



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

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IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

January 3, 2013

Donna Wilder, Administrator  
River City Hospice  
1610 Hyde Court  
Beaumont, TX 77706-2102

RE: River City Hospice, Provider #131561

Dear Ms. Wilder:

This is to advise you of the findings of the complaint survey, which was concluded at your facility on December 19, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Hospice into compliance, and that the Hospice remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

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

Donna Wilder, Administrator  
January 3, 2012  
Page 2 of 2

January 13, 2013, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,



GARY GUILLES  
Health Facility Surveyor  
Non-Long Term Care

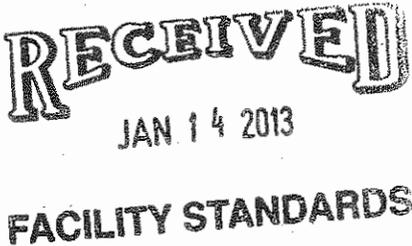


NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

GG/nw  
Enclosures

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  131561	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/19/2012
NAME OF PROVIDER OR SUPPLIER  RIVER CITY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 3726 EAST MULLAN AVENUE POST FALLS, ID 83854	
(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 complaint survey of your agency. Surveyors conducting the investigation were:  Gary Guiles, RN, HFS, Team Leader Sylvia Creswell, LSW, HFS Susan Costa, RN, HFS  Acronyms used in this report include:  BRODA chair - a high backed reclining chair DME - Durable Medical Equipment IDG/IDT - Interdisciplinary Group/Interdisciplinary Team MRI - Magnetic Resonance Imaging OT - Occupational Therapy PT - Physical Therapy RN - Registered Nurse SNF - Skilled Nursing Facility w/c - wheelchair	L 000		
L 778	418.112(e)(1)(i) COORDINATION OF SERVICES  [The designated interdisciplinary group member is responsible for:] (i) Providing overall coordination of the hospice care of the SNF/NF or ICF/MR resident with SNF/NF or ICF/MR representatives;  This STANDARD is not met as evidenced by: Based on staff interview and review of hospice and SNF medical records, it was determined the hospice failed to ensure the care provided to 3 of 7 patients (#1, #2, and #6) was coordinated between the hospice and SNFs. This decreased the effectiveness of services provided to patients. Findings include:	L 778		The Plan of Correction has been reviewed and accepted by the Administrator, Director of Patient Care Services, the IDG and the Governing body. Full compliance to the following deficiencies will be in effect by Jan. 13, 2013.

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

TITLE

(X6) DATE

*Norma J Wilder, ADU*

1/11/13

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 778	Continued From page 1  1. Patient #2's medical record documented an 87 year old female whose start of care date was 2/08/12 and discharge date was 10/25/12. She resided in SNF B. Her diagnoses included failure to thrive, chronic kidney disease, and diabetes. She was readmitted to hospice on 11/21/12 and was currently a patient as of 12/13/12.  The hospice agency records included a Hospice Agreement with SNF B, dated 3/10/10. Exhibit F of the agreement stated the hospice RN responsibilities included communication with SNF B regarding needs for "...x-rays, lab studies, therapy, consults and supplies." The agreement also stated the hospice RN would give "Approval of special services such as PT, OT, Speech Therapy, Dietary consult as indicated on the Joint Plan of Care." However, Patient #2's medical records did not include documentation that care and services were sufficiently coordinated as follows:  a. Patient #2's medical record documented orders from the SNF B's physician on 9/05/12 for a PT evaluation. A subsequent order, from SNF B's physician dated 9/06/12 stated she was to receive PT services 3 times a week for 4 weeks for shoulder and arm pain.  Patient #2's record documented the following regarding her shoulder pain:  - 9/7/12: A "NURSES [sic] NOTE," timed at 11:00 AM, stated a physical therapist came at the end of her visit.	L 778	An in-service was given to all staff regarding policy and procedure (PC.02.02.01) "Hospice Coordination of Services" (attached as exhibit #1). This in-service was given by the Vice President of Clinical Operations in conjunction with the Director of Clinical Services on Jan. 3, 2013. The in-service covered information required to coordinate with the Long Term Care facility staff, including the delineation of duties between the Hospice and facility staff as outlined in all the contracts for facilities.  A new Coordination of Care form was introduced to all staff at the above in-service on Jan. 5, 2013. (Exhibit # 2) and completed on all current patients or new admissions residing in Long Term Care Facilities and/or Assisted Living Centers. This form has 3 parts that requires a signature from the facility, family or patient representative and the hospice and will become part of the clinical record. This form further delineates the coordination of care between a Long Term Care Facility or Assisted Living Center and the Hospice. In addition the Comprehensive Palliative Plan of Care and Palliative Care Form (Exhibits #3 and #4) will be used to define the start of care, the hospice diagnosis, supplies, DME and medication coverage related to the hospice diagnosis.	

