



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
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CERTIFIED MAIL: 7000 1670 0011 3315 1538

August 5, 2015

Jana Stowell, Administrator
St Alphonsus Home Health & Hospice
9199 West Black Eagle Drive
Boise, ID 83709-1572

RE: St Alphonsus Home Health & Hospice, Provider #131507

Dear Ms. Stowell:

Based on the survey completed at St Alphonsus Home Health & Hospice, on July 24, 2015, by our staff, we have determined St Alphonsus Home Health & Hospice is out of compliance with the Medicare Hospice Conditions of Participation of **Patients' Rights (42 CFR 418.52)** and **Quality Assessment & Performance Improvement (42 CFR 418.58)**. To participate as a provider of services in the Medicare Program, a Hospice agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of St Alphonsus Home Health & Hospice, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;

Jana Stowell, Administrator
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- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Hospice agency into compliance, and that the Hospice agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before September 7, 2015. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than August 30, 2015.

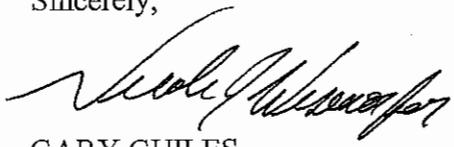
Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **August 17, 2015.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,



GARY GULES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/pmt
Enclosures

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

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

PRINTED: 08/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2015
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NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709
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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 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your hospice conducted from 7/20/15 through 7/24/15. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Suzi Costa, RN, HFS Teresa Hamblin, RN, MS, HFS COPD - Chronic Obstructive Pulmonary Disease Dx - Diagnosis EMS - Emergency Medical Services IDG - Interdisciplinary Group LPN - Licensed Practical Nurse MSW - Medical Social Worker NP - Nurse Practitioner PDAC - Plan Do Act Check PI - Performance Improvement PIP - Performance Improvement Project PO - By mouth POC - Plan of Care PRN - as needed pts. - patients Q4H - Every four hours QAPI - Quality Assessment and Performance Improvement RN - Registered Nurse SOC - Start of Care TID - Three times per day	L 000		
L 500	418.52 PATIENTS' RIGHTS This CONDITION is not met as evidenced by: Based on staff interview and review of clinical records and quality documents, it was determined the agency failed to ensure patients' rights were protected and promoted. This failure resulted in	L 500		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jana Stowell, RN TITLE: Director/Adm. (X6) DATE: 7-17-15

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 500	Continued From page 1 patient rights being violated and placed patients at risk for harm. Findings include: 1. Refer to L505 as it relates to the hospice's failure to ensure a process for prompt resolution of patient grievances was implemented in accordance with hospice policy. 2. Refer to L517 as it relates to the hospice's failure to ensure patients were free from neglect and abuse. The cumulative effective of these systemic practices resulted in the hospice's inability to ensure patients were protected and their rights were upheld.	L 500	TAG 500 TAG 500 action items, plan for implementing, completion date, monitoring and tracking procedures, and name of responsible person is included in the following Tags, 505,517 and 538.	
L 505	418.52(b)(1) EXERCISE OF RIGHTS/RESPECT FOR PROPERTY/PERSON (1) The patient has the right: (i) To exercise his or her rights as a patient of the hospice; (ii) To have his or her property and person treated with respect; (iii) To voice grievances regarding treatment or care that is (or falls to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and (iv) To not be subjected to discrimination or reprisal for exercising his or her rights. This STANDARD is not met as evidenced by: Based on review of agency policies, grievance logs, and staff interview, it was determined the agency failed to ensure a process for prompt resolution of patient grievances was implemented in accordance with hospice policy. This affected	L 505	TAG 505 Actions: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), PI Committee (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L500 & L505 deficiencies, corrective actions and policies/tools specific to each group's role and responsibilities. Home Office will update Patient Handbook to include correct address and telephone number for Idaho Department of Health & Welfare, Bureau of Facility Standards. Until updated printed copies of patient handbooks are available, the agency will update current Patient Handbooks with labels with corrected address and phone number.	

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L 605	<p>Continued From page 2</p> <p>the resolution of 6 of 6 grievances filed by patients or patient representatives (#9, #14, #16, #17, #18, and #19) who received hospice services from the agency, and had the potential to impact all patients or patient representatives who filed grievances. The failure to implement a grievance procedure had the potential to prevent patients from exercising their rights. Findings include:</p> <p>1. An agency policy, titled "COMPLAINT/GRIEVANCE PROCESS," revised June 2011, stated "The organization personnel receiving the complaint will discuss, verbally and in writing, the grievance with the Clinical Supervisor/Intake Coordinator within 5 days of the alleged grievance. The Clinical Supervisor/Intake Coordinator will investigate the grievance within 5 days after receipt of such grievance and will make every effort to resolve the grievance to the patient's satisfaction. Response to the patient regarding the complaint will occur within 10 days of receipt."</p> <p>The policy also stated "If the grievance cannot be resolved to the patient's satisfaction, the patient or his/her representative is to notify, verbally or in writing, the Administrator." Additionally, the policy stated "Resolution information will be communicated in writing to the patient or his/her representative filing the complaint."</p> <p>Further, the Patient Handbook, dated 4/01/13, included information regarding concerns and complaints on page 7. The Patient Handbook stated "...Your concern or complaint will be handled as quickly as possible. You will receive feedback about your concern/complaint once a manager has adequately researched it."</p>	L 605	<p>The Director will call Patient #16 (still active), and review patient concerns, actions taken and ask the patient if he/she feels concerns have been addressed/resolved. If patient indicates that concerns have not been resolved, Director will provide options for putting concerns in writing to VP of Ops or contacting Idaho Department of Health & Welfare with complaint.</p> <p>The Director will send a written response to Patient #16 following the telephone conversation.</p> <p>The Director will provide the PI Committee with data from Survey citations (6 of 6 grievances documented between March 2014 - July 2015 not compliant with policy). This will be reflected in August 2015 PI meeting minutes.</p> <p>The PI Committee will initiate a Complaint/Grievance PDAC, using the 6 of 6 non-compliant documentation as a baseline data to measure improvement.</p> <p>The Director or Clinical Supervisor will complete a Hospice Sentinel or Potential Adverse Event Form on Patients #14 and #12 by August 30, 2015</p> <p>How Actions Will Improve Processes That Led To Deficiency: Actions will 1) heighten awareness of individual and group responsibilities related to Policy 1-010 Complaint/Grievance Process 2) clarify specific steps required in complaint investigation and documentation 3) clarify Agency Leader responsibility regarding policy requirement that "Resolution information will be communicated in writing to the patient or his/her representative filing the complaint" and 4) provide PI Committee data for Complaint/Grievance PDAC that indicates an opportunity exists (6 of 6 complaints) for improvement in compliance with Agency Policy and Federal Regulations related to Complaint Investigation, Documentation, Response to Complainant. Actions will 1) heighten awareness of individual and group responsibilities related to Policy 4-018 Sentinel Event 2) provide clear direction to Agency Leaders about types and categories of events that require Case review vs. Root Cause Analysis (Sentinel Events), documentation required and PI Committee reporting.</p>	

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NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 9189 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
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L 505	<p>Continued From page 3</p> <p>The Patient Handbook included a section titled "How Concerns/Complaints Are Handled." It stated "You will receive information after the concern or complaint has been thoroughly researched and a resolution has been planned or implemented."</p> <p>The Patient Handbook also included information for the patient and/or representative to file a complaint with the State. However, the address and the telephone number it listed was not correct.</p> <p>Upon request, the agency provided a notebook titled Performance Improvement. The notebook included complaints and grievances from March 2014 to July 2015. A total of 8 grievances were documented. However, the Performance Improvement notebook did not include evidence the agency responded to the grievances, either verbally or in written form, as follows:</p> <p>a. Patient #9 was a 64 year old male admitted to the agency for hospice services from 1/03/15 to 1/13/15, related to lung cancer. A consent for Hospice Admission was signed on 1/03/15 by Patient #9's wife. The consent also included acknowledgement of receipt of the Patient Handbook.</p> <p>The written grievance letter, dated 1/19/15 and addressed to the Administrator, included 4 pages of allegations by Patient #9's wife regarding how the hospice failed to deliver services as promised during the admission process on 1/03/15.</p> <p>The allegations the agency identified in the grievance letter and the agency's actions were</p>	L 505	<p>Monitoring and Tracking:</p> <p>The Director or Designee will review 100% of Complaints documented starting August 2015, to assess if documentation is compliant with Complaint/Grievance Policy.</p> <p>The PI Committee will monitor Complaint review results; document the outcomes when the PDAC is updated monthly.</p> <p>The PI Committee will determine when the Complaint/Grievance PDAC can be discontinued, based on Complaint Review outcomes.</p> <p>The Director and VP of Ops will review PDAC updates and PI Committee meeting minutes to ensure completeness and compliance.</p> <p>Completion Date:</p> <p>All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.</p>		

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L 505	<p>Continued From page 4 noted as follows:</p> <p>i. Family using personal cell phone to relay messages to staff. Clinical staff will adhere to guidelines of not providing home phone numbers per Standards of Conduct provided by Frontier.</p> <p>ii. Delay of comfort care medications to home. RN case manager will ensure comfort care medications are in the home in accordance with pts. needs. RN will follow up with physicians to ensure orders are received and order is faxed to pharmacy.</p> <p>iii. Poor telephone connection with on-call service. Call service complaints will be documented and supervisor will notify director of nursing.</p> <p>iv. Care coordination of weekend on call staff. Both primary and backup on-call nurses will communicate effectively. For all unresolved pt/family issues the on-call nurse will notify clinical supervisor or the director.</p> <p>Documentation that the grievance letter was responded to or that Patient #9's wife received resolution of her concerns was not present.</p> <p>During an interview on 7/23/15 at 3:00 PM, the Hospice Director reviewed the grievance submitted by Patient #9's wife, and the grievance policy. She stated the agency did not necessarily provide a written response to a grievance. She stated if the Clinical Supervisor could deal with the issue by a phone call, that would be enough. If a phone call was not sufficient, she stated the Clinical Supervisor would go to the home and make a visit. The Hospice Director stated the Clinical Supervisor contacted Patient #9's family</p>	L 505	<p>Monitoring and Tracking: The Director or Designee will review 100% of Complaints documented starting August 2015, to assess if documentation is compliant with Complaint/Grievance Policy.</p> <p>The PI Committee will monitor Complaint review results; document the outcomes when the PDAC is updated monthly.</p> <p>The PI Committee will determine when the Complaint/Grievance PDAC can be discontinued, based on Complaint Review outcomes.</p> <p>The Director and VP of Ops will review PDAC updates and PI Committee meeting minutes to ensure completeness and compliance.</p> <p>Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.</p>		

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L 505	<p>Continued From page 5</p> <p>by phone after the grievance letter was received, and that took care of the matter. The Hospice Director was not able to obtain documentation of a phone call to Patient #9's family, or of documentation the grievance was responded to and if it was resolved.</p> <p>The agency failed to respond to patient representative grievances.</p> <p>b. A complaint, dated 3/13/15, related to Chaplin services, was reviewed on behalf of Patient #16. There was no documentation in the grievance files to indicate the hospice investigated and responded to the complaint.</p> <p>The Hospice Director was interviewed on 7/22/15 at 2:20 PM. She stated a phone call was made to the family to resolve the concern.</p> <p>The Hospice Director confirmed grievance records did not document the phone call or resolution. She confirmed a response was not provided in writing in accordance with hospice policy.</p> <p>RN and MSW progress notes, dated 7/22/15, related to the complaints were provided for surveyor review. They were written after the request for documentation. The RN note referenced discussing a family members complaint with the RN Manager and Chaplin. The MSW note documented a phone call with the patient's daughter on 3/06/15.</p> <p>The complaint related to Patient #16 did not include grievance documentation or a written response in accordance with hospice policy. Resolution of the complaint was incomplete.</p>	L 505			

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L 505	<p>Continued From page 6</p> <p>c. A complaint, dated 3/22/15, related to patient care, was reviewed on behalf of Patient #14. There was no documentation in the grievance files to indicate the hospice investigated and responded to the complaint.</p> <p>The Hospice Director was interviewed on 7/22/15 at 2:20 PM. She provided a clinical note, "HOSPICE SOCIAL WORKER CLINICAL NOTE," dated 3/23/15 from 1:00 PM to 2:15 PM from Patient #14's medical record. The note indicated a social worker and RN made a home visit to discuss and address the family concerns. She confirmed grievance documentation did not show the intervention and a response was not provided in writing in accordance with hospice policy.</p> <p>The complaint related to Patient #14 did not include grievance documentation or a written response in accordance with hospice policy. Resolution of the complaint was incomplete.</p> <p>d. Complaints were reviewed on behalf of Patient #18, dated 10/21/14, and Patient #19, dated 12/23/14, related to problems with the hospice's after-hours call system. There was no documentation of resolution of the complaints or responses in writing in accordance with hospice policy.</p> <p>The Hospice Director was interviewed on 7/22/15 beginning at 2:20 PM. She stated that as a result of the complaints, the hospice had instituted a new call system in 2015. She confirmed responses were not provided in writing in accordance with hospice policy.</p> <p>e. Patient #17's name was entered on the</p>	L 505			

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L 505	Continued From page 7 grievance log, documenting a complaint received on 8/14/14. There were no details on the grievance log to indicate who filed the complaint, the nature of the complaint, or the resolution of the complaint. The Hospice Director was interviewed on 7/22/15 beginning at 2:20 PM. She confirmed the grievance documentation was missing and said she would look for it. Later, she provided a copy of a document "Tuck in Program Volunteer Call Record," dated 8/14/14, completed by a volunteer. It documented Patient #17's unhappiness with services. She also provided a "COMMUNICATION/CONTINUATION NOTE," dated 8/15/14. It documented an MSW in-person visit to resolve patient concerns. There was no written follow-up in accordance with hospice policy.	L 505			
L 517	The complaint related to Patient #17 did not include grievance documentation or a written response in accordance with hospice policy. Resolution of the complaint was incomplete. 416.52(c)(6) RIGHTS OF THE PATIENT [The patient has a right to the following:] (6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property; This STANDARD is not met as evidenced by: Based on staff interview and medical record review, it was determined the hospice failed to ensure 2 of 20 patients (#12 and #14) whose records were reviewed, were free from neglect	L 517	Actions: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), IDG (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L 500 & L 517 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities. Home Office (VP Ops, COO) will update Reportable Events Form to indicate events that meet definition of Sentinel/Serious Adverse Events per Policy 4-018 ("unexpected occurrence involving death or serious physical or psychological injury or the risk thereof" "risk thereof: any process variation for which recurrence would carry a significant chance of a serious outcome")		

