



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
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CERTIFIED MAIL: 7003 0500 0003 1966 8756

October 10, 2012

Sue Kurruk, Administrator
Syringa General Hospital Hospice
607 West Main Street
Grangeville, ID 83530

RE: Syringa General Hospital Hospice, Provider #131534

Dear Ms. Kurruk:

Based on the survey completed at Syringa General Hospital Hospice, on October 2, 2012, by our staff, we have determined Syringa General Hospital Hospice is out of compliance with the Medicare Conditions of Participation of **Quality Assessment & Performance Improvement (42 CFR 418.58); Infection Control (42 CFR 418.60); and Organizational Environment (42 CFR 418.100)**. To participate as a provider of services in the Medicare Program, a 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 Syringa General Hospital 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 Condition 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;
- Description of how the actions will improve the processes that led to the deficiency cited;

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October 10, 2012
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- 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 into compliance, and that the 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 November 16, 2012. 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 November 8, 2012.

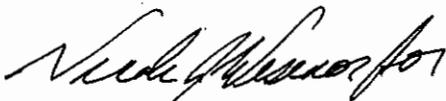
Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 22, 2012.**

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 GILES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/nw

Enclosures

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

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

PRINTED: 11/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131534	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER SYRINGA GENERAL HOSPITAL HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 607 WEST MAIN STREET GRANGEVILLE, ID 83530	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Rebecca Lara, RN, BA, HFS CEO = Chief Executive Officer DON = Director of Nursing FY2012 = fiscal year 2012 IDG = Interdisciplinary Group IC = Infection Control LSW = Licensed Social Worker PDSA = Plan, Do, Study, Act-a management method used in business for continuous improvement of processes PI = performance improvement QAPI = Quality Assessment and Performance Improvement RN = Registered Nurse SHC = Syringa Hospital and Clinics	L 000		
L 559	418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT This CONDITION is not met as evidenced by: Based on staff interview and review of policies, meeting minutes, and quality documents, it was determined the hospice failed to ensure a QAPI program had been developed, implemented, monitored, and overseen. This resulted in the inability of the hospice to evaluate its program. Findings include: 1. The hospice failed to ensure an effective,	L 559		11/2/12

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

TITLE

(X6) DATE

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

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L 559	<p>Continued From page 1</p> <p>ongoing, hospice-wide data-driven quality assessment and performance improvement program had been developed and implemented. Refer to L560.</p> <p>2. The hospice failed to ensure its QAPI program was capable of showing measurable improvement in quality indicators. Refer to L561.</p> <p>3. The hospice failed to ensure its QAPI program measured, analyzed, and tracked quality indicators, including adverse patient events. Refer to L562.</p> <p>4. The hospice failed to ensure its QAPI program used quality indicator data in the design of its program. Refer to L563.</p> <p>5. The hospice failed to ensure its QAPI program used data to monitor the effectiveness and safety of services and identify opportunities and priorities for improvement. Refer to L564.</p> <p>6. The hospice failed to ensure the frequency and detail of the data collection for its QAPI program was approved by the hospice's governing body. Refer to L565.</p> <p>7. The hospice failed to ensure its performance improvement activities focused on high risk, high volume, and problem-prone areas. Refer to L566.</p> <p>8. The hospice failed to ensure its QAPI program included the development and implementation of performance improvement projects. Refer to L571.</p>	L 559			

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L 559	Continued From page 2 The hospice failed to ensure the governing body assumed responsibility for ensuring that an ongoing program for quality improvement and patient safety was defined, implemented, and maintained. Refer to L574.	L 559		
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 improved 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 policies and quality documents, it was determined the hospice failed to ensure an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program had been developed and implemented. This resulted in the inability of the hospice to evaluate its processes.	L 560		11/2/12

