



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
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Boise, Idaho 83720-0009  
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October 5, 2015

Chad Mangum, Administrator  
Access Hospice Care  
240 West Burnside Avenue, Suite B  
Chubbuck, ID 83202

RE: Access Hospice Care, Provider #131552

Dear Mr. Mangum:

This is to advise you of the findings of the complaint survey at Access Hospice Care, which was concluded on September 17, 2015.

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

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

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

Chad Mangum, Administrator  
October 5, 2015  
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **October 19, 2015**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626, option 4.

Sincerely,



SUSAN COSTA  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

SC/pmt  
Enclosures

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

PRINTED: 10/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  131552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/17/2015
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NAME OF PROVIDER OR SUPPLIER  ACCESS HOSPICE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202
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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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during a complaint investigation of your hospice from 9/15/15 to 9/17/15. Surveyors conducting the investigation were:</p> <p>Susan Costa, RN, HFS, Team Leader Gary Guiles, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>ADL - Activity of Daily Living ALF - Assisted Living Facility B/P - Blood pressure CG - Caregiver c/o - Complaints of DME - Durable Medical Equipment DPS - Director of Professional Services d/t - Due to H&amp;P - History and Physical Examination HHA - Home Health Aide HR - Heart Rate IDG - Interdisciplinary Group IV - Intravenous L - Left lbs - Pounds MAR - Medication Administration Record POC - Plan of Care PRN - As Needed Pt - Patient q - Every R - Right RN - Registered Nurse S/S - Signs and Symptoms SN - Skilled Nurse SOC - Start of Care UTI - Urinary Tract Infection VS - Vital Signs</p>	L 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>NOV 19 2015</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  Director of Operations	(X6) DATE  11/16/2015
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 000 L 524	Continued From page 1 WC - Wheelchair 418.54(c) CONTENT OF COMPREHENSIVE ASSESSMENT  The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.  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 comprehensive assessment was conducted for 2 of 9 patients (#1 and #7) whose records were reviewed. This prevented the hospice from developing comprehensive POCs. Findings include:  1. Patient #1 was a 69 year old female who was admitted for hospice services on 8/19/15. She was cared for by her daughter. Her terminal diagnosis was Huntington's Disease, a progressive neurological disease. She was currently a patient as of 9/16/15.  An H&P, dated 8/17/15, stated Patient #1 was not able to eat any type of solid food but could drink a little bit of thickened fluids. The document stated she was losing weight rapidly. The document stated she was not able to get out of bed and was beginning to have skin breakdown.  A SOC assessment by the RN, dated 8/19/15, stated Patient #1 "...is now bed bound and	L 000 L 524	Hospice will ensure that ongoing comprehensive assessment is conducted for all patients admitted for hospice services.  Hospice will continue utilizing the format for the comprehensive assessment as found within its electronic medical record. Hospice clinical staff, including nursing, social work and chaplain, will specifically address each system section of the assessment to identify any potential needs of the patient admission and re-certification.  Any actual or potential problems identified within the assessment will receive further evaluation by the appropriate discipline and interdisciplinary team in an attempt to determine the cause of the actual of potential problems.  Ongoing assessment of the patient, including and new problems or unmet needs, appropriateness of care plan goals and interventions and the caregiver's ability to perform interventions necessary to meet patient's needs will be assessed and documented within the visit notes as evaluated by the members of the	

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L 524	<p>Continued From page 2</p> <p>dependent for all ADLs and all cares. Pt has involuntary jerking or writhing movements, muscle problems, such as rigidity and muscle contractures and muscle spasms. Pt is non verbal at this time, unable to make any of her needs know. Pt is very thin with her bones protruding, she is likely to weigh around 80 lbs. Pt is not able to take in any solid foods, now only able to take thickened liquids and is choking on them. Pt family states that she is rapidly losing weight and not able to sleep for more than about 2 hours at a time d/t her disease, muscle spasms and contractures. Pt is quite emaciated, all care including oral cares are very difficult d/t choreiform [jerky involuntary] movements. Pt's family states that she is not safe anywhere but in her bed."</p> <p>The SOC assessment did not include a complete nutritional assessment. It did not describe what Patient #1 ate or which food consistency and patient positioning worked best to prevent choking. A nutritional assessment was not conducted. A speech therapy evaluation was not conducted.</p> <p>The SOC assessment stated Patient #1 was a high fall risk. The assessment did not specifically explain why. The DPS for the multiple location, interviewed on 9/15/15 beginning at 3:25 PM, stated Patient #1 had frequent involuntary muscle movements which could cause a fall from the bed. She stated Patient #1 had a hospital bed with side rails and the family placed blankets over the rails to protect her from bruises. The SOC Assessment did not describe this arrangement or evaluate how safe it was. The DPS stated Patient #1 and her family only spoke Spanish. The SOC assessment did not evaluate the ability</p>	L 524	<p>interdisciplinary team. Ongoing assessment findings will be addressed in the interdisciplinary plan of care.</p> <p>Hospice will ensure that all clinical staff are re-educated to the process and components of the comprehensive assessment through a mandatory inservice to occur in the parent location, as well as each of the two multiple locations. The inservice will address the necessity of assessing each component of the comprehensive assessment on admission, at re-certification and ongoing as the patients conditions changes with progression of disease processes. The inservices will be completed in each location prior to October 30, 2015.</p> <p>To ensure ongoing compliance with the plan of correction, the interdisciplinary team will conduct monthly peer reviews of selected re-certification comprehensive assessments.</p> <p>The administrator is responsible to make sure the comprehensive assessment inservice is completed in each office prior to October __, 2015. The administrator will also supervise the peer review audits overseeing the selection of records to</p>	

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L 524	<p>Continued From page 3 of staff to communicate with Patient #1 or her caregiver.</p> <p>The SOC assessment did not include an evaluation of the caregiver's ability to care for Patient #1.</p> <p>The DPS for the multiple location was interviewed on 9/15/15 beginning at 3:25 PM. She confirmed the SOC assessment did not include the above items.</p> <p>Patient #1's SOC assessment was not comprehensive.</p> <p>2. Patient #7 was a 97 year old female who was admitted for hospice services on 1/31/15. She lived in an ALF. A physician note from an Emergency Department, dated 1/30/15 at 12:40 AM, stated Patient #1 had a new fractured hip that was not surgically repaired. She was currently a patient as of 9/16/15.</p> <p>A SOC assessment by the RN Case Manager, dated 1/31/15 but not timed, stated Patient #7 had a fractured femur. The assessment stated "Pt is being treated with Bactrim for the next 5 days for UTI. Pt has been losing weight steadily over several years. Family reports she was at one time 140 lbs, but is now 96 lbs...Pt is now on 5 L [liters] oxygen via mask and oxygen sats are 86%, pt is lethargic and oriented to person and self only. Family reports she did not eat yesterday, but has eaten lunch today...Is now non-ambulatory and non-weight bearing due to hip fracture. Will be total cares in bed. Cannot tolerate sitting at this time. Has Foley [catheter] ordered for comfort."</p>	L 524	<p>be audited and the compilation of the peer suggestions and follow through by interdisciplinary staff with any additional assessment to be completed.</p>	October 30, 2015

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L 524	Continued From page 4 The assessment did not include an evaluation of the caregiver's ability to care for Patient #7. The ALF was staffed by non-professional personnel. The assessment did not include the number of staff on duty or their ability to care for a patient with a new fractured hip, including turning and positioning. The assessment stated Patient #7's pain was 5 of 10. The assessment did not discuss how the ALF would provide pain control for Patient #7. The assessment did not include a specific nutritional assessment.  Patient #7's RN Case Manager was interviewed on 9/17/15 beginning at 9:55 AM. She confirmed the assessment did not evaluate the above items.  Patient #7's SOC assessment was not comprehensive.	L 524		
L 533	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT  The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.  This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospice failed to	L 533	Hospice will ensure that ongoing comprehensive assessment is conducted for all patients admitted for hospice services.  Hospice will continue utilizing the format for the comprehensive assessment as found within its electronic medical record. Hospice clinical staff, including nursing, social work and chaplain, will specifically address each system section of the assessment to identify any potential needs of the patient admission and re-certification.	

