

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Western Division of Survey and Certification  
Seattle Regional Office  
701 Fifth Avenue, Suite 1600, M/S RX-400  
Seattle, WA 98104



---

**THIS SERVES AS OFFICIAL NOTICE SENT VIA FACSIMILE PURSUANT TO 42  
CFR §488 NO HARD COPY TO FOLLOW**

**IMPORTANT NOTICE – PLEASE READ CAREFULLY**

August 14, 2015

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

**CMS Certification Number: 13-1542**

**Re: Mandatory Termination Rescinded**

Dear Ms. Lane:

The Plan of Correction you submitted to the State agency has been reviewed. On August 5, 2015 the Bureau of Facility Standards notified CMS that your Plan of Correction was found to be acceptable. Based on the State agency's finding and recommendation, CMS is **rescinding the mandatory termination effective August 5, 2014.**

If you have any questions regarding this letter, please contact Fe Yamada of my staff at 206-615-2381 or by email at [marie.yamada@cms.hhs.gov](mailto:marie.yamada@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Patrick Thrift". The signature is written in a cursive style with some loops and flourishes.

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

cc: Idaho Bureau of Facility Standards  
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



---

**THIS SERVES AS OFFICIAL NOTICE SENT VIA FACSIMILE PURSUANT TO 42 CFR §488  
NO HARD COPY TO FOLLOW**

**IMPORTANT NOTICE – PLEASE READ CAREFULLY**

July 28, 2015

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

**CMS Certification Number: 13-1542**

**Re: Revisit Survey completed 07/13/2015  
Conditions of Participation Met but Standard Deficiencies Uncorrected**

Dear Ms. Lane:

On July 13, 2015, the Idaho Bureau of Facility Standards (State survey agency) conducted a revisit survey at your facility and found that the Conditions of Participation were met. However, there are standard deficiencies that remain uncorrected. Please see the attached CMS 2567 Summary of Deficiencies and submit a Plan of Correction within 10 days from the date of this letter or by end of business day on **August 7, 2015**.

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,

A handwritten signature in black ink, appearing to read "Patrick Thrift". The signature is written in a cursive, flowing style.

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

August 3<sup>rd</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

RECEIVED  
AUG 03 2015

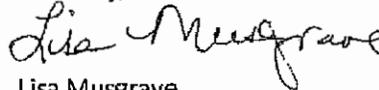
FACILITY STANDARDS

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

Attached for your review is the Plan of Correction for tag L570 on behalf of Intermountain Hospice at Cassia. I also want to thank you and your team again for your 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.

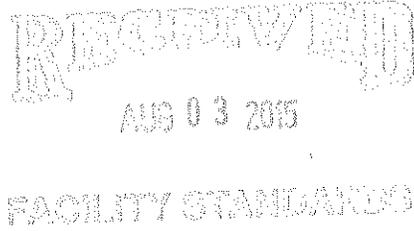
I look forward to your response and any feedback regarding our Plan of Correction.

Sincerely,



Lisa Musgrave  
Hospice Chief Nursing Officer  
Intermountain Homecare & Hospice

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131542</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>INTERMOUNTAIN HOMECARE HOSPICE - CASSIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1031 EAST MAIN STREET BURLEY, ID 83318</b>		
(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 deficiency was cited during the follow up survey of your hospice agency conducted on 7/13/15. Surveyors conducting the survey were:  Nancy Bax, RN, BSN, HFS Rebecca Lara, RN, HFS  Acronyms used in this report include:  Pt - patient QAPI - Quality Assurance Performance Improvement RN - Registered Nurse	{L 000}	The Chief Nursing Officer is responsible for Completion of the 2567 Plan of Correction.  		
L 570	418.58(c)(3) PROGRAM ACTIVITIES  (3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.  This STANDARD is not met as evidenced by: Based on review of QAPI and audit documents, record review and staff interviews, it was determined the agency failed to ensure performance improvement actions were taken. This failure directly impacted 9 of 11 patients (#1-#9) whose records had been audited and had the potential to impact all patients receiving services from the agency. This resulted in missed opportunities to improve patient care and services. Findings include:  During an interview on 7/13/15 at 10:45 AM, the Interim Nurse Manager stated the agency's current QAPI project was related to safe	L 570	QAPI plan for Safe Medication Administration by the Patient/Caregiver includes bi-weekly record reviews. The record reviews include POC documentation for new and recertification, as well as IDT note review for established patients. The record reviews are completed by the Quality Consultant and opportunities for improvement are shared with staff via written communication. Process reviewed and roles clarified on July 20th.  Cont.	July 20th, 2015	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