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L 778	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- 9/10/12: A written order by the hospice physician documented pain medication was ordered which was used to treat Patient #2's shoulder pain.</li> <li>- 9/18/12: "IDG/IDT MEETING NOTES," stated "PT for pain [left] shoulder." The note further stated she used a stimulator for her shoulder.</li> <li>- 9/21/12: A "NURSES [sic] NOTE," timed at 10:30 AM, documented Patient #2 reported the "PT stimulation" had helped her shoulder pain.</li> <li>- 10/02/12: "IDG/IDT MEETING NOTES" documented Patient #2 continued to use the stimulator for her shoulder.</li> <li>- 10/8/12: A written order by the hospice physician documented pain medication was ordered which was used to treat Patient #2's shoulder pain.</li> <li>- 10/10/12: An order written by the SNF B's physician stated Patient #2 was to continue PT 3 times a week for 4 weeks.</li> </ul> <p>Despite ongoing documentation of Patient #2's shoulder pain there was no documentation in Patient #2's record which described the specific PT services she was receiving. Her record did not include how often the stimulator was being used or the duration of the treatments, and no other PT interventions were documented. Additionally, Patient #2's record did not include documentation that the hospice had coordinated the PT services with SNF B and documentation explaining why hospice was not involved with these services was not present.</p> <p>The Director of Clinical Services was interviewed</p>	L 778	<p>The Director of Clinical Services or designee along with the Quality Assurance nurse will audit the records monthly to ensure ongoing compliance and confirm they are being utilized to coordinate care. These actions will assure that the Hospice and contracted facilities will remain in compliance with the regulatory requirements.</p> <p>The Administrator and Director of Clinical Services for River City Hospice are responsible for implementing the above plan and full compliance of this regulation will be completed by Jan. 13, 2013</p>	

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L 778	<p>Continued From page 3 on 12/20/12 beginning at 2:00 PM. She confirmed evidence of coordination of care with SNF B regarding therapy services was not present in Patient #2's medical record.</p> <p>b. Patient #2's hospice "DISCHARGE SUMMARY," dated 10/25/12, stated she was discharged because she "...decided to move from palliative care to seeking aggressive treatment." The aggressive treatment was not defined. A "NURSES [sic] NOTE," dated 10/25/12, stated the nurse "...explained to [Patient #2] that having an MRI done is considered aggressive treatment and that it goes against the hospice philosophy." No nursing note documented what type of MRI was being done or why this "aggressive treatment" was ordered.</p> <p>A subsequent "IDG/IDT MEETING NOTES" form, dated 10/30/12, stated Patient #2 was "Discharged from services for seeking aggressive treatment." It did not state what the "aggressive treatment" was or how it impacted Patient #2's care. Documentation from the IDG/IDT explaining the aggressive treatment or the decision to discharge Patient #2 was not present in the record and no order for an MRI was present in Patient #2's medical record.</p> <p>The RN Case Manager, who had written Patient #2's 10/25/12 discharge summary and the nursing note on 10/25/12, was interviewed on 12/18/12 beginning at 9:25 AM. She stated SNF B's physician ordered an MRI of Patient #2's head because of increasing ataxia (an impaired ability to coordinate movement). She stated she did not know who made the decision to discharge Patient #2 or why the MRI was considered aggressive</p>	L 778		

