



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  
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July 29, 2016

Meshell Mackey, Administrator  
Idaho Home Health & Hospice  
3356 E Goldstone Way Suite 3356  
Meridian, ID 83642

RE: Idaho Home Health & Hospice, Provider #131501

Dear Mr. Mackey:

This is to advise you of the findings of the Medicare survey of Idaho Home Health & Hospice, which was conducted on July 22, 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:

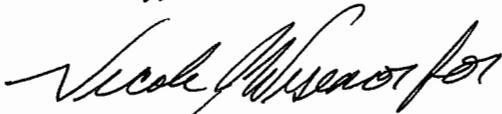
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date 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
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Meshell Mackey, Administrator  
August 1, 2016  
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **August 15, 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,



NANCY BAX  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

NB/pmt  
Enclosures

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

PRINTED: 08/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  131501	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/22/2016
NAME OF PROVIDER OR SUPPLIER  IDAHO HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 222 SHOSHONE ST EAST TWIN FALLS, ID 83301	
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L 000	INITIAL COMMENTS  The following deficiencies were cited during the Medicare recertification and complaint investigation of your hospice agency conducted from 7/18/16 through 7/22/16. Surveyors conducting the survey were:  Nancy Bax, RN, BSN, HFS, Team Leader Kristin Inglis, RN, HFS Susan Costa, RN, HFS Teresa Hamblin, RN, MS, HFS  Acronyms used in this report include:  ALF - Assisted Living Facility CHF - Congestive Heart Failure cm - centimeter CNA - Certified Nursing Assistant COPD - Chronic Obstructive Pulmonary Disease CTI - Certification of Terminal Illness DME - Durable Medical Equipment IDG - Interdisciplinary Group LPM - Liters per Minute LPN - Licensed Practical Nurse MSW - Medical Social Worker POC - Plan of Care QAPI - Quality Assessment Performance Improvement QI - Quality Improvement SOC - Start of Care RN - Registered Nurse SN - Skilled Nurse	L 000		
L 502	418.52(a)(1) NOTICE OF RIGHTS AND RESPONSIBILITIES  (1) During the initial assessment visit in advance of furnishing care the hospice must provide the patient or representative with verbal (meaning	L 502	<b>L502 418.52(a)(1) NOTICE OF RIGHTS AND RESPONSIBILITIES</b>  Administrator educated all administrative and licensed admitting staff the week of 07/25/16 and 8/2/16 on providing the patient's representative with verbal and written notice of patient's rights and responsibilities prior to providing care. When the patient's representative is unable to be present at the time of admission, Hospice representative will get verbal consent from patient's representative with one other witness. The conversation will be documented on a coordination note in the clinical record as to who gave verbal consent and confirmation of understanding of notification of rights and responsibilities, who witnessed said consent, and confirmation of patient representative contact information. The two Hospice representatives will each note on the consent form verbal consent received, by whom, and the date of consent and then sign the	8/3/16

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

TITLE

(X6) DATE

*M. Mackey* Administrator

08/11/2016

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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AUG 24 2016  
FACILITY STANDARDS

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L 502	<p>Continued From page 1</p> <p>spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews, record review, and review of admission documents, it was determined the agency failed to provide the patient's representative with verbal and written notice of the patient's rights and responsibilities prior to furnishing care for 1 of 12 patients (#4) whose records were reviewed. This failure had the potential to result in a lack of advocacy due to insufficient information being readily available to the patients' representatives. Findings include:</p> <p>Patient #4 was an 85 year old female admitted to the hospice on 4/29/16 with a terminal diagnosis of Alzheimer's disease.</p> <p>Patient #4's record included forms titled "Informed Consent Form," "IDAHO PATIENT'S RIGHTS AND RESPONSIBILITIES," "Covered Hospice Services," and "MEDICARE ELECTION FORM." The four forms included the signature of Patient #4's daughter, who was her Power of Attorney. The signatures were dated 4/30/16, 1 day after Patient #4's admission to hospice.</p> <p>During an interview on 7/20/16 at 10:35 AM, the Administrator confirmed the 4 forms, including the written notice of patient's rights and responsibilities, were signed by Patient #4's daughter on 4/30/16. She stated Patient #4's daughter lived in another state and was unable to be present at the SOC visit on 4/29/16, so she signed the forms and faxed them to the agency. The Administrator stated there was no documentation of receipt of verbal consent or</p>	L 502	<p>consents. Within 24 hours of admission on weekdays and 48 hours if admission is over the weekend, Office Manager will send consents and rights and responsibilities documents to patient's representative for signature. Office Manager will track the return of consents and notices and notify the Case Manager and Administrator to assist with follow-up if not returned within 10 calendar days. Administrator or designee to review all completed consents and notices for 100% of admissions prior to the document being attached to patient's record. Although patient #4's representative was provided verbal notice of patient's rights and responsibilities on 4/29/16 and gave verbal consent for care, the admitting clinician and witness failed to document the verbal consent and confirmation of patient representative's understanding. Patient's representative signed consents and notice of the patient's rights and responsibilities on 04/30/16. The first day of the billing episode was coded as "non covered" on 5/4/16 and not billed by the Hospice agency.</p>	

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L 502	Continued From page 2 confirmation of understanding of rights and responsibilities from Patient #4's daughter prior to furnishing care.  Patient #4's daughter, who was her POA, was not provided with verbal and written notice of her rights and responsibilities prior to services being provided.	L 502	<b>Responsible Hospice Representative:</b>  Administrator has overall responsibility for corrective action and ongoing completion of standard.		
L 531	418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT  [The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.  This STANDARD is not met as evidenced by: Based on record review, agency policy review, and staff interview, it was determined the agency failed to ensure the patients' SOC comprehensive assessments included a bereavement risk assessment for 3 of 12 patients (#2, #3, and #4) whose records were reviewed. This failure resulted in the potential for delayed identification of grief and loss issues in patients and their families, and impeded early interventions and services. Findings include:  The agency's policy number 2.002 "INITIAL & COMPREHENSIVE ADMISSION ASSESSMENT	L 531	<b>Completion Date:</b> 08/03/16 and ongoing  <b>L531 418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT</b>  Administrator reviewed policy 2.002 Initial & Comprehensive Admission Assessment & Plan of Care with MSW on 7/27/16 and 08/09/16. MSW to complete Bereavement Risk Assessment on all patients at initial MSW visit and document in the clinical record. If bereaved is unavailable at initial visit, MSW to complete Bereavement Risk Assessment via phone contact with bereaved within 5 days of Hospice election to ensure the patient's SOC comprehensive assessment includes a bereavement risk assessment. All attempts to contact bereaved for completion of the risk assessment will be documented in the clinical record when they occur.	11/1/16	