07/27/2015

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131542</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/13/2015</b>		
NAME OF PROVIDER OR SUPPLIER  <b>INTERMOUNTAIN HOMECARE HOSPICE - CASSIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1031 EAST MAIN STREET BURLEY, ID 83318</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L 570	<p>Continued From page 1</p> <p>medication administration. She stated the goal of the project was all patient records would document the ability of the patient and/or caregiver to safely administer medications. She stated the agency's nurses were educated to document the ability of the patient/caregiver to safely administer medications in the physician's order at the time of admission and recertification, in every visit note, and in every case conference note.</p> <p>The agency's document titled "Quality Assessment Performance Improvement (QAPI) Board Goals for 2015" identified safe medication administration as a problem prone/high risk area to be addressed by the agency. The document stated the performance improvement project would include bi-weekly audits performed by the Quality consultants, sharing of audit results with key stakeholders, to include clinicians, and stated "One to one education and feedback will be provided to clinicians to reinforce understanding of the requirement for assessment and supporting documentation."</p> <p>Patient #1 was an 87 year old female admitted to the agency on 6/20/13. Her record for the certification period 6/10/15 to 8/08/15 was reviewed.</p> <p>Patient #1's recertification physician's order dated 6/10/15 did not include the ability of the patient/caregiver to safely administer medications.</p> <p>Patient #1's record included a case conference note dated 6/25/15. The note stated "Pt's spouse still able to administer meds when needed."</p>	L 570	<p>The medical record review tool was enhanced to include bi-weekly review dates to facilitate timely reviews and establish clearly defined review periods. Complete.</p> <p>Additional training was completed with clinical staff to further emphasize the understanding of the requirement to assess and document how competency and understanding is demonstrated by the patient/caregiver. Education elements included teach back, verbalization of understanding, pill counts, and other monitoring techniques. This training occurred during Tuesday Topics and staff meetings. Complete.</p> <p>The medical record review tool was expanded to capture supporting documentation requirements for the above elements of performance. Complete.</p> <p>Following each bi-weekly review cycle, individual feedback is provided by quality consultants through written communication for any elements scored as not met. Initiated and ongoing.</p>	July 13, 2015	July 21, 2015	July 20, 2015	Began second bi-weekly review cycle in July 21, 2015.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131542</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>07/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>INTERMOUNTAIN HOMECARE HOSPICE - CASSIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1031 EAST MAIN STREET BURLEY, ID 83318</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 570	<p>Continued From page 2</p> <p>However, it did not document how it was determined her spouse was able to safely administer her medications.</p> <p>During an interview on 7/13/15 at 11:30 AM the Interim Nurse Manager reviewed Patient #1's record and confirmed the recertification order did not document the ability of the patient/caregiver to safely administer medications. Additionally, she stated the case conference note dated 6/25/15 did not document a comprehensive assessment of ability to safely administer medications.</p> <p>During an interview on 7/13/15 at 1:25 PM the Interim Nurse Manager stated patient records were audited every 2 weeks for compliance with documentation of safe medication administration. She stated the audits were performed by the parent organization's Quality Consultant, located in another state. She stated when the audit revealed lack of documentation of safe medication administration, the RN who completed the documentation was contacted by the Quality Consultant.</p> <p>An audit document dated 6/17/15 was reviewed. It included audits completed on 11 patient records. It indicated 9 of the 11 patient records (Patients #1-#9) lacked some or all of the required documentation related to safe medication administration.</p> <p>During a phone interview on 7/13/15 at 1:35 PM, the Quality Consultant stated the safe medication administration project was implemented in May. She stated she completed the first audit of patient records on 6/17/15. She stated she was currently performing the second audit of patient records, on 7/13/15.</p>	L 570	<p>Currently the Quality Consultant II position for Cassia is vacant. Applications are being reviewed to hire a dedicated professional to support this office to further assure ongoing compliance with QAPI work. In the interim the QAPI plan work tasks are being completed by the Quality Consultant team. The Director of Quality will review the QAPI to assure it is performed consistently, timely, and feedback provided to individuals and management. Director of Quality will provide feedback director to Office Manager and review findings for benchmarking at the Quality meeting.</p> <p>Initiated and in progress.</p> <p>PDSA cycles will be used to evaluate and implement additional actions to assure ongoing performance improvement. PDSA cycle #1 ends in August 2015. Initiated and ongoing.</p>	<p>July 21, 2015</p> <p>July 21, 2015</p>

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

PRINTED: 07/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131542</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>INTERMOUNTAIN HOMECARE HOSPICE - CASSIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1031 EAST MAIN STREET</b> <b>BURLEY, ID 83318</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 570	Continued From page 3  The Quality Consultant stated she audited patient records for compliance with documentation of patient/caregiver ability to safely administer medications monthly, rather than bi-weekly as stated in the QAPI goals for 2015. She stated the audit results were sent to the Hospice Clinical Director and the Interim Nurse Manager. She stated it was the responsibility of the Nurse Manager to address problems with the RNs, and to follow up to ensure the issues were resolved. She stated she did not communicate with the RNs.  During an interview on 7/13/15 at 1:50 PM the Interim Nurse Manager stated she did not know it was her responsibility to contact the RNs regarding lack of documentation identified during the audits. She confirmed the RNs had not been contacted to discuss audit results or lack of documentation related to safe medication administration.  The agency failed to complete bi-weekly medical record audits for documentation of safe medication administration. Additionally, the facility failed to provide feedback and instruction to the RNs to ensure improvement in documentation of patient/caregiver ability to safely administer medication.	L 570			