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L 560	Continued From page 3 Findings include: 1. A QAPI policy and a QAPI plan for hospice were not documented. The Director of Quality and Risk Management for Syringa General Hospital was interviewed on 9/27/12, beginning at 9:55 AM. She stated she oversaw quality for the hospice as a department of the hospital. She confirmed a QAPI policy and a QAPI plan for hospice had not been developed. The hospice did not develop a QAPI program. 2. Quality indicators related to palliative outcomes and the provision of hospice services were not documented between 9/01/11 and 9/27/12. Data to measure quality indicators was not documented. The Director of Quality and Risk Management was interviewed on 9/27/12, beginning at 9:55 AM. She confirmed specific quality indicators and subsequent related data were not documented. The hospice did not develop quality indicators and measure outcomes.	L 560		
L 561	418.58(a)(1) PROGRAM SCOPE (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and quality documents, it was determined the hospice failed to ensure its QAPI program was	L 561		11/2/12

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L 561	Continued From page 4 capable of showing measurable improvement in quality indicators. This resulted in a lack of information to judge the effectiveness of hospice services. Findings include: The policy "PERFORMANCE IMPROVEMENT PROGRAM" for Syringa General Hospital, dated August 2012, stated "Senior leadership and their respective departments or services lines are responsible for assessing and identifying opportunities for improvement in quality and safety..." The hospice agency was not specifically mentioned in the quality plan. The Director of Quality and Risk Management was interviewed on 9/27/12, beginning at 9:55 AM. She stated a policy defining a QAPI program for the hospice had not been developed. She stated the hospice did not have a specific quality plan. She stated the hospice was not currently measuring any quality indicators and had not measured any quality indicators related to improved palliative outcomes and hospice services in the past year.	L 561			
L 562	The hospice did not develop a QAPI program. 418.58(a)(2) PROGRAM SCOPE (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 policies and quality documents, it was determined the hospice failed to ensure its QAPI program	L 562		11/2/12	

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L 562	<p>Continued From page 5</p> <p>measured, analyzed, and tracked quality indicators, including adverse patient events. This resulted in the inability of the agency to utilize information to measure the effectiveness of hospice services. Findings include:</p> <p>1. The "PERFORMANCE IMPROVEMENT PROGRAM" for Syringa General Hospital, dated August 2012, discussed the QAPI plan for the hospital. The plan did not specifically mention the hospice.</p> <p>The Director of Quality and Risk Management was interviewed on 9/27/12, beginning at 9:55 AM. She stated the hospice did not have a specific quality plan which included quality indicators or adverse patient events. She stated the hospice was not currently measuring any quality indicators.</p> <p>The hospice did not develop a QAPI program which included quality indicators.</p> <p>2. No adverse patient events were documented during the previous 6 months (3/01/12 through 9/30/12.) In addition, no documentation was present that adverse patient events were tracked by the agency.</p> <p>It was not clear whether all adverse patient events were being reported. The Hospice Manager, interviewed on 9/27/12 beginning at 8:40 AM, stated falls without apparent injury were not routinely reported. She stated only falls with injury were reported.</p> <p>The hospital policy "INCIDENT REPORTS," dated January 2009, stated "...any occurrence</p>	L 562			

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L 562	Continued From page 6 that is not consistent with routine hospital operations or situations that may potentially or actually result in injury, harm, or loss to any patient..." including falls with or without injury were to be reported. A hospice specific policy was not present. In the same interview, the Hospice Manager stated a hospice policy specific to adverse patient events had not been developed. She also stated adverse patient events were not tracked through the agency's QAPI program.	L 562		
L 563	The hospice did not track adverse patient events. 418.58(b)(1) PROGRAM DATA (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program. This STANDARD is not met as evidenced by: Based on staff interview and review of quality documents, it was determined the hospice failed to ensure its QAPI program used quality indicator data in the design of its program. This resulted in the inability of the hospice to monitor the effectiveness of services. Findings include: 1. The Director of Quality and Risk Management was interviewed on 9/27/12, beginning at 9:55 AM. She stated a specific QAPI plan, including quality indicator data, had not been developed for the hospice. A plan to use quality indicator data in the design of the hospice QAPI program had not been developed.	L 563		11/2/12