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L 517	<p>Continued From page 8</p> <p>and abuse. This resulted in the inability of the hospice to ensure patients were safe from harm. Finding include:</p> <p>1. Patient #14 was a 77 year old female whose SOC was 2/01/15. She died on 4/28/15. Her diagnoses included congestive heart failure and lymphoma cancer.</p> <p>A "PROGRESS NOTE" by the Aide, dated 2/12/15, documented a visit between 10:00 AM and 1:15 PM. The note stated "Upon arrival, [Patient #14] was alone. [Patient #14] doesn't know how long she has been alone but does not want to be left alone. [Patient #14] was in pain and [left] foot dropped over bedside. [Patient #14's] oxygen water was empty." The note stated Patient #14 was in pain. The note stated the Aide called the RN. The note stated the RN asked the Aide to wait with the patient until she arrived.</p> <p>The "PROGRESS NOTE" by the RN, dated 2/12/15 at 12:40 PM, stated Patient #14 had been left alone on 2/10/15 and was also left alone today. Notification of Adult Protection and a plan to ensure Patient #14 had supervision was not documented.</p> <p>The RN who visited Patient #14 on 2/12/15 was interviewed on 7/24/15 beginning at 9:10 AM. She stated Patient #14 was alone. She stated the house was filthy, that there was dog feces on the floors, dirty dishes and decomposing food around the house, and rotten milk at the bedside. She stated Patient #14 was oriented to person, place, and time, but was confused and was not functional. She stated Patient #14 could not transfer or use the telephone. She stated she did not think Patient #14 was safe and she called the</p>	L 517	<p>Leaders and Staff will be oriented to the new form "Sentinel or Potential Adverse Event Tool" (Sentinel/PAE Tool) and the form will be implemented in August 2015.</p> <p>The Director or Clinical Supervisor will complete a Hospice Sentinel or Potential Adverse Event Form on Patients #14 and #12 by August 30, 2015</p> <p>The Director will facilitate a Root Cause Analysis related to failure of the team and the IDG to properly document, investigate and take action to prevent potential harm and keep patients #14 and #12 safe. The Root Cause Analysis (RCA) will be initiated by August 30, 2015.</p> <p>The Director or Designee will document the RCA of Patients #14 and #12, which will reflect recommended actions to be taken (policy revision, education, forms revision, process revision).</p> <p>The Director will report findings of RCA to the PI Committee at September 2015 to determine if further action is needed (PDAC, non-PDAC) to prevent lack of follow up by clinicians and/or IDG in similar situations in the future.</p> <p>How Actions Will Improve Processes That Led To Deficiency: Actions will 1) heighten awareness of individual and group responsibilities related to Policy 4-018 Sentinel Event 2) provide clear direction to Agency Leaders about types and categories of events that require Case review vs. Root Cause Analysis (Sentinel Events), documentation required and PI Committee reporting.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2015
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 9189 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
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L 517	<p>Continued From page 9</p> <p>local Adult Protection Agency to report the situation. She stated she assigned the Aide to stay with Patient #14 until the family came home and could supervise the patient.</p> <p>The next "PROGRESS NOTE" by the RN was dated 6 days later, on 2/18/15 at 4:30 PM. The caregiver situation was not mentioned.</p> <p>The IDG meeting "CARE PLAN UPDATE," dated 2/18/15, stated "Caregivers have many other issues/stresses." The form did not document discussion of the caregiver situation nor did it include a plan to ensure Patient #14 would be cared for.</p> <p>During the above interview, the RN confirmed Patient #14's caregiver status was not documented. She also stated she did not document the notification of Adult Protection, an investigation of the extent of the potential neglect, or a plan to ensure Patient #14 would be cared for.</p> <p>The agency failed to ensure Patient #14 would be cared for in a safe environment and would not be neglected.</p> <p>2. Patient #12 was an 85 year old female whose SOC was 11/06/14. She died on 12/27/14. Her diagnosis was congestive heart failure.</p> <p>A "PROGRESS NOTE" by the Aide, dated 12/01/14, stated "Patient [#12] said husband hit her on hand and in face before Aide arrived. Aide did not see any visible marks...Let Social Worker know and also nurse."</p> <p>An incident report, dated 12/01/14, stated "Patient</p>	L 517	<p>Monitoring and Tracking:</p> <p>The PI Committee will review any occurrences that meet the definition of sentinel event and minutes will reflect whether a root cause analysis has been conducted or is needed.</p> <p>Completion Date:</p> <p>All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.</p>		

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L 517	<p>Continued From page 10</p> <p>[#12] was whining and saying that her husband hit her-She wanted me to call and report it. She said Do you have a phone-Can you call and help me-Aide did not see any visible signs of abuse but patient did ask her to report that husband hit her on face and wrist." The report stated the Aide notified the focal Adult Protection agency on 12/02/14. The Incident report did not document an investigation of the alleged abuse.</p> <p>A "CLINICAL NOTE" documented the RN visited Patient #12 the next day, 12/02/14, from 2:45 PM until 3:34 PM. No mention was made of the alleged abuse. No plan to prevent abuse was documented on the note.</p> <p>A "CLINICAL NOTE" documented the MSW visited Patient #12 on 12/05/14 from 10:15 AM until 11:00 AM. No mention was made of the alleged abuse. No plan to prevent abuse was documented on the note. A "CLINICAL NOTE" documented the MSW visited Patient #12 on 12/12/14 from 3:45 PM until 4:45 PM. The note stated an Adult Protection worker was present during the visit. Again, there was no mention of abuse or plans to prevent it.</p> <p>The IDG meeting "CARE PLAN UPDATE," dated 12/10/14, did not mention the abuse allegations and the POC did not include a plan to monitor Patient #12 in order to ensure she was safe.</p> <p>The MSW was interviewed on 7/23/15 beginning at 11:05 AM. She stated the Aide reported allegations of abuse from Patient #12. She stated the Aide notified the Adult Protection agency. She reviewed Patient #12's clinical record and confirmed a plan to monitor the patient for abuse and keep her safe had not been</p>	L 517		

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L 517	Continued From page 11 developed.	L 517		
L 538	<p>The agency failed to ensure Patient #12 would be cared for in a safe environment free from abuse.</p> <p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospice failed to ensure a POC specified the care and services necessary to meet the needs of 2 of 20 patients (#12 and #14), whose records were reviewed. Findings include:</p> <p>1. Patient #14 was a 77 year old female whose SOC was 2/01/15. She died on 4/28/15. Her diagnoses included congestive heart failure and lymphoma cancer.</p> <p>Patient #14's MSW assessment, called an "ADDENDUM TO COMPREHENSIVE ASSESSMENT" and dated 2/02/15, stated the patient was bedbound. The assessment stated Patient #14 lived with her son and his girlfriend. The assessment stated the caregivers "...are overwhelmed with own issues, limited caregiver help." The assessment stated Patient #14's caregivers had limited availability. The assessment stated Patient #14's home was "cluttered, unclean with dirty dishes and papers on every flat surface in kitchen...Primary family in</p>	L 538	<p>Actions:</p> <p>Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), IDG (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L538 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities.</p> <p>The Director or Clinical Supervisor will complete a Hospice Sentinel or Potential Adverse Event Form on Patients #14 and #12 by August 30, 2015</p> <p>The Director will facilitate a Root Cause Analysis related to failure of the team and the IDG to properly document, investigate and take action to prevent potential harm and keep patients #14 and #12 safe. The Root Cause Analysis (RCA) will be initiated by August 30, 2015.</p> <p>The Director or Designee will document the RCA of Patients #14 and #12, which will reflect recommended actions to be taken (policy revision, education, forms revision, process revision).</p> <p>The Director will report findings of RCA to the PI Committee at September 2015 to determine if further action is needed (PDAC, non-PDAC) to prevent lack of follow up by clinicians and/or IDG in similar situations in the future.</p>	

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L 538	<p>Continued From page 12 home have newborn and legal/financial issues to cope with as well."</p> <p>Patient #14's "HOSPICE PLAN OF CARE" for the certification period 2/01/15-5/01/15 did not specifically address the caregiver situation. The "HOSPICE INTERDISCIPLINARY CARE PLAN," signed by the IDG on 2/04/15, stated "Primary caregiver is mom of newborn and had not anticipated being caregiver. MSW assisting with resources, offering support."</p> <p>A "PROGRESS NOTE" by the Aide, dated 2/12/15, documented a visit between 10:00 AM and 1:15 PM. The note stated "Upon arrival, [Patient #14] was alone. [Patient #14] doesn't know how long she has been alone but does not want to be left alone. [Patient #14] was in pain and [left] foot dropped over bedside. [Patient #14's] oxygen water was empty." The note stated Patient #14 was in pain. The note stated the Aide called the RN. The note stated the RN asked the Aide to wait with the patient until she arrived.</p> <p>The "PROGRESS NOTE" by the RN, dated 2/12/15 at 12:40 PM, stated Patient #14 had been left alone on 2/10/15 and was also left alone today. A plan to ensure Patient #14 had sufficient care and supervision to keep her safe was not documented by the nurse. The next nursing visit was documented on 2/18/15, 6 days later.</p> <p>The RN who visited Patient #14 on 2/12/15 was interviewed on 7/24/15 beginning at 8:10 AM. She stated Patient #14 was alone. She stated the house was filthy, that there was dog feces on the floors, dirty dishes and decomposing food around the house, and rotten milk at the bedside. She stated Patient #14 was oriented to person,</p>	L 538	<p>How Actions Will Improve Processes That Led To Deficiency: Actions will 1) heighten awareness of individual and group responsibilities related to Policy 4-018 Sentinel Event 2) provide clear direction to Agency Leaders about types and categories of events that require Case review vs. Root Cause Analysis (Sentinel Events), documentation required and PI Committee reporting.</p> <p>Monitoring and Tracking: The PI Committee will review any occurrences that meet the definition of sentinel event and minutes will reflect whether a root cause analysis has been conducted or is needed.</p> <p>Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.</p>		

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L 538	<p>Continued From page 13</p> <p>place, and time, but was confused and was not functional. She stated Patient #14 could not transfer or use the telephone. She stated she did not think Patient #14 was safe and she called the local Adult Protection Agency to report the situation. She stated she assigned an Aide to stay with Patient #14 until the family came home and could supervise the patient.</p> <p>The IDG meeting "CARE PLAN UPDATE," dated 2/18/15, stated "Caregivers have many other issues/stresses." The form did not include a plan to ensure a caregiver would be available to Patient #14 and she would be cared for.</p> <p>The MSW was interviewed on 7/24/15 beginning at 9:10 AM. She stated Patient #14's POCs before and after the visits, when the patient was found alone, did not specify the care and services needed to ensure a caregiver was available.</p> <p>The agency failed to ensure Patient #14's POC addressed her needs for a caregiver.</p> <p>2. Patient #12 was an 85 year old female whose SOC was 11/06/14. She died on 12/27/14. Her diagnosis was congestive heart failure.</p> <p>A History and Physical was faxed to the hospice on 11/06/14. The document, dated 10/22/14, stated Patient #12 suffered cardiac arrest and required intubation during a surgery on 9/19/14. The document stated Patient #12 subsequently was transferred to a rehabilitation unit on 10/08/14. The document stated Patient #12 was discharged home on 10/19/14. The document stated Patient #12 "...was there for a short while and was unsuccessful navigating the stairs and eventually slept on the floor. The subsequent</p>	L 538			

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L 538	<p>Continued From page 14</p> <p>morning she requested to go back to the hospital and her husband contacted EMS." The document stated Patient #12 was then readmitted to the hospital and treated for acute renal failure likely secondary to dehydration.</p> <p>Patient #12's MSW assessment, called an "ADDENDUM TO COMPREHENSIVE ASSESSMENT" and dated 11/06/14, stated the patient and her husband, who was also her caregiver, were in denial about how ill she was. The assessment stated the home had "many stairs!" and said Patient #12 "...couldn't get out of her car or upstairs today...[Patient #12] very weak and unable to walk or transfer without 2 person assist. Spouse is elderly and not able to get her upstairs. When MSW arrived, [Patient #12] could not get out of car and spouse couldn't get her out either...No family and no neighbors. Live in isolated area."</p> <p>The initial "HOSPICE INTERDISCIPLINARY CARE PLAN," dated 11/12/14, did not address the caregiver's inability to care for Patient #12.</p> <p>A "PROGRESS NOTE" by the Aide, dated 12/01/14, stated "Patient [#12] said husband hit her on hand and in face before Aide arrived. Aide did not see any visible marks...Let Social Worker know and also nurse."</p> <p>An incident report, dated 12/01/14, stated "Patient [#12] was whining and saying that her husband hit her-She wanted me to call and report it. She said Do you have a phone-Can you call and help me-Aide did not see any visible signs of abuse but patient did ask her to report that husband hit her on face and wrist." The report stated the Aide notified the local Adult Protection agency on</p>	L 538			

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L 538	Continued From page 15 12/02/14. A "CLINICAL NOTE" documented the RN visited Patient #12 the next day, 12/02/14, from 2:45 PM until 3:34 PM. No mention was made of the alleged abuse. No plan to prevent abuse was documented on the note. A "CLINICAL NOTE" documented the MSW visited Patient #12 on 12/05/14 from 10:15 AM until 11:00 AM. No mention was made of the alleged abuse. No plan to prevent abuse was documented on the note. The IDG meeting "CARE PLAN UPDATE," dated 12/10/14, did not mention the abuse allegations and the POC did not include a plan to monitor Patient #12 in order to ensure she was safe. The MSW was interviewed on 7/23/15 beginning at 11:05 AM. She reviewed Patient #12's clinical record and confirmed a plan to address the caregiver situation was not documented. She also stated a plan to monitor Patient #12 for abuse and a plan to keep her safe had not been developed after the allegations of abuse. The agency failed to ensure Patient #12's POC addressed her needs for a caregiver and the need to ensure she was not abused.	L 638			
L 559	418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT This CONDITION is not met as evidenced by: Based on staff interviews and review of QAPI	L 559	TAG 559 Refer to Corrective Actions for L560, L561, L562, L563, L564, L565, L566, L569, L570, L571, L574		

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L 559	<p>Continued From page 16</p> <p>policies, 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"> 1. Refer to L560 as it relates to the hospice's failure to ensure a comprehensive data driven QAPI program was developed, implemented, and maintained. 2. Refer to L561 as it relates to the hospice's failure to ensure its QAPI program was capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services. 3. Refer to L562 as it relates to the hospice's failure to ensure a process was developed to analyze adverse patient events. 4. Refer to L563 as it relates to the hospice's failure to ensure quality indicator data, including patient care data, was used in the design of its program. 5. Refer to L564 as it relates to the hospice's failure to ensure data was used to monitor the effectiveness of services and identify opportunities for improvement. 6. Refer to L565 as it relates to the hospice's failure to ensure the frequency and detail of the data collection was approved by the hospice's governing body. 	L 559			

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L 559	Continued From page 17 7. Refer to L566 as it relates to the hospice's failure to ensure performance improvement activities focused on high risk, high volume, problem-prone areas. 8. Refer to L569 as it relates to the hospice's failure to ensure PI activities analyzed the causes of adverse patient events and implemented preventive actions that included feedback throughout the hospice. 9. Refer to L570 as it relates to the hospice's failure to ensure actions were taken aimed at performance improvement and those actions were tracked. 10. Refer to L571 as it relates to the hospice's failure to ensure PIPs were implemented and evaluated. 11. Refer to L574 as it relates to the governing body's failure to accept responsibility for ensuring a QAPI program was defined, implemented, maintained and evaluated annually. 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			
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	L 560	Actions: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), PI Committee (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L559, L560 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities.		

