



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
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August 3, 2016

Jessica Velasquez, Administrator
Journeys Hospice
223 East Amity
Nampa, ID 83686

RE: Journeys Hospice, Provider #131555

Dear Mr. Velasquez:

This is to advise you of the findings of the Medicare survey of Journeys Hospice, which was conducted on July 21, 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

Jessica Velasquez, Administrator
August 3, 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 16, 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/pmt
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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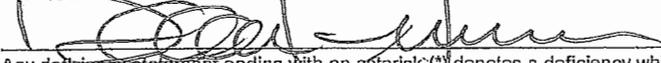
PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131555	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/21/2016
NAME OF PROVIDER OR SUPPLIER JOURNEYS HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 223 EAST AMITY NAMPA, ID 83686		
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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 7/14/16. The surveyor conducting the survey was: Robin Tuiskula, RN, BC Acronyms used in this report include: DON - Director of Nursing ICFs/IID - Intermediate Care Facilities for Individuals with Intellectual Disabilities. IDG - Interdisciplinary Group RN - Registered Nurse SNF/NF - Skilled Nursing Facility/Nursing Facility	L 000	<p style="text-align: center;">RECEIVED AUG 15 2016 FACILITY STANDARDS</p>		
L 548	418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the hospice failed to ensure care plans included measurable goals for 9 of 11 sample patients (Patients #1 - #3 and #5 - #10) whose records were reviewed. This had the potential to interfere with the IDG's ability to monitor patient progress. Findings include: 1. Patient care plans were reviewed and did not	L 548		Plan of correction for L548 Action: On August 17, 2016, an in-service will be conducted with IDG staff (RNs, Chaplains, and MSW) to provide training on developing and writing measurable goals/outcomes for patient care plans. IDG will have 2 weeks to review and update all patient care plans to reflect goals that contain measurable outcomes. At the end of that 2 week period, August 31, 2016, the DON and Administrator will review all care plans to ensure they contain goals with measurable outcomes. (continued on next page)	

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

TITLE

(X6) DATE



ADMINISTRATOR 8-15-16

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 548	Continued From page 1 consistently reflect measurable goals. Examples included, but were not limited to, the following: a. Patient #1's care plan goals included, but were not limited to: "...skin integrity will be maintained (bowel and bladder incontinence care plan)" and "...patient will remain free of injury (fall risk care plan)." Measurable goals, necessary to facilitate assessing Patient #1's progress, were not present. b. Patient #2's care plan goals included, but were not limited to: "...pain is managed with medication and/or other methods (pain care plan)," and "...constipation is well controlled with planned interventions (constipation care plan)." Measurable goals, necessary to facilitate assessing Patient #2's progress, were not present. c. Patient #3's care plan goals included, but were not limited to: "...aspiration risk minimized (aspiration risk care plan)," and "...patient will remain free of injury (fall risk care plan)." Measurable goals, necessary to facilitate assessing Patient #3's progress, were not present. d. Patient #5's care plan goals included, but were not limited to: "...pain is managed with medications and/or other methods (pain care plan)," and "...minimal edema (cardiovascular care plan)." Measurable goals, necessary to facilitate assessing Patient #5's progress, were not present. e. Patient #6's care plan goals included, but were not limited to: "...minimal edema (cardiovascular care plan)," and "...patient will remain free of	L 548	At the subsequent IDG meeting, (September 7, 2016) DON will review plans of care to ensure goals are measurable. Staff will be given feedback and adjustments will be made to care plans as needed to ensure compliance. On September 21, 2016 another quality check on the care plans will be performed by the DON. Again, staff will be given feedback and adjustments will be made to care plans as needed to ensure compliance. The DON will be responsible for implimentation and monitoring of this plan of correction. Completion of this Plan of Correction will be no later than September 30, 2016. However, for 6 more months following completion date, the DON will sample 10% of patient care plans to ensure care plans continue to reflect goals that contain measurable outcomes.		

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L 548	<p>Continued From page 2 injury (fall risk care plan)." Measurable goals, necessary to facilitate assessing Patient #6's progress, were not present.</p> <p>f. Patient #7's care plan goals included, but were not limited to: "...skin integrity will be maintained (incontinence care plan)," and "...patient will remain free of injury (fall risk care plan)." Measurable goals, necessary to facilitate assessing Patient #7's progress, were not present.</p> <p>g. Patient #8's care plan goals included, but were not limited to: "...activity of daily living needs are met (activity of daily living care plan)," and "...skin integrity will be maintained or improved as feasible (wound/pressure area care plan)." Measurable goals, necessary to facilitate assessing Patient #8's progress, were not present.</p> <p>h. Patient #9's care plan goals included, but were not limited to: "...patient will have decreased shortness of breath (respiratory care plan)," and "...patient will reflect a sense of peace and acceptance (spiritual care plan)." Measurable goals, necessary to facilitate assessing Patient #9's progress, were not present.</p> <p>i. Patient #10's care plan goals included, but were not limited to: "...patient will remain free of injury (fall risk care plan)," and "...activity of daily living needs are met (activity of daily living care plan)." Measurable goals, necessary to facilitate assessing Patient #10's progress, were not present.</p> <p>During an interview on 7/19/16 at 4:00 p.m., the DON stated that the care plans did not contain</p>	L 548			