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L 531	<p>Continued From page 3</p> <p>&amp; PLAN OF CARE," revised 8/01/12, stated "The Medical Social Worker will complete a psychosocial evaluation identifying goals and interventions, including the initial bereavement risk assessment, within 5 days of the hospice election as part of the comprehensive assessment."</p> <p>1. Patient #3 was a 92 year old female admitted to the hospice on 4/13/16 with a terminal diagnosis of CHF.</p> <p>Patient #3's record included a "Bereavement Risk Assessment" dated 4/28/16, 15 days after her admission to hospice. It was signed by the MSW.</p> <p>The Administrator was interviewed on 7/20/16 at 10:00 AM. She reviewed Patient #3's record and stated her bereavement risk assessment was not completed within 5 days of her admission.</p> <p>2. Patient #4 was an 85 year old female admitted to the hospice on 4/29/16 with a terminal diagnosis of Alzheimer's disease.</p> <p>Patient #4's record included a "Bereavement Risk Assessment" dated 5/06/16, 6 days after her admission to hospice. It was signed by the MSW.</p> <p>The Administrator was interviewed on 7/20/16 at 10:35 AM. She reviewed Patient #4's record and stated her bereavement risk assessment was not completed within 5 days of her admission.</p> <p>3. Patient #2 was a 90 year old male admitted to the hospice on 4/21/16 with a terminal diagnosis of COPD.</p> <p>An MSW visit note dated 4/22/16 at 12:15 PM,</p>	L 531	<p>Administrator or designee to run the Admission and Bereavement reports daily for morning meeting to track bereavement risk assessment completion for 100% of admissions. Administrator and MSW reviewed clinical records of Patient #2, #3 and #4. Administrator educated MSW on documenting in the clinical record while in the patients home or no later than 24 hours after the communication took place, to ensure Bereavement Risk Assessment is timely and part of the comprehensive SOC assessment. Team Lead and Administrator will audit 6 clinical records per month for 3 months for compliance with Bereavement Risk Assessment completed within 5 days of Hospice election or documentation supporting delay to ensure Bereavement Risk Assessment is part of the plan of care with a goal of 100% compliance. If 100% compliance is achieved at the end of third month, agency will return to 4 clinical record audits per month.</p>	

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L 531	Continued From page 4 was reviewed. It included a question posed to the clinician "WAS THE BEREAVEMENT RISK ASSESSED?" The MSW who completed the visit note responded "Yes," and included a risk level of "Low." However, the risk assessment form was not included in Patient #2's record.  The Administrator was interviewed on 7/20/16 at 10:45 AM. She reviewed Patient #2's record and stated a visit was performed on 4/22/16 by the MSW. She was unable to find a form titled "BEREAVEMENT RISKASSESSMENT." She located another document from the Bereavement Log, which documented the MSW performed the "BEREAVEMENT RISK ASSESSMENT" on 5/03/16. She stated the assessment was performed 12 days after Patient #2's election of benefits.  The agency failed to ensure patients' comprehensive assessments, completed within 5 days of admission, included bereavement risk assessments.	L 531	<b>Responsible Hospice Representative:</b>  Administrator has overall responsibility for corrective action and ongoing completion of standard.  <b>Completion Date:</b>  11/01/16 and ongoing		
L 543	418.56(b) PLAN OF CARE  All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.  This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the hospice failed to	L 543	<b>L543 418.56(b) PLAN OF CARE</b>  Administrator reviewed policy 2.001 with all staff the week of 7/25/16, 8/2/16 and 08/08 and educated on following the written plan of care, notifying the physician of all changes to the plan of care, following the plan of care, obtaining referral orders and timeliness of implementing orders. Office Managers educated on 07/29/16 and 8/01/16 on processing and tracking of missed visits and notification of physician of missed visits. Office	11/1/16	

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L 543	<p>Continued From page 5</p> <p>ensure care followed the written plan of care for 7 of 12 patients (#1, #2, #4, #6, #7, #8, and #11) whose records were reviewed. Failure to follow the individualized plan of care had the potential to interfere with hospice staff meeting the medical needs of the patient.</p> <p>1. Patient #1 was a 66 year old male admitted to the hospice on 6/10/16 with a terminal diagnosis of brain cancer. The POC for the certification period 6/10/16 to 9/07/16 was reviewed.</p> <p>Patient #1's POC included orders for SN visits 1 time per week for 1 week followed by 2 times per week for 12 weeks. There was 1 SN visit documented during week 5, a holiday week. There was no documentation in the record to explain the reason for the missed visit or to indicate Patient #1's physician was notified.</p> <p>The Administrator was interviewed on 7/20/16 at 11:36 AM. She reviewed Patient #1's record and confirmed the missed SN visit. She stated there should have been a missed visit note but she did not find one.</p> <p>SN visits for Patient #1 did not follow the written POC.</p> <p>2. Patient #11 was a 79 year old male admitted to the hospice on 5/21/16 with a terminal diagnosis of heart disease. The POC for the certification period 5/21/16 to 8/18/16, and updated physician orders, dated 5/23/16, were reviewed.</p> <p>Patient #11's POC included orders, effective 5/22/16 for aide visits 2 times per week for 13 weeks. The physician's order, dated 5/23/16,</p>	L 543	<p>Manager to run the missed visit report and scheduling report each Monday to verify that all missed visits have been processed correctly through the work flow and a notification has gone to the patient's physician. A process error was discovered causing the electronic medical record to not generate a missed visit notification workflow to the Office Manager for patient #1 and #6. All administrative staff have been educated on the correct workflow process. To ensure compliance, the missed visit report and scheduling report will be ran each Monday to verify missed visit notifications have been processed and sent to the patients primary physician. Physician for patient #11 gave orders for an increase in home health aide visits on 05/22/16. The Case Manager at the time did not plot the visits in the patient record and therefore the patient didn't receive all of the ordered visits. RN Team Lead to verifying 100% of orders are plotted in the patient calendar prior to approval. Verbal orders for initial Hospice visit will be obtained on all new patients prior to admission by the Team Lead or Case</p>		

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L 543	<p>Continued From page 6</p> <p>updated the POC to increase aide visits from 2 times per week to 5 times per week. During the weeks beginning 5/23/16 and 5/30/16, there were two documented aide visits per week. There was a 2 week delay in increasing the aide visits to 5 times per week for Patient #11. There was no explanation for the delay in visits.</p> <p>The Administrator was interviewed on 7/20/16 at 11:55 AM. She confirmed the missed aide visits and stated she could not find an explanation for the missed visits or documentation stating the missed visits were reported to Patient #11's physician.</p> <p>The frequency of aide visits for Patient #11 did not follow the written POC/physician orders.</p> <p>3. Patient #6 was an 83 year old male admitted to hospice on 5/17/16, with a terminal diagnosis of Alzheimer's disease. His record, including the POC, for the period 5/17/16 to 8/17/16, was reviewed.</p> <p>Patient #6's SN order frequency included 2 visits per week for 12 weeks. On week 6, which included a holiday (July 4th), there was only 1 visit documented by skilled nursing. No documentation of a missed visit was presented when requested.</p> <p>An interview was conducted with the RN Case Manager on 7/21/16 at 9:35 AM. She stated she was going on vacation, had talked with the ALF staff, and they preferred that she not come on a holiday. She stated she did not talk with Patient #6's family or notify his physician. The missed visit was not rescheduled for a different day in the same week.</p>	L 543	<p>Manager if not faxed with H&amp;P. Team Lead will not assign a start of care visit without a verbal or faxed order in the clinical record. Verbal orders for patients #2, #4, #7 and #8 were obtained and documented on the CTI although there was not a separate order for the initial visit. Team Lead and Administrator will audit 6 clinical records per month for 3 months for compliance with orders for Hospice services obtained prior to patient's admission to Hospice, all scheduled visits are performed according to the plan of care with a goal of 100% compliance. If 100% compliance is achieved at the end of third month, agency will return to 4 clinical record audits per month.</p> <p><b>Responsible Hospice Representative:</b></p> <p>Administrator has overall responsibility for corrective action and ongoing completion of standard.</p> <p><b>Completion Date:</b></p> <p>11/01/16 and ongoing</p>		