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L 533	<p>Continued From page 5</p> <p>ensure a comprehensive assessment was conducted for 1 of 2 patients (#8) who suffered falls while on service and whose records were reviewed. This prevented the hospice from developing a comprehensive POC. Findings include:</p> <p>Patient #8 was a 79 year old female admitted for hospice services on 8/12/15. Her terminal diagnosis was Alzheimer's Disease. She died on 9/11/15.</p> <p>An "RN Recertification" for Patient #8, dated 9/09/15, stated a visit was conducted to the ALF where she resided on 9/09/15 from 3:30 PM to 9:20 PM. The note stated Patient #8 "...was sitting in recliner when SN first arrived. On arrival pt looked comfortable, no s/s of pain. SN began assessment of pt. When measuring pt's [arm circumference], SN noticed a large bruise on pt's L bicep. SN and HHA were going to take pt to the other building to get a current weight on pt. When SN and HHA stood pt to transfer her to WC, pt began grimacing a lot and was shaking and became diaphoretic. Pt was placed in WC and wheeled into bathroom to toilet and further assess pt. Upon further assessment, SN found a golf ball sized lump below pt's L elbow. The lump was soft but protruding. At this time, SN called another nurse from hospice to come assist with further assessment. HHA and facility staff, [name], began to undress pt to shower before weighing. After removing pt's shirt, it was noticed that pt's L shoulder was very large and swollen. D/t pt being very sweaty, HHA and ALF staff, quickly cleaned pt up and placed a nightgown on pt to make it easier to put on and remove. [The second] RN arrived from hospice to assist SN with assessment. On further transfers, it was</p>	L 533	<p>Any actual or potential problems identified within the assessment will receive further evaluation by the appropriate discipline and interdisciplinary team in an attempt to determine the cause of the actual or potential problems.</p> <p>Ongoing assessment of the patient, including and new problems or unmet needs, appropriateness of care plan goals and interventions and the caregiver's ability to perform interventions necessary to meet patient's needs will be assessed and documented within the visit notes as evaluated by the members of the interdisciplinary team. Ongoing assessment findings will be addressed in the interdisciplinary plan of care.</p> <p>Hospice will ensure that all clinical staff are re-educated to the process and components of the comprehensive assessment through a mandatory inservice to occur in the parent location, as well as each of the two multiple locations. The inservice will address the necessity of assessing each component of the comprehensive assessment on admission, at re-certification and ongoing as the patients conditions changes with progression of disease processes. The</p>	

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L 533	Continued From page 6 noted that pt was not bearing weight on L leg, no noticeable bruising on leg but pt does appear to be turned in slightly. It was determined after discussing with facility administrator...RN and pt's family, that pt would be transported to the hospital for xrays and physician assessment. SN and HHA went to hospital with pt and family to assist with transferring and to give physician a report of what was thought to have happened at approx 16:50. SN and HHA assisted lab tech to transfer pt from WC to xray table at approx 17:40...Xrays were completed at approx 18:20 and it was determined that pt had a [fractured] humerus and a [fractured] femur. Physician and SN discussed this with family and determined that the options were to keep pt in the hospital for pain management or to obtain IV access and to send pt back to ALF with scheduled pain medications and to maintain pain control there via hospice, until pt passed away. Pt's family made the decision to return pt to [ALF] so she could be in a more comfortable environment and to provide pain control there. SN assisted hospital RN...to place a shoulder immobilizer on pt. Pt was transferred back to the facility via ambulance and stretcher at approx 19:30. Pt is placed on strict bed rest, with oral pain medication scheduled every 2 hours with the option of providing IV pain medication every 30 minutes as needed to maintain pain control. SN instructed facility staff on scheduled pain medication and prefilled syringes so scheduled [oral] pain medication could be given by ALF staff. SN instructed staff that if this wasn't enough to maintain pain control for pt, to call hospice on call and we could provide additional pain medications if needed, including PRN oral and IV medication. Staff [verbalized understanding]. SN also instructed staff that if pt was able to swallow and tolerate oral liquids and	L 533	inservices will be completed in each location prior to October __, 2015.  To ensure ongoing compliance with the plan of correction, the interdisciplinary team will conduct monthly peer reviews of selected re-certification comprehensive assessments.  The administrator is responsible to make sure the comprehensive assessment inservice is completed in each office prior to October __, 2015. The administrator will also supervise the peer review audits overseeing the selection of records to be audited and the compilation of the peer suggestions and follow through by interdisciplinary staff with any additional assessment to be completed.	October 30, 2015

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L 533	<p>Continued From page 7</p> <p>hydration well, to offer them, as well as pt's regularly scheduled medications but if at any time, pt had difficulty swallowing or tolerating them, to just provide comfort oral care frequently. Staff [verbalized understanding]. Pt was given an Ensure after arrival back to ALF facility. Pt was able to drink that through a straw and swallow it well. SN assisted HHA to turn and change pt's depends in bed. Pt administered 2 mg of IV morphine at 20:00 d/t increased pt grimacing and shaking after turning and repositioning. When SN left pt, pt appeared comfortable, no grimacing noted. SN reinforced teaching to staff and instructed them to call if at any time pt's pain increased and they needed additional pain medication. Pain 8/10. throbbing, continuous."</p> <p>The assessment did not include an evaluation of the caregiver's ability to care for Patient #8. The ALF was staffed by non-professional personnel. The assessment did not include the number of staff on duty or their ability to care for a patient with 2 new fractures. The assessment stated Patient #8 was grimacing and shaking after turning and repositioning. The assessment stated Patient #8 was incontinent. The assessment did not include the ability of staff to comfortably turn and position Patient #8 or keep her clean. The assessment stated the RN left at 9:20 PM on 9/09/15.</p> <p>The RN Case Manager who completed the assessment was interviewed on 9/16/15 beginning at 2:05 PM. She stated the ability of the ALF to care for Patient #8 was not evaluated. She stated she left the ALF on 9/09/15 at 9:20 PM and hospice staff did not visit Patient #8 until the following day.</p>	L 533		

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L 533 L 545	<p>Continued From page 8 Patient #8's assessment was not comprehensive. 418.56(c) CONTENT OF PLAN OF CARE</p> <p>The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:</p> <p>This STANDARD is not met as evidenced by: Based of record review and staff interview, it was determined the agency failed to ensure a comprehensive individualized POC was developed and updated by the IDG to ensure patient needs were met for 4 of 9 patients (#1, #4, #7, and #8) whose records were reviewed. Failure to develop individualized plans of care had the potential to interfere with the ability of hospice staff to meet each patient's current needs. Findings include:</p> <p>1. Patient #4 was an 85 year old male who was admitted to hospice on 7/14/15, with a terminal diagnosis of Alzheimer's disease. Additional diagnoses included Type II Diabetes, Hypertension, and Osteoarthritis. Patient #4 resided in an ALF.</p> <p>Patient #4's record included an H&amp;P dated 7/03/15, from a brief hospitalization just prior to his hospice admission. Patient #4's physician documented a recent decline in appetite, without</p>	L 533 L 545	<p>Hospice will ensure the appropriateness of the content of the plan of care.</p> <p>Hospice will continue utilizing the format for the comprehensive plan of care as found within its electronic medical record. Hospice clinical staff, including nursing, social work and chaplain, will specifically address each system section of the plan of care with identification of problems, goals and interventions as determined by the hospice interdisciplinary team, including the hospice physician, in conjunction with the patient and family wishes.</p> <p>Following the plan of correction for the comprehensive assessment will ensure that the clinical staff have the appropriate information to generate a comprehensive plan of care. Any actual or potential problems identified within the assessment will receive further evaluation by the appropriate discipline and interdisciplinary team in an attempt to determine the cause of the actual of potential problems.</p> <p>Ongoing assessment of the patient, including and new problems or unmet needs, will be updated on the</p>	