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L 580	<p>Continued From page 18</p> <p>organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative 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.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of policies and QAPI documents, it was determined the hospice failed to ensure a comprehensive data driven QAPI program was developed, implemented, and maintained. This resulted in the inability of the hospice to evaluate its processes and significantly impeded the hospice's ability to improve care and services. Findings include:</p> <p>The policy "Performance Improvement Plan," dated 2015, listed broad objectives and a methodology (PDAC). The policy was not specific to the hospice agency. For example, under a section titled "Monitoring," the policy included "Home Health Compare" and "Home Health Quality Initiative." The policy mentioned a "Branch PI Committee" and a "Frontier Home Health and hospice PI Committee," but did not define the participants in either committee.</p> <p>A plan that contained specific direction to staff, including identification of needs, specific quality indicators, and how staff would analyze data, was not documented. This led to a lack of data collection and a lack of analysis of agency</p>	L 560	<p>Home Office (VP of Ops, COO) will revise the Agency PI Plan by August 30, 2015, listing PI Committee Member. The Revised PI Plan will clearly define hospice specific data used to evaluate patient care processes and outcomes, the frequency of data collection, the definition of Sentinel Event, when Root Cause Analysis (Intense analysis) is required vs. Case Review (PAE), the definition of high-risk, high-volume and problem prone areas.</p> <p>The Governing Board Education Session will include orientation to the Governing Board's role & responsibility, Agency Annual Evaluation and 2015 hospice quality outcome monitors. Minutes of this Governing Board meeting will reflect Governing Board approval of the PI Plan that addresses quality monitors and frequency of data collection. The Governing Board will authorize the PI Committee to monitor hospice quality outcomes as outlined in the Agency Evaluation and the 2015 PI Plan.</p> <p>The Agency Leader Education Session will include the responsibility of the Director for reporting relevant findings of Agency performance improvement activities at each quarterly Governing Board meeting.</p> <p>During the PI Committee Education Session, the Director, based on the 2015 Agency Annual Evaluation, will present the revised PI Plan to the PI Committee activities for 2015. Education of PI Committee will include requirement for monitoring the hospice program using specific, measureable quality indicators that monitor the full scope of the program's performance.</p> <p>The Director will implement updated monthly and quarterly PI Agenda/Minutes templates, which separates the review of Home Health and Hospice quality outcomes. Implementation will begin with August 2015 monthly PI meeting and the October 2015 Quarterly PI meeting. (Attach revised agenda/minutes to POC)</p>		

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continued

The Director will maintain Hospice Monthly & Quarterly Hospice Quality Outcomes Data in a separate PI notebook.

The Director will ensure that Hospice CCR data is recorded on a Hospice CRR tool. The Director or designee will recap monthly CRR results on a Hospice Monthly Recap tool and submit to Home Office for inclusion on the Hospice CRR spreadsheet each month, beginning August 2015 and ongoing. The Director or designee will file CRR documents in the Agency Hospice PI Notebook.

The Agency PI Committee will identify improvement opportunities based on analysis of data presented at the August PI Meeting, develop and initiate PDACs (Plan, Do, Check, Act) or non-PDAC actions. The PI Committee will review Hospice quality data that includes quarterly Hospice CRR, Hospice Risk Management (Infections, Complaints, and Reportable Events), Hospice Information Set (HIS) Action Board and Hospice CAHPS data trends.

Home Office will revise the Hospice PDAC Template with "cues" to include baseline quality outcome data (and source) that indicates an opportunity exists and "cues" to include quality outcome data (and source) that show if improvement is achieved.

The Director will summarize hospice specific outcome measures from the LEAN project, update outcomes trends quarterly to report at the Quarterly PI Committee and Governing Board meetings.

The Agency PI Committee will identify improvement opportunities based on analysis of 2nd QTR data presented at the August PI Meeting that includes Hospice Risk Management (Infections, Complaints, and Reportable Events), Hospice Information Set (HIS) Action Board and Hospice CAHPS data trends and Hospice Survey CRR results.

The PI Committee will develop and initiate PDACs (Plan, Do, Check, Act) or non-PDAC actions based data analysis during August 2015 meeting. Actions will be prioritized based on high volume, high risk, and problem-prone areas.

The Director will maintain clear documentary evidence of Hospice specific quality assessment and PI program activities beginning in August 2015 and thereafter. Hospice specific review of data will clearly label in a separate section of all documents/minutes.

Documentary Evidence of the Agency's quality assessment and PI Program will include:

- Annual Agency Evaluation
- Annual PAC meeting minutes
- Quarterly Governing Board meeting minutes
- Monthly/Quarterly PI Minutes

How Actions Will Improve Processes That Led To Deficiency:
Actions will 1) heighten awareness of individual and group responsibilities related to QAPI 2) clarify what data is used to monitor hospice quality outcomes; 3) provide improved tools for capturing analysis of data and reflecting decisions regarding targeted areas of improvement and PDAC and non-PDAC actions.

Monitoring and Tracking:
Home Office (VP of Ops, COO) will use a Survey Plan of Correction Checklist to ensure all Corrective Actions are completed or initiated by August 30, 2015.

The Director and VP of Ops will review meeting minutes to ensure completeness and compliance. PI Minutes will reflect analysis of data generated by Hospice Clinical Record Reviews, Risk Management trends, Billing Audit Trends, Hospice Information Set Action Boards and Hospice CAHPS against monthly/quarterly data trends going forward.

Completion Date:
All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.

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L 560	Continued From page 19 processes.	L 560			
L 561	<p>The Hospice Director was interviewed on 7/24/15 beginning at 10:30 AM. She stated she was responsible for QAPI at the hospice. She stated a specific plan to direct the QAPI program had not been developed. She stated she could not give a documented example of a change to a hospice process in the past 12 months based on analysis of quality indicator data.</p> <p>The hospice failed to develop and implement a data driven QAPI program.</p> <p>418.58(a)(1) PROGRAM SCOPE</p> <p>(1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the hospice failed to ensure its QAPI program was capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services. This prevented the hospice from evaluating its ability to provide care. Findings include:</p> <p>The only data gathered by the hospice from 7/01/14 to 7/15/15 included patient satisfaction data, a listing of the top 10 terminal conditions and the average length of stay for each condition, and aggregate numbers of adverse events such as falls. No data was documented to show improvement or decline in patient outcomes.</p>	L 561	<p>Actions:</p> <p>Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), PI Committee (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L561 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities.</p> <p>The Director will summarize hospice specific outcome measures from the LEAN project, update outcomes trends quarterly to report at the Quarterly PI Committee and Governing Board meetings.</p> <p>The Agency PI Committee will identify improvement opportunities based on analysis of 2nd QTR data presented at the August PI Meeting that includes Hospice Risk Management (Infections, Complaints, Reportable Events), Hospice Information Set (HIS) Action Board and Hospice CAHPS data trends and Hospice Survey CRR results.</p> <p>The PI Committee will develop and initiate PDACs (Plan, Do, Check, Act) or non-PDAC actions based data analysis during August 2015 meeting. Actions will be prioritized based on high volume, high risk, problem-prone areas.</p>		

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L 561	Continued From page 20 The Hospice Director was interviewed on 7/24/15 beginning at 10:30 AM. She stated the only hospice specific data gathered in the past year was the patient satisfaction data and a listing of the terminal conditions. She stated no quality indicator data related to processes of care had been gathered in the past year.	L 561	How Actions Will Improve Processes That Led To Deficiency: Above actions will 1) heighten awareness of individual and group responsibilities related to QAPI 2) clarify what data is used to monitor hospice quality outcomes; 3) provide improved tools for capturing analysis of data and reflecting decisions regarding targeted areas of improvement and PDAC and non-PDAC actions.	
L 562	The hospice failed to develop a QAPI program capable of showing measurable improvement. 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 hospice failed to ensure a process was developed to analyze adverse patient events. This affected the care of 2 of 2 patients (#12 and #14) with identified adverse events which were reviewed and had the potential to affect all hospice patients. This prevented the hospice from implementing measures to decrease the number of adverse patient events. Findings include: The policy "Performance Improvement Plan," dated 2015, stated adverse patient events would be subjected to "intense analysis." The policy did not define what "intense analysis" meant nor did it outline a process to analyze adverse events and staff's role in them. 1. The hospice documented the number of	L 562	Monitoring and Tracking: The PI Committee will analyze data generated by Hospice Clinical Record Reviews, Risk Management trends, Billing Audit Trends, Hospice Information Set Action Boards and Hospice CAHPS against monthly/quarterly data trends beginning August 2015 and thereafter. PI Committee meeting minutes will reflect analysis and actions taken. The Director and VP of Ops will review meeting minutes to ensure completeness and compliance. Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step. L 562 Actions: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), PI Committee (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L562 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities.	

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L 562	<p>Continued From page 21</p> <p>adverse patient events by month including falls and incidents of abuse and neglect. Analysis of these events was not documented. For example:</p> <p>a. An incident report, dated 12/01/14, stated "Patient [#12] was whining and saying that her husband hit her-She wanted me to call and report it. She said Do you have a phone-Can you call and help me-Alde did not see any visible signs of abuse but patient did ask her to report that husband hit her on face and wrist." The report stated the Alde notified the local Adult Protection agency on 12/02/14. The incident report did not document an investigation of the alleged abuse.</p> <p>b. The RN who visited Patient #14 on 2/12/15 was interviewed on 7/24/15 beginning at 9:10 AM. She stated Patient #14 was alone. She stated the house was filthy, that there was dog feces on the floors, dirty dishes and decomposing food around the house, and rotten milk at the bedside. She stated Patient #14 was oriented to person, place, and time, but was confused and was not functional. She stated Patient #14 could not transfer or use the telephone. She stated she did not think Patient #14 was safe and she called the local Adult Protection agency to report the situation.</p> <p>An incident report was not documented for potential neglect of Patient #14 and an investigation of the incident was not documented.</p> <p>No investigation or analysis of the above events was documented.</p> <p>The Hospice Director was interviewed on 7/24/15 beginning at 10:30 am. She stated there was no documentation of investigation and analysis of</p>	L 562	<p>Home Office (VP of Ops, COO) will revise the Agency PI Plan by August 30, 2015, listing PI Committee Member. The Revised PI Plan will clearly define hospice specific data used to evaluate patient care processes and outcomes, the frequency of data collection, the definition of Sentinel Event, when Root Cause Analysis (Intense analysis) is required vs. Case Review (PAE), the definition of high-risk, high-volume and problem prone areas.</p> <p>Leaders and Staff will be oriented to the new form "Sentinel or Potential Adverse Event Tool" (Sentinel/PAE Tool) and the form will be implemented in August 2015.</p> <p>Leaders and Staff will be oriented to the new form "Sentinel or Potential Adverse Event Tool" (Sentinel/PAE Tool) and the form will be implemented in August 2015.</p> <p>The Director or Clinical Supervisor will complete a Hospice Sentinel or Potential Adverse Event Form on Patients #14 and #12 by August 30, 2015</p> <p>The Director will facilitate a Root Cause Analysis related to failure of the team and the IDG to properly document, investigate and take action to prevent potential harm and keep patients #14 and #12 safe. The Root Cause Analysis (RCA) will be conducted prior to the September 2015 PI Committee meeting.</p> <p>The Director or Designee will document the RCA of Patients #14 and #12, which will reflect recommended actions to be taken (policy revision, education, forms revision, process revision).</p>		

L TAG 562 Continued;

The Director or Designee will document the RCA of Patients #14 and #12, which will reflect recommended actions to be taken (policy revision, education, forms revision, process revision).

The Director will report findings of RCA to the PI Committee at September 2015 to determine if further action is needed (PDAC, non-PDAC) to prevent lack of follow up by clinicians and/or IDG in similar situations in the future.

How Actions Will Improve Processes That Led To Deficiency:

Actions will 1) heighten awareness of individual and group responsibilities related to Policy 4-018 Sentinel Event 2) provide clear direction to Agency Leaders about types and categories of events that require Case review vs. Root Cause Analysis (Sentinel Events), documentation required and PI Committee reporting.

Monitoring and Tracking:

The Director or Hospice Clinical Supervisor will review documentation in the clinical record when an event that may be a sentinel or Adverse event is identified and ensure that the Hospice Sentinel/PAE Form is completed and an appropriate analysis is conducted.

Completion Date:

All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.