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L 543	<p>Continued From page 7</p> <p>The agency failed to ensure all scheduled SN visits were performed according to the POC.</p> <p>4. The agency's policy number 2.001 "ADMISSION CRITERIA AND PROCESS," revised 4/01/16, stated "The patient must be under the care of a physician. The patient's physician (or other authorized independent practitioner) must order, approve the provision of hospice care..."</p> <p>The policy was not followed for all patients. Examples include:</p> <p>a. Patient #4 was an 85 year old female admitted to the hospice on 4/29/16 with a terminal diagnosis of Alzheimer's disease. Her record did not include an order for the initial hospice visit.</p> <p>The Administrator was interviewed on 7/20/16 at 10:35 AM. She reviewed Patient #4's record and stated it did not include an order for initiation of hospice services.</p> <p>b. Patient #2 was a 90 year old male admitted to the hospice on 4/21/16, with a terminal diagnosis of COPD.</p> <p>Patient #2's record included a CTI dated 4/20/16, and signed by the hospice Medical Director on 4/29/16. However, his record did not include a physician's order for the initial hospice visit.</p> <p>c. Patient #7 was an 92 year old female admitted to the hospice on 5/16/14, with a terminal diagnosis of CHF.</p> <p>Patient #7's record included a CTI, dated 6/16/14,</p>	L 543		

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L 543	Continued From page 8 signed by the hospice Medical Director on 5/21/16. However, her record did not include a physician's order for the initial hospice visit.  d. Patient #8 was a 65 year old female admitted to the hospice on 7/21/15, with a terminal diagnosis of severe protein-calorie malnutrition.  Patient #8's record included a CTI, dated 7/21/15, signed by the hospice Medical Director on 7/27/15. However, her record did not include a physician's order for the initial hospice visit.  The Administrator was interviewed on 7/19/16 at 3:00 PM. She reviewed records of Patients #2, #7 and #8. She stated the agency considered the CTI as an order to admit the patient. However, she confirmed the documents did not include a specific physician order for admission to hospice.  The agency failed to ensure orders for hospice services were obtained prior to patients' admission to hospice.	L 543	<b>L550 418.56(C)(5) CONTENT OF PLAN OF CARE</b>  Administrator and RN Team Lead reviewed policy 3.020 with all licensed and administrative staff on 07/25/16, 08/02/16 and 08/08/16 and educated on ensuring all DME and supplies necessary for patient care are identified on patient plan of care – including patient owned equipment. Administrative staff will not enter requests for supplies without orders in the clinical record. Administrator or designee to review 100% of Hospice Cloud equipment requests for 1 month for inclusion on the plan of care with a goal of 100%. If 100% compliance is met, 50% of Hospice Cloud equipment requests will be audited for an additional month. If 100% compliance is attained after the second month, agency will continue to monitor the inclusion of DME and supplies on a minimum of 4 charts per month. The records of patients #1, #2, #3, #4, #10 and #11 have been reviewed with the Case Mangers and care plans are being updated to include all DME and supplies by 08/19/16.		
L 550	<b>418.56(c)(5) CONTENT OF PLAN OF CARE</b>  [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (5) Medical supplies and appliances necessary to meet the needs of the patient.  This STANDARD is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the agency failed to ensure all DME and supplies necessary for patient care were identified on patient POCs for 6	L 550		10/3/16	

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L 550	<p>Continued From page 9</p> <p>of 12 patients (Patients #1, #2, #3, #4, #10, and #11) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include:</p> <p>The agency's policy 3.020 "Durable Medical Equipment Services," revised 8/01/12, was reviewed. It stated "The needs of the patient will be reviewed by the Interdisciplinary Group and appropriate equipment will be included on the POC."</p> <p>The agency's policy, "Plan of Care," dated 7/01/12, was reviewed. It stated "The Plan of care must include all services necessary for the palliation and management of the terminal illness, including...medical supplies and appliances necessary to meet the needs of the patient."</p> <p>1. Patient #3 was a 92 year old female admitted to the hospice on 4/13/16 with a terminal diagnosis of CHF. Her POC and IDG updates to the POC for the certification period 4/13/16 to 7/11/16, were reviewed. Her POC did not include all equipment used in her care. Examples include:</p> <ul style="list-style-type: none"> <li>- Patient #3's POC included a medication to be administered by nebulizer. Her POC did not include a nebulizer to administer the medication.</li> <li>- Patient #3's SOC assessment completed on 4/13/16, signed by her RN Case Manager, stated she used a wheelchair in her home. Her POC did not include a wheelchair.</li> </ul> <p>During an interview on 7/20/16 at 10:00 AM the Administrator reviewed Patient #3's record. She stated her nebulizer and wheelchair should have</p>	L 550	<p><b>Responsible Hospice Representative:</b></p> <p>Administrator has overall responsibility for corrective action and ongoing completion of standard.</p> <p><b>Completion Date:</b></p> <p>10/03/16 and ongoing</p>		

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L 550	<p>Continued From page 10 been included on her POC.</p> <p>Patient #3's POC did not include all equipment used in her home.</p> <p>2. Patient #4 was an 85 year old female admitted to the hospice on 4/29/16 with a terminal diagnosis of Alzheimer's disease. Her POC and IDG updates to the POC for the certification period 4/29/16 to 7/27/16, were reviewed. Her POC did not include all equipment used in her care. Examples include:</p> <ul style="list-style-type: none"> <li>- Patient #4's POC included oxygen to be used continuously. Her POC did not include supplies or equipment to deliver her oxygen.</li> <li>- Patient #4's POC included a medication to be administered by nebulizer. Her POC did not include a nebulizer to administer the medication.</li> </ul> <p>During an interview on 7/20/16 at 10:35 AM the Administrator reviewed Patient #4's record. She stated her nebulizer and oxygen supplies should have been included on her POC.</p> <p>Patient #4's POC did not include all equipment used in her home.</p> <p>3. Patient #10 was an 81 year old female admitted to the hospice on 11/19/15 with a terminal diagnosis of breast cancer. Her POC and IDG updates to the POC for the certification period 11/19/15 to 2/16/16, were reviewed. Her POC did not include all equipment used in her care.</p> <ul style="list-style-type: none"> <li>- Patient #10's SOC assessment completed on 11/19/15, signed by her RN Case Manager,</li> </ul>	L 550			

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L 550	<p>Continued From page 11</p> <p>stated she used a wheelchair, hooyer lift and oxygen concentrator in her home. Her POC did not include a wheelchair, hooyer lift or oxygen concentrator.</p> <p>During an interview on 7/20/16 at 11:00 AM the Administrator reviewed Patient #10's record. She stated her wheelchair, hooyer lift and oxygen concentrator should have been included on her POC.</p> <p>Patient #10's POC did not include all equipment used in her home.</p> <p>4. Patient #2 was a 90 year old male admitted to the hospice on 4/21/16, with a terminal diagnosis of COPD. His record, and POC for the benefit period of 4/21/16 to 7/19/16, was reviewed.</p> <p>On 7/19/16 at 9:30 AM, a visit was conducted at the ALF where Patient #2 resided. The CNA who performed bathing and hygiene was observed. During the visit, the following DME were noted in Patient #2's room:</p> <ul style="list-style-type: none"> <li>- An oxygen concentrator, portable oxygen tanks, a liquid oxygen delivery system, oxygen tubing and equipment, electric wheelchair, walker, cane, shower chair, grab bars, and pick up/grabber device.</li> <li>- Patient #2's POC included a medication to be administered by nebulizer. His POC did not include a nebulizer to administer the medication. A nebulizer was found in his room.</li> </ul> <p>Patient #2's POC stated he had no DME or supplies.</p>	L 550			