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L 545	<p>Continued From page 9</p> <p>nausea or vomiting, or other specific pains. Additionally, he was noted to have a UTI, for which he was treated with oral antibiotics. The H&amp;P did not include documentation related to level of pain, or evidence of chronic pain. The discharge sheet from his hospitalization included a referral for hospice services.</p> <p>Patient #4's SOC assessment, dated 7/18/15, documented his pain at a level 2/10. The pain assessment included the comment "Pt denies pain but does demonstrate occasional grimaces and moaning or groaning. Pt also c/o pain in his knees on occasion according to facility staff." Additionally, the RN who performed the admission assessment noted Patient #4 was receiving Hydrocodone/APAP 7.5/325 mg four times daily, as well as, a Fentanyl patch for pain.</p> <p>His SOC assessment also included a fall risk assessment, with a score of 8. The fall risk assessment noted a score of 4 or greater was considered "at risk" for falling. The RN documented he required a 2 person assist for transfers.</p> <p>Patient #4's POC dated 7/18/15, included a problem list. One problem was identified as "Chronic Pain." The section "Goals" included "Patient's pain will be managed effectively through cert." The section "Interventions," included "Assess pain every visit, Teach Med Regimen, Other." There was no further description as to what "other" meant.</p> <p>His POC problem list also included "At high risk for falls." The section "Goals," included "Patient's safety will be maintained through cert. Pt will be free from falls through cert. Falls will be reported</p>	L 545	<p>interdisciplinary plan of care at least every 14 days, and more frequently as needed based on the patient's individual ongoing comprehensive assessment. Goals and interventions, specifically including the caregiver's ability to perform interventions necessary to meet patient's needs will be assessed and documented within the visit notes as evaluated by the members of the interdisciplinary team each visit.</p> <p>Hospice will ensure that all clinical staff are re-educated to the process and components of the comprehensive plan of care through a mandatory inservice to occur in the parent location, as well as each of the two multiple locations. The inservice will address the necessity of assessing each component of the comprehensive plan of care at each patient visit, including appropriateness and effectiveness of the interventions on the patient's condition. The inservices will be completed in each location prior to October 30, 2015.</p> <p>To ensure ongoing compliance with the plan of correction, hospice director will conduct interdisciplinary team meetings at intervals no longer than 14 days, and more frequently as needed.</p>	

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L 545	<p>Continued From page 10 to hospice through cert." The section "Interventions," included "Teach pt and staff safety measures as needed. Pt requires 2 person assistance with transfers, ambulation and showers."</p> <p>Patient #4's record documented multiple changes in his condition, however, his POC did not reflect IDG updates and interventions that were reflective of his changing needs, as follows:</p> <p>a. Nursing visit notes dated 7/22/15 at 6:00 PM, stated "CG staff reports that pt was found on floor this morning, he has no injuries. Pt is weak and requires a 2 person assist with all transfers. Pt denies any pain at this time." The nursing visit note documented Patient #4 was up for only 1 meal that day, and remained in bed the rest of the day.</p> <p>IDG notes dated 7/22/15 by the RN Case Manager, stated "Pt's appetite is very poor, pt rarely eats meals. Pt spends most of his time in his room in bed, refusing to come out most of the time. Pt has lost more than 10 pounds over the past month."</p> <p>Patient #4's POC did not reflect changes based on his ongoing assessments and IDG discussions. No changes were made to his POC.</p> <p>b. Nursing visit notes 8/05/15 at 4:20 PM, stated "B/P 92/48. Pt is hypotensive today...Pt denies any pain...Pt was only up for one meal, he ate about 1/4 of his breakfast today."</p> <p>IDG notes dated 8/05/15 by the RN Case Manager, stated "Pt has lost more weight per HHA report. Pt is eating a little better than he has</p>	L 545	<p>The hospice director and medical director will review the plan of care at the interdisciplinary team meetings to ensure their appropriateness of the plan of care for the each patient.</p> <p>The interdisciplinary team will conduct monthly peer reviews of selected re-certification comprehensive assessments. The quality assurance performance improvement staff will conduct audits of 100% of all hospice admissions within 14 days to ensure appropriateness of comprehensive plan of care based on findings of comprehensive assessment.</p> <p>The administrator is responsible to make sure the comprehensive plan of care inservice is completed in each office prior to October __, 2015. The administrator will also supervise the peer review audits overseeing the selection of records to be audited and the compilation of the peer suggestions and follow through by interdisciplinary staff with any plan of care updates to be completed.</p>	October 30, 2015

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L 545	<p>Continued From page 11</p> <p>previously but not much. Pt has been found on the floor several times in the mornings and has some bruising on his arms."</p> <p>Patient #4's POC remained unchanged. His hypotension, decreased appetite, weight loss, and falls were not addressed and additional interventions were not implemented.</p> <p>c. Nursing visit notes dated 8/12/15 at 8:40 AM, stated "B/P 92/60, Pt is hypotensive...Pt denies having any pain at time of visit. Patient did not eat any of breakfast."</p> <p>Nursing visit notes dated 8/19/15 at 12:17 PM, stated "B/P 92/48, Pt denies having any pain, facility staff reports that he apparently had 2 falls on Tuesday last week that were just reported to this nurse. Facility has not got an accurate weight on him. He went from 111 to 151 to 200."</p> <p>IDG notes dated 8/19/15, did not include changes to his POC. However, Patient #4's hypotension, decreased appetite and falls were not addressed and additional interventions were not implemented. Additionally, Patient #4's nursing notes indicated his pain was minimal, he was hypotensive, and those details were not addressed during the IDG.</p> <p>d. Nursing visit notes dated 8/24/15 at 3:40 AM, documented "B/P 100/56, Pt has no pain. Notified of fall and treatment. SN arrived to find pt in bed and staff cleaning floor where he had crawled off of mattress and across carpet creating abrasions."</p> <p>Nursing visit notes dated 8/25/15 at 9:45 AM, stated "B/P 120/60, no falls since Sunday. no</p>	L 545		

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L 545	<p>Continued From page 12</p> <p>s/sx [signs or symptoms] of pain...Pt is in bed, stated that he was tired of all of this and was ready to die. Pt has multiple skin tears, abrasion, and bruises to arms and legs."</p> <p>IDG notes dated 9/02/15, documented "Pt pain meds were d/c [discontinued] and now are PRN per family request. Pt did have pain in his abdomen. Pt has been falling out of bed and has wounds on his BIL [bilateral] legs from falls."</p> <p>Patient #4's POC remained unchanged, the IDG notes did not include discussion related to his frequent falls, or implement interventions to prevent further falls. Additionally, the IDG notes did not include wound care. His pain medications were changed to prn, however, Patient #4 continued on the Fentanyl patch. The IDG notes did not indicate if his family was aware he continued with the Fentanyl patch.</p> <p>e. An incident report dated 9/12/15, stated "[Staff] came into the pt room to check on him and found him on the floor." A second incident report dated 9/13/15, stated "When they [staff] went by his room he was lying in the floor on his L side."</p> <p>IDG notes dated 9/16/15, did not reference to the fall incidents on 9/12/15 and 9/13/15. The problem list with identified problems of fall risk and chronic pain were not updated or reflective of his changing needs. Additionally, the IDG POC did not include wound care orders for the wounds he developed as a result of the fall on 8/24/15.</p> <p>As of the 9/16/15 IDG, Patient #4 was on hospice services for 9 weeks, and had 5 IDG conferences documented. However, his problem list, goals, and interventions remained unchanged from the</p>	L 545		

