



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7007 3020 0001 4038 8614

October 3, 2013

Cory Castagneto, Administrator
Accent Hospice Care
1857 South Millennium Way, Suite 100
Meridian, ID 83646-6349

COPY

RE: Accent Hospice Care, Provider #131554

Dear Mr. Castagneto:

Based on the survey completed at Accent Hospice Care, on September 13, 2013, by our staff, we have determined Accent Hospice Care is out of compliance with the Medicare Hospice Conditions of Participation of **Patients' Rights (42 CFR 418.52), Care Planning, Coordination of Services (42 CFR 418.56), Quality Assessment & Performance Improvement (42 CFR 418.58), Infection Control (42 CFR 418.60), Physical, Occupational Therapy & Speech-Language Pathology (42 CFR 418.72), Organizational Environment (42 CFR 418.100), Medical Director (42 CFR 418.102), Clinical Records (42 CFR 418.104)**. To participate as a provider of services in the Medicare Program, a Hospice must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these conditions to be unmet, substantially limit the capacity of Accent Hospice Care, 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:

Cory Castagneto, Administrator
October 3, 2013
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- 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 each form.

Such corrections must be achieved and compliance verified by this office, before October 28, 2013. 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 16, 2013.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 16, 2013.**

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/pt

Enclosures

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



October 16, 2013

Gary Guiles
Health Facility Surveyor

Nicole Wisenor
Supervisor

Non-Long Term Care
Bureau of Facility Standards
Idaho Department of Health & Welfare
P.O. Box 83720
Boise, Idaho 83720-0009

RECEIVED
OCT 16 2013
FACILITY STANDARDS

Re: Plan of Correction

Dear Mr. Guiles and Ms. Wisenor:

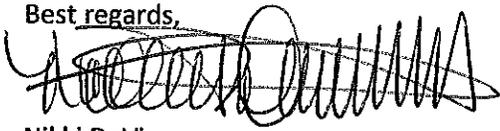
Attached to this letter you will find our Plan of Correction from the survey completed on September 13, 2013. Our Plan of Correction includes rebuttals, which are inserted behind the corresponding Condition of Participation.

During a phone conversation with Mr. Guiles on October 10, 2013, at 1330, we asked him to clarify the time frame for completion of the corrections that will bring us into compliance. Mr. Guiles stated that there is a general understanding that in-services are on-going and "they would work with us as it relates to these dates." We appreciate this courtesy as you will observe that our Plan of Correction includes In-services that are scheduled after October 16, 2013.

In addition, as suggested during our phone conversation with Mr. Guiles on October 10, 2013 at 1330, when appropriate, we have focused on "systems" that are now in place to correct our noted deficiencies, verses responding to each individual example.

If you have any questions, please don't hesitate to phone me at 208-854-7036.

Best regards,

A handwritten signature in black ink, appearing to read 'Nikki DeVinney', written over a horizontal line.

Nikki DeVinney

Administrator

Accent Hospice Care, LLC

Attached: Plan of Correction with Signature on page 1 of the Administrative Director

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

PRINTED: 10/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131554	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/13/2013
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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646
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(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
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L 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your hospice agency on 9/09/13 through 9/13/13. Surveyors conducting the recertification were:</p> <p>Gary Guiles, RN, HFS, Team Leader Libby Doane, RN, BSN, HFS Susan Costa, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>ADL - activity of daily living cg- caregiver CMS - Centers for Medicare and Medicaid Services CNA - Certified Nurse Aide CPR - Cardiopulmonary Resuscitation COPD - Chronic Obstructive Pulmonary Disease D/C'd - Discontinued DCS/SW - Director of Clinical Services/Social Worker DME - Durable Medical Equipment d/t - due to ED - Emergency Department EMR - Electronic Medical Record HAI - Healthcare Associated Infection IDG - Interdisciplinary Group MSW - Masters of Social Work OT - Occupational Therapy PCG - Paid Care Giver PCS - Personal Care Services POT - Plan of Treatment PRN - As needed pt - patient PT - Physical Therapy QAPI - Quality Assessment Performance Improvement</p>	L 000		
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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/8/13
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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 000	Continued From page 1 RN - Registered Nurse ROM - Range of Motion SOC - Start Of Care SLP - Speech Language Pathology SN - Skilled Nursing SW - Social Work Note: Immediate Jeopardy was identified at 42 CFR Part 418.56 (L538: Plan of Care) and the agency was notified on 9/12/13 at 5:00 PM. The agency submitted an Immediate Plan of Correction dated 9/13/13. On site verification of the plan's implementation was completed on 9/13/13 at 4:00 PM and the Immediate Jeopardy was abated.	L 000			
L 500	418.52 PATIENTS' RIGHTS This CONDITION is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patients were informed of their rights and that patient rights were upheld and promoted. This failure resulted in patient rights being violated and a potential lack of advocacy due to insufficient information being readily available to patients and their representatives. Findings include:	L 500	Please see L 501, L 517 and L 518 to address this deficiency.		
	1. Refer to L501 as it relates to the agency's failure to ensure patients were being informed of their rights and that patient rights were being protected.				
	2. Refer to L517 as it relates to the agency's failure to ensure patients were free from mistreatment, neglect, and misappropriation of property.				

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L 500	Continued From page 2 3. Refer to L518 as it relates to the agency's failure to ensure patients received comprehensive information about the services covered under the hospice benefit. The cumulative effective of these systemic practices resulted in the agency's inability to ensure patients were protected and their rights were upheld.	L 500			
L 501	418.52 PATIENTS' RIGHTS The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights. This STANDARD is not met as evidenced by: Based on record review, interview, and review of admission documents, it was determined the hospice failed to ensure patients were being informed of their rights and that rights were being protected for all patients receiving care from the agency. This resulted in the potential for patients to be unaware of their rights and actions to take should patient rights be violated. Findings include: The hospice failed to ensure patients were being informed of their rights as follows:	L 501	1. In-service training and education was conducted on 9/18/13 and 10/16/13 at the IDG meeting regarding the new policy and procedure on "Patient Rights." Attendance was taken and 100 % of the staff were educated. In-service training and education was conducted on 10/23/13 regarding the new policy on safe use and disposal of controlled drugs in the patients home. A policy title "Unsafe Patient Situations or Conditions" was developed on 10/15/13. The policy addresses that the patient has the right to be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property. A separate policy was developed on 10/15/13 in accordance with 418.106 (e) (2) addressing the Safe use and Disposal of Controlled Drugs in the Patient's Home.	November 15 2013.	
	The hospice admission packet was reviewed, including an Election of Hospice Benefit/Informed Consent form. The form included a section that stated by signing the form, the patient acknowledges that "Literature has been presented and explained to me about hospice patient rights and responsibilities." In addition, the form stated information for the Grievance Policy of Accent Hospice Care as well as				

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L 501	Continued From page 3 approved Privacy Practices and disclosure of protected health information was also included in the admission packet. The form stated that by signing, the patient acknowledges "I have also received information on how to report abuse." However, there was no literature related to patient rights, grievance policies, or information on reporting abuse in the admission packet. RN Staff F was interviewed on 9/10/13 at approximately 2:00 PM. She stated she was unaware patient rights was not included in the admission packet. She stated she was still having patients sign the Election of Hospice Benefit/Informed Consent form, but confirmed she was not actually looking in the packet and ensuring patients were receiving the patient rights information. The DCS/SW reviewed the admission packet and was interviewed on 9/11/13 at 10:50 AM. He confirmed the admission packet did not contain patient rights, grievance policies or information on reporting abuse. He stated that due to a change in secretarial staffing, patient rights were no longer being included in the admission packet. He stated that he did not know how long this had been going on, and was not aware of the problem until surveyors had discovered it. He stated he was unaware how many patients had not received patient rights information. He confirmed staff were still allowing patients to sign the Election of Hospice Benefit/Informed Consent even though they had not received the patient rights information.	L 501	2. All of these actions made are to improve the process by educating and informing patients of their rights and giving them recourse for reporting any concerns or violations of said rights. Additionally, the hospice staff and company as a whole, are to inform patients of their rights, protect and promote the exercise of said rights, and ensure patients are safe and free from neglect or abuse. 3. As of 10/15/13, all admission packets contain the documents Patients Rights and Safe Use and Disposal of Controlled Drugs in the Home, and all patients are required to sign that they have received such information. The documents are left with the patient while the signatures of acknowledgment are kept as part of the patients chart. 4. See completion date as indicated above: 11/15/2013. 5. The Administrative Assistant will insure that all admission packets are completed, specifically the "Release of Information" form contains the patients, or their legal representatives, signature where they will certify, "I.....acknowledge that I have reviewed this Notice of Privacy practices, and oral summary along with a written copy of my Patient Rights, and information on Safe Use and Disposal of Controlled Drugs in the Home." The Clinical Registered Nurse Coordinator (CRNC) or DCS/SW will monthly visit 100% of the agencies patients asking to review the patients admission packet to insure it contains the signed Patients Rights and Safe Use and Disposal of Controlled Drugs in the Home forms. In the case of missing forms, the CRNC Or DCS will insure that they are completed. Unsigned forms will be reviewed and immediately signed on site. 6. The Administrative Assistant will insure that all admission packets	
L 517	Patients were not informed of their rights. 418.52(c)(6) RIGHTS OF THE PATIENT	L 517		

