



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
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September 19, 2011

Teresa Dixon, Administrator
Alliance Hospice
440 E Clark St Ste A
Pocatello, ID 83201



RE: Alliance Hospice, Provider #131544

Dear Ms. Benson:

Based on the survey completed at Alliance Hospice, on September 13, 2011, by our staff, we have determined Alliance Hospice is out of compliance with the Medicare Hospice Conditions of Participation of **Quality Assessment & Performance Improvement (42 CFR 418.58); Infection Control (42 CFR 418.60); Hospice Aide and Homemaker Services (42 CFR 418.76); Volunteers (42 CFR 418.78); Organizational Environment (42 CFR 418.100); Personnel Qualification (42 CFR 418.114)**. To participate as a provider of services in the Medicare Program, a hospice agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Alliance Hospice, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;

Teresa Dixon, Administrator
September 19, 2011
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- 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 agency into compliance, and that the hospice agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before October 28, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than October 20, 2011.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 3, 2011.**

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

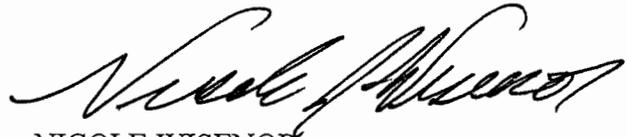
We urge you to begin correction immediately.

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

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/srm

Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/19/11
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NAME OF PROVIDER OR SUPPLIER ALLIANCE HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 218 FALLS AVENUE TWIN FALLS, ID 83301
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(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your hospice agency. Surveyors conducting the recertification were:</p> <p>Gary Guiles, RN, HFS, Team Leader Tersa Hamblin, RN, MSN, HFS Rebecca Lara, RN, BA, HFS</p> <p>Acronyms used in this report include:</p> <p>ALF = Assisted Living Facility CDC = Centers for Disease Control and Prevention CEO = Chief Executive Officer CHF = Congestive Heart Failure C.N.A. = Certified Nursing Assistant COP = Condition of Participation COPD = Chronic Obstructive Pulmonary Disease DME = Durable Medical Equipment DO = Doctor of Osteopathy DON = Director of Nursing ESRD = End Stage Renal Disease IC = Infection Control LPN = Licensed Practical Nurse LSW = Licensed Social Worker MD = Medical Director MRSA = Methicillin Resistant Staphylococcus Aureus MSW = Master Social Worker PIP = Performance Improvement Project POA = Power of Attorney PT = Physical Therapist QAPI = Quality Assessment Performance Improvement RN = Registered Nurse SNF = Skilled Nursing Facility</p>	L000		

RECEIVED
OCT 17 2011
FACILITY COMPLIANCE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Terresa Nelson RN* TITLE: *Administrator* (X6) DATE: *10-03-11*

Any deficiency statement ending with an (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 000	Continued from page 1	L 000		
L 559	<p>ST = Speech Therapist 418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT</p> <p>This CONDITION is not met as evidenced by: Based on staff interview and review of agency policies, QAPI documents and governing body meeting minutes, it was determined the hospice Failed to ensure a QAPI program was fully Developed, implemented, and maintained. This resulted in a lack of monitoring and tracking of data, an inability to identify problem-prone areas And a subsequent inability to take relevant measures to improve performance and palliative outcomes. It had the potential to negatively impact the quality of patient care and the ability of the hospice to best meet patient needs.</p> <p>1 Refer to L 560 as it relates to the failure of the hospice to ensure the development and implementation of an effective, ongoing, hospice-wide, data –driven QAPI program.</p> <p>2 Refer to L 561 as it relates to the failure of the hospice to ensure the hospice agency developed and implemented a QAPI program that measure, analyzed, and tracked quality indicators.</p>	L 559	<p>Alliance Hospice will develop and maintain an effective Quality Assessment Performance Improvement program which will track data to identify problems in the system that could negatively affect patient care and outcomes. Alliance will define a QAPI Coordinator and team that will develop, implement and maintain an effective hospice-wide program.</p> <p>This program will be data driven, use effective tools for collecting the data ie: chart reviews, patient/family satisfaction surveys, tools for monitoring and evaluating patient care and so on.</p> <p>Alliance Hospice will obtain and demonstrate in writing, by graphs, charts or other means, the measurable data that is as a result of the data collection. It will also document by graphs, charts or other documentation that demonstrates analysis of the data collected, the problems identified and trends noted that will provide information about the quality indicators that will help improve patient cares, identify any problems in the provision of services and indicate corrections needed to improve outcomes.</p>	<p>09/13/11</p> <p>09/13/11</p> <p>09/23/11</p>

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L 559	Continued From page 2 4. Refer to L563 as it relates to the failure of the hospice to ensure the QAPI program used quality indicator data, including patient care, and other relevant data, in the design of its program. 5. Refer to L 565 as it relates to the failure of the hospice to ensure the frequency and detail of data collection was approved by the hospice's governing body. 6. Refer to L 566 as it relates to the failure of the hospice to ensure the agency's QAPI program focused on high risk, high volume, and problem-prone areas. 7. Refer to L 569 as it relates to the failure of the hospice to ensure performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventive actions.	L 559	Alliance Hospice will design and use a new chart review form with quality indicators that will aide in the gathering of data related to patient care and the hospice's processes and the hospice's ability to provide that care. This form and the use of quality indicators and other relevant data will be implemented into the QAPI program. The Hospice Governing Body & Administrator will ensure that the QAPI program will include data collection & is to be done at least quarterly. The QAPI director will demonstrate this by submitting a quarterly report to the Administrator Governing Body related to the data that has been collected. This data will then be reviewed & approved by Administration. A new chart review form will be created which will include high risk, high volume, problem-prone areas related to patient care. This form will be available for review 09/16/11. Accepted by the Hospice Governing Body and distributed for use by 09/19/11. It will include quality indicators that focus on pain, symptom control, elimination, falls, infections, admission processes, POC and a new/revised patient satisfaction form (presented within 30 days from SOC). Once the data is gathered the QAPI team will identify any adverse patient events and design a performance improvement project that needs to be implemented to begin tracking, & analyzing the causes. The team will then determine the preventive actions that will be required to correct the identified problem and improve patient care and/or outcomes.	09/19/11 09/27/11 & ongoing 09/27/11 09/30/11 Will have documented PIP

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L 559	Continued From page 3 8. Refer to L 571 as it relates to the failure of the hospice to ensure PIPs were developed and implemented. 9. Refer to L 574 as it relates to the failure of the hospice to ensure the governing body assumed responsibility for implementing and maintaining the QAPI program. The cumulative effect of these systemic practices resulted in the inability to assess quality and improve performance.	L 559	Alliance Hospice ensure that once the data is collected a PIP will be identified, developed and implemented with documentation available for review. The Hospice Governing Body & Administrator will ensure that the QAPI program will be implemented and maintained by the QAPI team. A quarterly report will be submitted for review and evaluation. This report will be kept in the hospice office, submitted to the administrator quarterly and upon demand. The first report was submitted to the governing body for review on 09/23/11.	10/03/11 10/03/11 & ongoing
L 560	418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improve palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS. This STANDARD is not met as evidenced by: Based on staff interview and review of agency policies and QAPI documents, it was determined the hospice failed to ensure the Development and implementation of an effective, ongoing, hospice-wide, data-driven	L 560		09/27/11 09/30/11 Will have documented PIP

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L 560	<p>Continued From page 4</p> <p>QAPI program. The agency failed to ensure the program was capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services. This resulted in the inability of the agency to evaluate its services. Findings include:</p> <p>1. The policy "QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PROGRAM DESIRED OUTCOMES AND MONITORS," not dated, contained lists of desired outcomes including outcomes for governing body, the admission process, medical services, nursing services, social work services, spiritual services, volunteer services, interdisciplinary team services, continuity of care, clinical records, pharmacy services, durable medical equipment services, therapy services, and discharge/transfers/readmission. The policy "MONITORS," not dated, discussed 34 areas the agency would monitor such as the "Bereavement Activity Report...Hospice Aide training and Testing Book...Medical review...Pain Assessment Form..."</p> <p>The document "QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI) PROGRAM, Proposal for Twin Falls Alliance Hospice November 2010" stated the plan was to "Establish outcome measures for priority areas for quality assessment in each hospice discipline..." and listed 12 plus areas to establish outcome measures. These areas included physician services, nursing services, pharmacy services, contracted services, patient rights and others.</p> <p>No other documentation was present that quality indicators were developed for these areas.</p>	L 560	<p>Alliance Hospice will ensure that all QAPI program desired outcomes and monitors will be identified, dated, have documentation of desired outcomes related to the programs offered by the Hospice. The Agency will monitor such areas as Bereavement Activity, Hospice Aide training, Pain Assessment, Symptom Control, Volunteer Activity, Physician, nursing, pharmacy, DME services and so on.</p> <p>The Governing Body will ensure that the QAPI program will reflect improvement in processes identified as needed. These processes will be documented as a PIP, dated, presented to the Governing Body at least quarterly and tracked for evidence of improvement. All processes will be dated with the time the data was collected, the date the PIP was established, the date that interventions are identified, and the date interventions are started. Quality indicators will be documented, and the date will be added to the report. Goals will outlined and have a documented date that the desired outcome will be achieved.</p>	09/13/11 (the process was started) This will be ongoing

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L 560	<p>Continued From page 5</p> <p>The QAPI Director was interviewed on 09/08/11 beginning at 11:55 AM. He stated he was not aware of a QAPI policy or plan. He stated quality indicators for the above areas had not been developed. He stated the only data currently being gathered came from patient satisfaction surveys.</p> <p>2. A document titled "QAPI ANNUAL REPORT Alliance Hospice (Twin Falls Branch) 2010," not dated, focused on 6 areas. The summary stated:</p> <p>a. Two of 24 Post Admission surveys had been completed in 2010.</p> <p>b. Fifty-eight incident reports were documented but "...it is difficult to determine whether any given patient was a home health patient or hospice patient." [The hospice had a sister home health agency].</p> <p>c. Three recertification audits, 57% of discharge audits, and 13% of admission audits were completed in 2010. No determinations were rendered from these audits.</p> <p>d. No "Pain Assessment Audits" were completed in 2010, although 6 of these audits had been completed in the first quarter of 2011. No determinations were rendered.</p> <p>e. A "30-Day Post Discharge Survey" form should be created.</p> <p>f. A "Bereavement Survey" form should be created.</p> <p>No other data or quality indicators that had been monitored were mentioned in the report. The summary of "performance Improvement Opportunities in Past Year" contained blanks which were not filled in. the summary stated "Performance Improvement Opportunities in the past year seem to be the same as they have been...In most cases it appears that the initial data was collected but little was done actually showing that the data collected was compiled,</p>	L 560	<p>A QAPI Annual Report will be compiled at the end of each fiscal year. This report will be dated and should include the quarterly reports related to the QAPI projects for Alliance Hospice. The Annual Report will be submitted by the end of January to the Governing Body for review, recommendations and signatures.</p> <p>All the Alliance Hospice staff will be educated on the Quality Assessment Performance Improvement policy.</p> <p>All information regarding the PIPs will be posted for staff review, staff will be educated & given the opportunity to participate in the projects either by assisting with gathering the data, identifying the problems, the PIPs, implementing the interventions and establishing the goals with the date of desired goal completion.</p> <p>Patient information will be clearly designated as to the services they are receiving.</p> <p>Any audits that are performed will have identifiable determinations and these will be added to the PIP with interventions and goals and timelines.</p> <p>The 30-Day Post Discharge Survey form will be created and the Bereavement Survey form will be created.</p>	<p>10/17/11</p> <p>10/17/11</p> <p>10/20/11 Ongoing</p> <p>09/14/11</p> <p>10/20/11</p> <p>10/20/11</p>

