" had not been approved. She said it would be approved at the August 2015 meeting. She stated a specific	L 560	Quality Committee consisting of all Home Health and Hospice leadership met June 24, 2015. Quality coordinator was voted in, plan reviewed and approved. Minutes from the Quality Committee recorded. Complete  Quality indicators were identified, metrics developed, and frequency established in the QAPI. Complete.  PDSA element for education identified, developed and completed. All Hospice staff provided education on requirements of QAPI elements for Safe Medication Administration. May 2, 2015, July 2, 2015.  QAPI plan was reviewed with all Hospice staff during team meeting. July 2, 2015.	June 24, 2015  June 24, 2015  July 2, 2015 complete  July 2, 2015

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L 560	Continued From page 17 plan had been developed but was not documented.  2. Some data had been gathered by the agency. For example, data regarding the percentage of patients who were screened for pain during the initial nursing assessment and the percentage of patients who screened positive for pain had been gathered from 7/01/14-8/03/15. However, no documentation was present to show the agency had evaluated its ability to manage patients' pain.  The Chief Nursing Officer was interviewed on 6/04/15 beginning at 3:45 PM. She stated the agency evaluated care but it was not documented.	L 560	(cont.) Data reviewed from QAPI plan for Safe Medication Administration with Governing Board, Quality Committee and Cassia Hospice staff. Review of data will occur ongoing at the established frequency throughout the duration of the QAPI plan cycle. Initiated July 2015 - ongoing	July 2015-ongoing
L 562	The agency failed to develop and implement hospice-wide, data-driven QAPI program. 418.58(a)(2) PROGRAM SCOPE  (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.  This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the agency failed to ensure the QAPI program measured and analyzed, quality indicators, including adverse patient events. This impeded the agency's ability to evaluate about the care it provided. Findings include:  The "Quality & Patient Safety Plan, Draft" dated February 2015, was reviewed. The plan was not	L 562	Intermountain Hospice- Cassia Quality Plan developed and approved. A fully integrated QAPI plan is developed from assessment of needs specific to this location that is based on complexity and service. Complete June 24, 2015  Governing board reviewed and approved QAPI plan. Governing Board QAPI Goal that includes frequency and data collection methodology is developed, reviewed and approved. Complete July 2015.  Quality Committee consisting of all Home Health and Hospice leadership met June 24, 2015. Quality coordinator was voted in, plan reviewed and approved. Minutes from the Quality Committee recorded. Complete June 24, 2015  Quality indicators were identified, metrics developed, and frequency established in the QAPI.	June 24, 2015  July 10th, 2015  June 24, 2015  June 24, 2015

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L 562	<p>Continued From page 18</p> <p>specific to the Burley hospice agency, but included home health, hospice, and DME companies throughout the Intermountain Healthcare System. The plan did not state how the agency planned to measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance. The plan did not include specific quality indicators nor did it include a methodology to analyze adverse patient events and recommend ways to prevent them.</p> <p>A data summary for 2014 was reviewed. The only data specific to the hospice agency was "Hospice Events," Adverse Drug Events, and Employee Injuries. The only adverse event listed in 2014 was a Patient/Visitor Behavioral Action. No other events, including falls, were noted in 2014.</p> <p>Some data was available, such as data on pain scoring from a company called Strategic Healthcare Programs. However, no documentation was present to indicate the data was analyzed or specific action was taken based on the data.</p> <p>The Regional Compliance Officer was interviewed on 6/03/15 beginning at 1:45 PM. He confirmed the plan was not comprehensive and was not specific to the Burley hospice agency. He confirmed the plan did not specifically state how data would be measured and analyzed.</p> <p>The Chief Nursing Officer, interviewed on 6/03/14 beginning at 3:45 PM, confirmed the 2014 adverse event data only contained 1 event. She stated she was sure more events had occurred in 2014 that were not reported. She was</p>	L 562	<p>(Cont.)</p> <p>QAPI plans includes specific monitors and measures for Intermountain Hospice- Cassia. Complete June 2015</p> <p>Provide Education on appropriate use of event reporting system, use of new system. Educate on Event reporting policy, abuse/neglect policy. Manager will review all events monthly.</p>	<p>June 24, 2015</p> <p>May 2015, Complete</p>