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L 517	Continued From page 4 [The patient has a right to the following:] (6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property; This STANDARD is not met as evidenced by: Based on review of medical records and staff interview it was determined the hospice failed to ensure 2 of 11 patients (#10 and #11) were free from mistreatment, neglect, and misappropriation of property. This failure resulted in patients being placed in unsafe situations and diversion of medication. Findings include: 1. Patient #11 was a 57 year old female admitted to hospice services on 9/12/12 with a terminal diagnosis of COPD. Patient #11's right to be free from mistreatment, neglect, and misappropriation of property was not protected as follows: a. The initial RN assessment note dated 9/12/12 documented Patient #11 was living with a grown daughter who "does Meth and could take narcotics." The RN documented Patient #11 was keeping her clonazepam (or Klonopin, a medication to treat anxiety) at the home of another daughter to keep it safe. The RN documented she instructed Patient #11 to do the same with Tylenol #3, which contains codeine. The note documented that family was willing to care for Patient #11, but that there was "possible drug diversion and lack of caregivers." The POT dated 9/12/12, signed by the RN on 9/12/12 and the physician on 9/16/12, did not	L 517	contain the documents as indicated above and the CRNC Or DCS/SW will insure that 100% of all patient admission packets contain these signed and completed forms. L517 begins here: 1. The following actions have been taken to ensure that patients are free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property. As indicated in L 501 all new patient admission packets will include the forms "Patient Right" and "Safe Use and Disposal of Controlled Drugs in the Home." In addition, a new policy on Unsafe Patients Situations or Conditions has been written and in-service has been held with 100% of all staff educated on these forms and policies. 2. All of the actions made are to improve the process by educating and informing patients of their rights and giving them recourse for reporting any concerns or violations of said rights. Additionally, the hospice staff and company as a whole are to inform patients of their rights, protect and promote the exercise of said rights, and ensure that patients are safe and free from neglect or abuse. 3. In order to ensure that patients medications are safe and available to them the policy on "Safe Use and Disposal of Controlled Drugs in The Patients Home" contains a procedure that insures that once the DCS/SW or CRNC is notified of the potential drug diversion the following steps are followed: • The DCS will immediately notify the Medical Director of the potential drug diversion that is taking place in the patient's home. • The DCS will immediately contact all members of the patient's primary Interdisciplinary Group (IDG) team which will consist of the Medical Director, DCS, RN CM of the involved patient, the assigned Certified Nursing Assistance (CNA), Chaplain and Social Worker, if applicable.	

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L 517	<p>Continued From page 5</p> <p>contain interventions related to the possible diversion of medications by Patient #11's daughter.</p> <p>The first IDG meeting held after Patient #11 was admitted to hospice was documented on 9/19/12. There was no documentation to indicate the risk of diversion had been addressed in the IDG meeting. The only documentation for the IDG meeting was "keep monitoring pt and educating pt and family."</p> <p>On 10/12/12 the RN documented Patient #11's daughter was in jail and would not be released for at least 90 days. A DCS/SW visit note dated 12/05/12 documented that Patient #11 talked for several minutes about the upcoming release of her daughter from jail. The DCS/SW documented that Patient #11 stated she did not want her daughter to live with her because of the potential for medication diversion. There was no documentation to indicate interventions were taken by the hospice to ensure Patient #11 would be in a safe living situation.</p> <p>The POT for the certification period of 12/11/12 through 3/10/13 was signed by the physician on 11/29/12 and the RN on 11/30/12. There was no documentation on the POT to address the risk for diversion, except a notation that there was "no comfort kit in home due to diversion from family and friends."</p> <p>During a visit on 12/14/12, the RN documented Patient #11's new bottle of Klonopin was missing and she was using medication out of the old bottle from October. The RN documented that Patient #11's daughter had been released from jail and the RN suspected the daughter had taken</p>	L 517	<ul style="list-style-type: none"> At the conclusion of the Primary IDG team meeting, the RN CM will be responsible for updating patients Plan of Care (POC) regarding the suspected drug diversion. In addition, the RN CM will document the Primary IDG team meeting via a detailed RN CM visit note in the EMR. The RN CM will be responsible for implementing the POC regarding the related suspected drug diversion and report back to the above IDG team within 48 hours. The RN CM will be responsible for documenting the final outcome of the related suspected drug diversion as a detailed RN CM visit note in the EMR. If the RN CM determines that a "Drug Contract" is required then one will be implemented by the DCS/SW. To ensure patients are free from abuse, an in-service was conducted by Adult Protection on 10/30/13. This in-service educated staff on vulnerable adults and the need to report all suspected cases of abuse to Adult Protection immediately. In addition, All Hospice staff will be knowledgeable of what action to take when they discover a patient who appears to be in an unsafe situation or condition where personal safety, safety of others, or abuse/neglect is suspected. The following procedures will be followed: Hospice staff, upon discovery of a patient who appears to be in an unsafe situation or condition, will: 		

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L 517	Continued From page 6 the pills. The RN documented Patient #11 denied that she gave her daughter any pills. There was no documentation to indicate the POT had been altered to ensure Patient #11's medications were not stolen by her daughter. An IDG note, dated 12/26/12, documented "Patient is missing her Clonopin [sic] from 12/21/2012. She has called the office to get it refilled and called [RN's name] on the 24th to get it filled. She denies her daughter [daughter's name] took it. She has a verbal agreement with me and hospice agency since her daughter got out of jail on the 8th of Dec. that she will only get 28 tabs a week and if they disappear then 'consequences' are that she waits until the next refill before she gets more. It has been 2 weeks and this is the 2nd week that medications finally disappeared. [Physician's name] is aware and agrees to go with consequences of missing drugs. When SW gets back will do a written contract with patient and have her sign it." The DCS/SW's next visit note was documented on 1/21/13. There was no documentation to indicate a contract had been discussed with Patient #11.	L 517	<ul style="list-style-type: none"> Immediately, via a phone call, notify the Director of Clinical Services (DCS). If the DCS is not available, the Administrative Director will be notified. Note: Volunteer employees, who suspect a patient is in an unsafe situation or condition, will immediately phone the office "notifying the administrative person in charge," that it appears the patient they are visiting is in an unsafe situation or condition. The "administrative person in charge" will immediately notify the DCS of the patient who appears to be in an unsafe situation or condition. Hospice Aides (Certified Nursing Assistance) will immediately notify the Registered Nurse Case Manager (RN CM), of the involved patient, who will notify the DCS as indicated below. The DCS will immediately notify the Medical Director of the potential unsafe situation or condition. The DCS will immediately contact all members of the patients Primary Interdisciplinary Group (IDG) team which will consist of the Medical Director, DCS, RN CM of the involved patient, the assigned Certified Nursing Assistance (CNA), Chaplain and Social Worker, if applicable. At the conclusion of the IDG team meeting, the RN CM will be responsible for updating patients Plan of Care (POC) regarding the related unsafe situation or condition. In addition, the RN CM will document the IDG team meeting via a detailed RN CM visit note in the EMR. The RN CM will be responsible for implementing the POC regarding the related unsafe condition or situation and report back to the patients Primary IDG team within 48 hours. The RN CM will be responsible for documenting the final outcome of the related unsafe situation or condition as a detailed RN CM visit note in the EMR. 	
	An RN visit note dated 12/21/12 documented the number of Klonopin administered to Patient #11 had been decreased because "this is what we do for patients at risk of diversion" by family members. The RN documented even though Patient #11's daughter was not living with her, she was still diverting medications without Patient #11 being aware. The RN also documented she would not be refilling the Tylenol #3 because of the diversion and because Patient #11 was "not really using them." There was no documentation			

reported to Adult Protection or the local authorities immediately.
Facility ID: 131554
If conducted on pages 1 of 128

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L 517	<p>Continued From page 7</p> <p>to indicate how often Patient #11 had been using Tylenol #3 or that Patient #11 was involved in the decision to stop using Tylenol #3.</p> <p>An RN visit note dated 12/28/12 documented Patient #11 thought her daughter had taken some of her Tylenol #3. The RN documented she "went over our agreement about missing narcotics again today" and that if medications were missing again the police would be called.</p> <p>An RN visit note dated 1/08/13 documented Patient #11's daughter had stolen the rest of her Tylenol #3 but had not taken the Klonopin because Patient #11 had hidden it in her pillow. The RN documented she notified the DCS and Administrative Director and they directed her to file a report with the police. The RN documented Patient #11 refused to file charges against her daughter. She documented she informed Patient #11 if any more Klonopin were missing she would not get any more until her refill date.</p> <p>An IDG note, dated 1/09/13, documented Patient #11 was "having the medications stolen by her daughter....Police were notified but they can't do anything unless [sic] the patient files charges."</p> <p>An IDG note, dated 1/23/13, documented "Should we be concerned about 3 tabs clonopin [sic] that showed up from her daughter, that [were] not part of her supply-green. Also, she borrowed clonopin [sic] from another resident in the building when she ran out the first time. She also has 3 boxes of Spiriva, which [physician's name] D/C'd with another person's name on the labels that she is going to use."</p> <p>There was no documentation to indicate whether</p>	L 517	<p>4. Completion date will be 11/15/2013.</p> <p>5. In order to ensure patients medications are safe and available to them and that hospice staff take action to prevent the abuse of patients the DCS or Administrator will be present at each Entire IDG Team meeting ensuring that all potential suspected cases of drug diversion and patient abuse are addressed in accordance with agency policy. In addition, the CRNC or DCS will review 100 percent of patient charts at least weekly to ensure that any cases of suspected drug diversion or patient abuse are addressed in accordance with agency policy.</p> <p>6. The DCS or Administrator will ensure that each case of suspected drug diversion or patient abuse is addressed in accordance with company policy. The CRNC OR DCS will ensure that all patient records are reviewed at least weekly insuring implementation of agency policy as needed.</p> <p>Addendum:</p> <p>5. In order to ensure patients medications are safe and available to them and that hospice staff take action to prevent the abuse of patients the DCS/SW Or Administrator Or Qualified Designee (QD) will be present at Entire IDG Team Meeting ensuring that all potential suspected cases of drug diversion and patient abuse are addressed in accordance with agency policy. In addition, the CRNC or Qualified Nursing Designee (QND) will review 100 percent of patient charts at least weekly to ensure that any cases of suspected drug diversion or patient abuse are addressed in accordance with agency policy.</p>		