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L 560	Continued From page 6 analyzed and reported.” A “1 st Quarter QAPI Report 2011,” not dated, mentioned “30 Day Post Admission surveys” and Post Discharge Satisfaction Surveys.” The report did not include any data or specifics. The report also mentioned incident reports but again did not contain any data or specifics. A “2 nd Quarter QAPI Report 2011,” not dated, noted the number of admissions and discharges. The report stated only 1 “Post Discharge Satisfaction Survey” had been received. Finally, the report stated “Chart Audits are regularly being conducted trying to keep the percentage of charts reviewed at 50% or more.” No actual data was mentioned. A report titled “Satisfaction Surveys,” dated August 2011, contained graphs under several headings such as DME and Pain and Symptom Management. The Office Manager was interviewed on 09/08/11 beginning at 12:15 PM. He was asked about the chart audits mentioned in the “2 nd Quarter QAPI Report 2011.” He stated he checked clinical records to see if certain forms were in the record and had been completed. He said he did not evaluate the quality of the information in the medical record. The QAPI Director was interviewed on 09/08/11 beginning at 11:55 AM. He stated he was not aware of a QAPI policy or plan. He stated that, except for patient satisfaction surveys and chart audits, no other data had been gathered in 2011. He stated incident reports were not compiled or tracked. The QAPI Director was asked to name one change that had occurred in the agency’s practices as a result of information gathered by the QAPI program. He stated he was not aware of any changes to the hospice program.	L 560	The 30 Day Post Admission survey form will be given to all patients receiving services from Alliance Hospice. These surveys will be taken to the patient and family by either the Social Worker or Chaplain to assist them with completing them if they are willing. This information will be given to the QAPI Director for evaluation and presented to the team to assist in gathering data that may help determine the weaknesses and/or strengths that exist within the Hospice services. Post Discharge Satisfaction Surveys will be done and information that is gathered by these surveys will be included in the QAPI meetings to determine if there are any weaknesses (or strengths) that need to be addressed as a PIP. This information will be included in the quarterly reports provided to the governing body. New Chart Audit forms will be created that indicate the quality of patient cares that have been performed, the need for and appropriateness of the hospice services rendered. Alliance Hospice will do monthly audits of at least 10 % of the patient charts. At least 50% of the hospice patient charts should be audited using the new form biannually. The Alliance Hospice QAPI team will incorporate the use of incident reports and the information in these reports will be tracked and used in the QAPI program. Alliance staff will be educated on the use of these incident reports, the PIPs and practices that indicate what changes have occurred as a result of the QAPI program.	10/20/11 10/25/11 09/16/11 10/03/11 09/16/11 10/14/11

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L 562	Continued From page 8 (2) The Hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations. This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the hospice failed to ensure development and implementation of a QAPI program that measured, analyzed, and tracked quality indicators. This resulted in a lack of data which the agency could monitor and evaluate its services. Findings include: A report titled "Satisfaction Surveys," dated August 2011, contained graphs under several headings such as DME and Pain and Symptom Management. Otherwise, no data regarding the agency's services had been gathered and reported in 2011. No objective quality indicators had been developed. The QAPI Director was interviewed on 09/08/11 beginning at 11:55 AM. He stated he was not aware of a QAPI policy or plan. He stated the only data currently being gathered came from patient satisfaction surveys. He stated he did not have documentation that showed quality indicators had been developed, measured, and analyzed for 2011.	L 562	Alliance Hospice will demonstrate the ability to measure, analyze and track quality indicators with its new chart audit forms, satisfaction surveys, chart reviews, 30 day satisfaction surveys, incident reports, infection reports and so on. Data that is gathered will demonstrate the agency's ability to show services provided, quality of those services, improvements to be made as needed and the goals that are desired to be reached thereby improving patient care and Alliance Hospice's processes in providing that care. The QAPI Director will be instrumental in leading the quality program for Alliance and gathering data to improve patient cares and outcomes.	Started 09/19/11 And will be ongoing 09/19/11 ongoing 10/03/11
L 563	The hospice did not measure, analyze, or track quality indicators through its QAPI program. 418.58(b)(1) PROGRAM DATA (1)The program must use quality indicator data,			

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L 563	Continued From page 10 PROGRAM, Proposal for Twin Falls Alliance Hospice November 2010" stated the plan was to "Establish outcome measures for priority areas for quality assessment in each hospice discipline..." The plan did not mention quality indicators or how data would be used. Except for satisfaction survey, quality indicators had not been developed. The QAPI Director was interviewed on 09/08/11 beginning at 11:55 AM. He confirmed objective quality indicators had not been developed. He stated he was not aware of a QAPI policy or plan that mentioned how data would be used.	L 563	Alliance Hospice will use such quality indicators as incident reports, infection reports and logs, 30 day satisfaction surveys, volunteer reports, bereavement reports, chart reviews, a QAPI chart audit form and so on.	10/03/11
L 565	The hospice did not develop a QAPI program that defined which quality indicators the hospice would use or how the data would be used. 418.58(b)(3) PROGRAM DATA (3) The frequency and detail of the data collection must be approved by the hospice's governing body. This STANDARD is not met as evidenced by: Based on staff interview and review of agency QAPI documents and governing body meeting minutes, it was determined the hospice failed to ensure the frequency and detail of data collection was approved by the hospice's governing body. This resulted in a lack of direction to agency staff regarding data collection. Findings include: 1. The document "QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI) PROGRAM, Proposal for Twin Falls Alliance	L 565	The quality indicators and QAPI program will be reviewed and evaluated by the Governing Body monthly. The QAPI team will meet at least monthly. Monthly reports are to be submitted to the Governing Body and upon request. Quarterly up-dates related to the program will be required quarterly and a summary of the year's QAPI will be submitted annually for review by the Governing Body and Administrator.	10/14/11

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L 565	<p>Continued From page 11 Hospice November 2010" stated the plan was to "Establish outcome measures for priority areas for quality assessment in each hospice discipline..." and listed 12 plus areas to establish outcome measures. The plan did not include quality indicators to be measured or the frequency and detail of data collection.</p> <p>The QAPI Director was interviewed on 09/08/11 beginning at 11:55 AM. He stated he was not aware of a QAPI policy or plan that included specific quality indicators. He stated the only data currently being gathered came from patient satisfaction surveys.</p> <p>The hospice's QAPI plan did not define quality indicators or how data would be gathered and used.</p> <p>2. A document titled "QAPI ANNUAL REPORT Alliance Hospice (Twin Falls Branch) 2010," not dated, focus on 6 areas. The summary stated:</p> <p>a. Two of 24 Post Admission Surveys had been completed in 2010.</p> <p>b. Fifty-eight incident reports were documented but "... it is difficult to determine whether any given patient was a home health patient or hospice patient." [The hospice had a sister home health agency].</p> <p>c. Three recertification audits, 57% of discharge audits, and 13% of admission audits were completed in 2010. No determinations were rendered from these audits.</p> <p>d. No "pain Assessment Audits" were completed in 2010, although 6 of these audits had been completed in the first quarter 2011. No determinations were rendered.</p>	L 565	<p>QAPI ANNUAL REPORTS will be completed in full and submitted to the Governing Body for review and evaluation by the first month (ex: January 2013) of the next year.</p> <p>The hospice will ensure that Hospice data and Home Health data are gathered separately and will at no time be included in the same reports or quality improvement programs.</p>	

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L 565	<p>Continued From page 12</p> <p>e. A "30-Day Post Discharge Survey" form should be created.</p> <p>f. A "Bereavement Survey" form should be created.</p> <p>No other data or quality indicators were referenced in the report as being monitored. The summary of "Performance Improvement Opportunities in Past Year" contained blanks which were not filled in. the summary stated "Performance improvement opportunities in the past year seem to be the same as they have been... In most cases it appears that the initial data was collected but little was done actually showing that the data collected was compiled, analyzed and reported."</p> <p>A "1st Quarter QAPI Report 2011," not dated, noted the number of admissions and discharges. The report stated only 1 "Post Discharge Satisfaction Survey" had been received. Finally the report stated "Chart Audits are regularly being conducted trying to keep the percentage of charts reviewed at 50% or more." No actually data was mentioned.</p> <p>A report titled "Satisfaction Surveys," dated August 2011, contained graphs under several headings such as DME and Pain and Symptom Management but this was all based on subjective data that people remembered from the past. No</p>	L 565	<p>A Post Discharge Survey form already exists. A Bereavement Survey form (which can be used at 6 months and at 13 months) is completed. The QAPI director will be educated on the forms that are available through Alliance. This education will also include the QAPI policy with a copy to be placed in the QAPI manual. The above education will be presented at staff meetings, Governing Body meetings and QAPI meetings.</p> <p>The QAPI reports will not contain blanks. The PIPs will indicate whether data is still being gathered, interventions are being done and monitored and dates goals are expected to be met.</p>	<p>10/30/11</p> <p>10/31/11 and on-going</p> <p>10/14/11 And on-going</p>

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L 566	Continued From page 14 This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the hospice failed to ensure the agency's QAPI program focused on high risk, high volume, and problem-prone areas. This resulted in a lack of prioritization for the QAPI program. Findings include: The document "QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI) PROGRAM, Proposal for Twin Falls Alliance Hospice November 2010" stated "Regular reports will be produced and distributed for evaluation especially identifying and focusing on areas of highest risk, high volume or areas that tend to have problems." The plan did not define what those areas were. A "1 st Quarter QAPI Report 2011," not dated, did not mention quality indicators or data related to high risk, high volume, problem-prone areas. A "2 nd Quarter QAPI Report 2011," not dated, did not mention quality indicators or data related to high risk, high volume, problem-prone areas. The QAPI Director was interviewed on 09/08/11 beginning at 11:55 AM. He stated high risk, high volume, problem-prone areas had not been specified through the QAPI program. The hospice QAPI program did not focus on high risk, high volume, and problem-prone areas.	L 566	The Alliance Hospice governing body will ensure that the agency's QAPI program focuses on high risk, high volume, and problem-prone areas. These areas will be addressed in the monthly reports and evaluated monthly and as needed by the governing body. The plan will be defined as to the problems(s) that are identified as high risk, high volume or problem-prone and focus on the areas of greatest concerns first. The governing body will be educated on all of the above.	10/10/11
L 569	418.58(c)(2) PROGRAM ACTIVITIES (2)Performance improvement activities must track adverse patient events, analyze their	L 569		

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L 569	Continued From page 15 Causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice. This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the hospice failed to ensure performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventative actions. This resulted in the inability of the agency to develop strategies to decrease adverse events. Finding include: Reports of 14 incidents were filed by the agency in 2011. Nine of these were patient falls. While the agency had noted the incidents, no analysis or tracking of the events in relation to agency practices was documented. The QAPI Director was interviewed on 09/08/11 beginning at 11:55 AM. He stated adverse events were not analyzed or tracked through the QAPI program. The hospice did not analyze and track adverse events.	L 569	Alliance hospice will gather data through incident reports, infection reports and logs, via chart reviews and so on to track adverse patient events. This data will be analyzed as to cause and preventive actions will be implemented to ensure patient safety, quality of life and positive outcomes. The governing body will ensure that all adverse events are documented and followed up with corrective actions in place at least monthly and more often as needed. Any adverse events (example: patient falls) will be tracked and a plan put in place for correction. These events will also be tracked and compared annually by the governing body to see if there is an improvement or decline in processes. These will also include monthly analysis, tracking and planning or more often as necessary.	10/10/11 and on-going
L 571	418.58(d) PERFORMANCE IMPROVEMENT PROJECTS Beginning February 2, 2009, hospice must develop, implement and evaluate performance improvement projects. This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the hospice failed to ensure development and implementation of	L 571		