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L 562	Continued From page 19 Interviewed again on 6/11/15 beginning at 9:00 AM. She stated the agency had reviewed and analyzed QAPI data but she said this was not documented.	L 562	(cont.)		
L 564	The hospice failed to measure and analyze quality indicators. 418.58(b)(2) PROGRAM DATA  (2) The hospice must use the data collected to do the following: (i) Monitor the effectiveness and safety of services and quality of care. (ii) Identify opportunities and priorities for improvement.  This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents and meeting minutes, it was determined the agency failed to ensure the QAPI program used data to monitor the effectiveness of its services and to identify opportunities and priorities for improvement. This interfered with the agency's ability to identify opportunities to improve its processes. Findings include:  Four "Home Health & Hospice Managers Leadership Meeting" minutes were given to surveyors. These were dated 11/21/14, 2/25/15, 5/07/15, and 5/27/15. The managers were responsible for Intermountain Homecare's system wide QAPI program. The committee minutes referred to Intermountain Homecare's home health and hospice agency's in Utah and Idaho. Individual agencies were not typically referenced.  None of the meeting minutes included or mentioned data specific to the Burley hospice	L 584	Quality plan includes the collection of data, requirements for response to the data collected for effectiveness and safety of services and quality of care. The plan further includes how opportunities and priorities for improvement are identified and incorporated into right time, right place, right response actions. Complete June 24, 2015  Quality action plans, outcomes and additional actions will be recorded in monthly minutes. Process established- complete June 24, 2015	June 24, 2015  July 10, 2015  July 10, 2015	

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L 564	Continued From page 20 agency. No opportunities or priorities for improvement specific to the Burley hospice agency were documented in the minutes.  The Chief Nursing Officer was interviewed on 6/11/15 beginning at 9:00 AM. She agreed that agency specific data and was not referenced in the minutes. She stated efforts had been made to monitor the effectiveness of services but said these efforts were not documented. She also stated agency specific opportunities and priorities for improvement were not documented.	L 564	(cont.)		
L 565	The agency failed to use data to monitor the effectiveness of its services and to identify opportunities and priorities for improvement. 418.58(b)(3) PROGRAM DATA  (3) The frequency and detail of the data collection must be approved by the hospice's governing body.  This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents and meeting minutes, it was determined the agency failed to ensure the frequency and detail of data collection was developed and approved by the hospice's Governing Board. This interfered with the agency's ability to gather data. Findings include:  The agency's "Quality & Patient Safety Plan, Draft," dated February 2015, did not include specific quality indicators and did not include the frequency and detail of the data collection.  Four "Intermountain Homecare & Hospice Board	L 565	Quality plan developed, reviewed and approved by the QAPI Committee including areas recommended for monitoring, data, frequency and ongoing plans.  Governing board to approve quality plan that was developed including the monitoring, data collection, frequency, and ongoing plans.  Ongoing quality data will be a part of the board meetings to include data measured, outcomes, and additional actions for recommendations. Minutes will reflect oversight of the quality plan.	June 24, 2015  July 10, 2015  July 10, 2015	

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L 565	Continued From page 21 Meeting" minutes were documented between 6/01/14 and 5/31/15. These were dated 6/19/14, 11/20/14, 2/05/15, and 5/29/15. None of the minutes included discussion or approval of the agency's QAPI plan. None of the minutes included discussion of the frequency or detail of data collection.  The Director of Compliance was interviewed on 6/03/15 beginning at 1:45 PM. He stated the frequency and detail of the QAPI program's data collection was not defined and had not been approved by the hospice's Governing Board.  The hospice failed to approve the frequency and detail of data collection.	L 565	(cont.)		
L 566	418.58(c)(1)(i) PROGRAM ACTIVITIES  (1) The hospice's performance improvement activities must: (i) Focus on high risk, high volume, or problem-prone areas.  This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the agency failed to ensure the hospice's performance improvement activities focused on high risk, high volume, or problem-prone areas. This prevented the hospice from developing a QAPI program based on the agency's needs. Findings include:  The agency's "Quality & Patient Safety Plan, Draft," dated February 2015, did not identify the agency's high risk, high volume, or problem-prone areas on which the plan was	L 566	Hospice Quality plan includes assessment of high risk, high volume, or problem-prone areas. Tools for used for evaluation of these areas include but are not limited to; Survey findings, event reports, trends, and internal quality monitors. Complete June 24, 2015  Data monitoring will occur as part of the standard operations and trends presented to the Quality Committee and Governing Board for further recommendations. Begin June 2015- ongoing.	June 24, 2015  June 24, 2015 and ongoing	