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L 545	<p>Continued From page 13 original POC which was implemented the day he started on hospice services.</p> <p>During a phone interview interview on 9/17/15 beginning at 9:15 AM, the RN Case Manager reviewed Patient #4's record and confirmed the frequency of his falls. She stated he had a fall mat and a low bed was ordered, but he did not have it yet. The RN Case Manager was asked about a bed or chair alarm, and she stated she did not think about that, but it was a good idea. The RN Case Manager stated the facility kept Patient #4 in bed all day and she thought that maybe if he was up out of bed more frequently, he would have less falls and probably would rest better when he was in bed. The RN Case Manager was asked about the pain medication Patient #4 was on. She stated his family did not want him on so much pain medications and the hydrocodone was changed from 4 times daily to prn. She confirmed he continued to have the Fentanyl patch for chronic pain. The RN Case Manager confirmed Patient #4's record did not include documentation of chronic pain and stated he was on a Fentanyl patch when he was admitted to hospice services. She confirmed Patient #4's POC did not include wound care orders for cleaning and dressing his wounds that he had developed on 8/24/15 after falling out of bed. When asked about Patient #4's documented hypotension, the RN Case Manager confirmed she did not consider his pain medications to be a factor and did not discuss hypotension during the IDG meetings. She confirmed he was still receiving anti-hypertensive medications.</p> <p>The IDG failed to implement interventions and update the POC as Patient #4's needs changed.</p>	L 545		

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L 545	<p>Continued From page 14</p> <p>2. Patient #1 was a 69 year old female who was admitted for hospice services on 8/19/15. She was cared for by her daughter. Her terminal diagnosis was Huntington's Disease. She was currently a patient as of 9/16/15.</p> <p>An H&amp;P, dated 8/17/15, stated Patient #1 was not able to eat any type of solid food but could drink a little bit of thickened fluids. The document stated she was losing weight rapidly. The document stated she was not able to get out of bed and was beginning to have skin breakdown.</p> <p>A SOC assessment by the RN, dated 8/19/15, stated Patient #1 "...is now bed bound and dependent for all ADLs and all cares. Pt has involuntary jerking or writhing movements, muscle problems, such as rigidity and muscle contractures and muscle spasms. Pt is non verbal at this time, unable to make any of her needs know. Pt is very thin with her bones protruding, she is likely to weigh around 80 lbs. Pt is not able to take in any solid foods, now only able to take thickened liquids and is choking on them. Pt family states that she is rapidly losing weight and not able to sleep for more then about 2 hours at a time d/t her disease, muscle spasms and contractures. Pt is quite emaciated, all care including oral cares are very difficult d/t choreiform [jerky involuntary] movements. Pt's family states that she is not safe anywhere but in her bed."</p> <p>The SOC assessment stated Patient #1 was a high fall risk. The DPS for the multiple location, interviewed on 9/15/15 beginning at 3:25 PM, stated Patient #1 had frequent involuntary muscle movements which could cause a fall from the</p>	L 545		

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L 545	<p>Continued From page 15</p> <p>bed. She stated Patient #1 had a hospital bed with side rails and the family placed blankets over the rails to protect her from bruises. Also, the DPS stated Patient #1 and her family only spoke Spanish.</p> <p>The POC, dated 8/23/15 and still current, included problems of "Malnutrition" and "Dysphagia." Interventions for both problems stated "Intervention Type: Diet/Fluids as tolerated, Teach oral hygiene, Teach comfort/symptom control, Other." Falls was not listed as a problem. No plans addressed the involuntary movements, side rails, or side rail padding. No plans addressed how staff would communicate with the Patient #1 and her family.</p> <p>The DPS for the multiple location was interviewed on 9/15/15 beginning at 3:25 PM. She confirmed the POC did not address the above items.</p> <p>Patient #1's POC was not comprehensive.</p> <p>3. Patient #7 was a 97 year old female who was admitted for hospice services on 1/31/15. She lived in an ALF. Her terminal diagnosis was a fractured hip. She was currently a patient as of 9/16/15.</p> <p>A physician note from an local Emergency Department, stated Patient #7 was diagnosed with the fracture on 1/30/15 at 12:40 AM. Patient #7 was kept at the hospital for a day and was discharged back to the ALF on 1/31/15, Hospice care also began on 1/31/15.</p> <p>A SOC assessment by the RN Case Manager, dated 1/31/15 but not timed, stated Patient #7 had a fractured femur. The assessment stated</p>	L 545		

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L 545	<p>Continued From page 16</p> <p>Patient #7's family had decided not to surgically correct the fracture. The assessment stated "Pt is being treated with Bactrim for the next 5 days for UTI. Pt has been losing weight steadily over several years. Family reports she was at one time 140 lbs, but is now 96 lbs...Pt is now on 5 L [liters] oxygen via mask and oxygen sats are 86%, pt is lethargic and oriented to person and self only. Family reports she did not eat yesterday, but has eaten lunch today...Is now non-ambulatory and non-weight bearing due to hip fracture. Will be total cares in bed. Cannot tolerate sitting at this time. Has Foley [catheter] ordered for comfort."</p> <p>Patient #7's POC included problems of left hip fracture, hip pain, bed bound, and hypoxemia. The POC for hip fracture stated "Intervention Type: Other: Non-operative, comfort measures, Teach aides palliative care of hip fracture." The POC for hip pain stated "ComfortPak for pain, Assess pain every visit, Teach med regimen, Other." The POC for bed bound status stated "Intervention Type: Prevent skin breakdown, Other." The POC for hypoxemia stated "Intervention Type: Oxygen, Comfort and symptom control, Educated on care of DMEs, Other." Specific plans of care, including specific direction to staff to address Patient #7's care needs, were not documented.</p> <p>Patient #7's RN Case Manager was interviewed on 9/17/15 beginning at 9:55 AM. She confirmed POCs with specific direction to staff caring for Patient #7 were not developed.</p> <p>Patient #7's POC was not comprehensive.</p> <p>4. Patient #8 was a 79 year old female admitted for hospice services on 6/12/15. Her terminal</p>	L 545		

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L 545	<p>Continued From page 17</p> <p>diagnosis was Alzheimer's Disease. She lived in an ALF, a facility without licensed caregivers. She fell on 9/09/15 and suffered fractures of her left shoulder and left hip. Following a visit to a local Emergency Department, she returned to the ALF on the evening of 9/09/15 without surgical intervention or reduction of the fractures. She died on 9/11/15.</p> <p>An "RN Certification" assessment, dated 9/09/15 but not timed, stated Patient #8 had severe pain from the fractures.</p> <p>Patient #8's POC, dated 9/09/15, included problems of pain, risk of skin breakdown, risk of falls, anticipatory grief, uncontrolled pain, and hypoxemia.</p> <p>The plan for pain stated "Problem: Name: Pain Description: Pt is in intermittent pain as demonstrated by grimacing and tenseness. Goal: Patient's pain will be managed effectively through cert Problem: Pain Reason: Identified: 06/12/2015 Resolved: Intervention Type: Assess pain every visit, Teach med regimen, Other [sic]."</p> <p>The plan for uncontrolled pain stated "Problem: Name: Uncontrolled pain Description: Continuous care for uncontrolled pain d/t multiple injuries from recent fall. Goal: Patient's pain will be managed effectively through cert Problem: Pain Reason: Identified: 09/09/2015 Resolved: Intervention Type: Other: Continuous care to manage pain and other symptoms [sic]."</p> <p>The plan for risk of skin breakdown stated "Problem: Name: Risk for skin breakdown Description: Pt is at high risk for skin breakdown</p>	L 545		