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L 517	<p>Continued From page 8</p> <p>Patient #11 was allowed to keep the medications that came from an unknown source. There was no documentation by the IDG group to address the issue of Patient #11 obtaining medications from unknown sources.</p> <p>An RN note dated 2/08/13 stated Patient #11's daughter was out of jail as of 12/08/12. She "Takes mom's clonopin [sic] or any narcotics. Patient has been reluctant to press charges against [daughter] so far. Medications are delivered on Wednesday of every week #28 tabs. Patient knows that if she runs out before then that she goes without." In addition, the note stated "Medications are missing today. Patient is aware of the consequences and refuses to press charges against her daughter who is currently in the bathroom with the shower on. She does not want me to wait and talk to [daughter] either. No refills of Clonopin [sic] before Wed. 02/13/2013."</p> <p>An RN note on 2/12/2013 documented Patient #11 had been admitted to the hospital on 2/09/13. The note stated Patient #11 had run out of her Klonopin on "Saturday some time after her daughter...took them" and had suffered a panic attack and became hypoxic and called 911. Patient #11 was discharged from the hospital on 2/11/13. The note also documented that Patient #11's daughter had overdosed and was admitted to the hospital. Because Patient #11's daughter was in the hospital, and Patient #11 had filed a police report, the RN documented she would call and get her Klonopin refilled. There was no documentation to indicate the event had been investigated to determine if withholding medication from Patient #11 contributed to her admission to the hospital. The incident was not addressed in IDG meeting notes.</p>	L 517	<p>6. The DCS/SW Or Hospice Administrator or QD will ensure that each case of suspected drug diversion or patient abuse is addressed in accordance with company policy. The CRNC or QND will ensure that all patient records are reviewed at least weekly ensuring implementation of agency policy as needed.</p>		

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L 517	Continued From page 9 During an interview on 9/12/13 beginning at 10:15 AM, the DCS/SW reviewed Patient #11's record and confirmed the event had not been discussed during IDG meetings. The DCS/SW stated as he reviewed the EMR "We did not discuss the theft of her medications or how we could have prevented it from happening." The hospice failed to ensure Patient #11's medication were safe and available to her. b. The admission note documented by the RN on 9/12/12 stated Patient #11 lived with her daughter in an apartment. In an RN note dated 10/12/12, the RN documented Patient #11's daughter was now in jail for at least 90 days and was suspected of taking her mother's medications "as none have disappeared since she left." There was no documentation to indicate a change in the POT due to Patient #11 living alone. The IDG meeting note dated 10/17/12 did not include any documentation to indicate the issue had been addressed, the note only stated "Klonopin will be filled at [name of pharmacy]."	L 517			
	In an RN note, dated 11/27/12, the RN documented Patient #11 had called the hospice to say she had fallen after her bath and had hit her head and wanted a nurse to assess her. The RN documented Patient #11 had hit her head above her right eye and had sustained a 4 cm cut to her left shin, which Patient #11 had dressed with bandaids.				
	An IDG meeting note dated 4/30/13, stated "patient has become unsafe by herself as she				

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L 517	<p>Continued From page 10</p> <p>forgets to plug in or check Oxygen tubing to see if connected and working. She may forget to take Oxygen off to smoke. She does not take her medications if not set out for her. She did not eat for a whole day. Or take medications for 3 days. She needs supervision. Has PCS available but will not use it, she is afraid of???? [sic] Cries. Wants to think about it. A meeting with family and hospice SW Monday, what happened?" There was no documentation on the IDG note to indicate what interventions were taken by the hospice to keep Patient #11 safe.</p> <p>An RN visit note for 5/09/13 documented Patient #11 had spent the night in the hospital after family members had decided they could not stay with her. She was readmitted to hospice the following day. The note documented family had requested to take her to the ED because there was no one to care for Patient #11 at the time. The note also documented Patient #11 had moved to a family member's home and would remain there until the end of her life.</p> <p>During an interview on 9/12/13 beginning at 10:15 AM, the DCS/SW reviewed Patient #11's record and confirmed she had been admitted to the hospital. He stated the nurse who had been the case manager for Patient #11 at that time no longer worked for the agency, so he was unable to question her. As the DCS/SW reviewed Patient #11's EMR, he stated the IDG meeting notes had documented the safety issues identified above. He was unable to find evidence the agency had immediately taken measures to assist and protect her.</p> <p>The hospice did not ensure Patient #11 was safe and free from neglect.</p>	L 517		

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L 517	Continued From page 11 2. Patient #10 was a 78 year old female who was admitted to the hospice on 3/12/13. She revoked hospice services on 6/20/13. Her diagnoses included COPD, lung cancer, and depression. A nursing note dated 4/02/13 at 1:30 PM, stated Patient #10's "...husband was in quite a foul mood, [it was] reported that yesterday he had gone into an uncontrollable rage, shouting and swearing with foul language. He has been talking about 'putting patient in a nursing home so someone can teach her how to take her medicine.' Patient confirms this. She adds, 'Sometimes he just gets so violent!'...RN noted a shotgun sitting propped against a bookcase near his chair so asked, 'is he capable of getting so angry that he would grab a gun?' and she replied that yes, she thought he might with enough anger...patient's husband has a gun in every room...when asked about the situation, she replied 'I don't know what to do.'" A nursing note, dated 4/30/13 at 1:30 PM, stated Patient #10's "Husband is present today and patient is clearly very nervous and fearful...patient informed [the nurse] that [the husband] had been especially ugly this morning. He has been calling her names, telling her she is 'just a dirty bitch,' and in fact threatened to kill her." A nursing note, dated 5/14/13 at 4:20 PM, stated Patient #10's oxygen saturation level was 92%. The note stated the nurse assisted Patient #10 to put her oxygen on. The note stated "After 10 minutes there was no improvement noted in sats so RN checked the tubing. It had been disconnected at the swivel, the 2 ends held up straight and tied in a knot. Patient said [her	L 517			

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L 517	Continued From page 12 husband] did that." The RN corrected the the problem and Patient #10's oxygen saturation level improved slightly. No documentation was present in the medical record that police or adult protection workers were notified of the abuse. A specific plan to address the abuse was not documented in Patient #10's medical record. The RN who wrote the above visit notes was interviewed on 5/13/13 beginning at 1:20 PM. She stated Patient #10's husband called her a "filthy bitch" and confirmed she was afraid for Patient #10's safety. She stated she did not notify the police or adult protection workers of the abuse. The DCS/SW was interviewed on 9/12/13 beginning at 10:50 AM. He stated Patient #10 was a "classic case of battered woman syndrome" and he encouraged her to get away from her husband. He stated a specific plan to address the abuse was not documented. He also confirmed he did not notify the police or adult protection workers of the abuse. Hospice staff did not take action to prevent the abuse of Patient #10.	L 517			
L 518	418.52(c)(7) RIGHTS OF THE PATIENT [The patient has a right to the following:] (7) Receive information about the services covered under the hospice benefit;	L 518	1. In In service training and education was conducted by the DCS/SW on 10/16/13 at the IDG meeting regarding the services covered under the Hospice Benefit, including short-term inpatient and respite care, dietary counseling, and physical, speech and occupational therapies. Staff were educated on informing patients and their families about their right to all covered services. Attendance was taken		
	This STANDARD is not met as evidenced by:				