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L 566	Continued From page 22 based.	L 566	(cont)	June 24, 2015	
	The Director of Compliance was interviewed on 6/03/15 beginning at 1:45 PM. He stated the agency had not identified its high risk, high volume, problem-prone areas in order to develop its QAPI plan.		Complete an assessment of high risk, high volume, problem-prone areas with QAPI Committee in order to develop QAPI plan.		
	The hospice failed to identify its high risk, high volume, problem-prone areas in order to focus its performance improvement activities.				
L 569	418.58(c)(2) PROGRAM ACTIVITIES  (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.	L 569	All staff required to attend and complete training for event reporting requirements in May 2015. 100% all staff Completed	May 15, 2015	
	This STANDARD is not met as evidenced by: Based on staff interview and a review of incident reports and QAPI documents, it was determined the hospice failed to ensure adverse patient events were tracked and their causes were analyzed. This failure directly impacted 1 of 11 patients (#6) whose records were reviewed and had the potential to impact all patients receiving services by the agency. This failure impeded the hospice's ability to determine if the care it provided was appropriate. Findings include:		Additionally monthly trend reports are currently monitored to assure reports are being generated by all offices. Begin July 2015	July 2015	
	Patient #6 was a 75 year old female who was admitted for hospice services on 5/07/14 and died on 2/03/15. Her diagnosis was COPD.		Hospice leadership further monitors all events and actions including reporting through IDT and rounding activities. Begin May 2015- ongoing	May 2015 and ongoing	
	A "Case Communication Report" by the Social Worker, dated 1/27/15 at 12:03 PM, stated Patient #6 "fell this AM getting out of bed.		Quality plan includes methodologies for tracking of adverse events, root cause analysis, and actions for established monitoring, response monitoring and process monitoring. Use of RCA and PDSA for effective planning and monitoring will be ongoing and performed by hospice staff, quality, compliance, and education.	June 24, 2015 and ongoing	← SC Final correction date
			Adverse events will be monitored via trend reports on a monthly basis. Patient safety committee and Infection Control committee will review, plan actions and respond to trends. Actions of these committees will be reported to Quality Committee and the Governing Board as part of the quality report. Begin July 2015.	Begin July 2015	

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L 569	<p>Continued From page 23</p> <p>[Complained of] pain to leg, stomach. Family notified EMS in [another town]. Discussed respite care with [daughter] &amp; her spouse which they desire. Explained that hospice does not cover ambulance transport; family determined that they would transport her themselves after CM manager visited to examine [Patient #6]."</p> <p>A late nursing visit note by the RN, dated 1/31/15 for a visit made on 1/27/15, stated Patient #6 complained of pain in her right knee and was grimacing and moaning. The note stated "Nothing observable at this time. However, patient states 'ouch' when moving [right leg] with repositioning. MD notified and will follow up with patient after her arrival to hospital for respite stay." The note stated Liquid Morphine and Lorazepam were given for pain and anxiety. The note stated the physician was notified at 1:30 PM and respite stay at the hospital was arranged. The note also stated the nurse instructed Patient #6's "family about safely transferring patient from bed to w/chair for transfer."</p> <p>The family transported Patient #6 to a hospital approximately 33 miles over rural roads. She arrived at the hospital on 1/27/15 at 5:05 PM. The first physician note was dated 1/28/15 at 4:10 PM. The note did not include documentation of a physical examination. It stated Patient #6 did not have a knee fracture and would be checked for a hip fracture. An X-ray report, dated 1/28/15 at 5:34 PM, confirmed a hip fracture.</p> <p>Because of Patient #6's frail condition, her hip was not surgically repaired. She was transferred to a skilled nursing facility on 1/31/15 and died on 2/03/15.</p>	L 569	(cont.)	<p>Completed June 24th, 2015</p> <p>Completed June 24th, 2015</p>

