



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
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 27, 2016

Joye Simpson, Administrator
Minidoka Memorial Hospice
1218 9th Street, Suite 4
Rupert, ID 83350

RE: Minidoka Memorial Hospice, Provider #131539

Dear Ms. Simpson:

This is to advise you of the findings of the Medicare survey of Minidoka Memorial Hospice, which was conducted on July 13, 2016.

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. It is important that your Plan of Correction address each deficiency in the following manner:

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

Joye Simpson, Administrator
July 27, 2016
Page 2 of 2

- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **August 9, 2016**, and keep a copy for your records.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

A handwritten signature in black ink, appearing to read "Nicole Wisenor". The signature is fluid and cursive, written over a light blue horizontal line.

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/pt
Enclosures



MINIDOKA MEMORIAL HOSPITAL
MINIDOKA HOME HEALTH & HOSPICE

August 3, 2016

Nicole Wisenor, Co-Supervisor
Non-Long Term Care
Idaho Bureau of Facility Standards
P.O. Box 83720
Boise, Idaho 83720—0009

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Dear Ms. Wisenor,

Attached is our Plan of Correction for our Hospice Survey which concluded on July 13, 2016. We appreciated the exchange of information with Stephen Mickschl, RN, MS contactor with CMS through Healthcare Management Solutions, LLC.

In addition, I appreciate your help and insight throughout the process with my Plan of Correction.

If you have any questions, please contact me.

Sincerely,

Joye Simpson, RN—BC
Minidoka Memorial Hospice Director

Enclosures
Attachments—5 with several pages in each group

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

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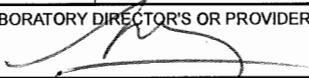
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131539	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2016
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NAME OF PROVIDER OR SUPPLIER MINIDOKA MEMORIAL HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1218 9TH STREET, SUITE 4 RUPERT, ID 83350
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L 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare and Medicaid (CMS) from 7/11/16 to 7/13/16. The surveyor conducting the survey was:	L 000		
L 501	Stephen Mickschl, RN, MS 418.52 PATIENTS' RIGHTS The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights. This STANDARD is not met as evidenced by: Based on review of the agency's patient admission/orientation information, record review and interview, it was determined the agency failed to ensure patients or their representatives were fully informed of their rights. This failure directly impacted 8 of 8 patients (Patients #1 - #8) whose records were reviewed and had the potential to impact all patients receiving hospice services at the agency. This resulted in the potential for patients or their representatives to be unaware of their rights and actions to take should patient rights be violated. Findings include: 1. Upon admission, the agency provided a "Patient Orientation for Hospice Packet" to each hospice patient or their representatives. The packet included a "Rights and Responsibilities as a Hospice Patient" section which had been provided to Patients #1 - #8. However, the patient rights information did not include comprehensive rights information, as follows:	L 501	418.52 Based on findings of L501 Patient's Rights, the following action was taken: The policy was revised and Rights and Responsibilities form/consent was updated with changes. Staff have been in serviced on the form and policy. Compliance will be monitored by Chart Auditor and Director. See: Attachment #1 Policy "Rights and Responsibilities (3pgs) Patient Rights and Responsibilities (2 pgs) patient signature form (1 pg)	08/03/2016

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 8-2-16
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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 501	<p>Continued From page 1</p> <p>a. Information related to the patient's or representative's right to a verbal presentation of the patient rights, necessary to ensure an accurate understanding of their rights, was not present.</p> <p>b. Information that advised the patients or their representatives that unless the patient was adjudged incompetent, the patient had the right to designate someone else exercise his/her rights for him/her was not present.</p> <p>c. Information that advised the patients or their representatives of the patient's right to have allegations of mistreatment reported immediately to the administrator was not present.</p> <p>d. Information that advised the patients or their representatives of the patient's right to expect that the agency would immediately take action to prevent further potential violations from occurring while an alleged violation involving real or perceived abuse, neglect or exploitation from staff, volunteers, or family members was under investigation was not present.</p> <p>e. Information that informed the patients or their representatives of the patient's right to be free from mistreatment, neglect, or abusive behaviors was not present.</p> <p>When asked, on 7/12/16 at approximately 2:00 p.m., the hospice Administrator was unable to demonstrate where the agency documented a verbal review of the patient rights information. During an interview on 7/13/16 at approximately 9:00 a.m., the hospice Administrator was unable to demonstrate where the agency documented the missing patient rights information.</p>	L 501			