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L 548	Continued From page 3 measurable goals. The DON stated all patient care plans are reviewed every other week during the Interdisciplinary Team meeting.	L 548			
L 647	The hospice failed to ensure care plans included measurable goals. 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 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 record review and 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, for at least 8 of 18 months reviewed. This failure had the potential to impact all patients receiving hospice services in the 8 month period and resulted in the potential for patient needs not being met. Findings include: The facility Volunteer percentage records from January 2015 through June 2016 documented the following 8 months failed to meet the 5% level: - February 2015: the volunteer to direct patient care percent was documented at .7% with a cost savings of \$61.11.	L 647	Plan of correction for L647 Note: In the past, this agency has evaluated the volunteer cost saving percentage on an annual basis. This is our first recertification survey and we have learned that this must be evaluated on a monthly basis. Action: Effective immediately, volunteer cost savings percentages will be considered and evaluated on a monthly basis rather than on an annual basis. Additionally, the Volunteer Coordinator will increase recruitment efforts for hospice volunteers by: 1.) Utilizing social media - specifically, making weekly posts advertising need for volunteers. 2.) Weekly monitoring of our "JustServe.org" account in order to update and refresh postings and to follow up on leads.		

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L 647	Continued From page 4 - March 2015: the volunteer to direct patient care percent was documented at 1.0% with a cost savings of \$74.69. - April 2015: the volunteer to direct patient care percent was documented at .8% with a cost savings of \$54.32. - May 2015: the volunteer to direct patient care percent was documented at .5% with a cost savings of \$27.16. - June 2015: the volunteer to direct patient care percent was documented at 0% with a cost savings of \$0.00. - August 2015: the volunteer to direct patient care percent was documented at 0% with a cost savings of \$0.00. - October 2015: the volunteer to direct care percent was documented at 0% with a cost savings of \$0.00. - June 2016: the volunteer to direct patient care percent was documented at 2.8% with a cost savings of \$203.70. During an interview on 7/20/16 at 10:10 a.m., the Volunteer Coordinator stated the hospice experienced recruitment issues for volunteers which resulted in the decreased percentage rates. She said she was actively advertising and used a website specifically for volunteers. The Volunteer Coordinator said she was not aware of any time that a patient wanted a volunteer and the hospice could not meet the need.	L 647	(L647 continued) Furthermore, a system of communication by which the Volunteer Coordinator will update the Governing Body/Owner will be implimented. Beginning August 29, 2016, the Volunteer Coordinator will update the Governing Body/Owner no less than 2 times per month on the current status, recruiting efforts, and needs of the Volunteer Program. This will provide a process by which our agency will ensure compliance. This process will be monitored by the Hospice Administrator and will be the Hospice Administrator's responsibility to impliment and monitor compliance. Completion of correction will be no later than August 31, 2016		

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L 647	Continued From page 5 During an interview on 7/20/16 at 10:50 a.m., the DON stated the volunteer to direct patient care percent was less than the 5% requirement several times between January 2015 and June 2016. She said sometimes other staff filled in if a volunteer was needed and not available.	L 647			
L 663	418.100(g)(3) TRAINING (3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the hospice failed to ensure the skills and competencies of 4 of 9 employees (the Administrator, RN A, the Chaplain, and the Social Worker) were evaluated. This resulted in a lack of validation of current skills and competencies. Findings include: 1. The hospice policy, "Job Descriptions and Performance Evaluations," dated 11/1/06, documented performance appraisals were to be completed at the end of an employee's probationary period after hire and annually thereafter. The hospice personnel files were reviewed. The files did not include documentation that the policy had been implemented, as follows:	L 663	Plan of correction for L663 Action: The Hospice Administrator will review all hospice personnel files. The Hospice Administrator will create a spreadsheet identifying "previous review date" and "future/next review date" that will be within one year from the "previous review date." Additionally, a calendar notification will be created in advance of the "next review date" in order to assure STANDARD will be met. The DON will be alerted and will schedule performance reviews on Administrator, Nurses, SW, and Hospice Aides. The Administrator will be alerted and will schedule performance reviews on the DON and the Chaplain(s). This correction will be implimented no later than August 31, 2016. All personnel who have not had performance reviews within the last 12 months will have them completed no later than September 30, 2016.		