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L 550	<p>Continued From page 12</p> <p>During an interview on 7/21/16 beginning at 3:33 PM, the RN Case Manager reviewed Patient #3's record. She stated the nebulizer, wheelchair, and other equipment/supplies should have been included on his POC.</p> <p>Patient #2's POC did not include all equipment used in his residence.</p> <p>5. Patient #1 was a 66 year old male admitted to the hospice on 6/10/16 with a terminal diagnosis of brain cancer. The POC for certification period 6/10/16 to 9/07/16, and the IDG updates to the POC, dated 6/23/16 and 7/07/16, and SN visit notes, dated 6/10/16 and 6/14/16, were reviewed.</p> <p>Patient #1's POC referenced a wheelchair as an "activity permitted." An SN visit note, dated 6/14/16, included documentation that a hospital bed with alternating air mattress had been set up in his bedroom.</p> <p>A visit was made to Patient #1's home on 7/19/16 from 9:35 to 10:45 AM. During the visit, it was observed that Patient #1 was lying in a hospital bed with a trapeze appliance attached to his bed. An electric wheelchair was observed near his bed.</p> <p>The Administrator was interviewed on 7/20/16 at 11:36 AM. She reviewed Patient #1's record and confirmed the DME was missing from the POC.</p> <p>Patient #1's initial and updated POCs did not include his hospital bed, trapeze or electric wheelchair.</p> <p>6. Patient #11 was a 79 year old male admitted to the hospice on 5/21/16 with a terminal</p>	L 550			

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L 550	Continued From page 13 diagnosis of heart disease. The POC for certification period 5/21/16 to 8/18/16, and the initial SN visit, dated 5/21/16 were reviewed.  Medication orders on Patient #11's POC included orders for continuous oxygen at 2 LPM. The initial SN visit, dated 5/21/16, indicated Patient #11 had a foley catheter, that he used a nebulizer, oxygen equipment, and a wheeled walker.  Oxygen equipment and supplies, foley catheter, nebulizer, and a wheeled walker were not included on Patient #11's POC.  The Administrator was interviewed on 7/20/16 at 11:55 AM. She reviewed Patient #11's record and confirmed the DME should have been listed on the POC.  Patient #11's POC did not include all medical supplies/equipment necessary to meet Patient #11's needs.	L 550			
L 557	418.56(e)(4) COORDINATION OF SERVICES  [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.  This STANDARD is not met as evidenced by: Based on review of medical records and staff	L 557		11/1/16	

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L 557	<p>Continued From page 14</p> <p>Interview, it was determined the hospice failed to ensure medication allergies were evaluated prior to medications being ordered for 1 of 12 patients (#7) whose records were reviewed. This failure resulted in the potential for patients to experience adverse reactions to medications.</p> <p>Patient #7 was a 92 year old female admitted to the hospice on 5/16/14, with a terminal diagnosis of CHF. Her record, including the POC for the benefit period of 9/8/15 to 11/06/15, was reviewed.</p> <p>Patient #7's record included a document titled "Client Medication Report," dated 7/18/16. It included Morphine as an allergy. The Morphine allergy was entered into her medical record on 5/19/14. The form did not include a description of Patient #7's reaction to morphine.</p> <p>IDG meeting minutes dated 10/07/15 documented Morphine was added to her medication list on 9/29/15. The RN documented Patient #7 was receiving Morphine every 4 hours. Patient #7's record did not include documentation that her allergy to Morphine was discussed with the IDG before it was prescribed.</p> <p>- The "Hospice IDG Comprehensive Assessment and Plan of Care Update Report," dated 10/07/15, stated an order was obtained to increase Morphine doses to 5 mg every 3 hours as needed. The IDG meeting minutes for 10/07/15, included Morphine as an allergy. Patient #7's record did not include documentation her allergy to Morphine was discussed with the IDG before the dose was increased.</p> <p>During an interview on 7/22/16 beginning at 9:00</p>	L 557	<p><b>L557 418.56(e)(4) COORDINATION OF SERVICES</b></p> <p>Administrator and Team Lead educated all licensed staff on 07/25/16, 08/02/16 and 08/08/16 on ensuring medication allergies are evaluated, discussed and documented with IDG members prior to medication being ordered and a description of the reaction to the medication is to be documented in the clinical record. Medical Director or Associate Medical Director will review medication changes and medication allergies during IDG and document changes as part of the comprehensive medication review. Team Lead and Administrator will audit 6 clinical records per month for 3 months for compliance with orders for documentation of communication with patient physician and IDG team regarding medication allergies with a goal of 100% compliance. If 100% compliance is achieved at the end of third month, agency will return to 4 clinical record audits per month.</p>		

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L 557	Continued From page 15 AM, the Administrator reviewed Patient #7's record. She was unable to find documentation stating Patient #7's allergy to Morphine was discussed with her physician before it was administered.  The agency failed to ensure communication occurred related to Patient #7's medication allergy.	L 557	<b>Responsible Hospice Representative:</b>  Administrator has overall responsibility for corrective action and ongoing completion of standard.  <b>Completion Date:</b>  11/01/16 and ongoing		
L 574	<b>418.58(e)(1) EXECUTIVE RESPONSIBILITIES</b>  The hospice's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.  This STANDARD is not met as evidenced by: Based on review of hospice policy, governing board meeting minutes, QAPI documentation, and staff interview, it was determined the hospice failed to ensure the QAPI program was evaluated annually by the Governing Body. This had the potential to result in an outdated QAPI plan that no longer reflected the complexity of the organization and services it provided. Findings include:  A hospice policy 5.001 titled "HOSPICE QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN" dated 7/01/15, was reviewed. The policy included the following information:  - "The QAPI Program Plan will be developed, implemented, regularly reviewed and updated in	L 574	<b>L574 418.558 EXECUTIVE RESPONSIBILITIES</b>  The Administrator and key Governing Board Members reviewed policy 5.001 Hospice Quality Assessment Performance Improvement Plan on 8/15/2016.  The Governing Board reviews the agency QAPI program on a Quarterly basis for progress and action planning according to the approved plan. The Governing Board reviewed the 2015 data, as well as the agency QAPI program plan for 2016, at the Governing Board meeting on 02/15/2016.		

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L 574	<p>Continued From page 16</p> <p>accordance with the following five QAPI standards:</p> <ol style="list-style-type: none"> <li>Program Scope;</li> <li>Program Data;</li> <li>Program Activities;</li> <li>Performance Improvement Projects; and</li> <li>Executive Responsible"</li> </ol> <p>- "The QAPI program may include, and is not limited to, assessment of the following activities:</p> <ol style="list-style-type: none"> <li>Ethics, Rights and Responsibilities</li> <li>Provision of Care, Treatment and Services</li> <li>Medications Management</li> <li>Leadership</li> <li>Annual Agency Evaluation</li> <li>Surveillance, Prevention and Control of Infection</li> <li>Improving Organization Performance</li> <li>Utilization Management</li> <li>Safety/Risk Management</li> <li>Management of Human Resources</li> <li>Care of the Environment</li> <li>Management of Information."</li> </ol> <p>- "The organizational quality assurance performance improvement program is evaluated for effectiveness at least annually and revised as necessary to:</p> <ol style="list-style-type: none"> <li>assure appropriateness of the approach to data collection and process improvement;</li> <li>set priorities for process improvement;</li> <li>assess performance systematically, using statistically valid methods;</li> <li>implement improvement activities on the basis of systematic assessment;</li> <li>review current and historical improvement outcomes."</li> </ol> <p>A copy of the last annual evaluation was</p>	L 574	<p>On September 2, 2016, the Governing Board of Idaho will meet and evaluate the QAPI program for the first three quarters of 2016.</p> <p>Moving forward the Governing Board will document the approval of the agency's annual QAPI program in the meeting minutes of every fourth quarter Governing Board meeting. The Governing Board notes for third quarter 2016 and fourth quarter annually, will show the organizational performance improvement program is evaluated for effectiveness at least annually and revised as necessary to assure appropriateness of the approach to planning processes of improvement, setting priorities for improvement, assessing performance systematically, using statistically valid methods, implementing improvement activities on the basis of assessment, and improvement outcomes.</p>		