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L 778	<p>Continued From page 4</p> <p>treatment. She stated there was no documentation by the IDG/IDT discussing the decision to discharge. She stated she did not discuss the need for an MRI with SNF B or how that decision impacted Patient #2's ability to remain on hospice.</p> <p>The hospice failed to ensure Patient #2's care was sufficiently coordinated with SNF B in accordance with the 3/10/10 Service Agreement.</p> <p>2. Patient #6's medical record documented an 81 year old female whose start of care date was 11/12/11. She resided in SNF C. She was currently a patient as of 12/13/12. Her diagnoses included failure to thrive, chronic kidney disease, and dementia.</p> <p>The hospice agency records included a Hospice Agreement with SNF C, dated 9/25/09. The agreement stated the Hospice Plan of Care would identify care and services that were needed and specify which provider would be responsible for performing the respective functions. However, Patient #6's medical records did not include documentation that care and services were sufficiently coordinated as follows:</p> <p>Patient #6's medical record contained an order by the hospice physician, dated 4/27/12, for "Swallow eval referral: [agency name] Home Health." Underneath this order in different print was written "D/C." The order was listed as "Hospice related." An explanation of the order or what "D/C" meant was not documented.</p> <p>Patient #6's medical record contained another order by the hospice physician, dated 4/30/12, for</p>	L 778		

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L 778	<p>Continued From page 5</p> <p>"Swallow eval &amp; treat." This was listed as unrelated to hospice. Documentation that the swallowing evaluation had been conducted or other reference to the evaluation after 4/30/12 was not present in the hospice medical record. In addition, no documentation that speech therapy services had been provided was present in Patient #6's medical record.</p> <p>Hospice staff contacted SNF C on 12/14/12 and requested records related to speech therapy. They received a fax from SNF C, dated 12/14/12 at 12:25 PM, labeled "REHABILITATION SERVICES MULTIDISCIPLINARY SCREENING TOOL." The tool, written by a speech therapist, was dated 3/13/12 but was not timed. It stated the Speech Therapist observed the patient with a mechanical soft diet and nectar thick liquids. It stated "Pocketing &amp; lingual residue noted. Would benefit from skilled [speech therapy]." No documentation was present in Patient #6's hospice medical record to indicate hospice staff was aware of the speech therapy assessment or any speech therapy services that had been provided prior to receiving the fax on 12/14/12.</p> <p>The Hospice Director of Clinical Services was interviewed on 12/14/12 beginning at 12:05 PM. She reviewed Patient #6's medical record and confirmed the record did not document speech therapy services or the speech therapy evaluation. She stated she did not know if Patient #6 received speech therapy services after the evaluation. She stated no documentation was present stating whether or not the order for a swallowing evaluation on 4/30/12 had been carried out.</p>	L 778		

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L 778	<p>Continued From page 6</p> <p>The hospice failed to ensure Patient #6's care was sufficiently coordinated with SNF C.</p> <p>3. Patient #1 was a 100 year old female who resided in a SNF and was admitted to the agency on 4/07/12 with a terminal diagnosis of end stage renal failure. Patient #1 resided at SNF A until 6/28/12 when she moved to SNF C.</p> <p>The hospice agency records included a Hospice Agreement with SNF A, dated 9/29/09. The agreement stated the Hospice Plan of Care would identify care and services that were needed and specify which provider would be responsible for performing the respective functions. However, Patient #1's medical records did not include documentation that care and services were sufficiently coordinated as follows:</p> <p>Patient #1's medical record documented she had fallen on 4/14/12. The fall resulted in a neck fracture and Patient #1 was required to wear a soft neck brace. Patient #1's medical record documented she did not tolerate sitting in a standard wheelchair as follows:</p> <ul style="list-style-type: none"> <li>- A "NURSES [sic] NOTE" dated 5/29/12 at 1:15 PM, documented Patient #1 "would like to explore the possibility of a w/c with tilt in space or/and a head rest." The note did not contain documentation of communicating the need to SNF A.</li> <li>- A "NURSES [sic] NOTE" dated 6/08/12 at 10:20 AM, documented Patient #1 "states she is comfortable at this time but tires easily and is unable to tolerate extended time in her w/c d/t [due to] lack of head support." The note further</li> </ul>	L 778		
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L 778	<p>Continued From page 7</p> <p>stated Patient #1 "would benefit from tilt in space w/c." The note did not contain documentation of communicating the need to SNF A.</p> <p>- A "NURSES [sic] NOTE" dated 6/25/12 at 11:30 AM, documented "Facility supplied her with BRODA chair which she tolerates much better than w/c."</p> <p>- An "IDG/IDT MEETING NOTES" entry, dated 6/12/12 stated Patient #1 was "improving. Weak and in bed a lot- expresses need for tilt in space w/c."</p> <p>- "PHYSICIAN ORDERS" dated 6/28/12 at 1:30 PM, documented a verbal order was written for a tilt in space wheelchair with headrest. The order was signed by the hospice physician.</p> <p>In an interview on 12/20/12 at 10:05 AM, the RN Case Manager for Patient #1 stated she had communicated with SNF A regarding Patient #1's need for the specialized wheelchair. The RN Case Manager stated she had been told by SNF A staff that the chair was in use by another patient and not available. She stated she had tried first to have SNF A provide the wheelchair as it was not a hospice related DME for the terminal condition, but as a result of a fall at the facility. The RN Case Manager stated when SNF A did not provide the specialized chair, she ordered the tilt in space wheelchair through the Hospice DME supplier. She stated she was unsure when the wheelchair was obtained for Patient #1, but knew she had it before 6/28/12, when Patient #1 moved from SNF A to SNF C.</p> <p>The hospice failed to ensure Patient #1's care</p>	L 778		