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L 562	Continued From page 22 the above events. She confirmed the "Performance Improvement Plan" policy did not include a procedure to investigate adverse patient events.	L 562	<p>Actions: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), PI Committee (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L563 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities.</p> <p>Home Office (VP of Ops, COO) will revise the Agency PI Plan by August 30, 2015, listing PI Committee Member. The Revised PI Plan will clearly define hospice specific data used to evaluate patient care processes and outcomes, the frequency of data collection, the definition of Sentinel Event, when Root Cause Analysis (Intense analysis) is required vs. Case Review (PAE), the definition of high-risk, high-volume and problem prone areas.</p> <p>Home Office (VP of Ops, CDO) will revise Monthly and Quarterly PI Meeting Agenda/Minute Templates by August 30, 2015, to better reflect hospice specific focus; leaders will be educated on proper recording of PI meeting minutes to capture analysis of data and decisions regarding PDAC and non-PDAC actions to be taken.</p> <p>How Actions Will Improve Processes That Led To Deficiency: Above actions will 1) heighten awareness of individual and group responsibilities related to QAPI 2) clarify what data is used to monitor hospice quality outcomes; 3) provide improved tools for capturing analysis of data and reflecting decisions regarding targeted areas of improvement and PDAC and non-PDAC actions.</p>		
L 583	418.58(b)(1) PROGRAM DATA (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and QAPI documents, it was determined the hospice failed to ensure quality indicator data, including patient care data, was used in the design of its program. This prevented the hospice from developing a comprehensive QAPI program. Findings include: The policy "Performance Improvement Plan," dated 2015, listed broad objectives for the QAPI program. The policy did not mention data collection or the analysis of that data. A specific plan directing staff to collect and analyze data had not been developed. The only data gathered by the hospice from 7/01/14 to 7/15/15 included patient satisfaction data, a listing of the top 10 terminal conditions and the average length of stay for each condition, and aggregate numbers of adverse events such as falls. No data analysis related to agency processes was documented. The Hospice Director was interviewed on 7/24/15	L 583			

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L 563	Continued From page 23 beginning at 10:30 AM. She stated a specific plan specifying the use of quality indicator data had not been developed. She confirmed data analysis was not documented.	L 563	Monitoring and Tracking: PI Committee Minutes will reflect analysis of data generated by Hospice Clinical Record Reviews, Risk Management trends, Billing Audit Trends, Hospice Information Set Action Boards and Hospice CAHPS against monthly/quarterly data trends going forward.	
L 564	The hospice failed to use quality indicator data in the design of its QAPI program. 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 QAPI documents, it was determined the hospice failed to ensure data was used to monitor the effectiveness of services and identify opportunities for improvement. This interfered with the hospice's ability to implement changes to improve care. Findings include: The only data gathered by the hospice from 7/01/14 to 7/15/15 included patient satisfaction data, a listing of the top 10 terminal conditions and the average length of stay for each condition, and aggregate numbers of adverse events such as falls. No data analysis related to agency processes was documented. No documentation was present to show changes had been made to hospice processes based on the use of data. The Hospice Director was interviewed on 7/24/15 beginning at 10:30 AM. She stated no documentation was present to show hospice	L 564	The Director and VP of Ops will review meeting minutes to ensure completeness and compliance. Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step. L 564 ACTIONS: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), PI Committee (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L564 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities. Home Office (VP of Ops, COO) will revise the Agency PI Plan by August 30, 2015, listing PI Committee Member. The Revised PI Plan will clearly define hospice specific data used to evaluate patient care processes and outcomes, the frequency of data collection, the definition of Sentinel Event, when Root Cause Analysis (Intense analysis) is required vs. Case Review (PAE), the definition of high-risk, high-volume and problem prone areas.	

L TAG 564
Continued

During the PI Committee Education Session, the Director, based on the 2015 Agency Annual Evaluation, will present the revised PI Plan to the PI Committee activities for 2015. Education of PI Committee will include requirement for monitoring the hospice program using specific, measurable quality indicators that monitor the full scope of the program's performance.

The Agency PI Committee will identify improvement opportunities based on analysis of 2nd QTR data presented at the August PI Meeting that includes Hospice Risk Management (Infections, Complaints, Reportable Events), Hospice Information Set (HIS) Action Board and Hospice CAHPS data trends and Hospice Survey CRR results.

The PI Committee will develop and initiate PDACs (Plan, Do, Check, Act) or non-PDAC actions based data analysis during August 2015 meeting. Actions will be prioritized based on high volume, high risk, problem-prone areas.

The Director will summarize hospice specific outcome measures from the LEAN project, update outcomes trends quarterly to report at the Quarterly PI Committee and Governing Board meetings.

Home Office (VP of Ops, COD) will revise Monthly and Quarterly PI Meeting Agenda/Minute Templates by August 30, 2015, to better reflect hospice specific focus; leaders will be educated on proper recording of PI meeting minutes to capture analysis of data and decisions regarding PDAC and non-PDAC actions to be taken.

How Actions Will Improve Processes That Led To Deficiency:

Above actions will 1) heighten awareness of individual and group responsibilities related to QAPI 2) clarify what data is used to monitor hospice quality outcomes; 3) provide improved tools for capturing analysis of data and reflect decisions regarding targeted areas of improvement and PDAC and non-PDAC actions.

Monitoring and Tracking:

PI Committee minutes will reflect PDAC and non-PDAC actions based on data analysis.

The Director and VP of Ops will review meeting minutes to ensure completeness and compliance.

Completion Date:

All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.

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L 564	Continued From page 24 processes were evaluated based on the use of quality indicator data and no opportunities for change had been identified based on the data.	L 564			
L 565	The hospice failed to use quality indicator data to monitor services or identify opportunities to improve care. 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 QAPI documents, it was determined the hospice failed to ensure the frequency and detail of the data collection was approved by the hospice's governing body. This resulted in a lack of direction to staff regarding how to implement the QAPI program. Findings include: A specific hospice QAPI plan to gather quality indicator data, including the frequency and detail of the data collection was not documented. There was no documentation that the governing body discussed a QAPI plan which included data collection. The Hospice Director was interviewed on 7/24/15 beginning at 10:30 AM. She stated a specific hospice QAPI plan, including the frequency and detail of the data collection, had not been developed. She stated there was no documentation the governing body had discussed such a plan.	L 565	ACTIONS: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), on L574, L 565 deficiencies, corrective actions and policies/tools specific to Agency Leader and Governing Board member role and responsibilities. Home Office (VP of Ops, COO) will revise the Agency PI Plan by August 30, 2015, listing PI Committee Member. The Revised PI Plan will clearly define hospice specific data used to evaluate patient care processes and outcomes, the frequency of data collection, the definition of Sentinel Event, when Root Cause Analysis (intense analysis) is required vs. Case Review (PAE), the definition of high-risk, high-volume and problem prone areas. The Governing Board Education Session will include orientation to the Governing Board's role & responsibility, Agency Annual Evaluation and 2015 hospice quality outcome monitors. Minutes of this Governing Board meeting will reflect Governing Board approval of the PI Plan that addresses quality monitors and frequency of data collection. The Governing Board will authorize the PI Committee to monitor hospice quality outcomes as outlined in the Agency Evaluation and the 2015 PI Plan.		

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L 565	Continued From page 25 The hospice failed to ensure the frequency and detail of the data collection was approved by the hospice's governing body.	L 565	<p>How Actions Will Improve Processes That Led To Deficiency: Above actions will 1) heighten awareness of individual and group responsibilities related to QAPI 2) clarify what data is used to monitor hospice quality outcomes; 3) provide improved tools for capturing analysis of data and reflecting decisions regarding targeted areas of improvement and PDAC and non-PDAC actions.</p> <p>Monitoring and Tracking: The Director and VP of Ops will review Governing Board meeting minutes to ensure completeness and compliance.</p> <p>Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.</p> <p>Actions: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), PI Committee (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L566 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities.</p> <p>Home Office (VP of Ops, COO) will revise the Agency PI Plan by August 30, 2015, listing PI Committee Member. The Revised PI Plan will clearly define hospice specific data used to evaluate patient care processes and outcomes, the frequency of data collection, the definition of Sentinel Event, when Root Cause Analysis (intense analysis) is required vs. Case Review (PAE), the definition of high-risk, high-volume and problem prone areas, process used to investigate and analyze potential adverse events.</p>		
L 566	<p>418.58(c)(1)(i) PROGRAM ACTIVITIES</p> <p>(1) The hospice's performance improvement activities must: (i) Focus on high risk, high volume, or problem-prone areas.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of policies, QAPI documents, and meeting minutes, it was determined the hospice failed to ensure performance improvement activities focused on high risk, high volume, problem-prone areas. This resulted in a lack of direction to staff responsible for the program. Findings include:</p> <p>The policy "Performance Improvement Plan," dated 2015, listed broad objectives and a methodology (PDAC). A specific plan which identified high risk, high volume, problem-prone areas was not documented.</p> <p>No meeting minutes were documented between 7/01/14 and 7/15/15 which identified high risk, high volume, problem-prone areas.</p> <p>The Hospice Director was interviewed on 7/24/15 beginning at 10:30 AM. She stated she could not provide any documents which identified high risk, high volume, problem-prone areas as a focus for the QAPI program.</p> <p>The hospice failed to develop high risk, high</p>	L 566			

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NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709	
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L 568	Continued From page 26 volume, problem-prone areas as a focal point for the QAPI program.	L 566	How Actions Will Improve Processes That Led To Deficiency: Actions will provide clear direction to Agency Leaders and PI Committee about how to prioritize PI Actions (PDAC and non-PDAC) based on high risk, high volume or problem prone areas identified during data analysis.	
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. This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the hospice failed to ensure PI activities analyzed the causes of adverse patient events and implemented preventive actions that included feedback throughout the hospice. This affected the care of 2 of 2 patients (#12 and #14) with identified adverse events which were reviewed and had the potential to affect all hospice patients. This prevented the hospice from implementing measures to prevent future adverse patient events from occurring. Findings include: 1. The hospice documented the number of adverse patient events, including falls and incidents of abuse and neglect. The number of events such as falls and "Known/suspected abuse/neglect by other" were documented. However, analysis of these events and preventative actions taken was not documented, as follows: a. An incident report, dated 12/01/14, stated "Patient [#12] was whining and saying that her husband hit her-She wanted me to call and report it. She said Do you have a phone-Can you call and help me-Aide did not see any visible signs of	L 569	Monitoring and Tracking: PI Committee minutes will reflect PDAC and non-PDAC actions based on high risk, high volume or problem prone areas per data analysis. The Director and VP of Ops will review meeting minutes to ensure completeness and compliance. Completion Date: All Corrective Actions will be initiated or completed or initiated by August 30, 2015 by the designee identified in each action step. Actions: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), PI Committee (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L569 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities. Director will review Agency Policy 4-018 Sentinel Events with staff during August 2015 staff meeting, the definition of Sentinel Event, when Root Cause Analysis (intense analysis) is required vs. Case Review (PAEs), and how high-risk, high-volume and problem prone areas are used to focus PI actions.	

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L 569	<p>Continued From page 27</p> <p>abuse but patient did ask her to report that husband hit her on face and wrist." The report stated the Aide notified the local Adult Protection agency on 12/02/14.</p> <p>An investigation of the incident was not documented. Possible causes of the alleged abuse were not documented. Actions taken to keep Patient #12 safe were not documented. Feedback to other staff members in order to prevent future incidents of abuse was not documented.</p> <p>b. A "PROGRESS NOTE" by the Aide, dated 2/12/15, documented a visit between 10:00 AM and 1:15 PM. The note stated "Upon arrival, [Patient #14] was alone. [Patient #14] doesn't know how long she has been alone but does not want to be left alone. [Patient #14] was in pain and [left] foot dropped over bedside. [Patient #14's] oxygen water was empty." The note stated Patient #14 was in pain. The note stated the Aide called the RN. The note stated the RN asked the Aide to wait with the patient until she arrived.</p> <p>The RN who visited Patient #14 on 2/12/15 was interviewed on 7/24/15 beginning at 9:10 AM. She stated Patient #14 was alone on 2/12/15. She stated the house was filthy, that there was dog feces on the floors, dirty dishes and decomposing food around the house, and rotten milk at the bedside. She stated Patient #14 was oriented to person, place, and time, but was confused and was not functional. She stated Patient #14 could not transfer or use the telephone. She stated she did not think Patient #14 was safe and she called the local Adult Protection agency to report suspected neglect.</p>	L 569	<p>The Director will orient staff to the new form "Sentinel or Potential Adverse Event Tool" (Sentinel/PAE Tool) and the form will be implemented in August 2015.</p> <p>How Actions Will Improve Processes That Led To Deficiency: Actions will 1) heighten awareness of individual and group responsibilities related to Policy 4-018 Sentinel Event 2) provide clear direction to Agency Leaders about types and categories of events that require Case review (PAE) vs. Root Cause Analysis (Sentinel Event), documentation required and PI Committee reporting.</p> <p>Monitoring and Tracking: The Director and the Hospice Clinical Supervisor will monitor staff compliance in identifying and documenting Sentinel and/or Potent Events.</p> <p>The Director and/or the Hospice Clinical Supervisor will review medical record documentation when a Sentinel/PAE is identified, will ensure the Sentinel/PAE Form is completed and will ensure that "Intense analysis" occurs and is documented. Documentation includes actions identified to prevent a similar occurrence in the future.</p> <p>The Director and/or Hospice Clinical Supervisor will review each Sentinel/PAE with the PI Committee.</p>		

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L 569	Continued From page 28 An incident report was not documented for potential neglect of Patient #14. An investigation of the incident was not documented. Possible causes of the alleged neglect were not documented. Actions taken to keep Patient #14 safe were not documented. Feedback to other staff members in order to prevent future incidents of neglect was not documented. The Hospice Director was interviewed on 7/24/15 beginning at 10:30 AM. She stated there was no documentation of investigation and analysis of the above events. She stated there was no documentation that preventative actions had been taken or that such actions had been shared with other staff members. The hospice failed to ensure PI activities analyzed the causes of adverse patient events and implemented preventive actions that included feedback to staff.	L 569	The PI Committee will ensure that documentation and intense analysis (Root Cause Analysis) is compliant with Policy 4-018 s. Hospice Sentinel/PAE review will be documented in the PI Committee Minutes. The Director and VP of Ops will review meeting minutes to ensure completeness and compliance. Completion Date: All Corrective Actions will be initiated or completed or initiated by August 30, 2015 by the designee identified in each action step.	
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 staff interview and review QAPI documents, it was determined the hospice failed to ensure actions were taken aimed at performance improvement and those actions were tracked. This interfered with the hospice's ability to identify corrective actions and track their effectiveness. Findings include:	L 570	Actions: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), PI Committee (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L570 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities. Home Office (VP of Ops, COO) will revise the Agency PI Plan by August 30, 2015, listing PI Committee Member. The Revised PI Plan will clearly define hospice specific data used to evaluate patient care processes and outcomes, the frequency of data collection, the definition of Sentinel Event, when Root Cause Analysis (Intense analysis) is required vs. Case Review (PAE), the definition of high-risk, high-volume and problem prone areas.	