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L 569	Continued From page 24 An incident report was not documented.  The RN who wrote the nursing note dated 1/31/15 was interviewed on 6/04/15 beginning at 10:30 AM. She confirmed Patient #6 had fallen and had been transported by private vehicle to a hospital for respite care. She stated she had not filled out an incident report regarding the events. She stated the events surrounding the fall had not been investigated.  The Chief Nursing Officer was interviewed on 6/04/15 beginning at 10:00 AM. She confirmed an incident report should have been completed following Patient #6's fall. She said there was no documentation regarding an investigation of the fall or the subsequent care in order to evaluate the care of Patient #6. She stated falls were one item tracked by the agency's QAPI program. No falls were documented as occurring on the 2014 summary of events. She agreed the number of falls reported by the QAPI program was not reliable.	L 569	(cont)	
L 571	418.58(d) PERFORMANCE IMPROVEMENT PROJECTS  Beginning February 2, 2009, hospices must develop, implement and evaluate performance improvement projects.  This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the agency failed to ensure PIPs were developed and implemented. This interfered with the agency's	L 571	Quality planning includes the collection of data, requirements for response to the data collected for effectiveness and safety of services and quality of care. Performance improvement plans further includes opportunities and priorities for improvement that are identified and incorporated into right time, right place, right response actions. Initiated June 2015-ongoing.  Quality action plans, outcomes and additional actions will be recorded in monthly minutes of staff, Quality Committee and Governing Board meetings. Initiated June 2015- ongoing	Completed June 24th, 2015  Completed June 24th, 2015

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L 571	Continued From page 25 ability to evaluate and improve its services. Findings include:  A document titled "Quality & Patient Safety Plan, Draft" dated February 2015, did not define PIPs and did not state the agency would conduct PIPs.  No PIPs specific to the agency were documented between 1/01/14 and 5/31/15.  The Director of Compliance was interviewed on 6/03/15 beginning at 1:45 PM. He stated the agency gathered ongoing data but had not conducted any PIPs.  The hospice failed to develop and implement PIPs.	L 571	(cont.)  Implemented a quality program regarding Patient/Caregiver safe medication administration.	June 24, 2015
L 574	418.58(e)(1) EXECUTIVE RESPONSIBILITIES  The hospice's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.  This STANDARD is not met as evidenced by: Based on staff interview and review of meeting minutes, it was determined the agency's Governing Board failed to assume responsibility for developing, implementing, and maintaining the QAPI program. This resulted in a lack of oversight of the QAPI program and a lack of direction to staff responsible for the program. Findings include:  Five "Intermountain Homecare & Hospice Board	L 574	Intermountain Hospice- Cassia Quality Plan developed and approved. A fully integrated QAPI plan is developed from assessment of needs specific to this location that is based on complexity and service. Complete July 2015  Governing Board QAPI Goal that includes frequency and data collection methodology is developed, reviewed and approved. Governing board reviewed and approved QAPI plan.	June 24, 2015  July 10, 2015

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L 574	<p>Continued From page 26</p> <p>Meeting" minutes were documented between 6/01/14 and 5/29/15. The minutes were dated 6/19/14, 8/21/14, 11/20/14, 2/05/15, and 5/29/15. All of the minutes covered both home health and hospice agencies throughout the Intermountain Homecare system which included 8 different locations in Utah and Idaho. No minutes specific to the Burley, Idaho hospice were documented except the 5/29/15 minutes, which stated the board discussed the results of a recent CMS audit and an action plan to address deficiencies was currently in place.</p> <p>None of the meeting minutes referred to the QAPI program at the Burley hospice. No documentation was present that the Governing Board had discussed, approved, or evaluated the agency's QAPI program.</p> <p>The Chief Nursing Officer was interviewed on 6/03/15 beginning at 1:45 PM. She agreed there were no Board meeting minutes or other documentation to show the Governing Board had discussed, approved, or evaluated the agency's QAPI program.</p> <p>The Governing Board failed to define, implement, and maintain the QAPI program.</p>	L 574	<p>Quality plan includes methodologies for tracking of adverse events, root cause analysis, and actions for established monitoring, response monitoring and process monitoring. Use of RCA and PDSA for effective planning and monitoring will be ongoing and performed by hospice staff, quality, compliance, and education. Complete.</p> <p>Adverse events will be monitored via trend reports on a quarterly basis. Patient safety committee and Infection Control committee will review, plan actions and respond to trends. Actions of these committees will be reported to Quality Committee and the Governing Board as part of the quality report.</p>	<p>June 24, 2015</p> <p>June 24, 2015</p> <p>July 10, 2015</p>	