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L 563	Continued From page 7 2. A document titled "SHC PI - PDSAs not included on the Dashboard: Quarter 1 FY2012 Updates," for the period of October through December 2011 but not specifically dated, stated the hospice was going to improve documentation of patient/family teaching. The document stated "Initial audit found that 10 of 10 charts had the teaching sheet started. Admission teaching documented on 100%." Two other undated updates were documented encompassing the second and third quarters for FY2012. No data related to the hospice was documented in either of these 2 reports. The Director of Quality and Risk Management for Syringa General Hospital was interviewed on 9/27/12, beginning at 9:55 AM. She stated except for the above, quality indicator data had not been collected between 10/01/11 and 9/27/12.	L 563			
L 564	The hospice did not collect data for use in its QAPI program. 418.58(b)(2) PROGRAM DATA (2) The hospice must use the data collected to do the following: (i) Monitor the effectiveness and safety of services and quality of care. (ii) Identify opportunities and priorities for improvement. This STANDARD is not met as evidenced by: Based on staff interview and review of quality documents, it was determined the hospice failed to ensure its QAPI program used data to monitor the effectiveness and safety of services and identify opportunities and priorities for improvement. This resulted in a lack of	L 564		11/2/12	

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L 564	Continued From page 8 information to base program decisions on. Findings include: A document titled "SHC PI - PDSAs not included on the Dashboard: Quarter 1 FY2012 Updates," for the period of October through December 2011, stated the hospice was going to improve documentation of patient/family teaching. The document stated "Initial audit found that 10 of 10 charts had the teaching sheet started. Admission teaching documented on 100%." Two other updates were documented encompassing the second and third quarters for FY2012. No data related to the hospice was documented after the first quarter of FY2012. The Director of Quality and Risk Management was interviewed on 9/27/12, beginning at 9:55 AM. She stated except for the above, quality indicator data had not been collected between 10/01/11 and 9/27/12. The hospice did not utilize data to monitor the quality of its services.	L 564			
L 565	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 policies and quality documents, it was determined the hospice failed to ensure the frequency and detail of data collection for its QAPI program was approved by the hospice's governing body. This resulted in a lack of direction to staff responsible	L 565		11/2/12	

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L 565	Continued From page 9 for the hospice QAPI program. Findings include: A hospice QAPI policy was not documented. A QAPI plan for implementation including the frequency and detail of data collection was not documented. Three "PERFORMANCE IMPROVEMENT COMMITTEE MINUTES" between 10/01/11 and 9/27/12 were documented. The committee included 2 Board of Trustee members. None of the minutes contained documentation regarding the frequency and detail of data collection for hospice. The Director of Quality and Risk Management was interviewed on 9/27/12, beginning at 9:55 AM. She confirmed the frequency and detail of the data collection had not been approved by the Board of Trustees. The hospice's governing body did not approve the use of data for its QAPI program.	L 565		
L 566	418.58(c)(1)(i) PROGRAM ACTIVITIES (1) The hospice's performance improvement activities must: (i) Focus on high risk, high volume, or problem-prone areas. This STANDARD is not met as evidenced by: Based on staff interview, it was determined the hospice failed to ensure its performance improvement activities focused on high risk, high volume, and problem-prone areas. This resulted in the inability of the hospice to set priorities for its	L 566		11/2/12