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L 570	<p>Continued From page 29</p> <p>1. Four forms labeled "Performance Improvement Opportunity" were provided. These included:</p> <p>a. "Initiation of Bowel Program." The form stated "Lack of bowel program initiation on start of care." It stated all patients would be started on a bowel regimen on admission to hospice. It was dated 1/05/15 and said the program was reviewed and updated on 2/05/15. No data was documented for this program. No documentation was present that the program was tracked to see if the actions had been effective.</p> <p>b. "Medication Profile Update." The form stated "Medication profiles are not current." It stated medication profiles would be reviewed and updated at each IDG meeting. It was dated 3/10/15 and said the program was reviewed and updated on 4/03/15. No data was documented for this program. No documentation was present that the program was tracked to see if the actions had been effective.</p> <p>c. "Documentation of Bed Rail Safety supervision." The form stated education would be provided to patients about bed rails and patients/caregivers would sign consents for bed rails. It was dated 4/01/15 and said the program was reviewed and updated on 5/05/15. No data was documented for this program. No documentation was present that the program was tracked to see if the actions had been effective.</p> <p>d. "Documentation of LPN supervision." The form stated staff was instructed on the need to document LPN supervision every 30 days. It was dated 6/01/15 and said the program was reviewed and updated on 7/02/15. No data was documented for this program. No documentation</p>	L 570	<p>During the PI Committee Education Session, the Director, based on the 2015 Agency Annual Evaluation, will present the revised PI Plan to the PI Committee activities for 2015. Education of PI Committee will include requirement for monitoring the hospice program using specific, measurable quality indicators that monitor the full scope of the program's performance.</p> <p>The Agency PI Committee will identify improvement opportunities based on analysis of 2nd QTR data presented at the August PI Meeting that includes Hospice Risk Management (Infections, Complaints, Reportable Events), Hospice Information Set (HIS) Action Board and Hospice CAHPS data trends and Hospice Survey CRR results.</p> <p>The PI Committee will develop and initiate PDACs (Plan, Do, Check, Act) or non-PDAC actions based data analysis during August 2015 meeting. Actions will be prioritized based on high volume, high risk, problem-prone areas.</p> <p>The Director will summarize hospice specific outcome measures from the LEAN project, update outcomes trends quarterly to report at the Quarterly PI Committee and Governing Board meetings.</p> <p>Home Office (VP of Ops, COO) will revise Monthly and Quarterly PI Meeting Agenda/Minute Templates by August 30, 2015, to better reflect hospice specific focus; leaders will be educated on proper recording of PI meeting minutes to capture analysis of data and decisions regarding PDAC and non-PDAC actions to be taken.</p>		

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L 570	Continued From page 30 was present that the program was tracked to see if the actions had been effective. The Hospice Director was interviewed on 7/24/15 beginning at 10:30 AM. She stated no documentation was present to show actions were taken and performance was tracked.	L 570	How Actions Will Improve Processes That Led To Deficiency: Above actions will 1) heighten awareness of individual and group responsibilities related to QAPI; 2) clarify what data is used to monitor hospice quality outcomes; 3) provide improved tools for capturing analysis of data and reflecting decisions regarding targeted areas of improvement and PDAC and non-PDAC actions.	
L 571	The hospice failed to ensure actions were taken aimed at performance improvement and those actions were tracked. 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 QAPI documents, it was determined the hospice failed to ensure PIPs were implemented and evaluated. This prevented the hospice from examining its processes. Findings include: No PIPs, including quality indicators and data collection, were documented between 7/01/14 and 7/15/15. The Hospice Director was interviewed on 7/24/15 beginning at 10:30 AM. She stated no documentation was present to show PIPs were conducted.	L 571	Monitoring and Tracking: Monitoring will occur via the PI Committee Minutes that will reflect an analysis of data generated by Hospice Clinical Record Reviews, Risk Management trends, Billing Audit Trends, Hospice Information Set Action Boards and Hospice CAHPS against monthly/quarterly data trends going forward. The Director and VP of Ops will review meeting minutes to ensure completeness and compliance. Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.	
L 574	418.58(e)(1) EXECUTIVE RESPONSIBILITIES	L 574	Actions: Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), PI Committee (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L571 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities.	

LTAG 571

L TAG 571 Continued

Home Office (VP of Ops, COO) will revise the Agency PI Plan by August 30, 2015, listing PI Committee Member. The Revised PI Plan will clearly define hospice specific data used to evaluate patient care processes and outcomes, the frequency of data collection, the definition of Sentinel Event, when Root Cause Analysis (Intense analysis) is required vs. Case Review (PAE), the definition of high-risk, high-volume and problem prone areas.

The Agency PI Committee will identify improvement opportunities based on analysis of 2nd QTR data presented at the August PI Meeting that includes Hospice Risk Management (Infections, Complaints, Reportable Events), Hospice Information Set (HIS) Action Board and Hospice CAHPS data trends and Hospice Survey CRR results.

The PI Committee will develop and initiate PDACs (Plan, Do, Check, Act) or non-PDAC actions based data analysis during August 2015 meeting. Actions will be prioritized based on high volume, high risk, problem-prone areas.

The Director will summarize hospice specific outcome measures from the LEAN project, update outcomes trends quarterly to report at the Quarterly PI Committee and Governing Board meetings.

Home Office (VP of Ops, COO) will revise Monthly and Quarterly PI Meeting Agenda/Minute Templates by August 30, 2015, to better reflect hospice specific focus; leaders will be educated on proper recording of PI meeting minutes to capture analysis of data and decisions regarding PDAC and non-PDAC actions to be taken.

How Actions Will Improve Processes That Led To Deficiency:

Above actions will 1) heighten awareness of individual and group responsibilities related to QAPI 2) clarify what data is used to monitor hospice quality outcomes; 3) provide improved tools for capturing analysis of data and reflecting decisions regarding targeted areas of improvement and PDAC and non-PDAC actions.

Monitoring and Tracking:

Monitoring will occur via the PI Committee Minutes that will reflect analysis of YTD baseline data generated by Hospice Clinical Record Reviews, Risk Management trends, Billing Audit Trends, Hospice Information Set Action Boards and Hospice CAHPS against monthly/quarterly data trends going forward. The Director and VP of Ops will review meeting minutes to ensure completeness and compliance.

Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.

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L 574	<p>Continued From page 31</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents and meeting minutes, it was determined the governing body failed to accept responsibility for ensuring a QAPI program was defined, implemented, maintained and was evaluated annually. This resulted in a lack of guidance to staff responsible to implement the QAPI program. Findings include:</p> <p>A specific QAPI plan, including quality indicators and data collection, was not documented.</p> <p>Minutes of governing body meetings between 7/01/14 and 7/15/15, where QAPI projects, quality indicators, and data collection were discussed, were not documented. An annual review of the hospice's QAPI program was not documented.</p> <p>The Hospice Director was interviewed on 7/24/15 beginning at 10:30 AM. She stated there were no governing body minutes which contained documentation that the agency's QAPI program was discussed.</p> <p>The hospice's governing body failed to oversee the QAPI program.</p>	L 574	<p>Actions</p> <p>Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), on L574, L 565 deficiencies, corrective actions and policies/tools specific to Agency Leader and Governing Board member role and responsibilities.</p> <p>The Governing Board Education Session will include orientation to the Governing Board's role & responsibility, Agency Annual Evaluation and 2015 hospice quality outcome monitors. Minutes of this Governing Board meeting will reflect Governing Board approval of the PI Plan that addresses quality monitors and frequency of data collection. The Governing Board will authorize the PI Committee to monitor hospice quality outcomes as outlined in the Agency Evaluation and the 2015 PI Plan.</p> <p>The Agency Leader Education Session will include the responsibility of the Director for reporting relevant findings of Agency performance improvement activities at each quarterly Governing Board meeting.</p> <p>During the PI Committee Education Session, the Director, based on the 2015 Agency Annual Evaluation, will present the revised PI Plan to the PI Committee activities for 2015. Education of PI Committee will include requirement for monitoring the hospice program using specific, measureable quality indicators that monitor the full scope of the program's performance.</p> <p>The Director will report relevant findings of performance improvement activities at quarterly Governing Board meetings. Governing Board minutes will reflect review of this information and may make recommendations regarding PI activities.</p>		
L 595	<p>418.64(d) COUNSELING SERVICES</p> <p>Counseling services must be available to the</p>	L 595			

L Tag 574 Continued

How Actions Will Improve Processes That Led To Deficiency:

Above actions will 1) heighten awareness of individual and group responsibilities related to QAPI 2) clarify what data is used to monitor hospice quality outcomes; 3) provide improved tools for capturing analysis of data and reflecting decisions regarding targeted areas of improvement and PDAC and non-PDAC actions.

Monitoring and Tracking:

The VP of Ops and the Director will ensure the Governing Board Agenda and Minutes will reflect the Governing Board's review of agency QAPI Plan and quality outcomes and any recommendations the Board may make regarding PI activities.

Completion Date:

All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.

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L 595	<p>Continued From page 32</p> <p>patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records, personnel documents, and staff interview, it was determined the hospice failed to ensure spiritual counseling was provided in a timely manner to meet patient needs for 1 of 9 patients (#20) who accepted Chaplain services, whose records were reviewed. This resulted in unmet counseling needs at a critical time prior to a patient's death. Findings include.</p> <p>The agency's job description for the "Hospice Chaplain," dated 4/13, was reviewed. Essential job functions/responsibilities included the expectation the Chaplain "assured spiritual assessment of patients and families/caregivers in the hospice program and appropriate services are rendered in a timely manner."</p> <p>Spiritual services were not provided in a timely manner as follows:</p> <p>Patient #20 was 40 year old male who was admitted to hospice on 11/15/14 and died on 11/19/14. The medical record included, but was not limited to, the following clinical notes:</p> <p>The "HOSPICE INITIAL/COMPREHENSIVE NURSING ASSESSMENT," dated 11/15/14 from 2:05 PM to 4:15 PM, stated Patient #20 "would like Chaplain consult for catholic burial info."</p> <p>An MSW progress note, dated 11/17/14 at 10:00 AM, stated that the spouse reported patient #20</p>	L 595	<p>Actions</p> <p>Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops) and Staff (by Director and Hospice Clinical Supervisor) on L595 deficiency, corrective actions and policies/tools specific to each group's role and responsibilities.</p> <p>The Clinical Supervisor will conduct a Clinical Record Review on 100% of active patient records, using Hospice Survey Clinical Record Review Tool in August 2015.</p> <p>The Clinical Supervisor will report the findings to the PI Committee at the August 2015 meeting regarding the number of records compliant with Spiritual Counseling.</p> <p>The PI Committee will determine what actions need to be taken, if data analysis indicates an opportunity exists. PDAC or non-PDAC decisions regarding continued monitoring will be reflected in the PI Committee minutes (September 2015)</p> <p>How Actions Will Improve Processes That Led To Deficiency:</p> <p>Above actions will 1) heighten awareness of individual and group responsibilities related to Policy Spiritual Counseling, Federal Regulation 481.64(d) Counseling Services 2) provide data to determine if the problem is wide-spread and requires PI Intervention and 3) assign responsibility to ensure PI Committee documentation reflects analysis and any PI actions taken.</p>	

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NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83708		
(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 595	<p>Continued From page 33</p> <p>was confused. She requested a Chaplain for last rights as a Catholic. The progress note further stated the MSW left a voice message for the Chaplain, made a request in writing for the Chaplain to do an assessment, and informed the RN case manager.</p> <p>A "HOSPICE SOCIAL WORKER ASSESSMENT," dated 11/17/14 from 4:45 PM to 6:00 PM, included the following questions and answers:</p> <p>Does Patient/Family Wish their clergy to be contacted by the hospice team? "No" Does Patient/Family wish contact from the hospice clergy? "Yes"</p> <p>There was no documentation in the record the Chaplain responded to the patient and family request for spiritual counseling prior to Patient #20's death on 11/19/14. This was confirmed by the Director of Hospice during an interview on 7/24/15 at 12:06 PM.</p> <p>The MSW who provided care to Patient #20 was interviewed by telephone on 7/24/15 at 12:15 PM. She stated she remembered Patient #20 and she did not know why the Chaplain did not respond. The RN who pronounced Patient #20 dead on 11/19/14, also stated, during an interview on 7/24/15 at 1:30 PM she did not know why the Chaplain did not respond. The Chaplain was no longer an employee of the hospice.</p> <p>The hospice failed to meet Patient #20's spiritual counseling needs.</p>	L 595	<p>Monitoring and Tracking: The Clinical Supervisor will ensure the Clinical Record Review is completed by August 30, 2015.</p> <p>The PI Committee will analyze the CRR results (data) and determine if further action is needed during the September 2015 meeting.</p> <p>Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015</p>		
L 665	418.102 MEDICAL DIRECTOR	L 665			

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L 665	<p>Continued From page 34</p> <p>The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with, the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.</p> <p>This STANDARD is not met as evidenced by: Based on interview and administrative document review, the hospice failed to ensure a physician was designated to assume the responsibilities of the medical director when the medical director was not available. This had the potential to result in gaps of medical director oversight. Findings include:</p> <p>The "Medical Director Agreement," dated 4/09/15, was reviewed. It stated "B.1.10. Call Coverage; Backup. Medical Director shall notify Hospice who the designated backup medical director is and shall ensure that such backup is available to provide call coverage and/or services during the relevant period. Any backup medical director must be qualified and under contract with hospice to provide such services."</p> <p>The Hospice Director was interviewed on 7/24/15 at 10:40 AM. When asked who was responsible in the absence of the medical director, she stated an NP filled in on the director's behalf. When asked if the hospice had a physician designated to serve in this capacity, she stated the hospice had been looking for an associate medical director for some time, but did not currently have one. She stated the medical director was "always available by phone."</p>	L 665	<p>Actions</p> <p>Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), on L665 deficiency corrective actions and policies/tools specific to Agency Leader and Governing Board member role and responsibilities.</p> <p>The Governing Board Education Session will include discussion regarding CoP requirement 418.102 Medical Director.</p> <p>The Governing Board was informed of the survey deficiency L 665 on August 3 and the need for the identification of an Associate Medical Director (AMD). The action goal is to have established an Associate Medical Director on or before August 30, 2015. The action plan has two parallel paths, one working with [REDACTED] with the identification of candidates, interviews and contracting process and the second path is working with current Medical Director and identification of temporary Associate Medical Director from his practice to provide coverage if required.</p> <p>How Actions Will Improve Processes That Led To Deficiency: Action will bring agency into compliance.</p> <p>Monitoring and Tracking: The VP of Ops and Agency Director will monitor until physician coverage is obtained.</p> <p>Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.</p>		