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L 574	<p>Continued From page 17</p> <p>requested. The last 4 quarterly reports, titled "QAPI Performance Improvement Analysis/Action Plan," were provided. The reports included columns of information, titled findings, corrective action, date due, monitoring plan (if applicable) and person responsible. The findings addressed specific quality issues, such as medication reconciliation not being completed at each visit, hospice ratings, oxygen storage, and documentation issues. There was no documentation of an annual review that addressed the overall organizational QAPI plan, such as the program scope, program data, program activities, priorities for performance improvements projects and executive responsibilities.</p> <p>"HOSPICE GOVERNING BOARD MEETING" minutes, dated 8/18/15, 11/10/15, 6/03/16, and 2/15/16, were also provided for review. Each board meeting addressed quality related activities and executive summaries of findings, such as CAHPS (Consumer Assessment of Healthcare Providers and Systems) quality measures, complaints, occurrences, satisfaction surveys, infection control findings, analysis of data and recommendations for quality projects. There was no reference to an annual evaluation of the overall organizational QAPI plan/program.</p> <p>The Administrator was interviewed on 7/21/16 at 2:00 PM. She stated the hospice policy was the QAPI plan. There was no separate plan or specific annual evaluation. She stated the quarterly reports (referenced above) and the information included in the governing board meeting minutes reported the activities. She stated that since the QAPI data was analyzed quarterly, she thought they exceeded the</p>	L 574	<p><b>Responsible Hospice Representative:</b></p> <p>Administrator has overall responsibility for corrective action and ongoing completion of standard.</p> <p><b>Completion Date: 09/02/2016 and ongoing</b></p>		

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L 574	Continued From page 18 requirements for an annual review of the QAPI plan.	L 574			
L 665	<p>The hospice's Governing Body did not ensure the QAPI program was evaluated annually.</p> <p><b>418.102 MEDICAL DIRECTOR</b></p> <p>The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with, the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.</p> <p>This STANDARD is not met as evidenced by: Based on agency policy, physician contracts, and staff interviews, it was determined the agency failed to provide a single Medical Director for all of its locations. This resulted in duplicate lines of authority and lack of clear physician leadership overseeing the agency. Findings include:</p> <p>The agency's policy 6.001, titled "STRATEGIC AGENCY PLANNING/HOSPICE GOVERNING BODY RESPONSIBILITIES" stated "The Governing Body will designate a Medical Director who will assume overall responsibility for the medical component of patient care for the agency."</p> <p>During an interview on 7/19/16, starting at 2:35 PM, the Administrator was asked to name the Medical Director. She stated "Dr. [Physician A] for Twin Falls, and Dr. [Physician B] for Meridian." She was asked to clarify who had overall medical supervision of the agency. She stated Physician</p>	L 665	<p><b>L665 418.102 MEDICAL DIRECTOR</b></p> <p>Administrator met with Medical Director (Physician A) and Associate Medical Director (Physician B) 07/22/16 and 07/26/16 to discuss the CMS requirement of one Medical Director per provider. Physician A's contract was amended to reflect the status of Medical Director providing oversight for both locations. Physician B's contract was amended to reflect the status of Associate Medical Director. Physician A, as the providers single Medical Director, will provide oversight of both locations with Physician B assuming responsibilities and obligations when Physician A is not available. Both Physicians signed the amended contracts.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>IDAHO HOME HEALTH &amp; HOSPICE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>222 SHOSHONE ST EAST TWIN FALLS, ID 83301</b>		
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L 665	<p>Continued From page 19</p> <p>A and Physician B each directed their own branch. She stated the physicians "worked well together," but neither had authority over the other.</p> <p>The Administrator presented copies of the Physician contracts on 7/20/16. Physicians A and B had signed contracts titled "HOSPICE MEDICAL DIRECTOR AGREEMENT." Both physician contracts included the same information. Section number 2, subsection 2.2, included specific Medical Director Duties, as follows:</p> <p>"Hospice appoints Physician as its Medical Director and Physician hereby accepts the appointment. In this capacity, Physician shall provide all services at the request of Hospice, and shall assume the administrative authority, responsibility, and accountability of overseeing medical services, policies, and procedures, including the following duties ....."</p> <p>Following this, sections labeled "A" through "L" included multiple duties required of the Medical Director. Letter "L" stated "Assist in physician recruiting, and provide training, supervision and evaluation of the physicians employed by Hospice and those under contract with Hospice."</p> <p>During an interview on 7/21/16, starting at 9:00 AM, Physician A stated the agency had two Medical Directors, one for each branch. He confirmed the physicians' interactions were limited to covering for each other when on vacation.</p> <p>The agency failed to designate a single physician to serve as the Medical Director.</p>	L 665	<p>Any future contracts pertaining to hospice Physicians/Medical Directors will specify as to whether or not the Physician is designated as an Associate Medical Director or Medical Director. 100% of new contracts will be reviewed prior to signature to ensure compliance.</p> <p><b>Responsible Hospice Representative:</b></p> <p>Administrator has overall responsibility for corrective action and ongoing completion of standard.</p> <p><b>Completion Date:</b></p> <p>08/12/16</p>		

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L 671	<p>418.104 CLINICAL RECORDS</p> <p>A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, observation, and staff interview, it was determined the agency failed to ensure correct clinical documentation was maintained for 6 of 12 patients (#1, #4, #5, #6, #8, and #10), whose records were reviewed. This resulted in inaccurate and incomplete documentation in the clinical record. Findings include:</p> <p>1. Patient #10 was an 81 year old female admitted to the hospice on 11/19/15 with a terminal diagnosis of breast cancer. Patient #10's record included documentation that lacked accuracy and clarity. Examples include:</p> <p>a. Patient #10's record included a "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 4/28/16. It included the following documentation:</p> <p>"NURSE'S UPDATED ASSESSMENT/DOCUMENTATION OF PROGRESS OR DIGRESSION: PATIENT IS DEPENDENT ON OTHERS FOR MOST ACCURATE 30 LEAVING. SHE'S EVEN 2 EMULATOR USING BED AND WATCH FOR SUPPORT APPROXIMATELY 45 FEET TO THE BATHROOM. IS USING CONTINENT OF URINE AND FREQUENTLY INCONTINENCE</p>	L 671	<p><b>L671 418.104 CLINICAL RECORDS</b></p> <p>Administrator and Team Lead educated all agency staff on 07/25/16, 08/02/16 and 08/08/16 on maintaining accurate clinical information in the patient's medical record including but not limited to complete and accurate spelling, grammar, vital signs and medications. Office Manager to confirm all staff have deactivated speak to text and auto correct on tablet devices by 08/19/16. All staff instructed to proof read all documentation entered in the clinical record prior to synching device. In the event an error is discovered after synching, a coordination note will be completed identifying the visit note or other document date and the correction. All patient vital signs will be added to the "vital signs record" as well as the individual visit note to be easily reviewed prior to documenting in IDG notes or narratives to avoid inaccuracies. Team Lead to submit a clarification order 08/11/16 for patient #1 regarding oxygen. Patient does not have oxygen and did not at the time of the documentation in clinical record.</p>	11/1/16