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L 571	Continued From page 16 PIPs. This resulted in missed opportunities for improvement. Findings include: The document "QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI) PROGRAM, Proposal for Twin Falls Alliance Hospice November 2010" stated reports would be produced identifying areas that had problems. The report said "On the basis of these reports, Performance Improvement Projects may be initiated. PIPs will track identified areas for improvement, analyze causes, initiate corrective actions, receive feedback and provide educational opportunities for hospice staff." The only documented information gathered by the QAPI program in 2011 was a patient satisfaction survey distributed to patients 30 days after admission. No PIP which utilized objective information had been established in 2011. The QAPI Director was interviewed on 09/08/11 beginning at 11:55 AM. He confirmed no objective data had been gathered as part of a PIP in 2011. The hospice had not developed and implemented PIPs.	L 571	The Alliance Hospice QAPI program will identify Performance Improvement Projects that are needed to initiate corrective actions on problems that have been noted as a result of data gathering and quality indicators information. These projects will be evaluated at least monthly and as needed by the governing body. The hospice staff will be educated and involved in the PIP projects as determined by the information acquired to establish the PIP. They will be involved in decisions related to providing feedback, analyzing the causes of the problems, and establishing/initiating corrective actions.	10/14/11 And on-going
L 574	418.58(e)(1) EXECUTIVE RESPONSIBILITIES 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.	L 574	Alliance Hospice's governing body will assume responsibility in ensuring that the ongoing QAPI program is well defined, implemented, maintained and evaluated at annually and more often as necessary.	10/10/11 and at the beginning of each year.

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L 574	Continued From page 18 Documentation of governing body involvement with the QAPI program. She stated the governing body had discussed the QAPI program but said this was not documented.	L 574	Documentation of the Alliance Hospice governing body's meetings and review of QAPI will be done. The minutes regarding the QAPI program will be provided to the clinical offices.	10/10/11 And on-going
L 577	The hospice's governing body had not provided oversight of the QAPI program. 418.60 INFECTION CONTROL This CONDITION is not met as evidenced by: Based on staff interview, review of IC policies and personnel files, it was determined the hospice failed to ensure 1) and infection control program was defined, implemented, and maintained; 2) development and implementation of a program for the surveillance, identification, and prevention of infectious diseases; and 3) infection control education for employees and contract staff. This resulted in the inability of staff to effectively detect, monitor, and prevent infections and insure acceptable standards of infection control were practiced. It had the potential to negatively impact patient safety. 1. Refer to L 578 as it relates to the hospice's failure to ensure an infection control program was defined, implemented, and maintained. 2. Refer to L 579 as it relates to the hospice's failure to ensure accepted standards of practice were followed to prevent the transmission of infections. 3. Refer to L 580 as it relates to the hospice's failure to ensure development and implementation of a program for the surveillance, identification, and prevention of infectious	L 577	Alliance Hospice will ensure that an infection control program is implemented, maintained and evaluated to ensure the identification and prevention of infectious diseases. There will be education offered to the hospice staff upon orientation and at least annually related to infection control. The hospice patients and families will receive information and education related to infection preventive measures and control upon admission and throughout their stay with Alliance as is necessary.	09/26/11

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L 577	Continued From page 19 diseases.	L 577	Alliance Hospice will document and put into effect an effective infection control program for the protection of its patients, families, visitors and hospice staff. The infection control program will follow the recommendations from the CDC, WHO, and JACHO. The infection control program will have infection control forms and logs for reporting any staff or patient/family infections (such as colds that is noted to spread throughout the Alliance staff in a short amount of time). This program will help staff to effectively detect, monitor, and prevent infections. Alliance Hospice will include in its policy a comprehensive Infection Control statement as recommended by JAHCO as follows: 1. Use evidence-based national guidelines 2. Plan infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate risk of infection and document these activities. 3. Evaluate prevention and control activities and document the method used. 4. Educate staff on responsibilities related to infection prevention and control. 5. Process of investigating outbreaks of infectious disease. 6. Communicate responsibilities about preventing/controlling infection to licensed independent practitioners, staff visitors, patients & families. Give information on hand and respiratory hygiene practices. 7. Reporting infections to external organizations. 8. May incorporate in QAPI program.	09/27/11
L 578	4. Refer to L 582 as it relates to the hospice's failure to ensure the hospice provided infection control education to employees/contract staff. The cumulative effect of these systemic practices resulted in an incomplete and ineffective infection control program. 418.60 INFECTION CONTROL The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases. This STANDARD is not met as evidenced by: Based on staff interview and review of IC policies, it was determined the hospice failed to ensure an infection control program was defined, implemented, and maintained. This resulted in the inability of staff to effectively detect, monitor, and prevent infections. Findings include: The hospice had not developed comprehensive IC policies. The policy "INFECTION CONTROL-EMPLOYEES," not dated, stated staff would wash their hands but no hand washing procedure was present. In addition, hand sanitizers were not addressed in the policy. The policy stated gowns and gloves would be worn but no comprehensive policy for the use of personal protective equipment was present. The definition of infections was not present in	L 578		

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L 578	<p>Continued From page 20</p> <p>policies. Standards for disease prevention from organizations, such as the CDC or the World Health Organization, were not present. The use of a log or method to track infections was not addressed in policies.</p> <p>The policy "INFECTION CONTROL-PATIENTS," not dated, stated "The infection control program will be conducted in accordance with recommendations by the American Hospital Association and the Joint Commission on the Accreditation of Healthcare Organizations." These standards were not included in the policies or present at the hospice. The policy "INFECTION CONTROL-PATIENTS" also stated the hospice inpatient unit would be subject to an IC program which included surveillance. The hospice did not have an inpatient unit. Also, a procedure for surveillance for infections for hospice patients was not present in policy.</p> <p>The IC Officer was interviewed on 9/09/11 beginning at 10:25 AM. She confirmed the limited policies. She stated she did not maintain an infection control log. She stated she thought the QAPI Director might have a log but said she did not know if this was the case. (A log of infections was not maintained by the QAPI Director per interview with him on 9/08/11 at 11:55 AM). She stated she thought the hospice had cared for patients with MRSA infections but she could not identify the patients or the time frames. She confirmed the hospice did not have written standards from IC organizations or the organizations listed in policy.</p> <p>The hospice did not maintain and document an effective infection control program.</p>	L 578	<p>Alliance Hospice will have copies of the CDC recommendations on infection control available for staff education and review. These recommendations such as hand washing, use of sanitizer, respiratory hygiene/cough etiquette in the Healthcare Settings will be on file in the Alliance office. Hand washing, use of hand sanitizer and respiratory hygiene/cough etiquette will be added to the admission packets for all patients and their families pertaining to education. Standard precautions, including the use of personal protective equipment, will be used to reduce the risk of infection. Staff, patients, families, visitors and contract staff will be educated on standard precautions. This information can be disseminated via education, posters, pamphlets and so on. (Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients). All of the above will be added to the infection control policy. The hospice will take precautions in response to the way suspected or identified infections are spread within the service setting and community. The hospice reports infection surveillance, prevention, and control information to the appropriate staff within the organization. The hospice reports infections to local, state, and federal public health authorities in accordance with the law. When the hospice becomes aware that it transferred a patient who has an infection requiring monitoring, treatment, and/or isolation it informs the receiving organization.</p> <p>Alliance hospice will document patient and staff infections on the infection report and the infection control log. This report will be reviewed monthly or more often as needed.</p>	09/30/11

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L 579	<p>418.60(a) PREVENTION</p> <p>The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of IC policies, it was determined the hospice failed to ensure accepted standards of practice were followed to prevent the transmission of infections. This resulted in a lack of guidance to staff regarding IC. Findings include:</p> <p>Standards for disease prevention, from organizations such as the Center for Disease Control and Prevention or the World Health Organization, were not present in agency policies.</p> <p>The policy "INFECTION CONTROL-PATIENTS," not dated, stated "The infection control program will be conducted in accordance with recommendations by the American Hospital Association and the Joint commission on the Accreditation of Healthcare Organizations." These standards were not included in the policies and were not present in the agency.</p> <p>The IC Officer was interviewed on 9/09/11 beginning at 10:25 AM. She confirmed written IC standards were not present and available to staff.</p>	L 579	<p>To be added to the Policy for Alliance Hospice: Alliance Hospice will follow the standards for disease prevention as recommended by the CDC and JAHCO.</p> <p>Copies of the CDC and JAHCO standards will be included in the hospice education and available for review by staff at all times.</p>	<p>9/30/11</p> <p>9/30/11</p>
L 580	<p>418.60(b)(1) CONTROL</p> <p>The hospice did not utilize accepted standards of practice in its IC program.</p> <p>The hospice must maintain a coordinated agency-wide program for surveillance,</p>	L 580	<p>Alliance Hospice will include and educate the entire staff on maintaining an agency wide program.</p>	09/30/11

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L 580	Continued From page 23 Surveillance and identification of infectious diseases.	L 580		
L 582	418.60(c) EDUCATION The hospice must provide infection control education to employees, contracted providers, patients and family members and other caregivers. This STANDARD is not met as evidenced by: Based on staff interview, and review of personnel files and policies, it was determined the agency failed to ensure the hospice provided infection control education to 13 of 14 employees and contract staff (A, B, C, E, H, I, J, K, L, M, N, O, and P) whose personnel records were reviewed. It had the potential to negatively impact patient safety. Findings include: 1. The Branch Director and surveyor reviewed personnel files together on 9/08/11 between 2:30 PM and 4:00 PM. There was no documentation of infection control education as follows: Staff A, a CNA whose hire date was 8/30/10, did not have evidence in her personnel file of agency initiated infection control education upon hire. Staff B, a CNA whose hire date was 7/27/10, did not have evidence in her personnel file of agency initiated infection control education since hire. Staff C, a CNA whose hire date was 5/01/09, did not have evidence in her personnel file of agency initiated infection control education upon hire. Staff E, a CNA whose hire date was 7/06/11, did not have evidence in her personnel file of agency	L 582	All Alliance Hospice employees and contract staff will be given education related to the infection control policies. This education will begin at time of hire with orientation and will be offered annually and as necessary throughout employment. All current employees and contract staff will be given education on infection control and will have documented evidence of this education in the office's employee education log or their employee files.	09/22/11 10/14/11

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L 582	<p>Continued From page 24 initiated infection control education upon hire.</p> <p>Staff H, an LPN whose hire date was 6/28/10, did not have evidence in her personnel file of agency initiated infection control education upon hire.</p> <p>Staff I, an LPN whose hire date was 5/01/09, did not have evidence in her personnel file of agency initiated infection control education upon hire.</p> <p>Staff J, an RN whose hire date was 5/01/09, did not have evidence in her personnel file of agency initiated infection control education upon hire.</p> <p>Staff K, an RN whose hire date was 2/21/11, did not have evidence in her personnel file of agency initiated infection control education upon hire.</p> <p>Staff L, an LSW whose hire date was 4/06/11, did not have evidence in her personnel file of agency initiated infection control education upon hire.</p> <p>Staff M, and MSW whose hire date was not listed, did not have evidence in her personnel file of agency initiated infection control education.</p> <p>Staff N, an ST whose contract date was 7/30/11, did not have evidence in her personnel file of agency initiated infection control education at or since hire.</p> <p>Staff O, a PT whose contract date was 1/01/10, did not have evidence in his personnel file of agency initiated infection control education since hire.</p> <p>Staff P, a PT whose contract date was 5/21/09, did not have evidence in his personnel file of</p>	L 582	See previous page.	10/14/11