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L 518	<p>Continued From page 13</p> <p>Based on interview, review of medical records and admission documents, it was determined the hospice failed to ensure 11 of 11 patients (#1 - #11) received information about the services covered under the hospice benefit. This failure resulted in the potential for patient needs to be unmet. Findings include:</p> <p>The agency's Hospice Request for Certification in the Medicare Program (Form CMS-417), signed by the Administrative Director on 9/13/13 documented the agency provided physical therapy, occupational therapy, and speech-language pathology services by arrangement.</p> <p>However, the agency's admission packet, which was currently being given to patients was reviewed. The admissions packet did not include information regarding the availability of therapy services.</p> <p>Further, patient records were reviewed. The patients' records did not include consistent information regarding the services which were available as follows:</p> <p>The Election of Hospice Benefit/Informed Consent forms for Patient #2 (signed on 3/9/12 and 8/10/12), Patient #3 (signed on 5/11/12), Patient #4 (signed on 10/28/11), Patient #5 (signed on 5/30/12, 7/13/12, and 1/27/13), and Patient #9 (signed on 7/30/13) all included a section titled "Services specified by Medicare in my Plan of Care may include..." The section listed multiple services, including physical, occupational and speech therapy.</p> <p>The Election of Hospice Benefit/Informed</p>	L 518	<p>and 100% of were educated. 2. All of these actions improve the process by ensuring all patients are consistently educated and informed of the services covered under the hospice benefit and assuring all of their needs are fully addressed and met.</p> <p>3. As of 10/10/13, all admission packets included updated and consistent Election of Hospice/Benefit/Informed Consent Forms that list (in addition to all other covered services) dietary counseling, short-term inpatient care, respite care, and physical, speech, and occupational therapies as part of the services specified by Medicare that may be included in the patient's Plan of Care. 4. The date of completion will be November 15, 2013. 5. The Administrative Assistant, prior to admission of a patient to service, will ensure that each new patient admitted to service, has a signed EOB that contains the correct services offered under the Hospice Medicare benefit. On a monthly basis the CRNC or the DCS/SW will ensure that 100% of patient admission packets contain the proper EOB that contains the correct services offered under the Hospice Medicare Benefit. In the event that an incorrect form or missing form is discovered the CRNC or DCS/SW will ensure a new correct EOB is completed and that patient or their representative is immediately made aware of the offered services under the Hospice Medicare Benefit. During each IDG, the DCS Or Administrator, will attend ensuring that any potential patient that may need one of these service is identified and offered them as appropriate. 6. The Administrative Assistance will be responsible for ensuring each new patient admitted to our service has a signed and correct EOB.</p>	

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L 518	<p>Continued From page 14</p> <p>Consent forms for Patient #1 (signed on 7/12/13 and 7/24/13), Patient #7 (signed on 7/26/13), Patient #8 (signed on 7/10/13), and Patient #10 (signed on 3/12/13) included a section titled "Services specified by Medicare in my Plan of Care may include..." The section listed multiple services. However, physical, occupational and speech therapy were not included on the list.</p> <p>The Election of Benefits forms were not consistent in informing patients of the availability of physical, occupational and speech therapy.</p> <p>Additionally, Patient #6's Election of Hospice Benefits/Informed Consent form signed on 7/29/11 included a section titled "Services specified by Medicare in my Plan of Care may include..." The section listed multiple services. However, the service of "Dietician" was lined through.</p> <p>Patient #6's record did not document whether dietetic services were offered.</p> <p>Further, Patient #11's record included 3 Election of Hospice Benefit/Informed Consent forms. The section titled "Services specified by Medicare in my Plan of Care may include..." listed physical, occupational and speech therapy on the forms signed on 9/12/12 and 2/12/13. However, Patient #11's Election of Hospice Benefit/Informed Consent form, signed 5/09/13 did not list physical, occupational and speech therapy in the "Services specified by Medicare in my Plan of Care may include..." section of the form.</p> <p>RN staff E and F were case managers for the agency. They were interviewed on 9/13/13 beginning at 8:25 AM and 1:20 PM, respectively.</p>	L 518	<p>The CRNC or DCS will ensure that each patient Admission packet contains a signed and correct EOB. The Administrator OR DCS will ensure they attend each IDG ensuring those in need of available services are offered to them as appropriate.</p> <p>Addendum: The Administrative Assistant or QD, prior to admission of a patient to service, will ensure that each new patient admitted to service, has a signed EOB that contains the correct services offered under the Hospice Medicare benefit. On a monthly basis the CRNC, DCS/SW or QD will ensure that 100% of patient admission packets contain the proper EOB that contains the correct services offered under the Hospice Medicare Benefit. In the event that an incorrect form or missing for is discovered the CRNC, DCS/SW or QD will ensure a new correct EOB is completed and that the patient or their representative is immediately made aware of the offered services under the Hospice Medicare Benefit. During each IDG, the DCS/SW, or Administrator or QD will attend ensuring that any potential patient that may need one of these service is identified and offered them as appropriate.</p> <p>6. The Administrative Assistance or QD will be responsible for ensuring each new patient admitted to our service has a signed and correct EOB. The CNRC Or DCS/SW or QD will ensure that each patient Admission contains a signed and correct EOB. The Administrator or DCS/SW or QD will ensure that they attend each IDG ensuring those in need of available services are offered to them as appropriate.</p>		

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L 518	Continued From page 15 Both Case Managers stated no therapists were on staff at the agency and available to provide services to patients.	L 518			
L 523	Patients were provided with inconsistent information about services offered by the hospice. 418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24. This STANDARD is not met as evidenced by: Based on interview and review of medical records and policies, it was determined the hospice failed to ensure IDG comprehensive assessments were completed within 5 calendar days of the election of hospice care for 2 of 11 patients (#9 and #11) whose records were reviewed. This failure had the potential to result in delayed assessment of patient needs and development of the POT. Findings include:	L 523	1. In-service training and education was conducted by the DCS/SW on 9/27/13 addressing and implementing the requirement for the primary IDG team to complete the comprehensive assessment no later than 5 calendar days after the Election of Hospice care. The DCS/SW, Chaplain, and 100% of the RNCM's were in attendance. A policy was created on 10/15/13 differentiating the members of the primary IDG team from the entire IDG team. 2. These actions will ensure that IDG comprehensive assessments will be completed within 5 days of hospice election. 3. For every admission, the Primary IDG Team will meet to collaborate and assure completeness of the comprehensive assessment no later than 5 calendar days after the election of hospice care. This will be consistently documented by the primary RNCM in each patients chart under IDG Comprehensive Assessment, indicating those in attendance and their agreement with the initial Plan of Care. 4. The date of completion will be . November 15, 2013. 5. Should the DCS/SW or CRNC discover during the Initial Primary IDG Team meeting that a portion of the IDG Comprehensive Assessment, because of an extraordinary circumstance, can not be completed within 5 days of hospice election, the DCS/SW or CRNC will contact the patient or their personal		
	1. The policy Initial Hospice Assessment, undated, stated "The Hospice Interdisciplinary group, in consultation with the patient's physician, shall complete the comprehensive assessment no later than five (5) calendar days after the election of hospice care."				
	The Administrative Director was interviewed on 9/12/13 at 9:30 AM. She stated that each member of the IDG team did a separate				

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L 523	Continued From page 16 assessment of the patient and then the members communicate by telephone to develop the treatment plan. She stated the hospice considered the IDG comprehensive assessment completed within 5 days as long as each member documented his or her assessment within that time period. The hospice failed to complete IDG comprehensive assessments within 5 calendar days of the election of hospice services as follows: a. Patient #9 was a 79 year old male admitted to hospice services on 7/30/13. His terminal diagnosis was advanced dementia. His medical record for the certification period of 7/30/13 through 10/27/13 was reviewed. A visit note dated 8/02/13 and signed by the DCS/SW on 8/06/13 stated that Patient #8's wife preferred the MSW to visit later in the week with the RN and therefore the assessment would be late. A bereavement assessment and social assessment was performed by the DCS/SW on 8/09/13, ten days after Patient #9 was admitted for hospice care.	L 523	representative immediately requesting that the Social Worker or Chaplain be allowed to visit ASAP to complete their portion of the IDG Comprehensive Assessment. 6. The DCS/SW and CRNC will be responsible for implementing this acceptable plan of correction. Addendum: 5. Should the DCS/SW or CRNC or QD discover during the initial Primary IDG Team Meeting that a portion of the IDG Comprehensive Assessment, because of an extraordinary circumstance, can not be completed within 5 days of hospice election, the DCS/SW or CRNC or QD will contact the patient or their personal representative immediately requesting that the Social Worker or Chaplain be allowed to visit ASAP to complete their portion of the IDG Comprehensive Assessment. 6. The DCS/SW or CRNC or QD will be responsible for implementing this acceptable plan of correction.		
	The DCS/SW reviewed the record and was interviewed on 9/11/13 at 4:00 PM. He confirmed the assessments had not been completed within 5 calendar days.				
	The IDG comprehensive assessment was not completed in 5 calendar days from the election of hospice care.				
	b. Patient #11 was a 57 year old female admitted to hospice services on 9/12/12 with a terminal				

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646	
(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 523	Continued From page 17 diagnosis of COPD. The initial certification period was 9/12/12 through 12/10/12. The a social assessment was performed by the DCS/SW on 9/28/12, 16 days after the SOC. In addition, the bereavement assessment, also dated 9/28/12, documented the DCS/SW was unable to contact Patient #11's primary caregiver and would follow up with her later to complete the assessment. There was no documentation in the medical record to indicate the bereavement assessment had been completed at a later time. The DCS/SW was interviewed on 9/11/13 at 4:00 PM. He confirmed the assessments had not been completed within 5 calendar days of Patient #11's election of hospice.	L 523		
L 533	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. This STANDARD is not met as evidenced by:	L 533	In-service training and education was conducted by the DCS/SW on 9/27/13, 10/4/13 and 10/9/13 with the DCS/SW, Chaplain and 100% of the RNCMs in attendance. In-service content covered the requirement on how to address and document, in the IDG comprehensive Assessment, any changes that have taken place since the initial assessment, including information on the patients progress towards desired outcomes, as well as as a reassessment of the patients response to care and any environmental issues that have arisen. 2. These actions will ensure patient needs and their response to care are continually assessed, communicated, documented and updated in the IDG Comprehensive Assessment.	