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L 501	Continued From page 2	L 501	418.58(a)(1) Based on findings of L561 Program Scope the following actions were taken:	08/03/2016
L 561	418.58(a)(1) PROGRAM SCOPE (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services. This STANDARD is not met as evidenced by: Based on a review of quality documentation and staff interview, it was determined the hospice failed to ensure the Quality Assessment and Performance Improvement (QAPI) program's scope was capable of showing measurable improvements in selected indicators for all patients receiving services from the agency. This interfered with the hospice's ability to evaluate its services and the potential of opportunities for improvement to be missed. Findings include: During a review of quality documentation and an interview on 7/13/16 at approximately 9:15 a.m., the hospice Administrator was asked to provide documentation which demonstrated the agency's monitoring for measurable improvement in quality indicators, including palliative outcomes and hospice services. The Administrator stated the QAPI documentation system did not have a place to record improvement data and thus, the agency could not show that they were monitoring indicators for improvements or declines. The agency failed to ensure its QAPI system was capable of showing measurable improvements.	L 561	1) The policy was revised, 2) forms have been added, 3) aspects have been identified, 4) high risk, high volume for trends for possible adverse events will be identified, 5) activities and tracking and analyzing data has been addressed and will occur at IDT meetings or sooner if needed, 6) findings will be compiled for overall improvement of care and patient safety, 7) Quality Assessment, Performance Improvement findings will be presented and evaluated to the Governing Body for recommendations to improve Quality care and address patient safety, quarterly. Compliance will be monitored by Director and Quality Assurance Coordinator. Additional actions: 1)Survey findings/Plan of Correction were identified with the Professional Advisory Board present on 7/22/16. 2)Staff were inserviced on policy and forms on 8/1/2016. 3)New position for Quality Assurance Coordinator has been approved. 4)Compliance will be monitored quarterly by the Governing Body, Director and Quality Assurance Coordinator. See: Attachments 2 Policy Quality Assurance Performance Improvement (4 pages) Attachments 3 Quality Assurance forms (17 pages) Professional Advisory Board Agenda (1 pg) Professional Advisory Board Minutes (2 pgs) Professional Advisory Board Attendance Sheet (1 pg) Hospice Staff Inservice (1 pg)	

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L 563	<p>418.58(b)(1) PROGRAM DATA</p> <p>(1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.</p> <p>This STANDARD is not met as evidenced by: Based on a review of quality documentation and staff interview, it was determined the hospice failed to ensure the Quality Assessment and Performance Improvement (QAPI) program included quality indicators which were reflective of all aspects of the hospice's operation for all patients receiving services from the agency. This resulted in the inability of the agency to comprehensively monitor all services provided to patients. Findings include:</p> <p>During a review of quality documentation and an interview on 7/13/16 at approximately 9:45 a.m., the hospice Administrator was asked to provide documentation which demonstrated the agency was using quality indicators for services other than just the nursing department.</p> <p>The Administrator stated the QAPI committee had not incorporated other services such as physicians, social worker, counseling staff, infection control, pharmacy, durable medical equipment, contractors, or volunteers into its QAPI program.</p> <p>The agency failed to ensure quality indicators were reflective of all aspects of the hospice's operation.</p>	L 563	L563 Refer to L561	08/03/2016	
L 566	<p>418.58(c)(1)(i) PROGRAM ACTIVITIES</p> <p>(1) The hospice's performance improvement activities must:</p> <p>(i) Focus on high risk, high volume, or</p>	L 566	L566 Refer to L561	08/03/2016	