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L 545	<p>Continued From page 18</p> <p>d/t immobility and incontinence. Goal: Any s/s of skin breakdown will be reported through cert Pt will be free from skin breakdown through next cert. Problem: Skin Reason: Identified: 06/12/2015 Resolved: Intervention Type: Teach comfort and symptom control, Prevent skin breakdown, Other: SN to teach staff to reposition pt frequently to prevent skin breakdown as needed [sic]."</p> <p>The POC did not provide specific direction to staff regarding how to care for a patient with 2 new untreated fractures or how to manage her pain and meet her ADL needs.</p> <p>Even though the POC stated Patient #8 would receive continuous care beginning 9/09/15, nursing progress notes showed hospice staff left Patient #8 in the sole care of the ALF from 9:20 PM on 9/09/15 to 9:30 AM on 9/10/15. After that, hospice nurses provided care for Patient #8. The POC did not address how hospice staff would monitor and supervise care provided by ALF staff.</p> <p>The RN Case Manager for Patient #8 was interviewed on 9/16/15 beginning at 2:05 PM. She confirmed the POC did not specifically address interventions to control pain and to provide care to meet Patient #8's ADL needs.</p>	L 545		
L 569	<p>Patient #8's POC was not comprehensive.</p> <p>418.58(c)(2) PROGRAM ACTIVITIES</p> <p>(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.</p>	L 569	<p>Hospice will ensure the quality assurance performance improvement program activities of the company track all adverse events and analyze their causes for the implementation of preventative action.</p>	

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L 569	Continued From page 19  This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and incident reports, it was determined the hospice failed to ensure the causes of adverse patient events were analyzed and preventive actions were implemented to prevent future adverse patient events. This directly affected the care of 2 of 2 patients (#4 and #8) who fell while on hospice and whose records were reviewed. This prevented the hospice from developing plans to prevent further injuries and to ensure appropriate care was provided. Findings include:  1. Patient #8 was a 79 year old female admitted for hospice services on 6/12/15. Her terminal diagnosis was Alzheimer's Disease. She fell in the ALF where she lived on 9/09/15 and fractured her left hip and left shoulder. She died on 9/11/15.  The RN Case Manager conducted a visit to Patient #8 on 9/09/15. Her progress note, dated 9/09/15, stated the visit was conducted on 9/09/15 from 3:30 PM to 9:20 PM. The note stated Patient #8 "...was sitting in recliner when SN first arrived. On arrival pt looked comfortable, no s/s of pain. SN began assessment of pt. When measuring pt's [arm circumference], SN noticed a large bruise on pt's L bicep. SN and HHA were going to take pt to the other building to get a current weight on pt. When SN and HHA stood pt to transfer her to WC, pt began grimacing a lot and was shaking and became diaphoretic. Pt was placed in WC and wheeled into bathroom to toilet and further assess pt. Upon further assessment, SN found a golf ball sized lump below pt's L elbow. The lump was	L 569	Hospice will utilize the electronic medical record for the documentation, and tracking of all incidents or adverse events. Any incident or adverse event witnessed by or reported to hospice staff will be documented in the patient's clinical record as well as the hospice's incident tracking.  Quality assurance performance improvement chart audits, as well as monthly peer review audits completed, as part of the hospice's QAPI program, will monitor for any unplanned outcomes which may be attributable to an unreported incident, fall or other adverse events. Any findings of such outcomes will trigger the incident tracking process and documentation.  Hospice will track such incidents including but not limited to; infections, complaints, grievances, other incidents and specifically falls. Incident documentation will include any precipitating events, causal factors as well as immediate assessment and interventions for patient comfort and safety.	

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L 569	Continued From page 20 soft but protruding. At this time, SN called another nurse from hospice to come assist with further assessment. HHA and facility staff, [name], began to undress pt to shower before weighing. After removing pt's shirt, it was noticed that pt's L shoulder was very large and swollen. D/t pt being very sweaty, HHA and ALF staff, quickly cleaned pt up and placed a nightgown on pt to make it easier to put on and remove. [The second] RN arrived from hospice to assist SN with assessment. On further transfers, it was noted that pt was not bearing weight on L leg, no noticeable bruising on leg but pt does appear to be turned in slightly. It was determined after discussing with facility administrator [the hospice] RN and pt's family, that pt would be transported to the hospital for xrays and physician assessment. SN and HHA went to hospital with pt and family to assist with transferring and to give physician a report of what was thought to have happened at approx 16:50. SN and HHA assisted lab tech to transfer pt from WC to x-ray table at approx 17:40...Xrays were completed at approx 18:20 and it was determined that pt had a [fractured] proximal humerus and a [fractured] femur. SN reviewed xrays with physician and discussed the options before having discussion with family. Based on pt's VS obtained at the hospital, of a BP of 70's/40's and HR in the 40's, physician determined that pt was not a candidate for surgery. Physician and SN discussed this with family and determined that the options were to keep pt in the hospital for pain management or to obtain IV access and to send pt back to ALF with scheduled pain medications and to maintain pain control there via hospice, until pt passed away. Pt's family made the decision to return pt to [the ALF] so she could be in a more comfortable environment and to provide pain control there. SN	L 569	All incident documentation will be reviewed every 14 days as part of the interdisciplinary meeting process. The clinical director will track any trending of incidents such as infections, falls, etc. The interdisciplinary team, under the direction of the clinical director will also assess the appropriateness of primary intervention and plan of care updates related to each incident documentation. The interdisciplinary team will address and assess causative factors with comprehensive plan of care updates for any patient or patients effected by the trending.  Hospice will ensure that all clinical staff are re-educated to the process and components of proper incident or adverse event tracking through a mandatory inservice to occur in the parent location, as well as each of the two multiple locations. The inservice will address the necessity of documenting each incident or adverse event, with specific direction as to the components of the documentation. The inservices will be completed in each location prior to October 30, 2015.	

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L 569	Continued From page 21 assisted hospital RN...to place a shoulder immobilizer on pt. Pt was transferred back to the facility via ambulance and stretcher at approx 19:30. Pt is placed on strict bed rest, with oral pain medication scheduled every 2 hours with the option of providing IV pain medication every 30 minutes as needed to maintain pain control. SN instructed facility staff on scheduled pain medication and prefilled syringes so scheduled pain medication could be given by ALF staff. SN instructed staff that if this wasn't enough to maintain pain control for pt, to call hospice on call and we could provide additional pain medications if needed, including PRN oral and IV medication. Staff [verbalized understanding]. SN also instructed staff that if pt was able to swallow and tolerate oral liquids and hydration well, to offer them, as well as pt's regularly scheduled medications but if at any time, pt had difficulty swallowing or tolerating them, to just provide comfort oral care frequently. Staff [verbalized understanding]. Pt was given an ensure after arrival back to ALF facility. Pt was able to drink that through a straw and swallow it well. SN assisted HHA to turn and change pt's depends in bed. Pt administered 2 mg of IV morphine at 20:00 d/t increased pt grimacing and shaking after turning and repositioning. When SN left pt, pt appeared comfortable, no grimacing noted. SN reinforced teaching to staff and instructed them to call if at any time pt's pain increased and they needed additional pain medication...Pain 8/10. throbbing, continuous."  The progress note stated the RN left at 9:20 PM. The next progress note by hospice nursing staff was dated 9/10/15 beginning at 9:30 am. Patient #8 was left in the exclusive care of the ALF. The ALF was staffed by non-professional personnel.	L 569	To ensure ongoing compliance with the plan of correction, hospice director will conduct interdisciplinary team meetings at intervals no less frequently than every 14 days, and more frequently as needed. The hospice director and medical director will review all incident documentation at the interdisciplinary team meetings to ensure the appropriateness of the causal assessment, primary interventions and determine if any further intervention is needed.  The administrator is responsible to make sure the incident reporting inservice is completed in each office prior to October __, 2015. The administrator will ensure that all incident tracking is logged and submitted to the director of quality assurance performance improvement not less that quarterly. The director of quality assurance performance improvement will compile all incident tracking and provide additional assessment and trending of data for reporting to the professional advisory committee and governing body. Professional Advisory Committee will utilize data to create the performance improvement plan related to the findings for the following quarter.	October 30, 2015