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L 566	Continued From page 10 QAPI program. Findings include: The Director of Quality and Risk Management was interviewed on 9/27/12, beginning at 9:55 AM. She stated the hospice did not have a specific quality plan which included quality indicators. She stated she could not provide documentation to show that the hospice's performance improvement activities focused on high risk, high volume, and problem-prone areas .	L 566			
L 571	418.58(d) PERFORMANCE IMPROVEMENT PROJECTS Beginning February 2, 2009, hospices must develop, implement and evaluate performance improvement projects. This STANDARD is not met as evidenced by: Based on staff interview and review of policies, it was determined the hospice failed to ensure its QAPI program included the development and implementation of performance improvement projects. This resulted in the inability of the hospice to thoroughly evaluate aspects of care and improve its services. Findings include: The hospice agency had not developed a quality plan, including a plan for performance improvement projects. The policy "PERFORMANCE IMPROVEMENT PROGRAM" for Syringa General Hospital, dated August 2012, outlined the QAPI program for the hospital. The policy did not mention the hospice	L 571		11/2/12	

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L 571	Continued From page 11 specifically nor did it mention any performance improvement projects. The Director of Quality and Risk Management was interviewed on 9/27/12, beginning at 9:55 AM. She stated a plan to develop and implement performance improvement projects had not been completed. She stated no performance improvement projects which gathered and analyzed data had been conducted during the previous year.	L 571		
L 574	The hospice did not initiate performance improvement projects. 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. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and meeting minutes, it was determined the hospice failed to ensure the governing body assumed responsibility for ensuring that an ongoing program for quality improvement and patient safety was defined, implemented, and maintained. This resulted in a lack of leadership to direct QAPI activities. Findings include: 1. The policy "PERFORMANCE IMPROVEMENT PROGRAM" for Syringa General Hospital, dated August 2012, stated "GOVERNING BOARD: The Board of Trustees of SHC has the ultimate	L 574		11/2/12

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L 574	<p>Continued From page 12</p> <p>responsibility for a comprehensive Quality Improvement Program. Responsibility for the development and implementation of the PI program is delegated by the Board of Trustees to SHC administrative leadership...The CEO is directly responsible to the Board for SHC's Performance Improvement Program. The Board delegates operation and oversight of the performance improvement activities to the CEO." The policy referred to the hospital's overall quality program. The policy did not mention the hospice's QAPI program.</p> <p>The Director of Quality and Risk Management was interviewed on 9/27/12, beginning at 9:55 AM. She stated she oversaw quality for the hospital. She stated hospice was included in the quality program because it was a department of the hospital. She stated a policy defining a QAPI program for the hospice had not been developed. She stated the hospice did not have a specific quality plan. She stated the hospice was not currently measuring any quality indicators and had not measured any quality indicators related to improved palliative outcomes and hospice services in the past year.</p> <p>The Governing Board did not ensure a QAPI policy and plan had been developed for hospice.</p> <p>2. Minutes from 3 "Performance Improvement Committee" meetings were documented between 11/01/11 and 9/27/12. Minutes, dated 11/11/11, stated the hospice used a new volunteer tracking form for 5 patients and the project was complete. Minutes, dated 2/08/12, stated the pharmacist was performing drug interaction checks but did not mention any quality indicators or the gathering</p>	L 574			

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L 574	Continued From page 13 or use of data. The final meeting minutes, dated 5/02/12, stated a patient teaching form had been used for 10 of 10 patients. No other data was mentioned in the minutes. No data related to palliative outcomes was mentioned in the minutes. The CEO was interviewed on 10/03/12 beginning at 2:00 PM. He stated 2 members of the Governing Board were also members of the Performance Improvement Committee. He confirmed the lack of data reviewed at committee meetings. He stated "We don't talk about hospice very much." The Performance Improvement Committee did not provide direction and oversight for the hospice QAPI program. 3. Eleven "BOARD REPORT-Senior Administrative Report" minutes were documented between 8/29/11 and 9/24/12. The reports were forwarded to the Governing Board. Each set of minutes contained a "QUALITY PILLAR" which discussed quality improvement activities at the hospital. None of the minutes mentioned hospice in relation to quality. The Director of Quality and Risk Management for Syringa General Hospital was interviewed on 9/27/12, beginning at 9:55 AM. She confirmed the lack of information presented to the Governing Board related to the hospice QAPI program. The Governing Board did not oversee the hospice QAPI program.	L 574			
L 577	418.60 INFECTION CONTROL	L 577		11/2/12	