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L 607	Continued From page 26 At least 12 hours of in-service training during each 12 month period; and 3) RNs prepared complete written patient care instructions for home health aide care plans. These failures had the potential to negatively impact safety, quality, and coordination of patient care. Findings include: 1. Refer to L 615 as it relates to the hospice's failure to ensure hospice aides successfully completed competency evaluations prior to initiating patient care. 2. Refer to L 620 as it relates to the hospice's failure to ensure hospice aides received at least 12 hours of in-service training during each 12 month period. 3. Refer to L 625 as it relates to the hospices failure to ensure complete, written patient care instructions were consistently prepared by the RN. The cumulative effective of these systemic practices resulted in the potential to negatively impact quality and coordination of patient care. 418.76(c)(1) COMPETENCY EVALUATION	L 607	All Alliance Hospice aides will receive at least 12 hours of education and training annually.	10/14/11 And on-going
L 615	An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with	L 615	All Alliance Hospice aides will have competency evaluations done during their hospice orientation period and at least annually thereafter. These competencies will be conducted through a visit with an RN, by written and/or oral examination. The CNAs will have a competency evaluation done annually throughout their employment with hospice. These will be documented and placed in their employee files and/or the office education log book.	10/14/11 and on-going

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NAME OF PROVIDER OR SUPPLIER ALLIANCE HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 218 FALLS AVENUE TWIN FALLS, ID 83301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 615	<p>Continued From page 27</p> <p>a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of hospice policies and hospice aides' personnel records, it was determined the agency failed to ensure hospice aides successfully completed competency evaluations prior to initiating patient care, for 4 of 5 hospice aides (A, B, C, and E) whose personnel records were reviewed. This had the potential to negatively impact the safety and quality of patient care. Findings include:</p> <p>An undated hospice policy, "HOSPICE AIDE SERVICES (HOME HEALTH AIDE)," made the following points: -Training must be complete, current and documented. -Upon hiring, and yearly, each hospice service aide will take a written test covering topics pertinent to the position to retain employment the hospice service aide must score at least 80% on the written test. -The hospice aide will be subjected to a skills check by a registered nurse, upon hire and annually, and will be allowed to perform only those procedures which have been demonstrated successfully.</p> <p>The Branch Director and surveyor reviewed personnel records together on 9/08/11 between 2:30 PM and 4:00 PM. There was no documentation in employee files for Staff A, B, C, and E of evaluation of hospice aide</p>	L 615	<p>The Alliance Hospice administration will re-educate the Branch Director in the "HOSPICE AIDE SERVICES (HOME HEALTH AIDE)," policy requirements for education and completion of competency in order for the aide to maintain employment. Each aide will demonstrate the ability to take and pass the written test. This will be done at time of hire and annually as long as they are employed by Alliance.</p> <p>Proof of this education for the Branch Director will be added to the employee file and/or the office education book.</p> <p>All education and competency evaluations for the aides will be documented and copies will be placed in their employee files and/or education books.</p>	09/30/11 And on-going

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L 615	Continued From page 28 competencies, upon hire, prior to furnishing care to hospice patients. The Branch Director stated aides did not routinely have competencies assessed at hire and the aides were oriented by other aides. She confirmed there was no documentation of aide competencies at hire for staff A, B, C, and E. The DON was interviewed on 9/09/11 beginning at 9:50 AM. She stated newly hired aides oriented with other aides, and she was contacted if there was an area of concern she needed to address. She stated the aides did not go through a competency checklist at hire, but did so at annual evaluation. The agency did not ensure hospice aides successfully completed competency evaluations prior to providing patient care.	L 615	All Alliance Hospice aides will have completed their competencies upon hire and will have demonstrated the ability to perform & pass their competencies in providing patient cares with evaluation by the RN prior to performing patient cares on their own. Aide orientation will be initiated by the RN and will then be continued with visits from an experienced aide working for the agency that has already completed and passes competencies and education. The Branch Director and Director of Nursing will be re-educated in this policy. Evidence of this education will be included in their employee files and/or education manual.	09/30/11 9/30/11 10/14/11
L 620	418.76(d) IN-SERVICE TRAINING A hospice aide must receive at least 12 hours of in-service training during each 12- month period. In-service training may occur while an aide is furnishing care to a patient. This STANDARD is not met as evidenced by: based on staff interview and review of personnel files, it was determined the agency failed to ensure hospice aides received at least 12 hours of in-service training during each 12 month period for 3 of 4 aides (A, B, and D) employed for 12 months or longer whose personnel files were reviewed. This had the potential to result in hospice aides who were less aware of issues/skills involving patient care. Findings include:	L 620	Alliance Hospice shall ensure that all aides will receive at least 12 hours of continuing education related to hospice and patient care services. This will occur upon hire and annually throughout their employment with Alliance. Proof of this education will be added to their personnel files and/or the office education book. This education will be offered on an individual basis or monthly during staff meetings or during CNA meetings.	9/30/11

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L 620	Continued From page 29 The Branch Director and surveyor reviewed personnel records together on 9/08/11 between 2:30 PM and 4:00 PM. Aide records did not keep a tally or total of in-service training hours. the Branch Director was unsure of the length of training because they were not stated on in-service documentation. There was no system in place that documented what time period the hospice used to count the 12 hours of required in-service training, whether on an employment anniversary basis, a rolling 12 month basis, or per calendar year. based on the Branch Director's estimate of in-service hours, totals of hours for Staff A, B, and D did not meet 12 hours, as follows: Staff A, a CNA whose hire date was 8/30/10, did not have a personnel file that included evidence of any in-service hours. Staff B, a CAN whose hire date was 7/27/10, had a personnel file with in-service information. The Branch Director estimated in-service hours were from 6.5 to 8.5 hours. Staff D, a CNA whose hire date was 5/01/09, had a personnel file with in-service information. The Branch Director estimated in-service hours were from 8 to 10 hours. The hospice did not ensure hospice aides received at least 12 hours of in-service training during each 12 month period.	L 620	The Branch Director and Director of Nursing will be re-educated on the in-service hours that are required for the CNAs as a condition of continued employment with Alliance. An education log will be added to each employee file or to the education book to demonstrate the hours of in-service that has been completed. Each in-service will have documented the date it was presented, the time the in-service started and the time it was completed, at the top of the page. This will enable easier tracking of the number of hours that has been provided and the number of hours that need to be completed for each aide to fulfill their education requirements.	10/14/11
L 625	418.76(g)(1) HOSPICE AIDE ASSIGNMENTS AND DUTIES (1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of	L 625		

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L 625	<p>Continued From page 30</p> <p>the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the hospice agency failed to ensure complete, written patient care instructions were consistently prepared by the RN, for use by the hospice aide, in 5 of 7 patients (#2, #4, #5, #6 and #11) who received aide services whose records were reviewed. This failure resulted in a lack of professional guidance for the hospice aides and had the potential to negatively impact the safety, quality and coordination of patient care. Findings include:</p> <p>1. Patient #2 was an 83 year old female, admitted to the hospice agency on 12/15/10, with a diagnosis of rectal cancer. On 9/07/11, between 12:00 PM and 1:35 PM, a visit to the SNF, where Patient #2 resided, took place in order to observe care provided by the hospice aide. According to observation and interview with the aide on 9/07/11 between 12:00 PM and 1:35 PM, Patient #2 was hearing impaired and unable or unwilling to communicate. Patient #2 was observed wearing oxygen at 2 liters, per nasal cannula and ace wraps on both ankles and feet. Patient #2 required full assistance with all activities of daily living. The aide was observed with all activities of daily living. The aide was observed performing the following activities: feeding, 2-person transfer with a gait belt from wheel-chair to bed, bathing, personal hygiene, and colostomy care.</p> <p>On 9/07/11, between 12:00 PM and 1:35 PM, the</p>	L 625	Alliance Hospice will ensure that all patient care instructions for the hospice aide will be completed by an RN prior to the aide rendering patient care. All of the cares will be defined by the RN and the aide will follow those instructions exactly as ordered on the POC. The aide will carry a copy of this POC to the patient home and will document the cares provided. Once the RN has completed the POC a yellow copy will be left in the home.	09/14/11

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L 625	<p>Continued From page 31</p> <p>Aide stated she had never performed colostomy care and had received no training. After discussing colostomy care with the SNF/LPN assigned to the patient on the day of the visit, the hospice aide proceeded to perform colostomy care. The aide was unable to explain the presence of ace wraps on Patient #2's ankles and feet and stated she had never changed them.</p> <p>The "Aide Plan of Care and Visit Note" for Patient #2, dated 8/27/11, and timed 12:40 PM to 2:20 PM, did not include instruction in the use of Oxygen or ace wraps. There was also no instruction related to colostomy care or 2-person assisted transfers.</p> <p>An interview with the DON was conducted on 9/09/11 at 9:15 AM. The DON stated she verbally communicated the plan of care to the aide, but confirmed the written plan of care was incomplete.</p> <p>The hospice agency did not ensure the aide was provided with complete written patient care instructions. The aide plan of care did not guide the aide in the use of oxygen, colostomy care, ace wraps and 2-person assisted transfers with a gait belt.</p> <p>2. Patient #4 was an 84 year old male, admitted to the hospice agency on 2/05/11, with diagnoses of dementia and COPD. According to the initial "HOSPICE PLAN OF CARE," dated 2.05/11 and established by the RN, the patient was cognitively impaired, with altered communication. The initial "HOSPICE PLAN OF CARE" also stated Patient #4 and his wife resided in an ALF.</p>	L 625	<p>All Hospice Aide care plans will be completed by the RN prior to delivery of cares. The POC will be detailed as to the special needs and cares required by the patient. If the aide is unsure of how to perform certain procedures then education will be provided prior to the aide providing care. The aides will be educated to call the RN Case Manager if there are services needed by the patient that they are unable to provide.</p> <p>Administration will revise the aide care plan by adding reminders and indicators for the RN to complete providing a more detailed set of patient care instructions. The RN will be re-educated to write on the POC any further detailed instructions that may be needed for the aide to provide safe and effective patient cares.</p>	10/03/11 10/20/11

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L 625	<p>Continued From page 32</p> <p>On 9/07/11 between 2:00 PM and 3:00 PM, a visit took place in order to observe care provided by the hospice aide. The patient appeared disoriented and confused at the time of the visit. The patient's wife, who was the designated POA, was present during the visit. The aide was observed performing the following activities: 2-person assisted transfer with the use of a gait belt and hand rails, bathing/shower assistance with use of shower chair, personal hygiene assistance, toileting assistance with the toilet riser, and assistance with dressing. The aide was observed transferring the oxygen tubing from a stationary oxygen container to a portable oxygen container for the purpose of showering. Once the tubing and cannula were in place, the aide turned off the stationary container, turned the portable container on, and adjusted the flow rate to 2 – 3 liters. Olive oil was applied to the lower extremities by the aide, which she reported would alleviate dryness. Topical cream was applied to rash areas as well.</p> <p>The "Aide Plan of Care and Visit Note" for Patient #4, dated 8/26/11, timed 2:00 PM to 5:15 PM and signed by the RN, was reviewed on 9/06/11. The plan of care was found to be incomplete and did not include instruction for use of the following: oxygen, 2-person transfer, wheel chair, gait belt, toilet riser, shower chair, olive oil, and topical cream.</p> <p>An interview with the DON was conducted on 9/09/11 at 9:00 AM. The DON stated she communicated the plan of care verbally to the aide and approved the use of olive oil to the lower extremities and topical cream to rash areas. She agreed no written instructions were included on</p>	L 625	<p>Administration will re-do the aide care plan so that it will include a more detailed set of instructions for the aide in relation to cares. The RNs will also add the necessary details in cares to the POC so there won't be any questions about services that are needed. All of the aide POCs will be signed and dated by the RN as to the date of the POC.</p> <p>The RNs and aides will be educated on the proper completion of the aide POC, how to follow the care plan and when to notify the RN case manager of needed changes for proper documentation and follow up.</p>	<p>10/15/11</p> <p>10/03/11</p>