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L 533	<p>Continued From page 18</p> <p>Based on interview and review of medical records it was determined the hospice failed to ensure the comprehensive assessment was updated in response to changes in condition that had taken place for 3 of 11 patients (#7, #9 and #11) whose records were reviewed. This failure resulted in POTs that did not meet patient needs. Findings include:</p> <p>1. Patient #9 was a 79 year old male who was admitted to hospice services on 7/30/13. His terminal diagnosis was advanced dementia.</p> <p>The Physician Certification of Terminal Illness for Medicare Hospice Benefit and Admission Orders was dated 7/30/13 and signed by the medical director 7/30/13. The certification included "...advanced end stage dementia who's caregivers & pt wish comfort measures."</p> <p>Patient #9's 7/30/13 admission assessment documented he lived at home with his wife. His level of overall functioning on the assessment was documented as minimal assistance for ADLs, and moderate assistance for medication. His wife needed to remind him to take medications. The admission assessment documented Patient #9 was visually impaired, (left retinal detachment) and hard of hearing, but did not wear his hearing aid.</p> <p>Patient #9's record documented on 8/02/13 and 8/09/13 he continued to drive his vehicle. However, no assessment updates regarding his driving could be found in his record.</p> <p>During a phone interview on 9/12/13 at 2:30 PM, the Medical Director stated Patient #9 had advanced dementia, and was not aware that he</p>	L 533	<p>3. These issue will be addressed immediately at each and every IDG meeting. 4. The completion date is 11/15/2013. 5. The RN CM is responsible for verifying all needs/responses are addressed and all of the team is informed and in agreement of the POC by affixing signatures to completed IDG Comprehensive Assessment notes. 6. The DCS/SW or CRNC is responsible for monitoring that each note has been completed and signatures affixed.</p> <p>Addendum:</p> <p>4. The completion date for compliance will be 11/15/2013. 5. The RN CM is responsible for verifying all needs/responses are addressed and all of them team is informed and agreement of the POC by affixing signatures to completed IDG Comprehensive Assessment notes. The CRNC Or QND will ensure that each Comprehensive Assessment is completed during their weekly 100 % audit of agency charts. 6. The DCS/SW or CRNC or QD is responsible for monitoring that each note has been completed and signatures affixed.</p>	

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L 533	<p>Continued From page 19</p> <p>continued to drive. The Medical Director stated he had visited with Patient #9 at his home, and felt he was too impaired to be able to operate any kind of machinery, let alone drive. He stated Patient #9 would not be safe driving his vehicle.</p> <p>During a phone interview on 9/12/13 at 3:20 PM, Patient #9 confirmed he continued to drive. He stated he routinely drove to church, doctors' appointments, and the store. He stated his wife was his co-pilot, as she did not have a driver's license. In addition, Patient #9 stated he continued to use his riding lawn mower and perform yard work at his home.</p> <p>During a phone interview on 9/12/13 at 4:00 PM, Patient #9's wife confirmed he continued to drive after being placed on hospice. She stated his vision was "not so good," and she would tell him if he was driving too close to the other lane.</p> <p>During an interview 9/12/13 at 3:50 PM, the RN Case Manager confirmed she had documented Patient #9 had continued to drive after his election of the hospice benefit. She stated she did not update the comprehensive assessment to include safety issues related to driving. She confirmed the IDG meetings had not discussed Patient #9's continued driving.</p> <p>Patient #9's comprehensive assessment was not updated to address safety concerns in regard to driving.</p> <p>2. Patient #11 was a 57 year old female admitted to hospice services on 9/12/12 with a terminal diagnosis of COPD. The admission note documented by the RN on 9/12/12 stated Patient #11 lived with her daughter</p>	L 533			

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L 533	Continued From page 20 in an apartment. In an RN note dated 10/12/12, the RN documented Patient #11's daughter was in jail for at least 90 days and was suspected of taking her mother's medications "as none have disappeared since she left." There was no documentation to indicate the comprehensive assessment had been updated to reflect Patient #11 living alone. The IDG meeting note dated 10/17/12 did not include any documentation to indicate the issue had been addressed, the note only stated "Klonopin will be filled at [name of pharmacy]." In an RN note, dated 11/27/12, the RN documented Patient #11 had called the hospice to say she had fallen after her bath, hit her head, and wanted a nurse to assess her. The RN documented Patient #11 had hit her head above her right eye and had sustained a 4 cm cut to her left shin, which Patient #11 had dressed with bandaids. The note stated "We discussed getting a shower rug, shower chair and shower curtain again." The note stated "Floor was probably wet due to missing shower curtain." There was no documentation to indicate safety concerns related to Patient #11 living alone had been assessed.	L 533			
	An IDG meeting note dated 4/30/13, stated "patient has become unsafe by herself as she forgets to plug in or check Oxygen tubing to see if connected and working. She may forget to take Oxygen off to smoke. She does not take her medications if not set out for her. She did not eat for a whole day. Or take medications for 3 days. She needs supervision. Has PCS available but will not use it, she is afraid of???? [sic] Cries. Wants to think about it. A meeting with family and hospice SW Monday, what happened?" There				

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L 533	<p>Continued From page 21</p> <p>was no documentation in the medical record to indicate the safety of Patient #11's living conditions had been included in the comprehensive assessment prior to this note.</p> <p>An RN visit note for 5/09/13 documented Patient #11 had spent the night in the hospital after family members had decided they could not stay with her. She was readmitted to hospice the following day. The note documented family had requested to take her to the ED because there was no one to care for Patient #11 at the time. The note also documented Patient #11 had moved to a family member's home and would remain there until the end of her life.</p> <p>During an interview on 9/12/13 beginning at 10:15 AM, the DCS/SW reviewed Patient #11's record and confirmed she had been admitted to the hospital. He stated the nurse who had been the case manager for Patient #11 at that time no longer worked for the agency, so he was unable to question her. As the DCS/SW reviewed Patient #11's EMR, he stated the IDG meeting notes had documented the safety issues identified above, but had not assessed Patient #11's living situation until after she fell and sustained an injury.</p>	L 533			
	<p>The hospice did not ensure Patient #11's comprehensive assessment had been updated to address her living situation.</p> <p>3. Patient #7 was a 73 year old female admitted to hospice care on 7/26/13. She revoked her hospice benefit on 8/12/13. Her diagnoses included COPD and congestive heart failure.</p> <p>The Admission Note Details form, dated 7/26/13</p>				

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L 533	Continued From page 22 by the RN, stated the patient lived in an assisted living facility. The form stated Patient #7's son was being released from prison after 15 years and she needed help to find a place where he could live with her when he got out. He was to be released on 8/15/13. A form labeled Assignment Details, dated 7/26/13, directed the DCS/SW to visit Patient #7 once a month. A Social Assessment, dated 7/31/13, stated Patient #7 was "...looking for a home to move into together [with her son] around the middle of August." The assessment did not mention the son's prisoner status or assess Patient #7's ability to find a home. No specific social service needs were identified. No other visits by the DCS/SW were documented. No change to the POT for the SW was documented after his visit. A document labeled Plan of Care for [Patient #7], dated 7/31/13, stated the DCS/SW was to perform non-specific tasks such as "Aid in connecting patient/family and community resources and services" and "Assess level of need."	L 533		
	The DCS/SW was interviewed on 9/11/13 beginning at 2:15 PM. He confirmed Patient #7's Social Assessment did not address her living situation or her son coming to live with her. He confirmed a specific plan to address her unique situation had not been developed.			
	The hospice did not ensure Patient #7's comprehensive assessment had been updated to address her living situation.			

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L 536 L 536	Continued From page 23 418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES This CONDITION is not met as evidenced by: Based on record review, review of agency policies and incident reports, observation, and patient and staff interview, it was determined the agency failed to ensure patient specific POTs, containing measurable outcomes, were developed, revised, and followed for each patient. This failure resulted in POTs being developed without addressing all pertinent patient issues, and without a process in place to determine if patients were receiving services as needed to reach established goals. Findings include: 1. Refer to L538 as it relates to the agency's failure to develop a POT specific to the needs identified in the comprehensive assessment. 2. Refer to L543 as it relates to the agency's failure to follow the written POT, 3. Refer to L544 as it relates to the agency's failure to provide training and education for each patient and caregiver as to their responsibilities for care and services as identified in the POT. 4. Refer to L550 as it relates to the agency's failure to include all services, medical equipment, and supplies in the POT necessary to meet the needs of the patient. 5. Refer to L555 as it relates to the agency's failure to develop or maintain a system of communication to ensure services were provided in accordance with the POTs.	L 536 L 536	Please refer to L538,L543,L544,L550,L555,L557		