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L 566	Continued From page 4 problem-prone areas. This STANDARD is not met as evidenced by: Based on a review of quality documentation and staff interview, it was determined the hospice failed to ensure the Quality Assessment and Performance Improvement (QAPI) program's quality indicators included an assessment for high risk, high volume, or problem-prone areas for all patients receiving services from the agency. This resulted in a lack of direction to staff responsible for the program. Findings include: During a review quality documentation and an interview on 7/13/16 at approximately 9:55 a.m., the hospice Administrator was asked to provide documentation which demonstrated the agency was using quality indicators which were based on an assessment of of high risk, high volume or problem-prone areas. The Administrator stated that the QAPI committee had not used assessments from high risk, high volume, or problem-prone areas in developing their current quality indicators. The agency failed to ensure quality indicators were selected based on an assessment of of high risk, high volume or problem-prone areas.	L 566			
L 569	418.58(c)(2) PROGRAM ACTIVITIES (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.	L 569	L569 Refer to L561	08/03/2016	

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L 569	Continued From page 5 This STANDARD is not met as evidenced by: Based on a review of quality documentation and staff interview, it was determined the hospice failed to ensure the Quality Assessment and Performance Improvement (QAPI) activities included the tracking of adverse patient events for all patients receiving services from the agency. This resulted in the potential for adverse events to occur without appropriate corrective action being taken. Findings include: During a review quality documentation and an interview on 7/13/16 at approximately 10:10 a.m., the hospice Administrator was asked to provide documentation which demonstrated the agency was tracking adverse events, analyzing their causes, and implementing preventative actions and mechanisms that included feedback and agency-wide learning. The Administrator stated the QAPI committee was not tracking adverse events and thus, had no analysis data. The Administrator further stated that he/she was not aware of any previous adverse events that occurred within the hospice program for at least the last ten years. The agency failed to ensure the Quality Assessment and Performance Improvement (QAPI) activities included the tracking of adverse patient events.	L 569			
L 575	418.58(e)(2) EXECUTIVE RESPONSIBILITIES [The hospice's governing body is responsible for ensuring the following:] (2) That the hospice-wide quality assessment and performance improvement efforts address	L 575	L575 Refer to L561	08/03/2015	

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L 575	Continued From page 6 priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness. This STANDARD is not met as evidenced by: Based on a review of quality documentation and Governing Body meeting minutes and staff interview, it was determined the hospice failed to ensure the Governing Body approved quality indicators for all patients receiving services from the agency. This resulted in the potential for insufficient information being collected on which to base performance improvement intervention decisions. Findings include: During an interview and review of governing body minutes and quality documentation on 7/13/16 at approximately 9:50 a.m., the hospice Administrator was asked to provide documentation which demonstrated the Governing Body had reviewed and approved the the agency's quality indicators. The Administrator stated the QAPI committee had not taken their currently selected indicators to the Governing Body for approval. The agency failed to ensure the Governing Body approved quality indicator.	L 575			
L 646	418.78(d) COST SAVING The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following: (1) The identification of each position that is occupied by a volunteer. (2) The work time spent by volunteers occupying	L 646	418.78(d) Based on findings of L646 Cost Savings, the following action was taken. The policy was revised, forms were developed, Volunteer Coordinator was inserviced. Compliance will be monitored quarterly by the Director and Quality Assurance Coordinator. See: Attachment 4 Policy "Volunteer Services" (2 pages) Forms (6 pages)	08/03/2016	