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L.671	<p>Continued From page 21</p> <p>HAVE DIARRHEA PATIENT HAS IF SHE OLIVER HURT OR SO I'M ON MY. CAN YOU BRING CASH. PATIENT HAS TO MANAGE PRESTONS WITH CRACKERS BILATERAL EAST AND FREEZES."</p> <p>The Administrator was interviewed on 7/20/16 at 11:00 AM. She reviewed Patient #10's "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 4/28/16, and stated she was unable to determine the meaning of the nurse's update. She stated it looked as though it was caused by the "auto correct" function of the electronic medical record, and stated it should have been reviewed and corrected.</p> <p>b. Patient #10's record included an RN SOC comprehensive assessment dated 11/19/15, beginning at 5:29 PM and ending at 5:48 PM, a total of 19 minutes. The visit note included assessment of vital signs, weight, pain, fall risk, pressure ulcer risk, cardiovascular, respiratory, genitourinary, gastrointestinal, nutritional, neurologic and functional status. The documentation stated medications were reviewed, and education was provided regarding medications, nutrition, skin care, bowel protocol, and signs and symptoms of dying. Additionally, the documentation stated the POC was discussed with Patient #10. It was unclear how this was accomplished in 19 minutes.</p> <p>During an interview on 7/20/16 at 11:00 AM, the Administrator stated the start and end times on the visit note were not accurate. She stated the RN should have completed a correction note with the correct times of his visit.</p> <p>Patient #10's clinical record contained information</p>	L.671	<p>Administrator reviewed patient #10's SOC visit with a duration of 19 minutes with Office Managers. Administrator educated Office Managers on running the "Visit Time Audit Report" weekly to identify any potential errors in visit times needing clarification from the clinician. Office Managers will run the "Visit Time Audit Report" isolating the Hospice SOC and Recertification visits less than 60 minutes in duration. Any SOC or Recertification visit less than 60 minutes will be brought to the Administrators attention for review with the Case Manager. Administrator to review "Visit Time Audit Report" bi-weekly utilizing the above parameters to monitor compliance ongoing. Team Lead and Administrator will audit 6 clinical records per month for 3 months for compliance with accurate clinical record documentation with a goal of 100% compliance. If 100% compliance is achieved at the end of third month, agency will return to 4 clinical record audits per month.</p>		

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L 671	<p>Continued From page 22 that was not accurate.</p> <p>2. Patient #4 was an 85 year old female admitted to the hospice on 4/29/16 with a terminal diagnosis of Alzheimer's disease. Patient #4's record included documentation that lacked accuracy and clarity. Examples include:</p> <ul style="list-style-type: none"> <li>- An SN visit note dated 5/12/16 included "SHE HAD TAKEN FOR DRINKS OF BOAT TODAY..."</li> <li>- An SN visit note dated 5/04/16 included "THEY SHOULD BREEZE FROM HER STOMACH MOSTLY."</li> <li>- An SN visit note dated 5/19/16 included "MEDICATIONS ARE PRISON APPROPRIATE."</li> </ul> <p>During an interview on 7/20/16 at 10:35 AM, the Administrator reviewed Patient #4's record and stated the documentation was not clear and accurate. She stated it looked as though it was caused by the "auto correct" function of the electronic medical record, and stated it should have been reviewed and corrected.</p> <p>Patient #4's clinical record contained information that was not accurate.</p> <p>3. Patient #5 was an 85 year old male admitted to hospice on 7/01/14, with terminal diagnoses of COPD and renal carcinoma. A "Coordination Note," dated 7/11/2014 and timed 11:09 AM, was reviewed. It included documentation stating:</p> <p>"VISIT MADE DEATH PRONOUNCED AT 5:40 FAMILY COERCING APPROPRIATELY ALL DISCIPLINES NOTIFIED."</p>	L 671	<p><b>Responsible Hospice Representative:</b></p> <p>Administrator has overall responsibility for corrective action and ongoing completion of standard.</p> <p><b>Completion Date:</b></p> <p>11/01/16 and ongoing</p>		

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L 671	<p>Continued From page 23</p> <p>An interview was held with the Administrator on 7/22/16 at 9:25 AM. She reviewed the "Coordination Note" for Patient #5, and confirmed it was not clear. She stated the auto correct function was used and errors did occur. She stated the staff should be reviewing notes for accuracy.</p> <p>4. Patient #6 was an 83 year old male admitted to hospice on 5/17/16, with a terminal diagnosis of Alzheimer's disease. A Coordination Note, dated 5/20/16 and timed 3:45 PM, was reviewed. It included documentation stating:</p> <p>"WHAT'S THE SPIRITS WITHIN FACILITY TO SEE ANOTHER PATIENT WHEN SHE WAS CALLED TO BILL'S ROOM."</p> <p>An interview was held with the Administrator on 7/22/16 at 9:25 AM. She reviewed the "Coordination Note" for Patient #6, and confirmed it was not clear. She stated the auto correct function was used and errors did occur. She stated the staff should be reviewing notes for accuracy.</p> <p>An interview was held with the RN Case Manager on 7/19/16 starting at 12:30 PM, following a patient visit. She stated that staff had been having problems with inaccurate charting due to the "talk and text" system on the documentation devices. She stated the the talk and text ability of the device was discontinued about 4 months ago, however, there was still auto correct on the documentation device. She stated the program would misinterpret words and the staff did not regularly proofread their notes to make corrections.</p>	L 671			

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L 671	<p>Continued From page 24</p> <p>The agency failed to ensure the staff documented accurately.</p> <p>5. Patient #1 was a 66 year old male admitted to the hospice on 6/10/16 with a terminal diagnosis of brain cancer.</p> <p>The POC for certification period 6/10/16 to 9/07/16, and the IDG updates to the POC, dated 6/23/16 and 7/07/16, were reviewed. There were no medication orders for oxygen on either document.</p> <p>SN visit notes, dated 7/01/16 and 7/08/16, were reviewed. They included the following information regarding oxygen equipment and use in Patient #1's home:</p> <p>"WAS AN OXYGEN SAFETY EVALUATION PERFORMED? YES"</p> <p>"IS THERE A SIGN INDICATING 'NO SMOKING/OXYGEN IN USE? YES"</p> <p>"ARE ALL EXTRA OXYGEN CYLINDERS PROPERLY STORED (SECURED IN A BASE OF LYING DOWN PROPER AIR CIRCULATION AND INABILITY TO ROLL? YES"</p> <p>"IS THE FILTER ON THE OXYGEN CONCENTRATOR CLEAN? YES"</p> <p>"IS THE OXYGEN TUBING CHANGED AT LEAST TWICE A MONTH? YES"</p> <p>"IF APPLICABLE IS THE WATER IN THE HUMIDIFIER BOTTLE CHANGED AT LEAST MONTHLY? YES"</p>	L 671			

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L 671	<p>Continued From page 25</p> <p>"ARE THERE AEROSOL CANS IN CLOSE PROXIMITY WHILE OXYGEN IS IN USE? NO"</p> <p>"WAS THE PATIENT'S RESPIRATORY SYSTEM ASSESSED? YES"</p> <p>"INDICATE RESPIRATORY TREATMENTS UTILIZED AT HOME (MARK ALL THAT APPLY): CONTINUOUS OXYGEN"</p> <p>A visit was made to Patient #1's home on 7/19/16 from 9:35 to 10:45 AM. No oxygen equipment or supplies were observed in the home. During the visit, the caregiver was interviewed and asked if Patient #1 had been on oxygen since he began on hospice. She stated he had not been on oxygen and "his oxygen levels have been good." The RN who was present at the visit was asked if Patient #1 had been on oxygen. She stated he had not been on oxygen.</p> <p>Patient #1's clinical record did not contain accurate clinical information related to oxygen equipment or use.</p> <p>6. Patient #8 was a 65 year old female admitted to the hospice on 7/21/15, with a terminal diagnosis of severe protein-calorie malnutrition. Her record, including the POC for the benefit period 7/15/16 to 9/12/16, was reviewed.</p> <p>Patient #8's record included inconsistencies related to patient clinical data as follows:</p> <p>Patient #8's record included a "PHYSICIAN VERBAL ORDER," dated 7/07/16. The order type was listed "HOSPICE RECERTIFICATION," and included a brief summary of Patient #8's current clinical status. The summary</p>	L 671			