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L 536	Continued From page 24 6. Refer to L557 as it relates to the agency's failure to ensure sharing of information with all disciplines involved in caring for the patient. The cumulative effect of these deficiencies resulted in the inability of the agency to adequately meet patient needs.	L 536			
L 538	418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions. This STANDARD is not met as evidenced by: Based on review of agency policies, record review and staff and patient interviews, it was determined the agency failed to incorporate patient needs that had been identified into the POT for 5 of 11 patients (#1, #7, #9, #10 and #11) whose records were reviewed. This resulted in incomplete POTs and safety concerns not being addressed which placed patients and others at risk of serious harm, impairment or death. Findings include:	L 538	1. In service training and education was conducted by the DCS/SW on 9/18/13, 9/27/13, 10/4/13, and 10/9/13 with 100% of target staff in attendance. In addition, an In-service, led by the DCS/SW and CRNC, will be held on 11/8/2013. The purpose of this in service will be to educate 100% of the RN CM's on the importance of ensuring each patients POT accurately reflects the care and services necessary to meet the patients and family specific needs as identified in the initial and on going comprehensive assessment process. 2. These actions will ensure that the POT is specific, complete, addresses any safety concerns and needs, and incorporates all information into provided care and services. 3 Beginning at the initial Primary IDG Team meeting, with a review of the Initial Comprehensive Assessment, to each Entire IDG Team meeting, the POT will be reviewed by the RNCM and updated as needed, ensuring that each patient specific POT accurately reflects the appropriate needs of the patient/family. 4. The completion date for this deficiency is 11/15/2013. 5. The DCS or CRNC will ensure that during the initial Primary IDG Team meeting the POT accurately reflects the care and services necessary to meet the patients and family specific needs as identified in the initial and on-going comprehensive process.		
	1. Patient #9 was a 79 year old male who was admitted to hospice services on 7/30/13. His terminal diagnosis was advanced dementia. The Physician Certification of Terminal Illness for Medicare Hospice Benefit and Admission Orders was dated 7/30/13 and signed by the Medical Director 7/30/13. The certification included "...advanced end stage dementia who's caregivers & pt wish comfort measures." Patient #9's POT was incomplete and safety concerns				

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L 538	<p>Continued From page 25 were not addressed as follows:</p> <p>a. Patient #9's admission assessment documented he lived at home with his wife. His level of overall functioning on the assessment was documented as minimal assistance for ADLs, and moderate assistance for medication (his wife would need to remind him to take medications). The admission assessment documented Patient #9 was visually impaired, (left retinal detachment) and hard of hearing, but did not wear his hearing aid.</p> <p>Patient #9's record documented on 8/02/13 and 8/09/13 he continue to drive his vehicle. The POT did not address patient safety in regard to driving.</p> <p>During a phone interview on 9/12/13 at 2:30 PM, the Medical Director stated Patient #9 had advanced dementia. He stated he was not aware that Patient #9 continued to drive. The Medical Director stated he had visited with Patient #9 at his home, and felt he was too impaired to be able to operate any kind of machinery, let alone drive. He stated Patient #9 would not be safe driving his vehicle.</p> <p>During a phone interview on 9/12/13 at 3:20 PM, Patient #9 confirmed he continued to drive. He stated he routinely drove to church, doctors' appointments, and the store. He stated his wife was his co-pilot, as she did not have a driver's license. In addition, Patient #9 stated he continued to use his riding lawn mower and perform yard work at his home.</p> <p>During a phone interview on 9/12/13 at 4:00 PM, Patient #9's wife confirmed he continued to drive</p>	L 538	<p>In addition, the DCS/SW or Administrator will attend each IDG ensuring that each POT accurately reflects the patients/family specific needs. In addition, the CRNC, will at least weekly, audit 100% of all patients POT for completeness and make sure they are updated as needed. The CRNC or DCS/SW will ensure that initial Comprehensive Assessments accurately reflect the patients/family specific needs by providing oversight a the initial Primary IDG Team meeting. On going implementation of this process will be the responsibility of the DCS/SW or Administrator as they attend the Entire IDG Team meeting each 14 days.</p> <p>Addendum: 5. The DCS/SW or CRNC or QD will ensure that during the initial Primary IDG Team Meeting the POT accurately reflects the care and services necessary to meet the patients and family specific needs as identified in the initial and on-going comprehensive process. In, addition, the DCS/SW or Administrator or QD will attend each IDG ensuring that each POT accurately reflects the patients/family specific needs. In addition, the CRNC or QND will at least weekly, audit 100% of all patients POT for completeness and make sure they are updated as needed. The CRNC or DCS/SW or QD will ensure that the initial Comprehensive Assessments accurately reflect the patients/family specific needs by providing oversight at the Initial Primary IDG Team Meeting. On going implementation of this process will be the responsibility of the DCS/SW or Administrator or QD as they attend the Entire IDG Team Meeting.</p>		

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L 538	<p>Continued From page 26</p> <p>after being placed on hospice. She stated his vision was "not so good," and she would tell him if he was driving too close to the other lane.</p> <p>During an interview 9/12/13 at 3:50 PM, the RN Case Manager confirmed she had documented Patient #9 had continued to drive after his election of the hospice benefit. She stated she did not incorporate safety interventions related to driving into Patient #9's POT. She confirmed IDG meetings had not discussed Patient #9's continued driving.</p> <p>The agency did not ensure Patient #9's safety in operation of his vehicle and other machinery.</p> <p>Immediate Jeopardy was identified as Patient #9's driving placed himself and others at risk for serious harm, impairment or death. Agency staff, though aware of the situation, had not evaluated Patient #9's ability to drive safely and had not taken steps to keep him or others safe. The agency was notified of the Immediate Jeopardy on 9/12/13 at 5:00 PM.</p> <p>The agency submitted a Plan of Correction for the Immediate Jeopardy on 9/13/13 at 3:00 PM. Staff approached Patient #9 regarding his ability to drive and he revoked hospice services. Hospice staff working 9/13/13 were all informed of the need to notify the DCS/SW or the Administrative Director and develop an immediate plan to address any patient who was identified as engaging in behavior that placed him or her at risk of serious injury. The DCS/SW had taken steps to notify off duty staff and volunteers of the need to report dangerous situations. A policy and procedure to notify the IDG and create an immediate plan to address unsafe situations was</p>	L 538		

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L 538	<p>Continued From page 27 developed and implemented. Plans were in place to ensure all staff and volunteers were notified of the changes prior to working their next shift.</p> <p>On site verification of the plan's implementation was completed on 9/13/13 at 4:00 PM and the Immediate Jeopardy was abated.</p> <p>b. The hospice failed to take Patient #9's needs into account when developing the POT as follows:</p> <p>A "Hospice Certification and Plan of Treatment," dated 7/30/13, included orders for CNA visits to assist with personal care and home making. In addition, the POT included Chaplain visits to provide spiritual support.</p> <p>-There were no CNA visits in the record.</p> <p>- There were no Chaplain visits in the record.</p> <p>Patient #9's Case Manager was interviewed on 9/12/11 at 3:00 PM. She reviewed his record and confirmed the CNA and Chaplain visit orders were included on the POT. She stated he would not need CNA services, and the CNA visit was a default in the electronic program that should have been deleted upon developing Patient #9's POT. The Case Manager stated Patient #9 and his family declined Chaplain visits, and the POT had not been updated to remove Chaplain and CNA visits.</p> <p>The POT was not developed in accordance with Patient #9's needs.</p> <p>2. Patient #11 was a 57 year old female who was admitted to hospice services on 9/12/12. Her terminal diagnosis was COPD. The Physician</p>	L 538		

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L 538	<p>Continued From page 28</p> <p>Certification of Terminal Illness for Medicare Hospice Benefit and Admission Orders was dated 9/12/12 and signed by the Medical Director 9/14/12. The certification included "...end stage COPD. Does not wish escalation of care comfort measures beyond current level."</p> <p>a. Patient #11's admission assessment documented she was a widow and lived alone in an apartment. Her assessment included a need for assistance with dressing, meal preparation, bathing and other ADLs.</p> <p>The comprehensive assessment dated 9/12/12 identified the following safety risks without POT intervention:</p> <ul style="list-style-type: none"> - She was on continuous oxygen, but was smoking cigarettes ½ to 1 pack per day. <p>The POT did not include interventions related to patient education regarding smoking and using oxygen together.</p> <ul style="list-style-type: none"> - Patient #11's home environment included concerns related to cleanliness, accessibility, she was at risk for falling and had tripped on her oxygen tubing. 	L 538			
	<p>The POT did not include interventions related to hazards and patient safety in her home.</p> <ul style="list-style-type: none"> - Patient #11's daughter had taken her medications. 				
	<p>The POT did not include interventions related to prevention of medication diversion by her daughter.</p>				

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L 538	<p>Continued From page 29</p> <p>- Patient #11 had financial concerns and needed housekeeping and grocery shopping services.</p> <p>The POT did not include interventions related to ensuring Patient #11's concerns regarding finances, housekeeping, and shopping needs were met.</p> <p>During an interview on 9/13/13 at 8:20 AM, the DCS/SW reviewed Patient #11's record and confirmed the safety concerns related to oxygen, falls, medication diversion and a safe home environment had been identified upon her admission and had not been addressed in the POT or during IDG meetings.</p> <p>Patient #11's POT did not include interventions to address safety.</p> <p>b. The hospice failed to take Patient #11's needs into account when developing the POT as follows:</p> <p>Patient #11 was on hospice services and revoked her hospice benefit on two occasions. For periods when Patient #11 was on hospice services, she did not receive services as specified on her POT as follows:</p> <p>A "Hospice Certification and Plan of Treatment," dated 9/12/12, included orders for Chaplain visits to provide spiritual support to patient and family.</p> <p>There were no Chaplain visits in the record.</p> <p>Patient #11's Case Manager was interviewed on 9/12/11 at 3:00 PM. She reviewed the record and confirmed the Chaplain visit orders were included on the POT. The Case Manager stated Patient #11 and her family declined Chaplain visits, and</p>	L 538		