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L 569	<p>Continued From page 22</p> <p>The 9/09/15 progress note did not include an assessment of the number of ALF staff on duty or their ability to care for a patient with 2 new fractures. The 9/09/15 progress note stated Patient #8 was grimacing and shaking after turning and repositioning. The assessment stated Patient #8 was incontinent. The assessment did not include information related to the ability of staff to comfortably turn and position Patient #8 or keep her clean. Specific ALF staff training and a specific plan for ALF staff to care for Patient #8 were not documented.</p> <p>The 9/09/15 progress note stated a second RN examined Patient #8 for injuries. The second RN did not document his findings.</p> <p>The 9/09/15 progress note stated Patient #8 was physically transferred several times by hospice personnel. It was not clear how many times Patient #8 was physically transferred after a fracture was suspected.</p> <p>The RN Case Manager, who accompanied Patient #8 to the hospital, was interviewed on 9/16/15 beginning at 2:05 PM. She stated Patient #8 was taken from the ALF to the hospital via wheelchair in the ALF van. An assessment of the safest mode of transfer was not documented.</p> <p>Patient #8's pain was poorly controlled. Nursing notes by RNs documented the following:</p> <p>9/10/15 from 9:30 - 10:30 AM. "Pt was moaning and lifting right leg, gave morphine at 0930 to help with pain, Pt continued to be agitated, SN gave 0.25 ml of lorazepam for agitation at 1015."</p> <p>9/10/15 from 11:00 AM - 1:20 PM. "Pt is bed</p>	L 569		

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L 569	<p>Continued From page 23</p> <p>bound, needs extensive 2 person assist with turning and repositioning d/t pain. Pt frequently kicks and moves right leg resulting in leg falling out of bed and movement of left leg. Pt was very restless through most of visit, kicking R leg out of bed. Pt became extremely grimaced, moaning and crying when SN and ALF staff turned pt. [sic] SN administered pain medications, including PRN's during visit...SN administered PRN pain medications before and after turning and changing pt to get in control of pain and to make pt comfortable. Pt continued to kck her R leg up and down and move it until it would fall off the side of the bed. SN and ALF staff...positioned a pool noodle beneath the right side of mattress to prevent pt from kicking her leg out of bed."</p> <p>SN 9/10/15 from 7:05 - 11:59 PM. "Pt loosened grip of hands slightly but remained with leg movement and restlessness evident. 1935: haldol 0.25 ml [administered under the tongue] for restlessness. Pt visibly decreased clenching within 10 minutes. 1950: MS 0.25 ml SL per MAR for episode of extreme pain with clenching and screaming. Relaxed by 2000. HR 100. 2010: lorazepam 0.5 ml SL per MAR d/t [heart rate] increased to 110 and pt clenching and crying and wringing hands. Pt heart rate 98 and respiration 12 and deep but breakthrough pain spasms evident every 5-10 minutes. 2030 0.25 ml MS SL given for breakthrough pain. 2050: haldol 0.25 ml SL for restlessness and gasping for air. Gasping respirations ceased but pt still clenching hands and tension assessed in rigidity of body. Lorazepam per MAR 0.25 ml SL at 2120 for agitation with hand clenching. MS 0.25 ml SL at 2210 for pain management with bed bath. Inserted Tylenol suppository per MAR for temp of 100 during bed bath at 2235. Pt tolerated well.</p>	L 569		

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L 569	<p>Continued From page 24</p> <p>Haldol per MAR 0.25 ml SL given for restlessness at 2245. Breakthrough pain at 2325 MS 0.25 ml SL given per MAR... SN reassessed at 2320 and noted apnea episodes up to 15 seconds with respirations ranging from 10-16 per minute. Pt HR down to 72 but pt arching right leg and moaning intermittently with breakthrough pain spasms. Lungs diminished and apneic episodes increased to 30 second episodes."</p> <p>9/11/15 from 12:00 - 8:00 AM. "SN assessed at 0000 apneic episodes increasing with diminished lung sounds. HR 86 pedal pulses faintly palpable. Breakthrough pain assessed with arching right leg and moaning with spasms. MS per MAR. Agitation and restless movement continued. Haldol per MAR at 0030. Oral cares completed. Medications per MAR [hourly] or more for pain and restlessness from 0055-0745. SN reassessed at 0055 with temp 97.6, lungs diminished, apical pulse decreased to 68, pulses palpable, [oxygen saturation level] 71% RA [room air]. SN reassessed 0155 [oxygen saturation level] 69% RA, Apical pulse 58. Grimacing, grasping, clenching present. Meds per MAR. Apnea persists with respirations 8, SN reassessed at 0200 and pt warm and clammy with temperature of 98.2. Rinsed with cool cloth. Meds per MAR. Respirations 8 with Cheyne stokes evident. Apnea 20 second intervals. Respirations remain symmetrical but gasping air hunger noted. Haldol per MAR. Repositioned to back with HOB [head of bed] slightly elevated. Pt rested. SN reassessed at 0250 apical heart rate 54 respirations 8. Breakthrough pain spasms evident and pt received MS per MAR. Repositioned 0300 with pillows: pt with increased restlessness after repositioning and received lorazepam 0.5 ml SL. Pt rested. Pt with</p>	L 569		

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L 569	<p>Continued From page 25</p> <p>breakthrough pain and MS administered at 0355. Restlessness increased and pt given lorazepam per MAR at 0415. Pt with increased gasping and air hunger. Haldol per MAR at 0425. Removed pillows to reposition legs 0430. Clammy skin noted. Cool Cloth to extremities/face at 0445. Breakthrough pain with movement noted. Pt received MS per MAR at 0450. SN reassessed pt. Respirations atonal, ineffective. Lungs diminished severely. Apical heart rate 45 with respirations of 8. [Oxygen saturation level] not reading. Skin gray. Gasping for air. Haldol per MAR for air hunger at 0520. Removed pillows to reposition. Tolerated well...SN reassessed at 0600. Pt remains apneic with 30 second intervals and respirations of 8, gasping returned. Haldol per MAR at 0620 for restlessness and air hunger. Premedicated with MS for pain management during bed bath at 0640. Aide assisted with bed bath and Tylenol suppository inserted by SN during pericare and attend change for low grade fever, warm, moist skin at 0700. Repositioned after bed bath. Pt with increased agitation after cares. Apical heart rate 72, respirations 10 with apneic episode of 30 seconds. Received lorazepam per MAR at 0710. Pt apical rate persisted at 72 and breakthrough pain noted at 0745 and pt received additional MS per MAR. Pt resting at 0800."</p> <p>An assessment to determine whether Patient #8's restlessness was caused by pain or other factors was not documented. She was medicated with Lorazepam, an antianxiety medication, and Haldol, an antipsychotic medication, from hospice standing orders, dated 6/12/15. Patient #8 had Morphine ordered IV or sublingual from the hospital for breakthrough pain. After 8:00 PM on 9/09/15, the IV Morphine was not documented as</p>	L 569		

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L 569	<p>Continued From page 26</p> <p>given, even though this was a more effective and reliable route of administration. The reason the Morphine was given sublingually was not documented. A specific plan to control Patient #8's pain was not documented.</p> <p>A MAR for medications administered to Patient #8 by hospice staff was not implemented. This made it impossible to know which medications were administered by hospice staff. The RN Case Manager, interviewed on 9/16/15 beginning at 2:05 PM, stated she failed to document at least 1 medication she administered.</p> <p>A causal analysis of the fall and the staff response to it was not documented. A hospice incident report, dated 9/10/15, stated Patient #8 fell in the ALF about 11:30 AM on 9/09/15. The incident report stated ALF staff put Patient #8 back in her wheelchair. The incident report stated Patient #8 showed signs of injury and was transported to a hospital. Under the heading "Corrective action," the incident report stated "Taught ALF staff to report any falls or incidents as soon as they occur." The incident report stated, after the fall, a hospice nurse identified injuries during the recertification visit. The incident report did not mention any action or care provided by hospice staff to Patient #8.</p> <p>A document titled "Incident Investigation Documentation," written 9/16/15, stated ALF staff did not report Patient #8's fall to hospice staff. The document stated the physician "stabilized the patient's comfort level and discharged the patient back to [the ALF] under the care of the hospice team, who initiated continuous care level of care to appropriately treat patient's pain and meet other needs." The investigation document</p>	L 569		