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L 671	Continued From page 26 documented Patient #8's mid upper arm circumference as 19 cm. However, the RN who performed the recertification assessment dated 7/05/16, (2 days previously) documented the mid upper arm circumference as 21 cm.  During an interview on 7/20/16 beginning at 3:30 PM, the hospice Administrator reviewed Patient #8's record. She was unable to determine why the "PHYSICIAN VERBAL ORDER" included a different mid upper arm circumference than what the RN documented in the 'HOSPICE RECERTIFICATION ASSESSMENT VISIT" on 7/05/16.  Patient #8's record was not clear, as it included inconsistent clinical data.	L 671			
L 673	418.104(a)(2) CONTENT  [Each patient's record must include the following:] (2) Signed copies of the notice of patient rights in accordance with §418.52 and election statement in accordance with §418.24.  This STANDARD is not met as evidenced by: Based on staff interview, review of clinical records, admission documents, and hospice policy, it was determined the hospice failed to ensure 12 of 12 clinical records (#1- #12) included a signed copy of hospice rights and responsibilities. This resulted in a lack of clarity as to whether patients or their representatives received appropriate information at admission regarding their hospice rights and had the potential to interfere with the exercise of patient rights. Findings include:	L 673	<b>L673 418.104 (a)(2) CONTENT</b>  Administrator educated all administrative and licensed admitting staff the week of 07/25/16 on the appropriate Patient Rights and Responsibilities form to be used effective immediately. All previously made admission packets have been updated to include the correct Hospice Patient Rights and Responsibilities document. The Home Health document has been removed from all Hospice admission material. Administrator has reviewed the admission packet for appropriate content. Staff educated	8/26/16	

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L 673	<p>Continued From page 27</p> <p>The agency's admission packet was reviewed. It included two separate documents explaining rights and responsibilities. One document "Idaho Patient's Rights and Responsibilities," was specific to the rights of patients who received services from home health agencies (rather than hospice agencies). A second document "Patient Rights and Responsibilities," included rights specific to hospice patients.</p> <p>Clinical records for patients #1- #12 included signed copied of the rights for patients in home health agencies. This document did not include the following hospice rights:</p> <ul style="list-style-type: none"> <li>- The right to receive effective pain management and symptom control from the hospice for conditions related to the terminal illness</li> <li>- The right to choose his or her attending physician</li> <li>- The right to receive information about the services covered under the hospice benefit</li> <li>- The right to receive information about the scope of services that the hospice would provide and specific limitation on those services.</li> </ul> <p>The Administrator was interviewed on 7/20/16 at 10:00 AM. She stated patients were receiving a copy of hospice rights and responsibilities, which was left in their homes, but she did not realize they were having patients sign the incorrect form for inclusion in patient records.</p> <p>Clinical records for patient's #1- #12 did not include signed copies of the notice of patient rights specific to hospice patients.</p>	L 673	<p>that additions or deletions to the Hospice admission packet will be made only with the approval of the Administrator. Licensed staff instructed to bring in any admission packets in their possession to be updated by 7/29. Case Managers for patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and all other active patients were given two copies of the correct Patient Rights and Responsibilities document to take to each patient or patient representative for signature. One copy will be left in the patient's home file and the other returned to the office and uploaded by the Office Manager into the clinical record by 8/26/16. Using an active patient list, Office Managers are tracking the return of all corrected Patient Rights and Responsibilities and reporting daily at morning meeting.</p> <p><b>Responsible Hospice Representative:</b></p> <p>Administrator has overall responsibility for corrective action and ongoing completion of standard.</p> <p><b>Completion Date:</b></p> <p>08/26/16 and ongoing</p>		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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July 29, 2016

Meshell Mackey, Administrator  
Idaho Home Health & Hospice  
3356 E Goldstone Way Suite 3356  
Meridian, ID 83642

Provider #131501

Dear Mr. Mackey:

An unannounced on-site complaint investigation was conducted from July 18, 2016 to July 22, 2016 at Idaho Home Health & Hospice. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006689**

**Allegation #1:** The hospice failed to provide the patient and family with a comfort kit, including pain medication, in a timely manner, prior to the patient's death.

**Findings #1:** An unannounced survey was conducted at the hospice agency from 7/18/16 to 7/22/16. During the survey, 12 clinical records were reviewed, and 3 visits were made to current patients' homes to observe hospice care and interview patients and their representatives or families. In addition, policies, occurrence reports, personnel files, and complaint documents were reviewed. Hospice administrative and nursing staff were interviewed.

One record documented an 83 year old male who was admitted to the hospice on 7/06/14. He died on 7/09/14. The record included documentation that a comfort kit had been ordered by a physician on 7/06/14, the date of admission to hospice. The comfort kit order included medications to treat pain, fever, agitation, anxiety, shortness of breath, nausea, vomiting, excessive secretions, and constipation. However, the order was not faxed to the pharmacy until 2 days later, on 7/08/14, and did not arrive in the patient's home prior to death on the morning of 7/09/14. This was confirmed by a nursing visit note, dated 7/09/14, indicating a comfort kit was not present in the patient's home.

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The hospice agency was made aware of the error when a complaint was received from a family member. As a result of investigating the complaint, hospice leadership took action to remedy the situation. Complaint resolution documentation indicated hospice leadership educated nursing staff on the importance of listening to the family's perception of patient pain and ensuring timely delivery of a comfort kit. They also re-educated staff on assessment of patients' pain. The nursing staff involved in the incident was no longer an employee of the hospice.

There were no similar incidents found during clinical record review, or review of complaints and incidents. Observations and interviews of patients/family members in homes indicated pain was adequately managed, comfort kits were present in the home, and family members were satisfied with services being provided. The hospice had established policies and procedures to guide effective pain management and symptom control.

The hospice failed to ensure the availability of a comfort kit to ensure comfort and pain management was provided during the dying process. Therefore, the allegation was substantiated. However, the hospice identified and resolved the issues prior to the survey being conducted and no current deficient practices related to pain management were identified.

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

**Allegation #2:** Nursing staff did not take vital signs or do a comprehensive initial assessment on the first visit.

**Findings #2:** Federal regulations allow the hospice agency five days to complete a comprehensive assessment. The hospice had policies and procedures that communicated the expectation that staff conduct a comprehensive initial assessment.

All twelve of the clinical records that were reviewed included documentation of vital signs on the first visit and a comprehensive assessment within 5 days of start of care. For example, one of the twelve records reviewed documented an 83 year old male who was admitted to the hospice on 7/06/14. The registered nurse (RN) visit note, dated 7/06/14, the first day of admission to the hospice, included documentation that 2.28 hours were spent in the patient's home, and another 2.62 hours were spent on completing documentation related to the visit. The vital signs recorded in the clinical record, dated 7/06/14, included the following: Temp 97.2; Pulse 72; Respiration: 12; and blood pressure: 110/60.

It could not be determined that nursing staff did not take vital signs or do a comprehensive assessment. Therefore, due to lack of sufficient evidence, the allegation was not substantiated and no deficiencies were identified.

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

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**Allegation #3:** Nursing staff did not leave hospice-related information on the first visit for family review.

**Findings #3:** The hospice provided a packet of information related to hospice services, patient rights, and information related to the dying process. During an interview on 7/20/16 at 10:00 AM, the Administrator stated the packet was routinely provided provided during the first visit. She explained that hospice staff had patients or representatives sign a document acknowledging receipt of the information. She also stated they had patients or representatives sign a copy of the Patient Rights and Responsibilities to be included in patient records.

Eleven of the twelve patient records that were reviewed included signatures from patients or their representatives confirming receipt of information on the hospice benefits, rights and responsibilities. One record documented a one day delay in providing the information to the patient and/or family.