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L 538	Continued From page 30 the POT had not been updated to remove chaplain visits. The POT was not developed in accordance with Patient #11's needs. 3. Patient #10 was a 78 year old female who was admitted to the hospice on 3/12/13. She revoked hospice services on 6/20/13. Her diagnoses included COPD, lung cancer, and depression. A nursing note, dated 4/02/13 at 1:30 PM, stated Patient #10's "...husband was in quite a foul mood, [it was] reported that yesterday he had gone into an uncontrollable rage, shouting and swearing with foul language. He has been talking about 'putting patient in a nursing home so someone can teach her how to take her medicine.' Patient confirms this. She adds, 'Sometimes he just gets so violent!'...RN noted a shotgun sitting propped against a bookcase near his chair so asked, 'Is he capable of getting so angry that he would grab a gun?' and she replied that yes, she thought he might with enough anger...patient's husband has a gun in every room...when asked about the situation, she replied 'I don't know what to do.'"	L 538			
	A nursing note, dated 4/30/13 at 1:30 PM, stated Patient #10's "Husband is present today and patient is clearly very nervous and fearful...patient informed [the nurse] that [the husband] had been especially ugly this morning. He has been calling her names, telling her she is 'just a dirty bitch,' and in fact threatened to kill her."				
	A nursing note, dated 5/14/13 at 4:20 PM, stated Patient #10's oxygen saturation level was 92%. The note stated the nurse assisted Patient #10 to				

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L 538	<p>Continued From page 31</p> <p>put her oxygen on. The note stated "After 10 minutes there was no improvement noted in sats so RN checked the tubing. It had been disconnected at the swivel, the 2 ends held up straight and tied in a knot. Patient said [her husband] did that." The RN corrected the problem and Patient #10's oxygen saturation level improved slightly.</p> <p>The RN who wrote the above visit notes was interviewed on 5/13/13 beginning at 1:20 PM. She stated Patient #10's husband called her a "filthy bitch" and confirmed she was afraid for Patient #10's safety.</p> <p>The DCS/SW was interviewed on 9/12/13 beginning at 10:50 AM. He stated Patient #10 was a "classic case of battered woman syndrome" and he encouraged her to get away from her husband.</p> <p>Patient #10's POT, dated 3/12/13 and included updates through 6/10/13, addressed Patient #10's respiratory and cardiac status, instructed staff to assess her anxiety level each visit, "Monitor feelings of depression and loneliness," and encourage mobility. The POT did not address issues with Patient #10's husband who was also her primary caregiver or her battered woman syndrome.</p> <p>The DCS/SW was interviewed on 9/12/13 beginning at 10:50 AM. He confirmed Patient #10's POT did not address her domestic issues or provide direction to staff regarding her depression beyond monitoring it.</p> <p>Patient #10's POT did not specify necessary care and treatment.</p>	L 538		

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L 538	<p>Continued From page 32</p> <p>4. Patient #7 was a 73 year old female admitted to hospice care on 7/26/13. She revoked her hospice benefit on 8/12/13. Her diagnoses included chronic obstructive pulmonary disease and congestive heart failure.</p> <p>Patient #7's admission note, dated 7/26/13, stated she lived in an assisted living facility. The form stated Patient #7's son was being released from prison after 15 years and she needed help to find a place where he could live with her when he got out. He was to be released on 8/15/13. A social assessment, dated 7/31/13, stated Patient #7 was "...looking for a home to move into together [with her son] around the middle of August." The assessment did not mention the son's prisoner status or assess Patient #7's ability to find a home. Patient #7's POT dated 8/07/13, did not include a plan related to her upcoming move or the transition of her son coming from prison to live with her. A form labeled Assignment Details, dated 7/26/13, directed the Social Worker to visit Patient #7 once a month.</p> <p>The DCS/SW was interviewed on 9/11/13 beginning at 2:15 PM. He confirmed Patient #7's POT did not address her living situation or her son coming to live with her.</p> <p>Patient #7's POT did not specify a plan for social services.</p> <p>5. Patient #1 was an 81 year old female admitted to the hospice on 7/12/13 with the terminal diagnosis of COPD. Her medical record for the certification period of 7/12/13 through 10/09/13 was reviewed.</p>	L 538			

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L 538	Continued From page 33 The POT was signed by the physician on 7/16/13 and the RN on 8/14/13. The POT included orders for "CNA visits to assist with personal care, home making, and to promote comfort per RN assignment." There was no documentation of a CNA assignment or of CNA visits in the medical record. The DCS reviewed the clinical record and was interviewed on 9/10/13 at 8:45 AM. He confirmed there was no documentation of CNA visits. He stated that Patient #1 had refused aide visits but confirmed this was not documented in the medical record. The DCS also confirmed the POT had not been changed to reflect Patient #1's refusal of CNA services.	L 538			
L 543	The POT was not developed in accordance with Patient #1's needs. 418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.	L 543	Besides the noted in-service training and education that was conducted by the DCS/SW on 9/27/13 and 10/4/13 with 100% of RNCMs in attendance an in-service will be held on 11/13/13, with the Entire IDG Team in attendance. This in-service will ensure that 100% of the hospice staff are educated on the importance of meeting the POT visit frequencies and the proper documentation/Action required should a patient/family member refuse a visit. In addition, the Entire IDG team will be educated/trained on how to document changes in visit frequencies in the EMR and the importance of notifying the RN/CM if a family member/patient request a change in visit frequency.		
	This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the hospice failed to ensure agency staff conducted visits at the frequencies determined by the IDG for 4 of 11 patients (#2, #5, #8, and #10) whose records were reviewed. This had the potential to result in unmet patient				

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L 543	Continued From page 34 needs. Findings include: 1. Patient #5 was a 73 year old female who was admitted to hospice services on 5/23/12. Her terminal diagnosis was COPD. Patient #5 was on hospice services and revoked her hospice benefit on three occasions. For the periods when Patient #5 was on hospice services, she did not receive services specified on her POT as follows: a. An Initial Comprehensive Assessment, dated 5/23/12, included orders for DCS/SW services monthly, Chaplain Visits twice monthly, SN visits twice weekly, and Hospice Aide visits 3 times per week. - A Social Assessment dated 6/08/12, included a Bereavement Assessment which was not completed. There were no further DCS/SW visit notes during that period of service. b. A "Hospice Certification and Plan of Treatment," dated 7/13/12, included orders for DCS/SW services monthly and Chaplain Visits twice monthly.	L 543	2. The combined actions will ensure that care and services provided, including visit frequencies, will follow the established, individualized POT. 4. The completion date of this correction will be 11/15/2013. Addendum: 5. The DCS/SW or CRNC Or QD will ensure that during the initial Primary IDG Team meeting the POT accurately reflects the correct visit frequencies to meet the patients and family specific needs as identified in the initial and on-going comprehensive process. In addition, the DCS/SW or Administrator OR QD will attend each IDG Team meeting ensuring that all Primary IDG team member visit frequencies are meeting the patient/family needs. The CRNC or QND will ensure that during their weekly audit of 100% of all patient records that the primary IDG Team members are meeting visit frequencies. 6. The DCS or CRNC OR QD will ensure that visits frequencies are established at the initial Primary IDG Team meeting. The DCS/SW or Administrator OR QD will ensure on going visit frequencies meet the patient/family needs by attending each Entire IDG Team Meeting. The CRNC or QND will ensure on-going compliance via the 100% weekly chart audits.	
	- Chaplain Visit notes were documented on 8/16/12, 8/30/12, 9/13/12, 9/26/12. No further notes for that period were documented, indicating 7 missed visits. - DCS/SW Visit notes were documented on 8/17/12 and 9/14/12. No further notes for that period were documented, indicating 4 missed visits. Chaplain and DCS/SW visit frequencies did not			

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L 543	<p>Continued From page 35 follow the written POT established by the IDG.</p> <p>c. A "Hospice Certification and Plan of Treatment," dated 3/28/13, included orders for DCS/SW services monthly and Chaplain Visits twice monthly.</p> <p>- Chaplain Visit notes for that period indicated he visited Patient #5 twice monthly except there were no visits for the month of April 2013, indicating 2 missed visits.</p> <p>- DCS/SW Visit notes for that period were missing for March and April, indicating 2 missed visits.</p> <p>The DCS/SW was interviewed on 9/13/11 at 9:00 AM. He reviewed Patient #5's record and confirmed the missed visits. He reviewed the EMR and stated he did not see any documentation to explain why the visits were missed.</p> <p>Chaplain and DCS/SW visit frequencies did not follow the written POT established by the IDG.</p> <p>c. A "Hospice Aide Assignment," dated 6/04/12, documented that the aide was to visit Patient #5 three times a week and obtain vital signs, assist with ambulation, assist Patient #5 to sit up in a chair, provide light housekeeping and food preparation, assist Patient #5 to the bathroom, assist with dressing, hair brushing, foot care, linen changes, shampoo, shower and skin care. However, on several visits the tasks had already been completed by the PCG. Care was not provided in accordance with the hospice aide assignment. Examples include, but were not limited to, the following:</p>	L 543		

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L 543	Continued From page 36 - A hospice aide note dated 7/30/13 documented Patient #5's food preparation, dressing and nail care was not needed and the PCG had already assisted Patient #5 with showering, shampoo, oral hygiene and linen change. - A hospice aide note dated 7/31/13 documented ambulation, food preparation, showering, shampoo, and nail care were not needed. The note also documented the PCG had already assisted Patient #5 with oral hygiene, linen change, and dressing. - A hospice aide note dated 8/12/13 documented all cares had been done prior to her arrival and the only task completed by the hospice aide was light housekeeping and vital signs. - A hospice aide note dated 8/23/13 documented the aide obtained vital signs, assisted Patient #5 to the bathroom and provided skin care, but all other cares were done by the PCG or not needed. - A hospice aide note dated 8/28/13 documented the aide assisted Patient #5 to the bathroom and provided skin and nail care, but all other cares were provided by the PCG or were not needed.	L 543			
	One of the CNAs providing care for Patient #5 was interviewed on 9/11/13 at 9:10 AM. She confirmed the above aide visits were made, and she would usually take vital signs and check on Patient #5. She stated between herself and the RN, Patient #5 would be seen almost every day. The CNA stated she had not discussed changing the Hospice Aide Plan of Care with the case manager.				