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L 625	<p>Continued From page 33</p> <p>the aide plan of care related to the use of oxygen, olive oil, topical cream, or the need for a gait belt, with 2-person assisted transfer.</p> <p>The plan of care did not provide comprehensive guidance for the hospice aide.</p> <p>3. Patient #5 was a 67 year old female, admitted to the hospice agency on 8/19/11, with diagnoses of diabetes mellitus and ocular cancer with metastasis. She died on 9/04/11.</p> <p>The initial "HOSPICE PLAN OF CARE," dated 8/19/11, stated Patient #5 required oxygen at 2 liters, maximum assistance with transfers, the need to avoid nail care for patients diagnosed with diabetes mellitus, a hospital bed, an alternative mattress and a bed side commode.</p> <p>The "Aide Plan of Care and Visit Note," dated 8/26/11, timed 12:00 PM to 1:40 PM, was signed by the RN. The plan did not include instruction or guidance related to the following: oxygen, the need for maximum assistance transfer, the need to avoid nail care for patients with a diagnosis of diabetes mellitus, the use of a hospital bed, alternative mattress and bed side commode.</p> <p>During an interview with the DON on 9/09/11 at 9:30 AM, she stated the plan of care was communicated to the aide verbally. She agreed the written aide plan of care was incomplete.</p> <p>4. Patient #11 was an 87 year old male, admitted to the hospice agency on 8/22/11, with diagnoses of CHF, ischemic cardiomyopathy (weakness in the muscle of the heart due to inadequate oxygen), COPD and ESRD. The "HOSPICE</p>	L 625	<p>The Alliance Hospice aide plan of care will include instructions or guidance related to oxygen, the need for maximum assist with ADLs, avoidance of types of cares due to increased health risks, use of different types of DME, 2-person assistance, gait belt and so on. If at any time the POC is in need of change or up-dates it will be completed with the date the up-date was needed and at every recertification.</p>	10/14/11 and on-going

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L 625	<p>Continued From page 34</p> <p>PLAN OF CARE, NURSING SERVICES," dated 8/22/11 and signed by the RN, documented Patient #11's need for oxygen at 2 liters per nasal cannula, a pulse oximeter to monitor oxygen saturation, compression stockings to lower extremities, eye glasses and hearing aids.</p> <p>The "Aide Plan of Care and Visit Note," dated 8/27/11 and timed 6:00 PM to 9:30 PM, offered no written instruction or guidance in the use of oxygen, pulse oximeter, or compression stockings. The aide plan of care also failed to include Patient #11's need to wear eye glasses and hearing aids.</p> <p>An interview with the DON was conducted on 9/09/11 at 9:40 AM. The DON agreed there were missing elements on the aide plan of care and confirmed the plan was incomplete.</p> <p>The hospice agency did not ensure the aide was provided complete written patient care instructions.</p> <p>5. Patient #6's medical record documented an 86 year old male, admitted to the hospice agency on 11/03/10, with a diagnosis COPD. On 9/08/11, between 3:00 PM and 4:25 PM, a visit with the DON was made to Patient #6's home. Patient #6 had a right above the knee amputation and multiple sores on his left foot from poor circulation. His left little toe was missing. The dressing to his foot was changed during the visit. He was wearing a nasal cannula for oxygen. He was in a wheelchair. His daughter stated he frequently was taken outside to smoke.</p> <p>The "Aide Plan of Care and Visit Note" for Patient #6, dated 8/26/11 at 1:50 PM and 8/19/11 at 2:00</p>	L 625	<p>The Hospice agency will ensure the aide is provided complete written patient care instructions before the aide makes the visit to provide cares. The RN will provide written instructions on the POC that will detail the cares the patient needs. If the patient is on oxygen it will be identified when the patient should wear oxygen, if it can be removed or if the patient requires it changed from a concentrator or to a portable cylinder. Instructions will also be added as to the amount of liter flow that the oxygen is supposed to be set on.</p>	10/14/11

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L 625	Continued From page 35 PM, directed the aide to provide services such as check his skin, shave him, and change his position. The Aide Plan of Care did not address transfers, the oxygen, safety when smoking, or the dressing on his foot. An interview with the DON was conducted during the visit. She confirmed the Aide Plan of Care was incomplete. The hospice agency did not ensure the aide was provided complete written patient care instructions.	L 625		
L 641	418.78 VOLUNTEERS This CONDITION is not met as evidenced by: based on staff interview and review of volunteer records, it was determined the hospice failed to ensure volunteer services were available and were provided to patients. This resulted in the inability of the hospice to provide a full range of services. Findings include: 1. Refer to L 642 as it relates to the failure of the agency to ensure the services of volunteers were utilized. 2. Refer to L 645 as it relates to the failure of the agency to ensure efforts were taken to retain volunteers. The cumulative effect of these systemic omissions resulted in the inability of the agency to provide volunteer services.	L 641	Alliance Hospice shall demonstrate ongoing efforts in recruiting, retaining and hiring of volunteers for the hospice program. This will enable the hospice to provide a wide variety of services to its patients and families. Documentation of the volunteer program will be available as noted by the orientation notes, visit notes, quality program indicating savings, recruiting efforts such as ads on television, newspapers, brochures and so on. An annual volunteer appreciation meeting will be conducted. Efforts to involve the volunteers with patient cares will be documented and on going.	10/14/11
L 642	418.78 VOLUNTEERS The hospice must use volunteers to the extent	L 642		

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L 642	Continued From page 36 specified in paragraph (e) of this section, these volunteers must be used in defined roles and under the supervision of a designated hospice employee. This STANDARD is not met as evidenced by Based on staff interview and review of volunteer records, it was determined the hospice failed to ensure the services of volunteers were utilized. This resulted in a lack of volunteer services available to hospice patients. Findings include: The Branch Director and the Social Worker were interviewed together beginning at 9:40 AM on 9/09/11. They stated no volunteers had been utilized to provide services to the hospice in 2011. They presented 3 files of persons who they said were volunteers but they stated these persons had not performed any services for the hospice in 2011.	L 642		
L 645	The hospice failed to utilize the services of volunteers. 418.78(c) RECRUITING AND RETAINING The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers. This STANDARD is not met as evidenced by: Based on staff interview and review of volunteer records, it was determined the hospice failed to ensure efforts to retain volunteers were documented and demonstrated. This resulted in a lack of volunteers who were available to provide services. Findings include: An updated policy under the volunteer section of	L 645	Alliance Hospice will have a volunteer orientation meeting on 09/23/11. The orientation will be documented and place in the volunteer files. Ongoing retention activities are scheduled to continue as well as plans for offering patient services to each of the volunteers once the orientation is completed. The volunteer coordinator will be responsible for keeping the records up to date related to the services provided, orientation process and retention efforts.	9/23/11 and on-going

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L 645	Continued From page 37 the policy manual labeled "0360 POLICY," not dated, stated "Documentation of retention efforts, for instance awards, dinners and other acknowledgments, will be maintained in the volunteer office. The Branch Director and the Social Worker were interviewed together beginning at 9:40 AM on 9/09/11. They stated no volunteers had been utilized to provide services to the hospice in 2011. They presented 3 files of persons who they said were volunteers but they stated these persons had not performed any services for the hospice in 2011. The staff were asked if the volunteers would still provide services for the agency if asked. They stated they did not know. The staff were asked what measures they had taken to retain the volunteers in 2011 were not documented. They stated contact had not been maintained with the volunteers and they could not state with certainty if the volunteers were still willing to perform services for the hospice	L 645	Documentation of the volunteer program recruitment, retention, orientation, services completed will be kept on file in the hospice office and overseen by the Volunteer Coordinator.	9/23/11 And on-going
L 648	The hospice failed to act to retain volunteers. 418.100 ORGANIZATIONAL ENVIRONMENT This CONDITION is not met as evidenced by: Based on staff interview and review of meeting minutes, agency policies, QAPI documents, IC files, it was determined the hospice failed to ensure organization and administration of services were conducted in a manner which provided direction and oversight of the agencies operations. This resulted in the inability of the agency to provide necessary services and	L 648		

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L 648	<p>Continued From page 38 systems. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to L651 as it relates to the failure of the hospice to ensure the governing body and administrator assumed responsibility for implementing programs and providing direction to the agency. 2. Refer to L652 as it relates to the failure of the hospice to ensure medical social services were provided consistent with accepted standards of practice. 3. Refer to L 661 as it relates to the failure of the hospice to ensure employees and contracted staff were oriented to the hospice philosophy. 4. Refer to L 662 as it relates to the failure of the hospice to ensure employees and contracted staff were oriented to the hospice philosophy. 5. Refer to L 663 as it relates to the failure of the hospice to ensure written policies and procedures were developed which described a method of assessment of staff competencies. 6. Refer to L 559, the COP for Quality Assessment/Performance Improvement, as it relates to the failure of the hospice to ensure a QAPI program was fully developed, implemented, and maintained. 7. Refer to L 577, the COP for infection Control, as it relates to the failure of the hospice to ensure an infection control program was defined, implemented and maintained. 8. Refer to L 607, the COP for Hospice Aide 	L 648	The Alliance Hospice Governing Body and Administrator will ensure and accept responsibility for planning, organizing, quality assessment, coordinating and controlling the activities of the organization. The Governing Body and Administrator will provide the necessary financial resources, education and training that will enable staff to provide safe and effective services to their patients and families.	09/14/11

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L 648	Continued From page 39 Services, as it relates to the failure of the hospice to ensure hospice Aide services were provided by qualified staff in accordance with written instructions. 9. Refer to L 641, the COP for the COP for Volunteers, as it relates to the failure of the hospice to ensure volunteer services were available and were provided to patients. 10. Refer to L 783, the COP for Personnel Qualifications, as it relates to the failure of the hospice to ensure evidence of current licensure, qualifications, education, competencies, background checks, and orientation had been gathered for employees and contract staff. The cumulative effect of these systemic problems resulted in the inability of the agency to provide hospice services consistent with accepted standards of practice.	L 648		
L 651	418.100(b) GOVERNING BODY AND ADMINISTRATOR A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body. This STANDARD is not met as evidenced by:	L 651	The Alliance Hospice Governing body and Administrator shall ensure that all employees will have current licensure, background checks, orientation, education and appropriate qualifications to perform patient care services. The Alliance Hospice Governing Body will accept responsibility for the legal authority and management of the hospice and all of the services it provides. The Administrator will be responsible for the day-to-day operations of the operations and is part of the governing body for Alliance Hospice. The administrator will report to the Governing Body the operations of the hospice.	9/14/11 and on-going 09/14/11 and on-going