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L 665	<p>Continued From page 34</p> <p>The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with, the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.</p> <p>This STANDARD is not met as evidenced by: Based on interview and administrative document review, the hospice failed to ensure a physician was designated to assume the responsibilities of the medical director when the medical director was not available. This had the potential to result in gaps of medical director oversight. Findings include:</p> <p>The "Medical Director Agreement," dated 4/09/15, was reviewed. It stated "B.1.10. Call Coverage; Backup. Medical Director shall notify Hospice who the designated backup medical director is and shall ensure that such backup is available to provide call coverage and/or services during the relevant period. Any backup medical director must be qualified and under contract with hospice to provide such services."</p> <p>The Hospice Director was interviewed on 7/24/15 at 10:40 AM. When asked who was responsible in the absence of the medical director, she stated an NP filled in on the director's behalf. When asked if the hospice had a physician designated to serve in this capacity, she stated the hospice had been looking for an associate medical director for some time, but did not currently have one. She stated the medical director was "always available by phone."</p>	L 665	<p>Actions</p> <p>Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), Governing Board (by VP of Ops), on L665 deficiency corrective actions and policies/tools specific to Agency Leader and Governing Board member role and responsibilities.</p> <p>The Governing Board Education Session will include discussion regarding CoP requirement 418.102 Medical Director.</p> <p>The Governing Board was informed of the survey deficiency L 665 on August 3 and the need for the identification of an Associate Medical Director (AMD). The action goal is to have established an Associate Medical Director on or before August 30, 2014. The action plan has two parallel paths, one working with Saint Alphonsus Hospital with the identification of candidates, interviews and contracting process and the second path is working with current Medical Director and identification of temporary Associate Medical Director from his practice to provide coverage if required.</p> <p>How Actions Will Improve Processes That Led To Deficiency:</p> <p>Action will bring agency into compliance.</p> <p>Monitoring and Tracking:</p> <p>The VP of Ops and Agency Director will monitor until physician coverage is obtained.</p> <p>Completion Date:</p> <p>All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.</p>		

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L 671	<p>Continued From page 36</p> <p>not think Patient #14 was safe and she called the local Adult Protection Agency to report the situation. She stated she assigned the Aide to stay with Patient #14 until the family came home and could supervise the patient.</p> <p>The "PROGRESS NOTE" by the RN, dated 2/12/15 at 12:40 PM, stated Patient #14 had been left alone. The note did not mention the environment. The note stated Patient #14 was oriented and did not mention her confusion. The notification of Adult Protection was not documented.</p> <p>A "PROGRESS NOTE" by the Aide, dated 2/12/15, documented a visit between 10:00 AM and 1:15 PM. The note stated "Upon arrival, [Patient #14] was alone. [Patient #14] doesn't know how long she has been alone but does not want to be left alone. [Patient #14] was in pain and [left] foot dropped over bedside. [Patient #14's] oxygen water was empty." The note did not document environmental issues nor did it state Adult Protection was called. The note did not state the Aide stayed with Patient #14 until a family member returned to the home. The note did not state what the Aide told the family member or how it was received.</p> <p>During the above interview, the RN confirmed Patient #14's record did not contain documentation about the environment or the caregiver situation.</p> <p>The agency failed to ensure Patient #14's medical record contained documentation of critical events.</p> <p>2. Patient #12 was an 85 year old female whose SOC was 11/08/14. She died on 12/27/14. Her</p>	L 671	<p>Monitoring and Tracking: The Director will ensure the Clinical Record Review is completed by August 30, 2015.</p> <p>The PI Committee will analyze the CRR results (data) and determine if further action is needed during the September 2015 meeting.</p> <p>Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015</p>		

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L 671	<p>Continued From page 37 diagnosis was congestive heart failure.</p> <p>A "PROGRESS NOTE" by the Aide, dated 12/01/14, stated "Patient [#12] said husband hit her on hand and in face before Aide arrived. Aide did not see any visible marks...Let Social Worker know and also nurse." Subsequent Aide notes did not document that the Aide notified the local Adult Protection agency of the abuse allegations.</p> <p>An incident report, dated 12/01/14, stated "Patient [#12] was whining and saying that her husband hit her-She wanted me to call and report it. She said Do you have a phone-Can you call and help me-Aide did not see any visible signs of abuse but patient did ask her to report that husband hit her on face and wrist." The report stated the Aide notified the local Adult Protection agency on 12/02/14. The incident report was not part of the medical record.</p> <p>A "CLINICAL NOTE" documented the RN visited Patient #12 the next day, 12/02/14, from 2:45 PM until 3:34 PM. No mention was made of the alleged abuse. No actions to prevent subsequent abuse were documented.</p> <p>A "CLINICAL NOTE" documented the MSW visited Patient #12 on 12/05/14 from 10:15 AM until 11:00 AM. No mention was made of the alleged abuse. No actions to prevent subsequent abuse were documented.</p> <p>The IDG meeting "CARE PLAN UPDATE," dated 12/10/14, did not mention the abuse allegations and the POC did not include a plan to monitor Patient #12 in order to ensure she was safe.</p> <p>The MSW was interviewed on 7/23/15 beginning</p>	L 671			

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L 671	Continued From page 36 at 11:05 AM. She reviewed Patient #12's clinical record and confirmed notification of the local Adult Protection agency was not documented. She also confirmed the RN and MSW did not document the allegations of abuse.	L 671		
L 679	The agency failed to ensure Patient #12's medical record contained documentation of critical events. 418.104(b) AUTHENTICATION All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the hospice failed to ensure medical record entries were complete for 3 of 20 patients (#7, #9, and #20) whose records were reviewed. This resulted in a lack of clarity as to the course of care and the communication that occurred between service providers. It had the potential to interfere with coordination of patient care. Findings include: 1. Patient #7 was a 79 year old male who was admitted to hospice on 5/22/15 and a current patient at the time of the survey. His diagnoses included COPD and pneumonia. LPN visit notes documented coordination with an RN. Examples included, but were not limited to, the following: 5/28/15 from 11:00 AM to 11:30 AM 6/09/15 from 1:56 PM to 2:30 PM 6/23/15 from 12:35 PM to 1:20 PM	L 679	Actions Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops) and Staff (by Director and Hospice Clinical Supervisor) on L679 deficiencies, corrective actions and policies/tools specific to each group's role and responsibilities. The Clinical Supervisor will conduct a Clinical Record Review on 100% of active patient records, using Hospice Survey Clinical Record Review Tool in August 2015. The Clinical Supervisor will report the findings to the PI Committee at the August 2015 meeting regarding the number of records compliant with Spiritual Counseling. The PI Committee will determine what actions need to be taken, if data analysis indicates an opportunity exists. PDAC or non-PDAC decisions regarding continued monitoring will be reflected in the PI Committee minutes (September 2015)	

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L 679	<p>Continued From page 39 7/08/15 from 1:25 PM to 2:00 PM</p> <p>The above referenced notes included a section where staff could document coordination. It included options to select with whom the staff member coordinated and allowed space to enter the content of the coordination and the time and date the coordination occurred. The LPN notes did not include the date, time, or content of the communication with the RN. This was confirmed by the Hospice Director during interview on 7/21/15 at 9:40 AM.</p> <p>Care coordination notes were incomplete.</p> <p>2. Patient #20 was 40 year old male who was admitted to hospice on 11/15/14 and died on 11/19/14. A "PHYSICIAN'S VERBAL TELEPHONE ORDER" for Methadone 2.5 mg PO TID and Lorazepam .5 mg tab PO Q4H PRN anxiety, was signed by the physician on 11/20/14, one day after Patient #20 died. The verbal order did not include the date and time the order was received. This was confirmed by the Hospice Director during interview on 7/24/15 at 12:08 PM.</p> <p>Verbal order documentation was incomplete.</p> <p>3. Patient #9 was a 64 year old male admitted to the agency for hospice services from 1/03/15 to 1/13/15, related to lung cancer. His record and POC for the certification period 1/03/15 to 4/02/15 were reviewed.</p> <p>Patient #9's record included physician's orders which were written by nursing staff that were not specific and not clarified, as well as, inaccurate and incomplete documentation, as follows:</p>	L 679	<p>How Actions will Improve Processes That Led To Deficiency: Above actions will 1) heighten awareness of individual and group responsibilities related to Policy 5-005 Entries into the Medical Record, Federal Regulation 418.104(b) Authentication 2) provide data to determine if the problem is wide-spread and requires PI intervention and 3) assign responsibility to ensure PI Committee documentation reflects analysis and any PI actions taken.</p> <p>Monitoring and Tracking: The Director will ensure the Clinical Record Review is completed by August 30, 2015.</p> <p>The PI Committee will analyze the CRR results (data) and determine if further action is needed during the September 2015 meeting.</p> <p>Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015</p>	

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L 679	<p>Continued From page 40</p> <p>a. A form titled "PHYSICIAN'S VERBAL TELEPHONE ORDER," dated 12/22/14, noted under the section "Summary of phone call," "Admit to Hospice. Please circle Yes or No for M.D. Management."</p> <p>The section on the order sheet "Orders," included a handwritten note to the physician: "1. Admit to Hospice Dx. Lung Cancer. Attending M.D. to continue to manage pts. care Yes or No. Hospice M.D. may assume the care of this pt. Yes or No. Hospice M.D. may co-manage pain or symptoms Yes or No."</p> <p>The form was initiated on 12/22/14, before Patient #9 was admitted to hospice services, and was signed on 1/13/15, after Patient #9's death. The form, as it was written, lacked clarity of who would manage Patient #9's medical care. The sections to be circled "Yes or No" were not circled, and the form was not clarified after being signed by the physician.</p> <p>During an interview on 7/23/15 beginning at 3:00 PM, the Hospice Director reviewed Patient #9's record and confirmed the way the orders were written on the physician's order sheet lacked clarity. She stated the physician should have circled the yes or no response before signing and returning the order sheet. The Hospice Director further confirmed the order was not a verbal order, but an order request.</p>	L 679		
L 687	<p>Orders were not clearly and accurately written.</p> <p>418.106 DRUGS BIOLOGICALS MEDICAL SUPPLIES & DME</p> <p>Medical supplies and appliances, as described in</p>	L 687	<p>Actions</p> <p>Education sessions will be conducted in August 2015 with Agency Leaders (by VP of Ops), IDG (by Director) and Staff (by Director and Hospice Clinical Supervisor) on L687 deficiencies, corrective actions and policies/tools specific to each group's role and responsibilities.</p>	

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L 687	<p>Continued From page 41</p> <p>§410.36 of this chapter; durable medical equipment, as described in §410.38 of this chapter; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, policy review, and medical record review, it was determined the hospital did not consistently supply all drugs and biologicals related to the palliation and management of the terminal illness to patients identified as "Charity Care." This directly impacted 1 of 1 "charity care" patient (#20) whose record was reviewed, and had the potential to financially impact other patients designated as charity care by requiring them to pay for drugs that were the responsibility of the hospice. Findings include:</p> <p>1. The policy, "Charity Care," dated 4/11, was reviewed. It included, but was not limited to, the following information:</p> <p>"When financial declarations reveal the patient is able to make partial payment for services, the Administrator, with the Branch Director, will determine the appropriate sliding-fee schedule to be implemented."</p> <p>"The sliding-fee schedule is in place to assist with determining the discount using the Health and Human Services National Poverty Guideline and will be presented to the patient for agreement and signature."</p> <p>The "Charity Care" policy did not address the</p>	L 687	<p>The Agency Leader Education Session will include reviewing of tag L687, the Charity Care Policy and that charity care includes provision of drugs and biologicals related to the palliation and management of the terminal illness.</p> <p>The IDG Education session will include reviewing of tag L687, the Charity Care Policy and that charity care includes provision of drugs and biologicals related to the palliation and management of the terminal illness.</p> <p>The Staff Education session will include reviewing of tag L687, the Charity Care Policy and that charity care includes provision of drugs and biologicals related to the palliation and management of the terminal illness.</p> <p>The Director or Designee will review all Charity Care clients plan of care to ensure that drugs and biologicals related to the palliation and management of the terminal illness are provided by the hospice.</p> <p>How Actions Will Improve Processes That Led To Deficiency:</p> <p>Actions will 1) heighten awareness of individual and group responsibilities related to QAPI 2) clarify what data is used to monitor hospice quality outcomes; 3) provide improved tools for capturing analysis of data and reflecting decisions regarding targeted areas of improvement and PDAC and non-PDAC actions</p> <p>Monitoring and Tracking:</p> <p>The Director, Clinical Supervisor and IDG will review all Charity Care Hospice Plans of Care to ensure that all Charity Care Patient's drugs and biologicals related to the palliation and management of their terminal illness are included in Plan of Care.</p>		

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NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 8199 WEST BLACK EAGLE DRIVE BOISE, ID 83708		
(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 687	<p>Continued From page 42</p> <p>hospice's responsibility to ensure drugs and biologicals related to the palliation and management of the terminal illness and related conditions would be provided by the hospice while the patient was under hospice care.</p> <p>Patient #20 was 40 year old male who was admitted to hospice on 11/15/14 and died on 11/19/14. An "Admission Service Agreement," dated 11/15/14, identified Patient #20 as "Charity CARE - NEEDS ONLY." The agreement did not specify Patient #20's specific financial responsibilities or lack thereof.</p> <p>A "PHYSICIAN'S VERBAL TELEPHONE ORDER" for Methadone 2.5 mg PO TID and Lorazepam .5 mg tab PO Q4H PRN anxiety, was included in Patient #20's medical record. It was signed by the physician on 11/20/14, one day after Patient #20 died. The verbal order did not include the date and time the order was received. The "faxed" date on the top of the page was 11/18/14. This was confirmed by the Hospice Director during interview on 7/24/15 at 12:06 PM.</p> <p>Two RNs were interviewed together on 7/24/15 at 1:31 PM. One RN, who reported pronouncing Patient #20 dead on 11/19/14, stated his family had called on 11/18/14 reporting the prescriptions were not available when they went to the pharmacy to pick them up that evening. She stated the family said they could manage without them.</p> <p>When asked why the medications had not been delivered to the family, the RN Clinical Supervisor of Hospice explained Patient #20 was on "charity care" and may have been responsible for the cost of the medications. He stated he was not sure.</p>	L 687	<p>Completion Date: All Corrective Actions will be initiated or completed by August 30, 2015 by the designee identified in each action step.</p>		

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

PRINTED: 08/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2015
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 8189 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
(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 687	Continued From page 43 Drugs related to the palliation and management of the terminal illness were not provided directly by the hospice to Patient #20 while under hospice care. The Charity Care policy did not ensure that hospice patients were provided with drugs and biological related to the palliation and management of the terminal illness.	L 687			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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September 15, 2015

Jana Stowell, Administrator
St Alphonsus Home Health & Hospice
9199 West Black Eagle Drive
Boise, ID 83709-1572

Provider #131507

Dear Ms. Stowell:

An unannounced on-site complaint investigation was conducted from July 20, 2015 to July 24, 2015 at St Alphonsus Home Health & Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006849

Allegation #1: The agency's after-hours message system had a poor connection, leading to difficulty communicating messages, calls were not returned in a timely fashion, and the agency was slow to respond to requests for medication, supplies, equipment, and services.