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L 577	Continued From page 14 This CONDITION is not met as evidenced by: Based on staff interview and review of IC policies and personnel files, it was determined the hospice failed to ensure; 1) an 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 was provided. This resulted in the inability of hospice staff to effectively detect, monitor, and prevent infections and ensure acceptable standards of infection control were practiced. It had the potential to negatively impact the safety of all hospice patients. 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 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 diseases. 3. Refer to L 581 as it relates to the hospice's failure to ensure a method of identifying infectious diseases and a plan for implementing actions that resulted in improved disease prevention was developed. 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.	L 577			

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L 577	Continued From page 15 The cumulative effect of these systemic practices resulted in an incomplete and ineffective hospice infection control program.	L 577		
L 578	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 and documents, it was determined the hospice failed to ensure an infection control program was defined, implemented, and maintained. This lack of a well defined program prevented the hospice from positively identifying and preventing infections and resulted in the inability of staff to effectively detect, monitor, and prevent infections. Findings include: 1. The hospice failed to develop and maintain an effective, comprehensive and ongoing IC program that protected hospice patients, families, visitors and personnel by preventing and controlling infections and communicable diseases as follows: a. The policy "INFECTION PREVENTION STANDARDS, DEPARTMENT: HOSPICE," last revised on 8/01/09 and last reviewed on 1/20/11, listed equipment/supplies necessary for "the widest possible protection against transmission of infection," as recommended by the Centers for Disease Control. The list included such items as gloves, masks, protective eyewear, face shields and gowns. The policy also included proper	L 578		11/2/12

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L 578	<p>Continued From page 16</p> <p>procedure for use of the protective equipment, as well as instructions for disposal of bio-hazardous waste and proper handling/transporting of specimens.</p> <p>The policy "INFECTION CONTROL PRECAUTIONS, DEPARTMENT: HOME HEALTH/HOSPICE SERVICES," last reviewed on 6/11/12, included directions about hand hygiene and the use/disinfection of protective equipment.</p> <p>The definition of infections was not included in the policies. Additionally, the policies did not address surveillance projects or a method to track and report infections.</p> <p>The Infection Prevention Assistant for the Syringa General Hospital was interviewed on 10/01/12, beginning at 10:00 AM. She stated the hospice IC program was included in the IC program for the hospital as hospice was considered a department of the hospital. However, she confirmed the IC policies failed to include a definition for infections or a method for tracking and reporting infections specific to hospice. The Infection Prevention Assistant also indicated the hospice did not have a process to utilize IC data to determine the infection rate for hospice or prevent and control infections for hospice patients, family and staff.</p> <p>The hospice did not maintain and document an effective IC program.</p> <p>b. The DON was interviewed on 10/01/12, beginning at 10:00 AM. She stated the overall IC program for hospice was her responsibility, but confirmed she had not been actively involved in</p>	L 578		

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L 578	Continued From page 17 IC specific to hospice.	L 578			
L 580	418.60(b)(1) CONTROL The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that- (1) Is an integral part of the hospice's quality assessment and performance improvement program; and This STANDARD is not met as evidenced by: Based on staff interview and review of IC policies and documents, it was determined the hospice failed to ensure an infection control program was defined, implemented, and maintained. This lack of a well defined program prevented the hospice from positively identifying and preventing infections and resulted in the inability of staff to effectively detect, monitor, and prevent infections. Findings include: 1. The hospice failed to develop and maintain an effective, comprehensive and ongoing IC program that protected hospice patients, families, visitors and personnel by preventing and controlling infections and communicable diseases as follows:	L 580		11/2/12	