All twelve of the records that were reviewed did not include signed copies of the hospice rights and responsibilities. Instead the signed copies of rights included in patient records related to home health patients and did not address additional rights of hospice patients.

Not all hospice related information was provided in a timely manner for all patients whose records were reviewed. Therefore, the allegation was substantiated. The hospice was cited at Code of Federal Regulations (CFR) 418.52(a) for failing to provide the patient or representative with verbal and written notice of the patient's rights and responsibilities prior to furnishing care. The hospice was also cited at CFR 418.104(a)(2) for failure to include signed copies of hospice rights and responsibilities in patient records.

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

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

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,



NANCY BAX  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

NB/pmt



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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August 1, 2016

Meshell Mackey, Administrator  
Idaho Home Health & Hospice  
3356 E Goldstone Way Suite 3356  
Meridian, ID 83642

Provider #131501

Dear Mr. Mackey:

An unannounced on-site complaint investigation was conducted from July 18, 2016 to July 22, 2016 at Idaho Home Health & Hospice. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00007173**

**Allegation #1:** The agency failed to ensure adequate pain control.

**Findings #1:** An unannounced visit was made to the hospice from 7/18/16 to 7/22/16. During the complaint investigation, medical records were reviewed, home visits were conducted, patients, family members, and staff were interviewed.

The medical records of 12 patients were reviewed. Eleven of the 12 records documented appropriate pain control. For example:

One patient record was that of a 92 year old female admitted to hospice services on 5/19/14, and died on 10/07/15. Her record for the certification period from 9/08/15 to 11/06/15, was reviewed.

In an SN visit note dated 9/23/15, the RN Case Manager documented he spent greater than 1 hour providing care. The SN visit note documented the patient's level of pain at 7 on a scale of 1-10. He wrote the patient had experienced a fall from her wheelchair during breakfast that morning. The RN Case Manager also noted the patient had a skin tear as a result of the fall.

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Additionally, he described increased restlessness. The patient's record included documentation the RN Case Manager received orders for pain medication, medication for restlessness, and wound care. The RN visit note included care coordination with the facility staff, the hospice DON, and the hospice Medical Director.

In Interdisciplinary Group meeting minutes, dated 9/23/15, the Medical Director documented the patient had increased weakness, agitation, and experienced a fall from her wheelchair that morning. The RN Case Manager reported the patient had a rapid disease progression, and would need increased nursing visits.

In an SN visit note dated 9/24/15, the RN Case Manager documented the patient had a pain level of 2 on a scale of 1-10. The visit note stated the pain medications were effective with control of her pain.

In an SN visit note dated 9/27/15, the RN Case Manager noted the patient had no pain, and "current medications are meeting the patient's needs."

In a SN visit note dated 9/28/15, The RN Case Manager documented "Patient reports some level of pain all over. Administered morphine."

In an SN visit note dated 9/29/15, the LPN described the patient's pain as 3 on a scale of 1-10. She documented "current medications are meeting the patient's needs."

In an SN visit note dated 10/01/15, the RN Case Manager documented the patient had no pain.

In an SN visit note dated 10/04/15, the RN Case Manager documented the patient denied pain at that time. He noted the patient was receiving Morphine three times daily, with an additional one time "as needed" dose.

In an SN visit note dated 10/05/15, the RN Case Manager documented the patient was non-verbal, her pain was assessed as 1 on a scale of 1-10, and responded only to painful stimuli. An additional nursing visit was performed later that day by the RN Case Manager. The reason for the additional visit was noted as "All Narcotics to be administered by Hospice Staff." The RN documented the patient's pain as 3 on a scale of 1-10.

SN visit notes documented 6 nursing visits were performed on 10/06/15 for administration of pain medications.

SN visit notes documented 2 nursing visits were performed on 10/07/15, one of which was the visit upon her death.

In Interdisciplinary Group meeting minutes, dated 10/07/15, the Medical Director documented the patient was requiring additional nursing visits.

The RN Case Manager reported the patient to be actively dying, required multiple prn (as needed) SN visits for pain medication administration.

During an interview on 7/20/16 beginning at 3:30 PM, the Administrator reviewed the patient's record and stated the RN Case Manager was no longer employed at the agency and could not be interviewed. The Administrator stated the documentation by the RN Case Manager demonstrated the patient received adequate pain and symptom control, and stated the patient's needs were discussed during the IDG meetings.

However, 1 of the 12 patient's records documented an 83 year old male who was admitted to the hospice on 7/06/14. He died on 7/09/14. The record included documentation that a comfort kit had been ordered by a physician on 7/06/14, the date of admission to hospice. The comfort kit order included medications to treat pain, fever, agitation, anxiety, shortness of breath, nausea, vomiting, excessive secretions, and constipation. However, the order was not faxed to the pharmacy until 2 days later, on 7/08/14, and did not arrive in the patient's home prior to death on the morning of 7/09/14. This was confirmed by a nursing visit note, dated 7/09/14, indicating a comfort kit was not present in the patient's home.

The hospice agency was made aware of the error when a complaint was received from a family member. As a result of investigating the complaint, hospice leadership took action to remedy the situation. Complaint resolution documentation indicated hospice leadership educated nursing staff on the importance of listening to the family's perception of patient pain and ensuring timely delivery of a comfort kit. They also re-educated staff on assessment of patients' pain. The nursing staff involved in the incident was no longer an employee of the hospice.

There were no similar incidents found during clinical record review, or review of complaints and incidents. Observations and interviews of patients/family members in homes indicated pain was adequately managed, comfort kits were present in the home, and family members were satisfied with services being provided. The hospice had established policies and procedures to guide effective pain management and symptom control.

The hospice failed to ensure the availability of a comfort kit to ensure comfort and pain management was provided during the dying process. Therefore, the allegation was substantiated. However, the hospice identified and resolved the issues prior to the survey being conducted and no current deficient practices related to pain management were identified.

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

**Allegation #2:** The agency did not answer calls from Assisted Living Facility's (ALFs).

**Findings #2:** During the investigation, agency complaint logs and patient records were reviewed. Observations were conducted and patients and staff were interviewed.

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Three home visits were conducted to evaluate hospice services provided to patients. Two of the home visits were for patients who resided in ALFs. During the visits, family members of the hospice patients, and the hospice patients were interviewed. The patients and families were asked if the hospice agency staff responded to requests. The response was the agency staff responded quickly to requests for supplies, medications, and treatments. Staff members of the ALFs were asked if the hospice agency was responsive to calls and requests. A Director of Nursing at one of the ALFs stated she received reports from the various clinicians from the hospice after patient visits were completed. She stated the hospice agency was quick to return phone calls and requests for medications or supplies.

Complaint and Grievance Logs were reviewed for the past 24 months. There were no complaints or grievances in the logs which related to poor response of the agency in returning calls from the facilities.

Twelve patient records were reviewed, 6 of which were patients who resided in ALFs. The medical records included documentation of both calls to the hospice and responses to requests. For example, One patient record was that of a patient who elected hospice benefits on 5/16/14 and died on 10/07/15. Her record documented daily CNA visits and multiple RN visits daily in her last week. The record included documentation of coordination of care with the ALF staff.

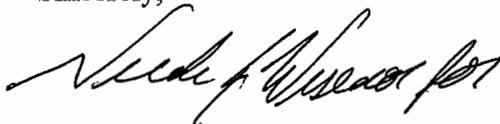
During an interview on 7/20/16 at 3:30 PM, the agency Administrator reviewed phone logs received after hours by the answering service. The Administrator was unable to find evidence of calls made to the hospice from the ALF that were unanswered.

It could not be determined that phone calls from the ALF went unanswered, however SN and CNA visits were made to the patient. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**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,



NANCY BAX  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

NB/pmt