Findings #1: During the investigation, agency call records, complaint logs and patient records were reviewed. Observations were conducted and patients and staff were interviewed.

Three home visits were made to observe social work and nursing services as they were provided, both in the residents' homes and in an assisted living facility. During the home visits, family members of the hospice patients were interviewed. Family members of current patients were asked how the agency staff responded to requests for supplies, medications, and treatments. The patients' responses were positive and complimentary of the agency for promptly returning phone calls and responding to requests.

The agency's complaint logs were reviewed for the past 16 months. Six documented complaints were reviewed and included, but were not limited to, complaints from patients and family members related to poor answering service connection and service. Those complaints resulted in an investigation and eventual contract change to another answering service provider. Since the change in service providers, there were no further complaints regarding the answering service.

The call records from the answering service and nurses on call were also requested and reviewed. The answering service documented prompt response to patient calls and messages to the nurses.

Twenty patient records were reviewed, 9 of which were current hospice patients, 11 were records of patients who either transferred, expired, or were discharged. The records documented both calls and responses to requests. For example, 1 patient record was that of a patient who was admitted to hospice services on 1/03/15 and died 1/13/15. His record included documentation of frequent phone calls from the family to the answering service and the nursing staff response, as follows:

A comprehensive assessment was performed by the Registered Nurse (RN) Case Manager on the day of admission. The RN Case Manager documented the patient's pain of 3 on a scale of 1-10, and that his current pain medication regime was effective. The RN Case Manager documented on the assessment that the patient was unsteady, weak, and fatigued. She noted the patient used a walker, and was able to ambulate to the bathroom.

The patient record included documentation he had a port for IV access that was used during the period of time he received chemotherapy. The comprehensive assessment did not include identification of the IV access port, nor did it address flushing or port care.

A progress note dated 1/05/15, documented the RN Case Manager spoke with the patient's family to reschedule the visit to the following day, and the family was in agreement. The RN noted there were no medication or supply needs identified at that time.

In a clinical visit note dated 1/06/15, the RN Case Manager documented aide services would be initiated that week to assist with bathing and hygiene. Additionally, the patient's family was educated on safety during transfers and ambulation. The RN documented she would provide the patient with a gait belt during the next visit. The RN documented the patient's pain as a 2 on a scale of 1-10 and documented his current pain medication was effective. The visit note included documentation the RN spoke with the family and confirmed the next visit for 1/08/15.

In a progress note dated 1/08/15 at 6:03 AM, the RN on call documented she received a message from the answering service to contact the patient's wife. The progress note included documentation the wife was called at 6:10 AM, discussed his care, and offered a visit. The wife declined a nursing visit, and stated she would wait for the scheduled visit with the RN Case Manager.

In a clinical visit note dated 1/08/15, provided by a different RN, she documented the patient denied pain at that time, and his scheduled pain medications were effective. The RN documented a gait belt was provided and the family was instructed how to use it for safe transfers. The RN documented the patient had not had a bowel movement for 4 days and she provided education to the family regarding bowel care.

In a progress note dated 1/09/15, the RN Case Manager documented a phone call with the family of the patient. The RN Case Manager stated the patient's wife was concerned he was unable to have a bowel movement. The RN Case Manager documented in the progress note that she was busy with another patient, and she would contact the RN on call to follow up with the patient.

The on call RN wrote in a progress note dated 1/09/15, that she contacted the patient's wife and, despite an enema and suppository, he was unable to have a bowel movement for 5 days. The on call RN offered to provide a home visit, but the wife declined a visit at that time.

The answering service recorded two calls from the patient's family on 1/10/15. The first call at 8:53 AM, was relayed to the RN Case Manager at 8:56 AM. There was no answer, so the back up Licensed Practical Nurse (LPN) was contacted at 9:22 AM. A second call was recorded at 9:25 AM, relayed to the RN Case Manager at 9:28 AM, with no answer until 9:36 AM. The RN Case Manager instructed the answering service call the on call RN. The LPN saw the patient at 11:15 AM.

In a progress note dated 1/10/15, the on call RN documented the patient's family contacted the answering service to request a bed pan, and to have the patient's IV port flushed. The on call RN documented she spoke with the patient's wife, and told her she did not have the supplies to flush the port, she was the on call nurse for the weekend, and the port could be flushed by the RN Case Manager on Monday. The wife requested a nursing visit that day, and the RN documented she would contact the LPN.

In a clinical visit note dated 1/10/15, provided by an LPN, she documented the patient had no complaints of pain. She documented the patient was confused, drowsy, and had low oxygen saturations. The LPN noted the patient had a bowel movement, but he was much weaker, and was unable to stand or walk to the bathroom. The IV access port was not flushed by the LPN.

The answering service recorded six calls from the patient's family on 1/11/15. In a progress note dated 1/11/15, the on call RN documented she was contacted by the answering service at 6:30 AM, that the patient was agitated. Her note documented she called the wife of the patient at 6:40 AM, and was told he was agitated and the emergency kit was requested. The on call RN documented she educated the patient's wife on comfort care and offered to come for a visit. The wife declined a visit, and was noted to state she would talk with the RN Case Manager when she was available. The on call RN documented she left a message for the RN Case Manager with information from her call to the family.

Calls to the answering service by the patient's family continued through the day,

-At 10:09, "Wife, second call, patient needs medication." Answering service attempted to contact RN, no answer, contacted LPN back up at 10:29 AM. The progress notes documented the LPN contacted the family at 10:30 AM.

-At 11:31 AM, "Wife, Needs to know when the medical kit will arrive, is desperate, needs now, ASAP." The answering service contacted the RN Case Manager at 1:40 PM. Progress notes documented the RN Case Manager spoke with the pharmacy at 1:30 PM.

-At 2:17 PM, "Wife, Waiting for medical kit from hospice to be delivered since 6 AM." The answering service documented the RN was contacted at 2:20 PM.

-At 3:01 PM, "Son, Would like to speak to nurse on call regarding kit with meds, no call back all day and still waiting." The answering service documented the RN was contacted at 3:04 PM. The RN Case Manager documented in the progress notes that the RN Clinical Director was contacted at 3:20 PM, and he would speak with the family.

-At 3:25 PM, "Wife, Having a hard time getting script from pharmacy, there are no directions." The answering service documented the RN Case Manager was contacted at 3:27 PM.

The patient's record included additional progress notes from the backup LPN on call, as well as, the RN Case Manager, dated 1/11/15. The progress notes were detailed, and included hour by hour documentation of phone calls to the patient's family, the pharmacy, the Medical Director, RN Clinical Director, and nursing staff related to the attempts to get an emergency (comfort) kit to the patient. The last progress note entry was on 1/11/15 at 4:27 PM, by the RN Case Manager, in which she documented she provided the pharmacy with billing information, then contacted the LPN to call the patient's family with an update.

In a clinical visit note by the RN Clinical Director on 1/12/15, documented the patient was comatose, his oxygen saturations were 85%, and the patient appeared to be in the dying process. The note did not include documentation of discussion with the patient's family regarding the previous day and the delay in obtaining the comfort kit. The RN Clinical Director did not document if the IV access port was flushed.

In a progress note dated 1/13/15, the on call RN documented the patient's wife contacted the answering service stating the patient had died.

In summary the patient's record documented the IV access port was not flushed. The gait belt and bed pan were provided in a timely manner. The comfort kit was requested and obtained by a family member after approximately 11 hours. Phone calls were documented by the nursing staff in progress notes, and correlated with the answering service records, which indicated calls were promptly returned.

However, the patient's progress notes also included documentation by the RN Case Manager and the RN Clinical Director, that the family had access to the cell phone number of the RN Case Manager. The progress notes documented numerous phone calls were made directly to the RN Case Manager's cell phone, rather than the hospice agency number. The progress notes documented the agency had requested that the family not call the nursing staff's cell numbers on multiple occasions.

During an interview with the Hospice Director on 7/23/15 at 9:30 AM, she stated the agency provided a phone allowance to the clinical staff and they used their own personal cell phones. She stated there was an option for the staff to block their number when calling patients, but most staff did not use that option. She stated the family would then have access to the staff member's personal cell number and would be able to call them at any time, even during off hours. The Hospice Director stated patients and families were told to call the hospice phone number and not the nursing staff cell phone numbers. She stated that some nurses ignored their phone when they were off duty, and hoped the patients used the hospice phone number.

When asked about the delay in the patient receiving the comfort kit, the Hospice Director, she stated the delay of the patient receiving the comfort kit resulted in a change of practice for the agency. She stated comfort kits are now ordered within the first 48 hours on hospice services to prevent occurrences like that in the future. She stated the agency does not allow staff to transport scheduled drugs, therefore, the comfort kit is delivered by the pharmacy on Mondays through Fridays, and the families would be responsible for picking them up on weekends. She stated hospice patients and families were advised of this practice during the admission process.

The agency experienced problems related to their answering service provider and was delayed in their response to providing medications, therefore, the allegation was substantiated. However, the agency had identified and resolved the issues prior to the survey being conducted and no current deficient practices were identified.

Conclusion #1: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: Hospice Staff failed to provide patients and their family members with comprehensive medication education.

Findings #2: During the investigation patient records were reviewed and staff were interviewed.

Twenty patient records were reviewed, 9 of which were current hospice patients, 11 were records of inactive patients. All of the records documented medication education had been provided to patients and/or their family members. For example, 1 patient's record was that of a patient who was admitted to hospice services on 1/03/15. He had 5 nursing visits from the time of his admission to his death on 1/13/15. The record included documentation of patient/family education with each visit as follows:

1/03/15: The patient was admitted to hospice services. The comprehensive assessment, completed by the RN Case Manager, documented education was provided related to medication administration, side effects and response, as well as, discarding discontinued medications.

1/06/15: The RN Case Manager documented she provided instruction related to patient safety and pain medication management.

1/08/15: The on call RN documented she provided education related to the use of the gait belt during ambulation, and bowel care management. The clinical visit note included RN documentation related to providing instruction about medications for bowel movements, when his medications would be refilled, and general medication review.

1/10/15: The on call LPN documented in a clinical visit note that she provided education to the patient's family regarding repositioning, specifically turning him using the draw sheet and prevention of skin breakdown. The section on the clinical visit note for education on infection control and equipment safety was marked to indicate it was provided. The LPN did not include documentation if medication education was provided during the visit.

Jana Stowell, Administrator
September 15, 2015
Page 7 of 7

In a progress note dated 1/11/15, the on call RN documented she was contacted by the answering service at 6:30 AM, that the patient was agitated. Her note documented she called the wife of the patient at 6:40 AM, and was told he was agitated and the emergency kit was requested. The on call RN documented she educated the patient's wife on comfort care and offered to come for a visit. The wife declined a visit.

1/12/15: The RN Clinical Director described family education in the clinical visit note. He documented he instructed and reviewed with the patient's wife the plan of care, end of life issues, and administration of medications.

The clinical staff documented patient and family education during each visit, therefore the allegation that family and patient education did not occur was unsubstantiated, and no deficiencies were cited.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

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,



GARY GULES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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September 15, 2015

Jana Stowell, Administrator
St Alphonsus Home Health & Hospice
9199 West Black Eagle Drive
Boise, ID 83709-1572

Provider #131507

Dear Ms. Stowell:

An unannounced on-site complaint investigation was conducted from July 20, 2015 to July 24, 2015 at St Alphonsus Home Health & Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006758

Allegation #1: Agency staff were not qualified or trained and criminal background checks were not completed in a timely manner.

Findings #1: Administrative and personnel documents were reviewed and staff interviews were conducted.

The Vice President (VP) of Operations was interviewed on 7/20/15 at 1:55 PM. The VP explained that the facility had a change in ownership and processes in 2014.

Agency personnel files were reviewed for evidence of appropriate qualifications, initial orientation and training, and timely criminal history checks. Review of personnel administrative documents indicated there was a gap in 2014, between 9/19/14 and 10/14/14, when the hospice did not have a qualified Chaplain available to provide spiritual counseling service. Two criminal background checks in 2014 were late and the file of one employee who was employed from 5/16/14 to 11/23/14, did not include evidence of initial training and orientation to the hospice.

All other personnel files, including the Administrator, Registered Nurses, and Licensed Practical Nurses included documentation of appropriate qualifications, training and timely background checks.

The Business Office Manager was interviewed on 7/21/15 at 3:00 PM. She confirmed the information was missing from the personnel files and there had been periods of time that a Chaplain was not available. She also stated that during the agency transition, miscommunication had occurred as to whose responsibility it was to ensure background checks were completed, which resulted in some late background checks.

However, 12 current employee files were reviewed and included evidence of initial orientation and training, timely criminal history checks, and a well-qualified Chaplain.

The agency's 2014 personnel files did not include complete, comprehensive documentation, therefore the allegation was substantiated. However, the agency had identified and resolved the issue prior to the survey being conducted and no current deficient practices were identified.

Conclusion #1: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: There was a significant delay in receiving patient admit orders and creating patient charts, leading to lost patient record information and agency staff being asked to re-create initial assessments. This resulted in inaccurate information being present in patients' medical records.

Findings #2: Medical records were reviewed and staff were interviewed.

Six patient records from 2013 and 2014 were reviewed. The records indicated a delay, at times, of admit orders until after the patients' admission had occurred.