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L 651	<p>Continued From page 40</p> <p>Based on staff interview and review of governing body meeting minutes and branch directors meeting minutes, it was determined the hospice failed to ensure the governing body and administrator assumed responsibility for implementing programs and providing direction to the agency. This resulted in the inability of the agency to maintain viable QAPI, IC, and volunteer programs and resulted in a lack of oversight of home health aides. Finding include:</p> <p>1. Three "Governing Body Meetings" were documented in the past year. these were dated 1/19/11, 4/20/11, and 6/27/11. The minutes referred to multiple separately certified hospices and home health agencies. It was difficult to determine if the meeting minutes referred to the Twin Falls hospice agency or other entity. Neither the 1/19/11 nor the 6/27/11 meeting minutes referred specifically to the Twin Falls agency. The 4/20/11 meeting minutes stated the "Twin Falls office" had hired C N A and nursing staff and a social worker. The minutes also stated the Chaplain was working on the QAPI program. However, the minutes did not state whether they applied to the home health or hospice certified agencies. No specific direction to the Twin Falls hospice agency was documented in any of the minutes.</p> <p>Meeting were also held between the branch directors of the parent corporation's home health and hospice branches, including the Twin Falls hospice agency. Meetings from 9/1/10 to 8/31/11 were documented on 12/21/10, 1/11/11, 3/01/11, 4/26/11, and 5/19/11. The CEO for the corporation and the Administrator were also in attendance. These minutes also did not</p>	L 651	<p>The Alliance Hospice Governing Body and Administrator will assume responsibility for having meetings with the Twin Falls office. The minutes will reflect the oversight and management from the Governing Body for Alliance Hospice in Twin Falls. Oversight for education, orientation, employee files, the QAPI program, infection control, maintaining compliance with COPs and the Volunteer program will be evident in the minutes and documented accordingly.</p> <p>Alliance Hospice in Twin Falls will be able to demonstrate and document meetings that are specific to their operations, with Governing Body and Administrator involvement.</p>	<p>9/27/11 And on-going</p> <p>09/23/11 And on-going</p>

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L 651	<p>Continued From page 41</p> <p>Differentiate between home health and hospice and various separately certified agencies. These meeting also did not document addressing specific issues or providing direction specifically to the Twin falls hospice agency.</p> <p>The Administrator, who was also a member of the governing body, was interviewed on 9/14/11 at 2:00 PM. She confirmed the governing body and branch directors meeting minutes did not specifically address the Twin Falls Hospice agency.</p> <p>2. The agency failed to develop a comprehensive QAPI program. Refer to L 560 as it relates to the lack of a defined QAPI program.</p> <p>No documentation of oversight of the QAPI program by the governing body or the administrator was present.</p> <p>The Administrator was interviewed on 9/14/11 at 2:00 PM. She confirmed documentation of oversight of the QAPI program by the governing body and administrator was not present.</p> <p>3. The agency failed to develop and comprehensive IC program. Refer to L 578 as it relates to the lack of a defined IC program.</p> <p>No documentation of oversight of the IC program by the governing body or the administrator was present.</p> <p>The Administrator was interviewed on 9/14/11 at 2:00 PM. She confirmed documentation of oversight of the IC program by the governing body or the administrator was not present.</p>	L 651	<p>Governing Body meeting schedule has been done for the rest of the year. These meetings will include minutes that separately address the Twin Falls Hospice and the education/direction provided to ensure the proper operations of the hospice are being managed appropriately. Copies of these meetings will be kept on file in the corporate office by the Administrator.</p> <p>The Alliance Hospice Governing Body and Administrator will ensure that meetings will be conducted and oversight will occur to supervise and maintain the operations of the hospice, including but not limited to the QAPI program, and Infection Control. Minutes of the meetings will reflect these programs as they are discussed and addressed and relate to the Twin Falls office. The Administrator will ensure that these meetings are documented and kept on file at the corporate office. From this, plans of correction that are related to the Twin Falls hospice will be given to the Branch Director and Director of Nursing for improvement and management.</p>	<p>09/23/11 and on-going</p> <p>9/23/11 and on-going</p>

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L 651	Continued From page 42 4. The agency did not have an active volunteer program 2011. Refer to L 642 as it relates to the lack of volunteer services in 2011. No documentation of oversight of the volunteer program by the governing body or the administrator was present in 2011. The Administrator was interviewed on 9/14/11 at 2:00 PM. She confirmed documentation of oversight of the volunteer program by the governing body or the administrator was not present in 2011.	L 651	The Alliance Hospice Governing Body will oversee the volunteer program (and all programs of the hospice). Documentation of the Twin Falls office volunteer program oversight & meetings by the Governing Body will be kept by the Administrator in the corporate office.	9/23/11 and on-going 9/23/11 and on-going
L 652	418.100(c)(1) SERVICES (1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice. (i) Nursing services. (ii) Medical social services. (iii) Physician services. (iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling. (v) Hospice aide, volunteer, and homemaker services. (vi) Physical therapy, occupational therapy, and speech-language pathology services. (vii) Short-term inpatient care. (viii) Medical supplies (including drugs and biologicals) and medical appliances.	L 652		

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L 652	Continued From page 43 This STANDARD is not met as evidenced by: Based on review of personnel records and staff interview, it was determined the governing body failed to ensure medical social services were provided consistent with accepted standards of practice. This affected the care of 9 of 11 patients (#s 1-6 and #9-11) who received medical social services and whose records were reviewed. This resulted in a lack of oversight or patients receiving medical social services. Findings include: Medical records documented 9 patients (#s 1-6 and #s 9-11) received medical social services between 4/15/11 and 9/01/11. These services were all provided by a bachelors level social worker without supervision by an MSW as required by 42 CFR Part 418.114.b(3). Staff L, the LSW, was interviewed 9/06/11 at 1:55 PM. She stated she was the only social worker providing medical social services at the hospice. She stated she was not formally supervised by an MSW and stated there was no documentation of such supervision. The Administrator was interviewed on 9/14/11 at 2:00 PM. She confirmed there was no system for oversight of the LSW. The governing body did not ensure medical social services were provided consistent with accepted standards of practice.	L 652	The Alliance Hospice governing body will ensure medical social services provided are consistent with accepted standards of practice. All bachelor level social workers employed by Alliance will be supervised by an MSW. This oversight will be documented with the MSW signature present in the medical record signing the visit notes. Evidence of education will be completed by the MSW on a routine basis with suggestions being given related to whether any concerns were addressed related to the LSW services being provided or the documentation noted in the records. A quarterly report will be provided to the Governing Body/Administrator reflecting the supervision that has taken place. The supervision will be documented on chart reviews and reported to the Administrator on a monthly basis. If there are any issues that arise as noted by the supervising MSW, this will be brought to the attention of the Administrator/Governing Body and addressed ASAP. This information will be documented and kept with the Governing Body meeting minutes and added to the QAPI program as necessary. Policy statement: to outline the expectations of Alliance Hospice regarding Social Work Supervision in respect of the requirements determined. Professional supervision is one of the essential means to develop workers and ensure quality service provision. Professional practice knowledge and skills are learned and gained through study, practice, and gaining social work qualifications. It is the direct practice, guidance and reflection provided by supervision that enhances professional development and supports competent,	09/23/11 And on-going 10/30/11 and on-going
L 661	418.100(g)(1) TRAINING (1) A hospice must provide orientation about the hospice philosophy to all employee and contracted staff who have patient and family	L 661	<i>See Next Page</i>	

CONTINUED FROM PAGE 44:

accountable and safe practice. Furthermore the Alliance Hospice considers that the interests of the public are best served by the profession requiring all licensed social workers to be in a formal supervision relationship.

PRINCIPLES OF SUPERVISION:

The following principles are social work supervision policies that provide a framework to guide the supervision practices of licensed social workers:

- a) Professional supervision promotes safe and accountable practice.
- b) Professional supervision promotes inclusive practice underpinned by sound and ethical principles.
- c) Professional supervision promotes active recognition of the cultural systems that shape the workers practice.
- d) Professional supervision encompasses a respectful, strengths-based approach which affirms people's dignity, capacity, rights, uniqueness, and commonalities.
- e) Professional supervision provides a forum to ensure accountability to the agency, to clients and the profession.
- f) Professional supervision is available to all practicing social workers.
- g) Professional supervision is located within a learning environment where professional development is valued and encouraged.
- h) Professional supervision will be consistent with the requirements associated with level of expertise.

Alliance expectations of Licensed Social Workers in respect to supervision (bachelor prepared social worker);

The bachelor prepared social worker will:

- 1) attend regular professional social work supervision at least monthly
- 2) attend supervision appropriate and consistent with their practice
- 3) attend supervision that is consistent of cultural world view experiences, skills, and requirements for accountability
- 4) provide evidence of supervision
- 5) comply with mechanisms of agency accountability of professional supervision that is appropriate to the experience or expertise
- 6) be able to provide attestation of supervision at the time of undertaking competency requirements or annual licensure renewal

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L 661	<p>Continued From page 44 contact.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of personnel records, it was determined the hospice failed to ensure the employees and contracted staff were oriented to the hospice philosophy for 15 of 16 staff (A-C and E-P) whose employee files were reviewed. This had the potential to result in inconsistent approaches to patient care and negatively impact coordination of patient care. Findings include:</p> <p>The Branch Director and surveyor reviewed personnel files together on 9/08/11 between 2:30 PM and 4:00 PM. Personnel records did not document orientation to the hospice philosophy for staff identified below:</p> <p>Staff A, a CNA whose hire date was 8/30/10; Staff B, a CNA whose hire date was 7/27/10; Staff C, a CNA whose hire date was 5/01/09; Staff E, a CNA whose hire date was 7/06/11; Staff F, a physician whose contract date was 11/09/09; Staff G, a physician whose contract date was 1/01/11; Staff H, an LPN whose hire date was 6/28/10; Staff I, an LPN whose hire date was 5/01/09; Staff J, an RN whose hire date was 5/01/09; Staff K, an RN whose hire date was 2/21/11; Staff L, an LSW whose hire date was 4/06/11; Staff M, an MSW whose hire date was not stated; Staff N, an ST whose contract date was 7/30/11; Staff O, a PT whose contract date was 1/01/10; Staff P, a PT whose contract date was 5/21/09;</p> <p>During the review of personnel files, the Branch</p>	L 661	<p>Alliance Hospice will ensure that the hospice orientation contains the company's philosophy related to the coordination of patient care. This will be added to the orientation program for all employees and for contract employees.</p> <p>All present employees and contract employees will be given a copy of the Alliance Hospice philosophy which will also include the mission statement, vision, values of the organization and education will be provided. This education will continue at least annually.</p>	<p>10/20/11</p> <p>10/20/11 and annually</p>

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L 661	Continued From page 45 Director was asked about orientation of employees and contract staff to hospice philosophy. She stated they did not orient contract employees to hospice philosophy and they did not have any specific orientation or written material for new employees related to hospice philosophy. During a second interview with the Branch Director over the telephone on 9/13/11 at 9:00 AM, she stated they talked to employees about the hospice philosophy during their interview prior to hire and some after hire. She again confirmed no formal orientation was provided and they did not have any written material.	L 661	Proof of education related to the hospice philosophy will be kept in the employee files and/or the education book. Employees and contract staff will sign that they have received the Alliance Hospice philosophy and education related to the philosophy.	10/20/11
L 662	The hospice did not ensure all employees and contracted staff were oriented to the hospice philosophy. 418.100(g)(2) TRAINING (2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel records, it was determined the hospice failed to ensure employees were oriented to job specific duties at hire for 10 of 11 employees (A, B, C, E, H, I, J, K, L, and M) whose employee files were reviewed. This had the potential to negatively impact the quality of patient care. Findings include: The Branch Director and surveyor reviewed personnel files together on 9/08/11 between 2:30	L 662	All employees will go through an initial orientation process related to their own individual job specifications. This orientation will include competency testing, reading of the hospice policy and procedure manual, and direct care evaluation from an RN, experienced peer and/or both. All of the orientation education and competencies will be documented and a copy of the documentation will be placed in their employee file and/or education book in the Twin Falls hospice office. The orientation process will continue as evidenced by the annual education provided (designated as November) which includes competencies.	9/28/11 And on-going