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L 580	<p>Continued From page 18</p> <p>a. The policy "INFECTION PREVENTION STANDARDS, DEPARTMENT: HOSPICE," last revised on 8/01/09 and last reviewed on 1/20/11, listed equipment/supplies necessary for "the widest possible protection against transmission of infection," as recommended by the Centers for Disease Control. The list included such items as gloves, masks, protective eyewear, face shields and gowns. The policy also included proper procedure for use of the protective equipment, as well as instructions for disposal of bio-hazardous waste and proper handling/transporting of specimens.</p> <p>The policy "INFECTION CONTROL PRECAUTIONS, DEPARTMENT: HOME HEALTH/HOSPICE SERVICES," last reviewed on 6/11/12, included directions about hand hygiene and the use/disinfection of protective equipment.</p> <p>The definition of infections was not included in the policies. Additionally, the policies did not address surveillance projects or a method to track and report infections.</p> <p>The Infection Prevention Assistant for Syringa General Hospital was interviewed on 10/01/12, beginning at 10:00 AM. She stated the hospice IC program was included in the IC program as hospice was a department of the hospital. However, she confirmed the IC policies failed to include a definition for infections or a method for tracking and reporting infections specific to hospice. The Infection Prevention Assistant also indicated the hospice did not have a process to utilize IC data to determine the infection rate for hospice or prevent and control infections for hospice patients, family and staff.</p>	L 580		

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L 580	Continued From page 19 The hospice did not maintain and document an effective infection control program. b. The DON was interviewed on 10/01/12, beginning at 10:00 AM. She stated the overall IC program for hospice was her responsibility, but confirmed she had not been actively involved in IC specific to hospice. The hospice failed to maintain a fully developed infection control program that accurately identified all incidents of infection, monitored for compliance, evaluated program effectiveness and revised the program when indicated.	L 580		
L 581	418.60(b)(2) CONTROL [The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that-] (2) Includes the following: (i) A method of identifying infectious and communicable disease problems; and (ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention. This STANDARD is not met as evidenced by: Based on staff interview and review of hospice IC documents and policies, it was determined the hospice failed to develop; 1) a method of identifying infectious diseases specific to hospice; 2) an implementation plan that included hospice specific actions to prevent diseases; and 3) a strategy to redesign it's infection prevention and	L 581		11/2/12

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L 581	Continued From page 20 control policies when problems were identified. This lack of a well defined plan to detect, respond to and re-evaluate incidents of infectious diseases in the hospice setting prevented on-going improvements in infection prevention for the hospice. Findings include: The hospice identified 3 IC related policies, including "INFECTION PREVENTION STANDARDS, reviewed 1/20/11, INFECTION CONTROL PRECAUTIONS, reviewed 6/11, and HAND HYGIENE PROCEDURE, reviewed 8/12." The policies did not contain a hospice specific plan to detect, treat and re-evaluate prevention strategies when infectious diseases occurred. The Infection Prevention Assistant for Syringa General Hospital was interviewed on 10/01/12, beginning at 10:00 AM. She confirmed the current hospice policies lacked a plan to identify, treat and re-evaluate actions for disease prevention when infectious diseases were detected. The hospice failed to develop and maintain an infection control program that accurately identified all incidents of infection, monitored treatment effectiveness and re-evaluated/ revised the hospice IC program and policies when indicated.	L 581			
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	L 582		11/2/12	

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L 582	Continued From page 21 files and policies, it was determined the hospice failed to ensure hospice specific infection control education was provided to employees and contract staff whose personnel records were reviewed. This systemic failure had the potential to negatively impact patient safety. Findings include: Thirteen hospice employee personnel files and 2 hospice contracted personnel files were reviewed for evidence of IC training. Included were 4 hospice aides, 4 RNs, 2 social workers, a physical therapist, a physical therapy assistant, a dietician, an occupational therapist, and a speech therapist. Documentation of IC training that was specific to hospice could not be found. The Hospice Manager was interviewed on 9/27/12, beginning at approximately 3:00 PM. She confirmed an IC training program that was specific to hospice had not been developed or provided to hospice employees and contracted staff. The hospice did not provide infection control education to employees and contracted staff.	L 582		
L 629	418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES (l) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.	L 629		11/2/12