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L 778	Continued From page 8 was sufficiently coordinated with SNF A.	L 778		

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DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

January 2, 2013

Donna Wilder, Administrator  
River City Hospice  
1610 Hyde Court  
Beaumont, TX 77706-2102

Provider #131561

Dear Ms. Wilder:

On **December 19, 2012**, a complaint survey was conducted at River City Hospice. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005621**

**Allegation #1:** The agency failed to ensure care was coordinated for patients residing in skilled nursing facilities (SNFs).

**Findings #1:** An unannounced complaint survey was conducted from 12/13/12 to 12/14/12. Clinical records, agency policies, and SNF Service Agreements were reviewed and staff and patient interviews were conducted with the following results:

The hospice records included multiple Service Agreements with multiple SNFs. Three separate Agreements for 3 separate SNFs were reviewed. All three Agreements, dated 9/25/09, 9/29/09, and 3/10/10 respectively, included parameters for the coordination of patient care between the hospice agency and the SNFs.

Additionally four SNF staff from three different SNF's were interviewed on 12/13/12 and 12/14/12 regarding communication of patient care needs by the Hospice nursing staff. All SNF staff verbalized satisfaction that there was effective communication between the Hospice staff in meeting patient needs.

However, the medical records of 7 hospice patients, who resided in SNFs were reviewed. Three of the records did not include documentation that care had been sufficiently coordinated with the SNFs as follows:

- One patient's record did not include documentation of sufficient coordination with a SNF regarding physical therapy services and an Magnetic Resonance Imaging (MRI) order, which resulted in the patient being discharged from hospice services.

When asked about the physical therapy services, during an interview with the hospice Director of Clinical Services on 12/20/12 beginning at 2:00 PM., the Director confirmed evidence of coordination of care with the SNF regarding therapy services was not present in the patient's medical record. When asked about the MRI and discharge, the RN Case Manager, stated during an interview on 12/18/12 beginning at 9:25 AM. that she did not know who made the decision to discharge the patient or why the MRI was considered aggressive treatment, warranting the discharge. She stated there was no documentation discussing the decision to discharge. She stated she did not discuss the need for an MRI with the SNF or how that decision impacted the patient's ability to remain on hospice.

- A second patient's record did not include documentation of sufficient coordination with a SNF regarding a swallowing evaluation and recommended speech therapy services.

When asked about the evaluation and speech therapy services, the hospice Director of Clinical Services stated, during an interview on 12/14/12 beginning at 12:05 PM, that the record did not document speech therapy services or the evaluation. She stated she did not know if the patient received speech therapy services.

- A third patient's record did not include documentation of sufficient coordination with a SNF regarding the patient's need for a specialized wheelchair.

When asked about the wheelchair, during an interview on 12/20/12 at 10:05 AM, the hospice RN Case Manager stated she had communicated with the SNF regarding the patient's need for the specialized wheelchair. The RN Case Manager stated she had been told by the SNF staff that the chair was in use by another patient and not available. She stated she had tried first to have the SNF provide the wheelchair as it was not hospice related equipment for the terminal condition. The RN Case Manager stated when the SNF did not provide the specialized chair, she ordered the tilt in space wheelchair through the hospice supplier.

The patient records did not include documentation that care had been sufficiently coordinated between the hospice agency and the SNFs. Therefore, the allegation was substantiated and deficient practice was cited.

Donna Wilder, Administrator  
January 2, 2013  
Page 3 of 3

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



GARY GILES  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

GG/nw