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L 569	<p>Continued From page 27</p> <p>concluded "Through our investigation in interviewing of staff including the hospice director; hospice RN Case Manager and hospice aide, as well as facility administration, we believe that Access staff took appropriate and timely action in assessment and intervention of the patient's needs..." The investigation focused on the delayed notification by the ALF, but did not include information related to the care provided by hospice staff.</p> <p>The investigation document stated hospice provided continuous care until Patient #8's death on the evening of 9/11/15. The document did not say hospice staff provided no direct care for 12 hours following Patient #8's return from the Emergency Department. Instead, continuous care was not started until approximately 10:00 AM on 9/10/15 and Patient #8 was left in the exclusive care of ALF staff for over 12 hours. The document did not assess why the implementation of continuous care was delayed or whether this was appropriate.</p> <p>The investigation document did not state why the hospice RN allowed Patient #8 to be taken to the Emergency Department in a wheelchair in the ALF van instead of being transported by ambulance.</p> <p>The investigation document did not assess whether actions by hospice staff, including the multiple transfers following the identification of injuries and the method of transport, may have caused increased injury and pain to Patient #8.</p> <p>The Director of Administrative Services called the state survey agency on 9/14/15 at 10:52 AM to report the incident regarding Patient #8. He</p>	L 569		

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L 569	<p>Continued From page 28 provided the "Incident Investigation Documentation" on 9/16/15.</p> <p>The Director of Administrative Services was interviewed on 9/24/15 beginning at 10:00 AM. He stated he spoke with employees from the ALF and hospice regarding Patient #8. He stated the hospice did not have a defined procedure to investigate incidents. He stated the hospice met the definition of "continuous care" provided to Patient #8 but he did not know if the hospice care was continual. He stated he did not know if hospice staff assessed the ability of the ALF to care for Patient #8. He stated Patient #8 did not have a specific plan for pain control. He stated he was not aware if all medications given by hospice staff were documented.</p> <p>The hospice did not thoroughly investigate Patient #8's adverse patient event and did not analyze the care provided by hospice staff.</p> <p>2. Patient #4 was an 85 year old male who was admitted to hospice on 7/14/15, with a terminal diagnosis of Alzheimer's disease. Additional diagnoses included Type II Diabetes, Hypertension, and Osteoarthritis. Patient #4 resided in an ALF.</p> <p>His SOC assessment dated 7/14/15, included a fall risk assessment, with a score of 8. The fall risk assessment noted a score of 4 or greater was considered "at risk" for falling. The RN documented he required a 2 person assist for transfers.</p> <p>Patient #4's POC dated 7/18/15, included a problem list that noted "At high risk for falls." The section "Goals," included "Patient's safety will be</p>	L 569		

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ACCESS HOSPICE CARE	240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202

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L 569	<p>Continued From page 29</p> <p>maintained through cert. Pt will be free from falls through cert. Falls will be reported to hospice through cert." The section "Interventions," included "Teach pt and staff safety measures as needed. Pt requires 2 person assistance with transfers, ambulation and showers."</p> <p>Patient #4's record documented 8 falls in the 9 weeks he was on hospice, however, the agency did not demonstrate analysis of why he was falling, interventions, and measures to prevent further falls from occurring. Patient #4's record documented the following:</p> <p>7/22/15 at 6:00 PM, Nursing visit notes stated "CG staff reports that pt was found on floor this morning, he has no injuries. Pt is weak and requires a 2 person assist with all transfers. Pt denies any pain at this time." The nursing visit note documented Patient #4 was up for only 1 meal that day, and remained in bed the rest of the day. There was no incident report initiated after the fall.</p> <p>7/22/15 IDG notes did not include analysis of his recent falls, and interventions were not implemented to prevent further falls. No changes were made to his POC.</p> <p>8/05/15 IDG notes, submitted 8/05/15 by the RN Case Manager, stated "Pt has been found on the floor several times in the mornings and has some bruising on his arms." The IDG notes did not include an analysis of why he was falling, or interventions to prevent falls from occurring. There were no incident reports to document his falls.</p> <p>Patient #4's POC remained unchanged. His falls</p>	L 569		

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

PRINTED: 10/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  131552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/17/2015
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HOSPICE CARE	240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202

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L 569	<p>Continued From page 30 were not addressed and additional interventions were not implemented.</p> <p>8/19/15 at 12:17 PM, Nursing visit notes stated "B/P 92/48, Pt denies having any pain, facility staff reports that he apparently had 2 falls on Tuesday last week that were just reported to this nurse." There were no incident reports to document his falls.</p> <p>8/19/15 IDG notes were reviewed. The notes did not include analysis of the falls and no changes were made to his POC.</p> <p>8/24/15 at 3:40 AM, Nursing visit notes stated "B/P 100/56, Pt has no pain. Notified of fall and treatment. SN arrived to find pt in bed and staff cleaning floor where he had crawled off of mattress and across carpet creating abrasions." There was no incident report initiated after the fall.</p> <p>8/25/15 at 9:45 AM, Nursing visit notes, documented "B/P 120/60, no falls since Sunday. No s/sx [signs or symptoms] of pain...Pt is in bed, stated that he was tired of all of this and was ready to die. Pt has multiple skin tears, abrasion, and bruises to arms and legs."</p> <p>9/02/15 IDG notes stated "Pt pain meds were d/c [discontinued] and now are PRN per family request. Pt did have pain in his abdomen. Pt has been falling out of bed and has wounds on his BIL [bilateral] legs from falls." Patient #4's POC remained unchanged. The IDG notes did not include discussion related to his frequent falls or potential interventions to prevent further falls.</p> <p>An Incident Report dated 9/12/15, stated "[Staff]</p>	L 569		

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NAME OF PROVIDER OR SUPPLIER  ACCESS HOSPICE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 240 WEST BURNSIDE AVENUE, SUITE B GHUBBUCK, ID 83202
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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 569	<p>Continued From page 31</p> <p>came into the pt room to check on him and found him on the floor" and an Incident Report dated 9/13/15, stated "When they [staff] went by his room he was lying in the floor on his L side."</p> <p>9/16/15 IDG notes were reviewed. The notes stated there were no changes and information related to the fall incidents on 9/12/15 and 9/13/15 was not present in the notes. The problem list with identified problems of fall risk was not updated or adapted to his changing needs.</p> <p>During a phone interview on 9/17/15 beginning at 9:15 AM, the RN Case Manager reviewed Patient #4's record and confirmed the frequency of his falls. She stated he had a fall mat, and she had just ordered a low bed, but he did not have it yet. The RN Case Manager was asked about a bed or chair alarm, and she stated she did not think about that, but it was a good idea. The RN Case Manager stated the facility kept Patient #4 in bed all day, and she thought that maybe if he was up out of bed more frequently, he would have less falls and probably would rest better when he was in bed.</p> <p>The hospice did not track patient falls, analyze their cause, and implement interventions for prevention as patients needs changed.</p>	L 569		



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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October 6, 2015

Chad Mangum, Administrator  
Access Hospice Care  
240 West Burnside Avenue, Suite B  
Chubbuck, ID 83202

Provider #131552

Dear Mr. Mangum:

An unannounced on-site complaint investigation was conducted from September 15, 2015 to September 17, 2015 at Access Hospice Care. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006397**

**Allegation #1:** The Hospice Medical Director did not attend Interdisciplinary Group (IDG) conferences.

**Findings #1:** During the investigation, 9 records of patients who were receiving hospice services, from 12/01/13 to 9/17/15, were reviewed and staff members from the main office and 2 multiple locations were interviewed.