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L 646	Continued From page 7 those positions. (3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section. This STANDARD is not met as evidenced by: Based on a review of administrative documents and staff interview, it was determined the hospice failed to calculate and document the cost savings achieved through the use of volunteers for all patients receiving services from the agency. This resulted in an incomplete volunteer program evaluation. Findings include: During an interview on 7/13/16 at 2:45 p.m., the Administrator stated the hospice had only 1 person on their volunteer list. The Administrator was asked to provide documentation to show the work time spent by the volunteer, and the estimated dollar costs the agency would have incurred if paid employees occupied the positions that volunteers could have filled. As of the exit conference on 7/13/16, the Administrator had provided no documentation. The agency failed to ensure a system for tracking and analyzing volunteer time was established and maintained.	L 646			
L 647	418.78(e) LEVEL OF ACTIVITY Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain	L 647	L647 Refer to L646	08/03/2016	

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L 647	Continued From page 8 records on the use of volunteers for patient care and administrative services, including the type of services and time worked. This STANDARD is not met as evidenced by: Based on a review of administrative documents and staff interview, it was determined the hospice failed to ensure volunteers provided day-to-day administrative and/or direct patient care services in an amount that at a minimum equaled 5% of the total patient care hours of all paid hospice employees and contract staff. This resulted in an incomplete volunteer program evaluation. Findings include: During an interview on 7/13/16 at 2:55 p.m., the Administrator stated the hospice had only 1 person on their volunteer list. The Administrator was asked to provide documentation to show the administrative and/or direct patient care services by volunteers equaled at least 5% of the total patient care hours of all paid hospice employees and contract staff. The Administrator stated the agency had no such documentation. The agency failed to ensure a system for tracking and analyzing volunteer time was established and maintained.	L 647			
L 672	418.104(a)(1) CONTENT Each patient's record must include the following: (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes. This STANDARD is not met as evidenced by:	L 672	418.104(a)(1) Based on findings of L672 Content, the following action has been taken. A policy was written, imminence of death tool defined, items to clinical record were added to address and define functional status and symptom management. Staff were in serviced on 8/1/2016. Compliance will be monitored by the Director and Quality Assurance Coordinator quarterly and as needed. See: Attachment 5 Policy "Imminence of Death/Severity of Symptoms" (1 page) Definition and Guidelines (5 pages) Sign in Sheet, Inservice Hospice Staff (1 page)	08/03/2016	

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L 672	<p>Continued From page 9</p> <p>Based on record review and staff interview, it was determined the hospice failed to ensure patient records included comprehensive information for 8 of 8 patients (Patients #1 - #8) whose initial assessments were reviewed. This failure had the potential to interfere with the development of the patients' plans of care. Findings include:</p> <p>1. The clinical records for Patients #1 - #8 were reviewed. The initial comprehensive assessments did not include the following:</p> <p>a. Patient #1's record included a comprehensive assessment, completed within five days of admission on 5/11/16. The assessment documentation did not clearly document Patient #1's functional status, including Patient #1's ability to understand and participate in his/her own care.</p> <p>Similar observations of the above noted missing documentation were made in the medical records of Patients #2 - #8.</p> <p>b. Patient #1's 5/11/16 initial comprehensive assessment did not clearly document Patient #1's status related to imminence of death.</p> <p>Similar observations of the above noted missing documentation were made in the medical records of Patients #2 - #8.</p> <p>c. Patient #1's 5/11/16 initial comprehensive assessment did not clearly document the severity of Patient #1's symptoms upon admission.</p> <p>Similar observations of the above noted missing documentation were made in the medical records of Patients #2 - #8.</p>	L 672			

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NAME OF PROVIDER OR SUPPLIER MINIDOKA MEMORIAL HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1218 9TH STREET, SUITE 4 RUPERT, ID 83350		
(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 672	Continued From page 10 During an interview on 7/13/16 at approximately 1:40 p.m., the Administrator was asked about the missing documentation from the agency's electronic assessment tool. The Administrator confirmed that the assessment tool did not contain a place for a licensed nurse to document the missing findings.	L 672			