The Hospice Director and Vice President of Operations were interviewed on 7/20/15 at 1:50 PM. They stated there had been a problem in 2014 during the agency's transition from an electronic medical record and a paper chart, which had resulted in a delay in creating charts and occasional lost paperwork. In order to correct the problem, the hospice instituted a performance improvement project to improve the timeliness of chart creation and completion and to improve a filing system to minimize lost information. They stated there had been no medical records lost in 2015.

An LPN and RN who had been with the agency multiple years were interviewed separately on 7/21/15 at 10:10 AM and 7/22/15 at 8:30 AM. Both denied being asked to recreate lost assessments. Both stated they kept copies of their charting. If something was lost, they would present their copies.

The Hospice Director was interviewed on 7/22/15 at 10:40 AM and asked how lost paperwork, such as initial assessments, was handled. She stated they would look to see if something had been misfiled and, if possible, retrieve it. She stated staff often kept their own copies. When asked if copies were not available, how would it be handled, she stated if the notes had been kept, the assessment, would be entered as a "late entry" and created. If notes were not available, nursing staff would have to conduct new assessments. She stated there had not been any incidents in 2015 when paperwork had to be re-created. When asked regarding the last time notes were lost and not found, she stated it had been October of 2014. She stated lost paperwork was tracked on an incident report. She stated the hospice improved their filing system to reduce the risk of lost documents.

The medical records of 9 patients who were on services in 2015 were reviewed. All of the records included timely admit orders. Evidence of lost patient information, including initial assessment information, was not identified.

The agency did experience a delay in obtaining admit orders and creating patient charts which resulted in lost patient records, therefore the allegation was substantiated. However, the agency had identified and resolved the issue prior to the survey being conducted and no current deficient practices were identified.

Conclusion #2: Substantiated. No deficiencies related to the allegation are cited.

Allegation #3: The hospice did not have a system in place to ensure weekend nursing staff had access to all necessary patient information to provide quality care.

Findings #3: Medical records were reviewed and staff and patients were interviewed:

An LPN and RN who had been with the agency multiple years were interviewed separately on 7/21/15 at 10:10 AM and 7/22/15 at 8:30 AM. They both stated they covered on the weekend at times. They stated there had been a problem accessing patient information for weekend visits during the agency transition, but it was no longer a problem. They stated weekend staff had access to patient information necessary to care for patients, such as the plan of care and current medication lists. They stated the information was kept in an "on-call box" and accessible to weekend staff.

The medical records of 9 patients who were on services in 2015 were reviewed. The medical records of 8 patients did not include evidence that patient needs were not being met during weekends. Although one patient's medication needs were not met during a weekend, the system issues that precipitated the problem had been corrected prior to the survey.

Three patients were interviewed. None of the patients interviewed indicated concerns regarding their weekend needs not being met.

The agency did experience difficulty accessing information for weekend visits, therefore the allegation was substantiated. However, the agency had identified and resolved the issue prior to the survey being conducted and no current deficient practices were identified.

Conclusion #3: Substantiated. No deficiencies related to the allegation are cited.

Allegation #4: Social work visits were not provided at the frequency specified in the plan of care and chaplain services/counseling was not provided to meet patient needs.

Findings #4: Medical records were reviewed and staff were interviewed.

The medical records of 13 patients who were on services in 2014 and 2015 were reviewed. Five of the medical records reviewed included patients who had Social Work orders. All 5 records included documentation that Social Work visits were provided in accordance with the patients' plans of care.

Additionally, 8 of the records documented requests for chaplain services. Seven records documented Chaplain services were provided as needed. However, 1 record documented a patient who was admitted to hospice on 11/15/14 and died on 11/19/14. The medical record indicated the patient had requested Chaplain services, on 11/15/14, for Catholic burial services and that on 11/17/14 the family had requested Chaplain services for administration of last rights as a Catholic. The patient died prior to receiving Chaplain services from the hospice agency.

The Social Worker who provided care to the patient was interviewed by telephone on 7/24/15 at 12:15 PM. She stated she remembered the patient and she did not know why the chaplain did not respond. The RN who pronounced the patient dead on 11/19/14 also stated, during an interview on 7/24/15 at 1:30 PM, that she did not know why the Chaplain did not respond. The Chaplain was no longer an employee of the hospice and could not be interviewed.

The facility failed to ensure Chaplain services were provided to meet the patient's needs. Therefore, the allegation was substantiated and deficient practice was cited at CFR 418.64(d).

Conclusion #4: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #5: The hospice is not reporting and tracking all falls and other incidents.

Findings #5: Incident reports and the medical records of 20 active and inactive patients were reviewed, a case management meeting was attended, and staff were interviewed.

An LPN and RN who had been with the agency multiple years were interviewed separately on 7/21/15 at 10:10 AM and 7/22/15 at 8:30 AM. They both stated it was the agency expectation and practice that fall reports be completed on any observed or reported falls.

During the case management meeting on 7/23/15 at 8:30 A, three patient falls were referenced. Upon request, the incident reports were promptly provided. Additionally, incident reports were requested on falls that were documented in a sample of 3 patient medical records. Incident reports were present on all of the patients requested.

However, one patient's record included an aide's progress note, dated 2/12/15, which stated "Upon arrival, {the patient} was alone. {The patient} doesn't know how long she has been alone but does not want to be left alone. {The patient} was in pain and {left} foot dropped over bedside. {The patient's} oxygen water was empty." The note stated the Aide called the RN. The note stated the RN asked the Aide to wait with the patient until she arrived.

The RN progress note, dated 2/12/15 at 12:40 PM, stated the patient had been left alone on 2/10/15 and was also left alone today.

The RN who visited the patient on 2/12/15 was interviewed on 7/24/15 beginning at 9:10 AM. She stated the patient was alone. She stated the house was filthy, that there was dog feces on the floors, dirty dishes and decomposing food around the house, and rotten milk at the bedside. She stated the patient was oriented to person, place, and time, but was confused and was not functional. She stated the patient could not transfer or use the telephone. She stated she did not think the patient was safe and she called the local Adult Protection Agency to report the situation. She stated she assigned an Aide to stay with the patient until the family came home and could supervise the patient.

However, an incident report was not documented for potential neglect of the patient and an investigation of the incident was not documented.

The agency failed to ensure an incident report was completed and an investigation was conducted for all allegations of potential neglect, resulting in deficient practice being identified and cited at CFR 418.52(c)(6), 418.58(a)(2), and 418.58(c)(2).

Conclusion #5: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #6: The hospice medication destruction policy was not in compliance with federal standards or appropriate destruction methods. Hospice staff were instructed to watch the family flush medications down the toilet which was not an appropriate destruction method.

Findings #6: Patient education information was reviewed and staff and patients were interviewed.

A patient handout "Proper Disposal of Prescription Drugs," included in the admission packet, stated the following:

"Do not flush prescription drugs down the toilet or drain unless the label or accompanying patient information specifically instructs you to do so. For more information on drugs that should be flushed visit the FDA's {Food and Drug Administration's} website."

"To dispose of prescription drugs not labeled to be flushed, you may be able to take advantage of community drug take-back programs or other programs, such as household hazardous waste collection events, that collect drugs at a central location for proper disposal. Call your city or county government's household trash and recycling service and ask if a drug take-back program is available in your community.

If a drug take-back or collection program is not available:

1. Take your prescription drugs out of their original containers.
2. Mix drugs with an undesirable substance, such as cat litter or used coffee grounds.
3. Put the mixture into a disposable container with a lid, such as an empty margarine tub, or into a sealable bag.
4. Conceal or remove any personal information, including Rx {prescription} number, on the empty containers by covering it with black permanent marker or duct tape or by scratching it off.
5. Place the sealed container with the mixture, and the empty drug containers, in the trash

Office of National Drug Control Policy."

An LPN and RN who had been with the agency multiple years were interviewed separately on 7/21/15 at 10:10 AM and 7/22/15 at 8:30 AM. They were asked to describe the medication destruction process. They both stated they did not destroy any medications. Instead they instructed patients how to appropriately dispose of medications and provided a patient handout with information on appropriate disposition of medications.

Three patients were interviewed during home visits. They were able to show the admission packet that contained the information in it related to the medication destruction policy.

It could not be determined that medications were disposed of improperly. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Jana Stowell, Administrator
September 15, 2015
Page 7 of 7

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

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,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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October 29, 2015

Jana Stowell, Administrator
St Alphonsus Home Health & Hospice
9199 West Black Eagle Drive
Boise, ID 83709-1572

Provider #131507

Dear Ms. Stowell:

An unannounced on-site complaint investigation was conducted from July 20, 2015 to July 24, 2015 at St Alphonsus Home Health & Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005976

Allegation #1: Patients were not provided with respite or discharge services.

Findings #1: During the investigation patient records were reviewed and observations and staff and patient interviews were conducted.

The Vice President (VP) of Operations was interviewed on 7/20/15 at 1:55 PM. The VP explained that the facility had a change in ownership and processes in 2014. Numerous care systems had changed since the agency's change in ownership.

Twenty records of patients who had been on services from 2013 - 2015 were reviewed. Six of the patient records documented respite care had been requested and received.

Eleven of the records were of patients who either transferred, expired, or were discharged. One of the 11 records, documented a 93 year old female who was admitted for hospice services on 4/17/12 and was transferred to another hospice on 3/23/13, prior to the agency's change in ownership.

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A nursing progress note, dated 3/21/13 at 1:45 PM, stated the nurse attempted to assist with the transfer but the caregiver refused. A discharge summary, dated 3/23/13 at 10:35 PM, stated the caregiver refused assistance to transition to the receiving hospice. No other transfer or discharge concerns were documented.

Upon request, the agency provided contracts with long term care facilities to provide respite care and information addressing the processes which were in place to assist patients who had been planning live discharges, including transfers to other hospice agencies.

Additionally, 3 home visits were made to observe services as they were provided, both in the patients' homes and in an assisted living facility. During the home visits, family members of the hospice patients were interviewed. Family members of current patients were positive and complimentary of the agency.

It could not be determined that the facility failed to provide appropriate respite or discharge services. Therefore the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patient supplies are of poor quality and patients are required to obtain their own medications.

Findings #2: During the investigation, patient records were reviewed, observations were conducted and patients and staff were interviewed.

Three home visits were made to observe services as they were provided, both in the residents' homes and in an assisted living facility. During the home visits, family members of the hospice patients were interviewed. Family members of current patients were asked how the agency staff responded to requests for supplies, medications, and treatments. The patients' responses were positive and complimentary of the agency for promptly returning phone calls and responding to requests. Concerns regarding the patients' medications and supplies were not identified during the observations.

Further, a room housing hospice supplies was observed on 7/23/15 beginning at 10:45 AM. The room contained a variety of personal care items including incontinent supplies, medication administration supplies, wound care supplies, catheter supplies, gloves, and other supplies. The supplies carried name brands. They were unopened and appropriately stored. Where appropriate, they were furnished in a variety of sizes.

Twenty medical records of patients who had been on services from 2013 - 2015 were reviewed. Nine of the records were of patients currently receiving hospice services and 11 were records of patients who either transferred, expired, or were discharged. The records documented both calls and agency responses to requests. Concerns regarding the quality of supplies was not noted. Concerns regarding obtaining medications were not identified in nineteen of the records. However, 1 record documented the patient's family requested emergency medications (comfort kit) on 1/11/15 at 6:40 AM due to the patient being agitated.

The patient's record included additional progress notes from the backup LPN on call, as well as, the RN Case Manager, dated 1/11/15. The progress notes were detailed, and included hour by hour documentation of phone calls to the patient's family, the pharmacy, the Medical Director, RN Clinical Director, and nursing staff related to the attempts to get an emergency (comfort) kit to the patient. The record documented the comfort kit was obtained by a family member after approximately 11 hours.

The Hospice Director was interviewed on 7/23/15 at 9:30 AM. When asked about the delay in the patient receiving the comfort kit, the Hospice Director stated the incident had resulted in a change of practice for the agency. She stated comfort kits are now ordered within the first 48 hours on hospice services to prevent occurrences like that in the future. She stated the agency does not allow staff to transport scheduled drugs, therefore, the comfort kit is delivered by the pharmacy on Mondays through Fridays, and the families would be responsible for picking them up on weekends. She stated hospice patients and families were advised of this practice during the admission process.

It could not be determined that patient supplies were of poor quality. It was determined there was a delay in a patient receiving medications and a subsequent agency practice change. This change resulted in patient families being responsible to obtain scheduled drugs during weekends. However, patients and their families were advised of this practice during the admission process and no current deficient practices were identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The hospice did not provide counseling services.

Findings #3: During the investigation, patient records were reviewed, observations were conducted and patients and staff were interviewed.

Three home visits were made to observe services as they were provided, both in the patients' homes and in an assisted living facility. During the home visits, family members of the hospice patients were interviewed. The patients' responses were positive and complimentary of the agency

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Twenty medical records of patients who had been on services from 2013 - 2015 were reviewed. Nine of the records were of patients currently receiving hospice services and 11 were records of patients who either transferred, expired, or were discharged. Five of the medical records reviewed included patients who had Social Work orders. All 5 records included documentation that Social Work visits were provided in accordance with the patients' plans of care.

Additionally, 8 of the records documented requests for chaplain services. Seven records documented Chaplain services were provided as needed. However, 1 record documented a patient who was admitted to hospice on 11/15/14 and died on 11/19/14. The medical record indicated the patient had requested Chaplain services, on 11/15/14 and 11/17/14, but the patient died prior to receiving Chaplain services from the hospice agency.

The Social Worker who provided care to the patient was interviewed by telephone on 7/24/15 at 12:15 PM. She stated she remembered the patient and she did not know why the chaplain did not respond. The RN who pronounced the patient dead on 11/19/14 also stated, during an interview on 7/24/15 at 1:30 PM, that she did not know why the Chaplain did not respond. The Chaplain was no longer an employee of the hospice and could not be interviewed.

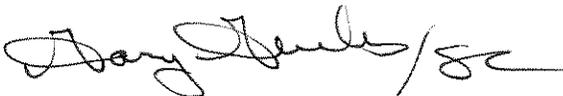
The facility failed to ensure Chaplain services were provided to meet the patient's needs. Therefore, the allegation was substantiated and deficient practice was cited at CFR 418.64(d).

Conclusion #3: Substantiated. Federal deficiencies related to the allegation are cited.

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

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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