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L 629	<p>Continued From page 22</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the hospice failed to ensure RNs attended supervisory visits for hospice aides at least every 14 days for 2 of 6 patients (#7 and #10) who received hospice aide services and whose records were reviewed. This failure allowed hospice aides to provide care without adequate oversight from a RN. Findings include:</p> <p>1. Patient #10's medical record documented a 94 year old woman who was admitted to the hospice on 5/08/12 for care related to a primary diagnosis of pancreatic cancer. The "HOSPICE DISCHARGE SUMMARY," dated 8/06/12, stated Patient #10 was discharged when her condition stabilized. She became asymptomatic and returned to her prior level of function.</p> <p>Hospice aide visits were documented 2 times a week between 5/10/12 and 7/30/12. Hospice aide supervisory visits were documented by the RN on "NURSE VISIT NOTE" forms. All RN visit notes were reviewed for Patient #10. Supervisory visits were documented by the RN only on 5/17/12 and 5/25/12.</p> <p>On 9/27/12, beginning at 2:15 PM, a RN was interviewed. The RN reviewed Patient #10's medical record and said the hospice practice was to conduct hospice aide supervisory visits every 14 days. She confirmed supervisory visits were not documented every 14 days for Patient #10.</p> <p>The hospice failed to conduct aide supervisory visits every 14 days.</p>	L 629			

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L 629	Continued From page 23 2. Patient #7's medical record documented a 74 year old male who was admitted to hospice care on 7/08/12 with a diagnosis of lung cancer. He died on 7/26/12. Hospice aide visits were documented on 7/09/12, 7/12/12, 7/16/12, 7/19/12, and 7/23/12. No supervisory visits were documented during that time. An RN who cared for Patient #7 reviewed the record and was interviewed on 7/26/12 beginning at 3:10 PM. She stated a supervisory visit was not documented. The hospice did not conduct an aide supervisory visit for Patient #7.	L 629		
L 648	418.100 ORGANIZATIONAL ENVIRONMENT This CONDITION is not met as evidenced by: Based on staff interview and review of policies, meeting minutes, and quality documents, it was determined the hospice failed to ensure the Governing Board provided organization and administration to provide effective hospice services. This resulted in the inability of the hospice to define critical processes and to provide required services. Findings include: 1. The hospice failed to ensure a QAPI program had been developed, implemented, monitored, and overseen. Refer to L559. 2. The hospice failed to ensure an infection control program had been defined, implemented, and maintained. Refer to L577. 3. The hospice failed to ensure the governing	L 648		11/2/12

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L 648	Continued From page 24 body assumed responsibility for the management of the hospice and for the hospice's QAPI program. Refer to L651.	L 648			
L 651	4. The hospice failed to ensure staff were oriented to the hospice philosophy. Refer to L661. The cumulative effect of these systemic problems resulted in the lack of the hospice to organize and monitor its services. 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: Based on staff interview and review of the organization chart, policies, and quality documents, it was determined the hospice failed to ensure the governing body assumed responsibility for the management of the hospice and for the hospice's QAPI program. This prevented the hospice from organizing along clear lines of authority and from implementing a comprehensive QAPI program. Findings include:	L 651		11/2/12	