Nine records were reviewed for meeting minutes and documentation of staff attendance at the IDG meetings. The records all included evidence of physician participation at all IDG meetings either in-person or via conference call, as well as attending physician communication.

For example, 1 record reviewed was that of a patient who was admitted to hospice services 12/01/13. The patient resided at an Assisted Living Facility. IDG meeting minutes were reviewed for the 20 month period the patient was on hospice services. The electronic medical record included documentation of physician oversight for each of the IDG meetings.

During a phone interview on 9/17/15 beginning at 9:15 AM, the Registered Nurse (RN) Case Manager stated the IDG meetings included a physician medical director. She stated they were held every two weeks, and each office had their own medical director assigned.

It could not be determined that the Medical Director failed to provide oversight to hospice patients. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The hospice agency did not acknowledge dietician recommendations.

**Findings #2:** During the investigation, 9 records of patients who were receiving hospice services, from 12/01/13 to 9/17/15, were reviewed and staff members from the main office and 2 multiple locations were interviewed.

Of the nine records reviewed, one included a dietician consult. The record documented a patient who was admitted to hospice services 12/01/13. The patient resided at an Assisted Living Facility. An IDG meeting note in the record included a nursing note which stated "Pt {patient} is not eating well and staff is not assisting her with her meals and she is gluten free, so they are not feeding her right." An order was written the day of the IDG which stated "Dietician consult to teach gluten free diet."

The medical record included a narrative note on a form titled "Nutrition Risk," dated 2/07/14. It was written by the dietician before an on-site consultation occurred. The note stated a phone conversation between the dietician and the facility Licensed Practical Nurse (LPN) occurred, and the LPN stated the patient was not on a gluten free diet, but a low gluten diet. The LPN told the dietician a sample menu would be sent for her review.

The dietician performed an on-site consultation on 2/25/14 and documented her visit on a form titled "Nutrition Risk." She included in her consultation report that the facility was not following a gluten free diet plan for the patient. The consultation also included 5 recommendations, as follows:

- "Clarify diet order to strict Gluten Free secondary to the patient's inability to vocalize discomfort."
- "Provide 1 can of nutritional supplement with lunch and dinner daily secondary to history of low/poor meal intake."
- "Follow up with the physician for possible Levothyroxine dose changes secondary to elevated TSH to improve energy."

- "Obtain and chart monthly weights."
- "Encourage facility staff to follow provided sample Gluten-Free menu."

The record included a form which documented IDG plan of care updates dated 3/05/14. The form documented the patient was on a gluten free diet and stated supplements between meals were to be encouraged. Additionally, physician orders, dated 3/10/14, included orders for a TSH level to be drawn and stated the patient was to be on a gluten free diet.

Review of the patient's medical record included documentation she remained on a gluten free diet with nutritional supplementation. Labs were drawn for the TSH, her medication dosage was not changed, and labs were drawn which confirmed the diagnosis of gluten intolerance.

A narrative note on a form titled "Case Communication," dated 3/18/14, written by the hospice social worker, described a phone conversation with the facility LPN. She stated the patient had a confirmed diagnosis of Celiac Disease, and the facility was hoping to consult with the dietician for menu planning and the patient's specific needs. The patient's record did not include documentation further visits by the dietician occurred.

Additionally, a "Case Communication" documented a meeting on 6/07/14 with the Hospice RN, Social Worker, and ALF facility representatives. The note documented the patient's needs were being closely monitored. The note did not further describe what needs, or how they were monitored.

During a phone interview on 9/17/15 beginning at 9:15 AM, the Registered Nurse (RN) Case Manager stated the Assisted Living Facility staff recorded patient weights monthly and the hospice agency recorded patient weights weekly. The hospice weights were recorded in the record.

It could not be determined that the agency failed to follow dietary recommendations. However, 3 of the 9 patient records reviewed did not include comprehensive assessment and plan of care interventions related to the 3 patients' dietetic needs, as follows:

One patient's record documented a 69 year old female who was admitted for hospice services on 8/19/15. The patient's history and physical examination stated she was not able to eat any type of solid food but could drink a little bit of thickened fluids. The document stated she was losing weight rapidly.

A Start of Care (SOC) assessment by the RN, dated 8/19/15, stated the patient was "... very thin with her bones protruding, she is likely to weigh around 80 lbs." The assessment stated the patient was not able to take in any solid foods, would choke on thickened liquids, and her family reported she was losing weight rapidly.

The assessment did not include a complete nutritional assessment. It did not describe what the patient ate or which food consistency and patient positioning worked best to prevent choking. A nutritional assessment was not conducted and a speech therapy evaluation was not conducted.

The Director of Professional Services for the multiple location was interviewed on 9/15/15 beginning at 3:25 PM. She confirmed the assessment did not include the above items.

A second patient's records documented a 97 year old female who was admitted for hospice services on 1/31/15.

A SOC assessment by the RN Case Manager, dated 1/31/15 but not timed, stated the patient had a fractured femur. The assessment stated the patient had been losing weight steadily over several years and currently weighed 96 pounds. However, the assessment did not include a specific nutritional assessment.

The patient's RN Case Manager was interviewed on 9/17/15 beginning at 9:55 AM. She confirmed the assessment did not include a specific nutritional assessment.

A third patient's record documented an 85 year old male who was admitted to hospice on 7/14/15. His record included a history and physical examination, dated 7/03/15, from a brief hospitalization just prior to his hospice admission. The patient's physician documented a recent decline in appetite, without nausea or vomiting, or other specific pains.

The patient's SOC assessment, dated 7/14/15, stated his appetite was poor, and he was able to swallow some solid foods. His corresponding Plan of Care (POC), dated 7/14/15, included on his problem list, "Risk for deficient nutrition." Interventions included "Diet/fluids as tolerated, Teach oral hygiene, Teach comfort/symptom control, Other."

The patient's record documented multiple meal refusals and weight loss while he was receiving hospice care. Examples included, but were not limited to, the following:

- Nursing visit notes dated 7/22/15 at 6:00 PM, stated the patient was up for only 1 meal that day and remained in bed the rest of the day.
- IDG notes dated 7/22/15 by the RN Case Manager, stated the patient's "...appetite is very poor" and he "rarely eats meals." The RN documented the patient spent most of his time in his room in bed and had "...lost more than 10 pounds over the past month."
- Nursing visit notes dated 8/05/15 at 4:20 PM, stated the patient was only up for one meal and that he ate about 1/4 of his breakfast.
- IDG notes dated 8/05/15 by the RN Case Manager, stated the patient had lost more weight, but was eating "...a little better than he has previously but not much."

Chad Mangum, Administrator  
October 6, 2015  
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- Nursing visit notes dated 8/12/15 at 8:40 AM, stated "Patient did not eat any of breakfast."

As of the 9/16/15, the patient was on hospice services for 9 weeks, and had 5 IDG conferences documented. However, his problem list, goals, and interventions remained unchanged from the original POC which was implemented the day he started on hospice services. Updates to the patient's POC, including additional interventions to address his ongoing meal refusals and weight loss, could not be found.

During a phone interview on 9/17/15 beginning at 9:15 AM, the RN Case Manager reviewed the patient's record and confirmed his weight loss, and stated as he was on hospice, she expected his appetite and ability to eat to decrease as part of the dying process.

It could not be determined that the agency failed to follow dietary recommendations. Therefore, the allegations was unsubstantiated. However, the agency failure to ensure each patient's dietary status was comprehensively assessed and re-assessed and that plans of care included adequate interventions based on each patient's assessed needs. Therefore, deficient practice was identified and cited at CFR 418.54(c) and 418.56(c).

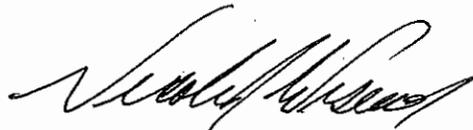
**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



SUSAN COSTA  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

SC/pmt