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L 662	Continued From page 46 PM and 4:00 PM. Personnel records did not document orientation to job specific duties for the employees identified below: Staff A, a CNA, whose hire date was 8/30/10; Staff B, a CNA, whose hire date was 7/27/11; Staff C, a CNA, whose hire date was 5/01/09; Staff E, a CAN, whose hire date was 7/06/11; Staff H, an LPN, whose hire date was 6/28/10; Staff I, an LPN, whose hire date was 5/01/09; Staff J, an RN, whose hire date was 5/09/09; Staff K, an RN, whose hire date was 2/21/11; Staff L, an LSW, whose hire date was 4/06/11; Staff M, an MSW, whose hire date was not stated. During the review of personnel files, the Branch Director stated employees were oriented to their duties. She stated CNA's were oriented by other CNA's to job specific duties. However, she confirmed the personnel files did not document orientation to job specific duties. The hospice did not ensure all employees received initial orientation to job specific duties.	L 662	Policy: In order to assure uniform performance of patient services, each staff member hired will receive a minimum of 40 hours of basic training into hospice services. Such training will be accomplished through a variety of schedules and media. SEE NEXT 3 ATTACHED PAGES.	9/14/11 and on-going
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 method(s) of assessment of competency and maintain written description of the in-service training provided during the previous 12 months.	L 663	Alliance Hospice shall assess the competencies of all employees furnishing care, including the volunteers furnishing services. In-service education will be provided at monthly in-services and include subjects that pertain to hospice services and programs. These in-services will be documented and place in the employees file and/or education book. The education records will be kept in the employees file as long as they maintain employment with Alliance Hospice.	9/19/11 and on-going

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L 663	<p>Continued From page 47</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of personnel information, it was determined the hospice failed to ensure development of written policies and procedures describing a method of assessment of staff competencies. It also failed to ensure assessment of the skills and competencies of contracted individuals for 2 of 2 contract employees (o and P) who furnished care for greater than one year whose personnel records were reviewed. This resulted in a lack of validation of current skills and competencies. Findings include:</p> <p>The Branch director and surveyor reviewed personnel files together on 9/08/11 between 2:30 PM and 4:00 PM. The personnel files for contract physical therapists did not document assessment of competencies for the following contract personnel:</p> <p>Staff O, a PT, whose contract date was 1/01/10; Staff P, a PT, whose contract date was 5/21/09:</p> <p>During the review of personnel files, the Branch Director stated although the agency evaluated competencies of employees annually, this practice did not extend to contract employees, such as the PT staff (identified above). When asked to provide copies of any written policies and procedures describing the hospice's methods of assessment of competencies, she stated she was not aware of any.</p> <p>The hospice did not ensure development of written policies and procedures describing its method of assessment of competencies. It did not ensure contract employees were assessed.</p>	L 663	<p>Contracted staff will receive competency evaluations and education/orientation to Alliance Hospice as part of their beginning contract to participate in providing patient cares. They will be required to provide proof of education that they do (like CPR) for their files located in the hospice office. Continuing education and in-services will be offered throughout their contracted employment with hospice.</p>	10/15/11 and on-going

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L 663	Continued From page 48	L 663		
L 694	<p>for competencies.</p> <p>418.106(e)(2)(i) LABEL DISPOSE STORAGE DRUGS</p> <p>(2) Disposing. (i) Safe use and disposal of controlled drugs in the patient's home. The hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient's home. At the time when controlled drugs are first ordered the hospice must:</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of hospice policies, it was determined the hospice failed to ensure policies and procedures were developed related to the management and disposal of controlled drugs in the patients' homes. This had the potential to result in inconsistent communication to patients. Findings include:</p> <p>The hospice policies and procedures were reviewed on 9/06/11. No policy was found that addressed the management and disposal of controlled drugs in the patients' homes.</p> <p>The DON was interviewed on 9/09/11 at 9:50 AM. When asked about hospice policies for the management and disposal of controlled drugs in the patients' homes, she stated she was not aware of any such policies. When asked what she told patients about how to dispose of controlled drugs, she stated she recommended they get a plastic container, fill it with kitty litter, put the controlled drugs in the kitty litter, fill the container with water, cap it, tape around the closed cap, and dispose of it in the trash. As an</p>	L 694	SEE ATTACHED POLICY: this policy is now added to the hospice patient admission packet with education to be provided to the patient and family/primary caregiver related to medication disposal. These recommendations were taken from the CDC.	

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L 664	Continued From page 49 alternative, she said patients could flush drugs down the toilet, if desired. When asked how the agency was consistent about what they told patients, she state she shared with other nurses how she educated patients and their families.	L 664	Alliance Hospice will educate the entire staff on the DISPOSAL OF MEDICATIONS policy and procedure. A copy of the policy will be placed in the admission packet. The nurses will educate the patient, family/primary caregiver on the policy. The disposal recommendations can be located on the CDC website.	9/21/11 and on-going
L 783	The hospice did not have written policies and procedures for the management and disposal of controlled drugs in the patients' homes. 418.114 PERSONNEL QUALIFICATION This CONDITION is not met as evidenced by: Based on staff interview and review of personnel files, it was determined the hospice failed to ensure evidence of current licensure, qualifications, education, competencies, background checks, and orientation for employees and contract staff. These failures had the potential to negatively impact the quality and safety of patient care. Findings include: 1. Refer to L784 and L785 as they relate to the failure of the agency to ensure evidence of current licensure for employees/contract personnel. 2. Refer to L 786 as it relates to the agency's failure to ensure hospice aides met qualifications. 3. Refer to L 787 as it relates to the agency's failure to ensure a bachelors level social worker was supervised by an MSW. 4. Refer to L 788 as it relates to the agency's failure to ensure verification of educational requirements for a speech therapist.	L 783	Alliance Hospice will re-educate the Branch Director on the review of personnel files. The files will be checked and updated at least twice a year. Licensure, competencies, background checks, education and proof of orientation will be located in each employee and contract employee's files. The Alliance Hospice Governing Body and Administrator will ensure that the files are correct and complete and will check this annually. Documentation will be provided to ensure accuracy of the files.	10/20/11 and on-going 10/20/11 and on-going

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L 783	Continued From page 50 5. Refer to L 791 as it relates to the agency's failure to ensure physical therapy qualifications were met. 6. Refer to L 795 as it relates to the agency's failure to ensure criminal background checks were obtained on hospice employees or contract staff who had direct patient contact or access to patient records. 7. Refer to L 796 as it relates to the agency's failure to ensure criminal background checks were obtained within three months of the date of employment. The cumulative effect of these deficient systemic practices resulted in the agency's inability to sufficiently monitor personnel qualifications and appropriateness in providing patient care.	L 783	Alliance Hospice will ensure that all employees and contracted staff will have proof of current licensure, certifications and/or registration according to their field of practice. The Governing Body will ensure that these licensure, certifications and/or registration will be kept current as long as they work with Alliance. All employees and contract staff will have background checks done at time of hire and at least within three months of date of employment. A copy of the background checks will be maintained in the employee file.	09/14/11 And on-going
L 784	418.114(a) PERSONNEL QUALIFICATION Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel files of employees and contracted personnel, it was determined the hospice failed to ensure evidence of current licensure for 5 of 11 employees/contract personnel (F, G, M, N, and	L 784		9/14/11 and on-going

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L 784	<p>Continued From page 51</p> <p>O) whose employee files were reviewed for evidence of licensure. This had the potential to allow unqualified personnel to provide or direct patient care. Findings include:</p> <p>A sample of employee files was reviewed with the Branch Director on 9/09/11 between 2:30 PM and 4:00 PM. At the time of the review, current licensure information was missing from the personnel files, as follows:</p> <p>Staff F's personnel file did not have evidence of current licensure to practice medicine (MD);</p> <p>Staff G's personnel file did not have evidence of licensure to practice medicine (DO);</p> <p>Staff M's personnel file did not include evidence of social work licensure (LSW);</p> <p>Staff N's personnel file did not include evidence of speech therapy licensure (ST);</p> <p>Staff O's personnel file did not include evidence of physical therapy licensure (PT).</p> <p>During an interview on 9/08/11 between 2:30 PM and 4:00 PM, the Branch Director explained they needed a copy of Staff F's and Staff G's license. She stated Staff M's personnel information was kept at another office and they could get it. They were in the process of collecting information for Staff N as she became a contract employee in July. She stated she did not realize they did not have a PT license for Staff O.</p> <p>The Hospice did not ensure evidence of current professional licensure.</p>	L 784	<p>Alliance Hospice will ensure that all personnel including contract will have copied proof of their licensure available for their employee files. This information will be checked at least every 6 months and will consistently be kept up-to-date throughout employment with Alliance.</p> <p>Evidence of current professional licensure will be maintained for each employee and contract staff at all times.</p>	<p>9/14/11 And on-going</p> <p>19/21/11</p>

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L 785	<p>418.114(b)(1) PERSONNEL QUALIFICATION</p> <p>Personnel qualifications for certain disciplines. The following qualifications must be met: (1) Physician. Physicians must meet the qualifications and conditions as defined in section 186(r) of the Act and implemented at §410.20 of this chapter.</p> <p>This STANDARD is not met as evidenced by: based on staff interview and review of physician personnel files, it was determined the hospice failed to ensure evidence of current licensure for 2 of 2 contracted physicians (F and G) whose employee files were reviewed. This had the potential to allow unlicensed personnel to provide or direct patient care. Finding include:</p> <p>A sample of employee files was reviewed with the Branch Director on 9/08/11 between 2:30 PM and 4:00 PM. At the time of the review, current physician licensure information was missing from the files, as follows:</p> <p>Staff F's personnel file did not have evidence of current licensure to practice medicine as an MD.</p> <p>Staff G's personnel file did not have evidence of licensure to practice medicine as a DO.</p> <p>During an interview on 9/08/11 between 2:30 PM and 4:00 PM, the Branch Director confirmed they did not have copies of current medical licensure for staff F or G.</p> <p>The hospice did not maintain documentation to ensure current physician licensure.</p>	L 785	Alliance Hospice will educate the Branch Director on the items required for the Medical Director's employee files. There will be current licensure maintained in the files at all times. Periodic file reviews will be conducted to properly maintain the files of the Medical Directors.	09/20/11 And on-going

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L 786	<p>418.114(b)(2) PERSONNEL QUALIFICATION</p> <p>[The following qualifications must be met:] Hospice aide. Hospice aides must meet the qualification required by section 1891(a)(3) of the Act and implemented at §418.76.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of hospice aides' personnel records, it was determined the agency failed to ensure hospice aides met qualifications for 4 or 5 hospice aides (A, B, C, and E) whose personnel records were reviewed. This had the potential to negatively impact the safety and quality of patient care. Findings include:</p> <p>The Branch Director and surveyor reviewed personnel records together on 9/08/11 between 2:30 PM and 4:00 PM. There was no documentation in employee files, for Staff A, B, C, and E, of evaluation of hospice aide competencies when hired and prior to furnishing care to hospice patients. The Branch Director stated aides did not routinely have competencies assessed at hire and the aides were oriented by other aides. She confirmed there was no documentation of aide competencies at hire for Staff A, B, C, and E.</p> <p>The DON was interviewed on 9/09/11 at 9:50 AM. She stated newly hired aides oriented with other aides and she was contacted if there was an area of concern. She stated the aides did not go through a competency checklist at hire, but did so at annual evaluation.</p>	L 786	All Alliance Hospice aides will be provided with at least 12 hours of education. This and competencies will be completed at time of hire and continue annually to help ensure patient safety and quality of care.	10/20/11 And on-going