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L 651	<p>Continued From page 25</p> <p>1. The hospice was a department of Syringa General Hospital. The organization chart titled "SYRINGA HOSPITAL & CLINICS," dated 5/01/12, listed in descending order-the Board of Trustees, the CEO, the DON, and the Hospice Manager. A second organizational chart, not dated, listed areas of responsibility for the DON. It listed the DON at the top, then the Hospice Manager, who was an LSW by discipline. Under the Hospice Manager were listed Hospice RNs and Hospice CNAs. This created confusion as to who had authority over RNs and CNAs in relation to clinical matters.</p> <p>The organizational chart showed the DON was responsible for nursing services for the hospital, including obstetrical services, inpatient services, emergency services, surgical services, and outpatient services as well as hospice services. In addition, the DON was responsible for dietary services and discharge planning. The role of the DON in relation to hospice services was not defined.</p> <p>The DON's job description, dated January 2012, stated she had oversight and supervision of all nursing services at the hospital as well as hospice. In addition, the DON had administrative duties including analysis, budgetary, personnel, pharmacy consultation, and performance improvement duties. The job description stated she was "Indirectly responsible for the hospital nursing staff." The job description did not define her duties in relation to the hospice.</p> <p>The Hospice Manager was an LSW. Her job description, revised 1/04/11, stated she "Supervises the nursing and other related staff in</p>	L 651			

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L 651	<p>Continued From page 26</p> <p>ensuring that plans of care, skilled nursing and case management of hospice patients is completed accurately and meets all regulatory standards." The job description did not define her specific role in the supervision of nurses who were outside of her discipline.</p> <p>The DON, CEO, and Hospice Manager were interviewed on 10/01/12 beginning at 10:00 AM.</p> <p>The DON stated she coordinated activities between the hospital and the hospice. She said she oversaw the hospice as a department of the hospital. She stated she did not have time dedicated specifically to hospice and no record was kept of her time in relation to hospice.</p> <p>The CEO stated he was a member of the hospice advisory board. He stated he supervised the DON but was not directly involved with the hospice.</p> <p>The Hospice Manager stated she assumed the administrative duties of the hospice. She stated she supervised the nurses but she was supervised by the DON.</p> <p>Lines of authority and responsibility for the management of the hospice were not clear.</p> <p>2. A QAPI program, including a QAPI plan and the gathering and analysis of data, had not been developed. A policy specific to QAPI and hospice had not been developed.</p> <p>Refer to L574 as it relates to the failure of the governing body to ensure a QAPI program had been developed and implemented.</p>	L 651			

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L 651	<p>Continued From page 27</p> <p>3. The hospice utilized a chaplain to provide spiritual counseling services. The official relationship between the chaplain and the hospice was not defined. A job description for the Chaplain was not present.</p> <p>The Chaplain was a volunteer. An agreement between the Chaplain and the hospice to provide spiritual counseling services was not documented. A "VOLUNTEER AGREEMENT," dated 5/16/07, was present. However, it was a standard volunteer agreement and did not specify what his duties were.</p> <p>The Chaplain was interviewed on 9/27/12 beginning at 3:30 PM. He confirmed he was the Hospice Chaplain. He confirmed he did not have a job description and did not have a formal agreement to provide Chaplain services.</p> <p>The hospice did not have a formal agreement with the Chaplain to provide services and had not defined the position.</p>	L 651		
L 661	<p>418.100(g)(1) TRAINING</p> <p>(1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family 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 3 of 15 staff were oriented to the hospice philosophy, (Occupational Therapist A, Physical Therapist A and Speech/Language Pathologist A) whose employee files were reviewed. This had</p>	L 661		11/2/12

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L 661	<p>Continued From page 28</p> <p>the potential to result in inconsistent approaches to patient care and negatively impact coordination of patient care. Findings include:</p> <p>The Hospice Manager and surveyor reviewed the hospice employee orientation/education files on the afternoon of 9/27/12, beginning at approximately 3:00 PM. The files did not contain orientation to the hospice philosophy for staff identified below:</p> <p>Occupational Therapist A, whose hire date was 1/04/10 Physical Therapist A, whose hire date was 8/21/06 Speech/Language Pathologist A, whose contract date was 7/10</p> <p>During the review of personnel files, the Hospice Manager confirmed the hospice had not oriented contracted staff to the hospice philosophy in the past. Additionally, she confirmed there was no documentation indicating Occupational Therapist A and Physical Therapist A had received hospice philosophy orientation.</p> <p>The hospice did not ensure all employees and contracted staff were oriented to the hospice philosophy.</p>	L 661		