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L 663	Continued From page 6 a. The Administrator's personnel file documented a date of hire as 8/9/08. There were no annual evaluations or performance appraisals found for 2012, 2013, 2014, and 2015. b. The Chaplain's personnel file documented a date of hire as 3/12/14. There was no annual evaluation or performance appraisal found for 2015. c. The Social Worker's personnel file documented a date of hire as 6/4/12. There were no annual evaluations or performance appraisals found for 2014, 2015, and 2016. d. RN A's personnel file documented a date of hire as 1/2/13. There were no annual evaluations or performance appraisals found for 2014, 2015, and 2016. During an interview on 7/20/16 at 11:00 a.m., the DON stated she was responsible for the annual evaluations or performance appraisals for Nurses, Social Workers, Aides, and the Administrator. The DON stated the Administrator was responsible for the evaluations or appraisals for the Chaplain and the DON. During an interview with the Administrator on 7/20/16 at 1:00 p.m., the Administrator stated the hospice policy specified that evaluations or performance appraisals were to be done annually on all employees. The Administrator stated he reviewed the personnel files and the missing annual evaluations or performance appraisals had not been done.	L 663			
L 771	418.112(c)(8) WRITTEN AGREEMENT	L 771	See next page for L771.		

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L 771	<p>Continued From page 7</p> <p>[The written agreement must include at least the following:] (8) A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the hospice failed to ensure comprehensive information was included in 1 of 4 contracts/written agreements reviewed. This resulted in the potential for allegations of abuse, neglect and mistreatment to be unreported to appropriate facility personnel for all patients residing in SNF/NFs or ICFs/IID. Findings include:</p> <p>1. A review of the contracts/written agreements on 7/18/16 indicated the hospice maintained contracts/written agreements with 4 facilities to provide various levels of care to hospice patients. The levels of care included general inpatient, routine (inpatient), and respite care.</p> <p>One of the 4 contracts reviewed did not include a provision indicating the responsibility of the hospice to report allegations of abuse, neglect, mistreatment, or misappropriation by anyone unrelated to the hospice to the Administrator of the facility that the specific patient resided in, within 24 hours of learning of the allegation.</p>	L 771	<p>Plan of correction for L771 Action: Contracts with all facilities will be reviewed and modified to include the provision that "hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation."</p> <p>Additionally, all future contracts will be generated from a standard template that includes this provision. In the event that a facility insists on using its own contract, that contract will not be signed by our agency until all necessary provisions including this one, are included.</p> <p>This will provide a process by which our agency will ensure compliance.</p> <p>This process will be monitored by the Hospice Administrator and will be the Hospice Administrator's responsibility to impliment and monitor compliance.</p> <p>Completion of correction will be no later than August 31, 2016</p>		

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L 771	Continued From page 8	L 771			
L 772	<p>During an interview on 7/20/16 at 11:00 a.m., the DON reviewed the contract/written agreement in question and agreed that the provision to report allegations of any type of abuse, neglect, mistreatment, or misappropriation by anyone unrelated to the hospice to the facility Administrator within 24 hours of becoming aware of the allegation was not included in the contract/written agreement.</p> <p>The hospice failed to ensure all contracts/written agreements included comprehensive information.</p> <p>418.112(c)(9) WRITTEN AGREEMENT</p> <p>[The written agreement must include at least the following:] (9) A delineation of the responsibilities of the hospice and the SNF/NF or ICF/MR to provide bereavement services to SNF/NF or ICF/MR staff.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the hospice failed to ensure comprehensive information was included in 1 of 4 contracts/written agreements reviewed. This resulted in the potential for bereavement services not being provided to staff serving hospice patients in SNF/NFs or ICFs/IID. Findings include:</p> <p>1. A review of the contracts/written agreements on 7/18/16 indicated the hospice maintained contracts/written agreements with 4 facilities to provide various levels of care to hospice patients. The levels of care included general inpatient,</p>	L 772	<p>Plan of correction for L772</p> <p>Action: Contracts with all facilities will be reviewed and modified to include the provision that "a deliniation of the responsibilities of the hospice and the SNF/NF or ICF/MR to provide bereavement services to SNF/NF or ICF/MR staff."</p> <p>Additionally, all future contracts will be generated from a standard template that includes this provision. In the event that a facility insists on using its own contract, that contract will not be signed by our agency until all necessary provisions including this one, are included.</p> <p>Continued on next page.</p>		

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L 772	<p>Continued From page 9 routine (inpatient), and respite care.</p> <p>One of the 4 contracts reviewed did not include a provision indicating the responsibility of the hospice to provide bereavement services to the staff caring for hospice patients at these facilities.</p> <p>During an interview on 7/20/16 at 11:00 a.m., the DON reviewed the contract/written agreement in question and stated the contract/written agreement did not contain the provision that hospice staff would provide bereavement services to the facility staff.</p> <p>The hospice failed to ensure all contracts/written agreements included comprehensive information.</p>	L 772	<p>(L772 continued)</p> <p>This will provide a process by which our agency will ensure compliance.</p> <p>This process will be monitored by the Hospice Administrator and will be the Hospice Administrator's responsibility to impliment and monitor compliance.</p> <p>Completion of correction will be no later than August 31, 2016</p>	
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