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L 786	Continued From page 54. An undated hospice policy, "HOSPICE AIDE SERVICES (HOME HEALTH AIDE)," made the following points: - Training must be complete, current, and documented; - Upon hiring, and yearly, each hospice service aide will take a written test covering topics pertinent to the position. To retain employment, the hospice service aide must score at least 80% on the written test; - The hospice aide will be subjected to a skills check by a registered nurse, upon hire and annually, and will be allowed to perform only those procedures which have been demonstrated successfully.	L 786	See correction as per page 28.	
L 787	The agency did not ensure hospice aides were evaluated and approved for competencies. 418.1144(b)(3) PERSONNEL QUALIFICATION [The following qualification must be met:] Social worker. A person who- (i) (A) Has a master Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education; or (B) Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education; or a baccalaureate degree in psychology, sociology, or other field related to social work and is supervised by an MSW as described in 418.114(b)(3)(i)(A); and (ii) Has one year of social work experience in a health care setting; or (iii) Has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education, is employed by the hospice	L 787		

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L 787	<p>Continued From page 55. before December 2, 2008, and is not required to be supervised by an MSW.</p> <p>This STANDARD is not met as evidenced by: Based on review of personnel records and staff interview, it was determined the agency failed to ensure a bachelors level social worker was supervised by an MSW for 1 of 1 bachelors level social worker (L) whose personnel file was reviewed. This resulted in planning and provision of social services without required oversight and guidance by an MSW for the bachelors level social worker. It had the potential to negatively impact the quality of patient care. Findings include:</p> <p>A job description for "HOME HEALTH/HOSPICE SOCIAL WORKER," stated the social worker reported to the "MSW Director." It also stated the social worker received patient assignments from the MSW/Branch Director.</p> <p>The Branch Director and surveyor reviewed personnel files together on 9/08/11 between 2:30 PM and 4:00 PM. Staff L, a bachelors prepared licensed social worker whose hire date was 4/06/11, was identified as the social worker for the agency. Staff M, an MSW was identified by the Branch Director as the supervising social worker for Staff L. there was no documentation in personnel records that Staff M had provided supervision of Staff L since date of hire.</p> <p>Staff L, the LSW, was interviewed on 9/06/11 at 1:55 PM. She stated she was not formally supervised by the MSW (Staff M). Staff L, the</p>	L 787	See corrections on page 44 and the attachments.	

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L 787	Continued From page 56. LSW, stated she called Staff M, the MSW, about once a month to consult. She stated to her knowledge, Staff M did not review patient records or the social work plans of care she (Staff L) developed.	L 787		
L 788	The agency did not ensure the bachelors level social worker was supervised by an MSW. 418.114(b)(4) PERSONNEL QUALIFICATION [The following qualifications must be met:] Speech language pathologist. A person who meets either of the following requirements: (i) The education and experience requirements for a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association. (ii) The educational requirements for certification and is in the process of accumulating the supervised experience required for certification. This STANDARD is not met as evidence by: based on staff interview and review of personnel records, it was determined the agency failed to ensure verification of educational requirements for 1 of 1 speech therapist (N) whose personnel files was reviewed. This had the potential to result in care provided by an unqualified speech therapist. Findings include: The Branch Director and surveyor reviewed personnel information together on 9/08/11 between 2:30 PM and 4:00 PM. The Branch Director identified Staff N as the agency's current contract speech therapist. She stated the	L 788	Alliance Hospice will ensure that the Speech Language Pathologist has the experience or a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association. A copy of this certification will be placed and maintained in the employee file. The file will be reviewed at frequent intervals to make sure the certification is kept up-to-date.	10/03/11

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L 788	Continued From page 57. Contract for services began on 7/30/11. There was no information available regarding licensure, educational background, experience, background check, or orientation. The Branch Director said the ST was fairly new and they had no yet obtained the employment information.	L 788		
L 791	The agency did not ensure requirements had been met prior to contracting with the speech therapist. 418.114(b)(7) PERSONNEL QUALIFICATION [The following qualifications must be met:] Physical therapist. A person who is licensed, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements: (i) Graduated after successful completion of one of a physical therapist education program approved by one of the following: (A) The Commission on Accreditation in Physical Therapy Education (CAPTE). (B) Successor organizations of CAPTE. (C) An education program outside the United States determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR 121.15(e) as it relates to physical therapists. (D) Passed an examination for physical therapists approved by the State in which physical therapy services are provided. (ii) On or before December 31, 2009- (A) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy	L 791	All Physical Therapists will have a license as applicable by the state in which practicing. Alliance Hospice will ensure that current licensure is being maintained by the hospice in the contract employee file. The file will be checked at least every 6 months or more often.	10/03/11 And on-going

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L 791	Continued From page 58. Education (CAPTE); or (B) Meets both of the following: (1) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry level education in the United State by a credentials evaluation organization approved by the American Physical Therapy Association or indentified in 8 CFR 212.15(e) as it relates to physical therapists. (2) Passed an examination for physical therapists approved by the State in which physical therapy services are provided. (iii) Before January 1, 2008- (A) Graduated from a physical therapy curriculum Approved by one of the following (1) The American Physical Therapy Association. (2) The Committee on Allied Health Education and Accreditation of the American Medical Association. (3) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association. (iv) On or before December 31, 1977 was licensed or qualified as a physical therapist and meets both of the following: (A) Has 2 years of appropriate experience as a physical therapist. (B) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service. (v) Before January 1, 1966- (A) Was admitted to registration by the American Registry of Physical Therapists; and (C) Graduated from a physical therapy curriculum in a 4-year college or university approved by a	L 791		

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L 791	<p>Continued From page 59.</p> <p>State department of education. (vi) Before January 1, 1966 was licensed or registered, and before January 1, 1970, had 15 years of fulltime experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy. (vii) If trained outside the United States before January 1, 2008, meets the following requirements: (A) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy. (B) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of personnel files, it was determined the agency failed to ensure physical therapy qualifications were met for 1 of 2 physical therapists (O) whose personnel records were reviewed. This had the potential to result in th agency providing physical therapy service by an unlicensed individual. Findings include:</p> <p>The Branch Director and surveyor reviewed personnel records together on 9/08/11 between 2:30 PM and 4:00 PM. Staff O, identified to be a physical therapist, had evidence of licensure as an athletic trainer in his personnel file. There was no evidence of licensure as a physical therapist in Staff O's personnel file. The Branch Director</p>	L 791	<p>Alliance Hospice Branch Director shall be educated on the importance of keeping all employee and contract personnel files up-to-date and current with appropriate licensure maintained in the file. The files will have appropriate documentation of licensure and credentials to perform the duties for which they were hired. These files will be checked at least every 6 months or more often as necessary to maintain accuracy and updated information.</p>	9/14/11 and on-going

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L 791	Continued From page 60. confirmed there was no evidence of physical therapy licensure.	L 791		
L 795	The agency did not maintain documentation that ensured physical therapy qualification had been met. 418.114(d)(1) CRIMINAL BACKGROUND CHECKS The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records. This STANDARD is not met as evidence by: based on staff interview and review of personnel files, it was determined the agency failed to ensure criminal background checks were obtained on hospice employees or contract staff who had direct patient contract or access to patient records for 5 of 16 staff members (F, G, J, M, and O) whose personnel files were reviewed. This had the potential to allow staff with criminal records access to patients. Finding include: The Branch Director and surveyor reviewed personnel files together on 9/08/11 between 2:30 PM and 4:00 PM. Personnel files were missing evidence of criminal background checks on staff as follows: Staff F, a medical doctor whose contract hire date was 11/09/09; Staff G, a doctor of osteopathic medicine whose	L 795	Alliance Hospice will ensure that all employees and contracted staff will have background check in their files upon hire. These files will be reviewed and maintained every 6 months for compliance. The contracts used by Alliance state that the "CONTRACTOR shall comply with all AGENCY policies including personnel qualifications". And now the following statement is also included: "CONTRACTOR shall have a background check completed in the state in which he/she resides and will provide the AGENCY with a copy prior to rendering patient services. If the CONTRACTOR requires assistance with obtaining information about the background checks the CONTRACTOR should contact the AGENCY for direction".	9/20/11 and on-going

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L 795	Continued From page 61. contract hire date was 1/01/11; Staff J, an RN whose hire date was 5/01/09; Staff M, an MSW whose hire date was not documented in local personnel files; Staff O, a physical therapist whose hire date was 1/01/10. The Branch Director explained they did not require background checks on Staff F and G because they were both physicians. She stated she did not know why they did not have a background check on Staff J, an RN. She stated personnel information for Staff M, an MSW, was kept in a different office where Staff M primarily worked. She confirmed the background check was missing on Staff O and explained he had not seen any patients for hospice yet but was available to do so.	L 795	Alliance Hospice will ensure that background checks are received from the Hospice medical directors and that they are maintained in the hospice personnel files according to state law.	9/14/11 And on-going
L 796	The hospice did not obtain criminal background checks on all hospice employees who had direct patient contact or access to patient records. 418.114(d)(2) CRIMINAL BACKGROUND CHECKS Criminal background checks must be obtained in accordance with State requirements. In the absence of State requirements, criminal background checks must be obtained within three months of the date of employment for all states that the individual has lived or worked in the past 3 years. This STANDARD is not met as evidenced by: based on staff interview and review of personnel files, the agency failed to ensure criminal background checks were obtained within three	L 796	ALL employees and contract personnel will have background checks done and copies of those checks will be maintained in their personnel files according to state regulations. All new employees or contract staff seeing employment by the hospice will have criminal background checks done prior to rendering patient care or viewing patient documentation.	9/14/11 and on-going

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L 796	<p>Continued From page 62.</p> <p>Months of the date of employment for 5 of 15 employees or contract employees (E, F, G, J, and L) who had been employed for longer than 3 months whose personnel files were reviewed. This had the potential to expose patients to staff with criminal backgrounds. Findings include:</p> <p>The Branch Director and surveyor reviewed personnel files together on 9/08/11 between 2:30 PM and 4:00 PM. Employees did not have a background check within 3 months of hires as follows:</p> <p>Staff E, a hospice aide, was hired on 7/06/11. The background check was completed on 5/10, approximately 10 months prior to employment.</p> <p>An employment contract was initiated for Staff F, a physician, on 11/09/09. There was no background check on file.</p> <p>An employment contract was initiated for Staff G, a physician, on 1/01/11. There was no background check on file.</p> <p>Staff j, an RN, was hired on 5/01/09. There was no background check on file.</p> <p>Staff L, a LSW, was hired on 4/06/11. A background check, dated 10/27/10, was on file, approximately 5.5 months prior to employment.</p> <p>An employment contract was initiated for Staff P on 5/21/09. The background check was completed on 11/03/03. 505 years prior to contract employment.</p> <p>The Branch director confirmed the information</p>	L 796	Background checks will be done at time of hire on all employees and contract staff prior to providing patient cares or access to patient records.	09/14/11 And on-going

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L 796	Continued From page 63. During the review of personnel files on 9/08/11 between 2:30 PM and 4:00 PM. She explained the agency did not required background checks on Staff F and G because they were physicians. She was unsure why the background check had not been done for Staff J, and she thought the background checks on Staff E and L were acceptable and was not aware of the rule requiring background checks within 3 months of hire. The agency did not ensure background checks were conducted within 3 months of hire.	L 796	All Alliance Hospice employees and contract staff will have evidence of background checks in their personnel files.	09/14/11 and on-going