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L 543	<p>Continued From page 37</p> <p>Care was not provided and coordinated with the PCG in accordance with the Hospice Aide Plan of Care.</p> <p>2. Patient #8 was an 88 year old male admitted to the hospice on 7/11/13 for a terminal diagnoses of Parkinson's disease. His medical record for the certification period of 7/11/13 through 10/08/13 was reviewed.</p> <p>The POT, signed by the physician on 7/16/13, ordered SN visits to be completed once a week, with seven PRN visits each week.</p> <p>The RN Case Manager documented a visit note on 7/16/13. On 7/24/13 the RN Case Manager documented that Patient #8's wife stated she and her husband would be out of town "today and tomorrow" and did not want a visit from the RN until "Thursday this week." The next visit note recorded by the RN was on 8/01/13, 16 days since the last RN visit.</p> <p>The RN Case Manager reviewed the record and was interviewed on 9/13/13 at 8:20 AM. He confirmed the RN visit frequency had not been followed in accordance with the POT.</p> <p>SN-visit-frequency did not follow the POT.</p>	L 543			
	<p>3. Patient #2 was an 80 year old male admitted to the hospice on 8/10/12 with a terminal diagnosis of Parkinson's disease. His medical record for the certification periods of 8/06/13 through 8/04/13 and 8/05/13 through 10/03/13 were reviewed.</p> <p>The POT for the certification period of 8/06/13 through 8/04/13, signed by the physician on</p>				

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83848		
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L 543	<p>Continued From page 38</p> <p>5/23/13, documented the DCS/SW was to visit monthly with 7 prn visits allowed a week. The POT for the certification period of 8/04/13 through 10/03/13, signed by the physician on 7/24/13, documented the same frequency for the DCS/SW. The DCS/SW visit frequency was not followed in accordance with the POT as follows:</p> <ul style="list-style-type: none"> - A "Missed Visit Details" note was recorded by the DCS/SW on 5/28/13 at 2:20 PM which stated Patient #2's wife had called to tell the DCS/SW that Patient #2 had friends visiting and "would prefer that SW not visit this month." - A "Missed Visit Details" note was recorded by the DCS/SW on 6/25/13 at 9:35 AM which stated Patient #2 had a "terrible headache and is not up to a visit." - A "Missed Visit Details" note was recorded by the DCS/SW on 7/30/13 5:05 PM which stated Patient #2 refused a visit for the month because he had family in town. The next visit provided by the DCS/SW was documented on 8/15/13. <p>Patient #2 was not seen by the DCS/SW for 3 months.</p> <p>The DCS/SW was interviewed on 9/10/13 at approximately 8:45 AM. He stated he attempted to reschedule missed visits but did not document this. He confirmed the DCS/SW visit frequency did not follow the POT.</p> <p>DCS/SW visit frequency did not follow the POT.</p> <p>4. Patient #10 was a 78 year old female who was admitted to the hospice on 3/12/13. She revoked hospice services on 6/20/13. Her diagnoses</p>	L 543			

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83846		
(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 543	Continued From page 39 included COPD, lung cancer, and depression. The POT, dated 4/26/13, ordered SN visits to be performed twice a week. The RN documented visit a visit on 5/30/13. The next visit was documented on 6/13/13, 14 days later. The DCS/SW was interviewed on 9/12/13 beginning at 10:50 AM. He confirmed SN visits had not been performed twice a week in accordance with the POT.	L 543			
L 544	SN visit frequency did not follow the POT. 418.56(b) PLAN OF CARE The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the hospice failed to ensure education on the responsibilities of care and services identified in the POT were provided to the caregivers for 4 of 11 patients (#11) whose records were reviewed. This failure resulted in a potentially unnecessary admission to the hospital and revocation of hospice services. Findings include: Patient #11 was a 57 year old female admitted to hospice services on 9/12/12 with a terminal diagnosis of COPD. Patient #11 revoked hospice care twice between admission and her death on	L 544	1. Besides the noted In-service training and education conducted by the DCS/SW on 9/27/13, 10/4/13, and 10/9/13 with 100% of RNCM's in attendance an In-service will be held on 11/13/13, attended by the Entire IDG Team ensuring they are educated on the new agency policy regarding hospitalizations which includes: education at hospice election of benefit and admission regarding hospice policy, education to prevent hospitalizations, the process taken if a patient is admitted, the need to include recent hospitalizations in certifications and re-certifications, and the requirement of the Entire IDG Team to discuss, review and document whether the revocation could have been prevented. 2. All of these actions will help prevent unnecessary hospitalizations and revocations by ensuring staff, patients and families know when and how to follow the established process and procedures.		

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(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)	(X6) COMPLETION DATE
L 544	Continued From page 40 5/24/13, as follows: The RN visit note for 2/12/13 documented Patient #11 had taken herself to the ED on 2/09/13 after suffering an anxiety attack. The hospice was unaware of this admission until Patient #11 was discharged from the hospital on 2/11/13. The RN documented that she reviewed the procedure with Patient #11 about calling the hospice first and put a sign on Patient #11's door with this information. The RN also put a card in Patient #11's wallet and gave her daughter a card with the hospice's name and phone number on it. There was no documentation in the medical record to indicate this education had been performed prior to this event. A Notice of Patient Enrollment Change form was signed by Patient #11 on 2/09/13 revoking hospice benefits. The Physician Certification of Terminal Illness for Medicare Hospice Benefit & Admission Orders form was signed by the physician on 2/12/13 and documented "+ End stage COPD. See recent face to face." The Face to Face Visit note was documented by the physician on 2/14/13. There was no documentation related to Patient #11's hospital admission.	L 544	3. As of 10/10/13, all admission packets were updated to include a Medical Coordination Service page, outlining the hospice agency as the first responder. In addition, a policy was created on Hospitalizations with an in-service held on 10/23/2013 which was attended by 100% of all RN CM's where they were educated on the contents of the policy which includes a portion on how to prevent hospitalizations. 4. The date of completion will be 11/15/2013. Addendum: 5. Charts will be audited quarterly by the CRNC OR QND to verify that revocation reviews have been conducted if needed. 6. The DCS/SW Or CRNC QD will be responsible for implementation this Plan of Correction ensuring compliance with the Medicare COP's regarding Hospice Care and this agency Policy and Procedures.	
	The IDG meeting notes for 2/20/13 did not address Patient #11's admission or the need to educate Patient #11 and her family. An RN visit note dated on 5/07/13 stated Patient #11 was confused, vital signs were irregular and nail beds were dusky. The RN stated Patient #11 had not taken any medication from the medi-set since the RN had given her some on Friday, three days prior. The RN stated she believed Patient			

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L 544	<p>Continued From page 41</p> <p>#11 was dying. She called Patient #11's family to inform them but was unable to stay with Patient #11 until family arrived. She called the hospice Chaplain to come until family could be there. At about 11:15 AM, the RN received a call from Patient #11's daughter stating that she was with her mother and wanted to talk her mother into being admitted to the hospital. The RN documented she received an email from the DCS/SW stating that Patient #11 was going to the ED. There was no documentation to indicate the RN had attempted to provide the family with education related to the dying process or when it was appropriate to transfer Patient #11 to the hospital.</p> <p>A Notice of Patient Enrollment Change was signed by Patient #11's daughter on 5/07/13 revoking hospice benefits.</p> <p>An RN visit note for 5/09/13 documented Patient #11 had spent the night in the hospital after family members had decided they could not stay with her. She was readmitted to hospice the following day. The note documented family had requested to take her to the ED because there was no one to care for Patient #11 at the time. The note also documented Patient #11 had moved to her daughter's home and would remain there until the end of her life. There was no documentation that the family was educated on when to call hospice or when to go to the hospital.</p> <p>The Physician Certification of Terminal Illness for Medicare Hospice Benefit & Admission Orders form was signed by the physician on 5/09/13 and documented Patient #11 had "end stage COPD. Pt had family [illegible] + exacerbation + went to hospital for encephalopathy. Now wants to</p>	L 544			

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L 544	Continued From page 42 resume hospice." IDG meeting notes for 5/15/13 did not contain documentation to indicate Patient #11's overnight stay in the hospital had been addressed by the IDG team. There was no documentation to indicate the need for further education of the family/caregivers had been addressed. In addition there was no documentation to indicate Patient #11's revocations had been investigated in order to determine if the hospitalizations could have been prevented. The DCS/SW was interviewed on 9/12/13 at 10:15 AM. He confirmed there was no documentation Patient #11's family had been educated in relation to the events that caused Patient #11 to revoke services. He confirmed the revocation events had not been investigated. The hospice failed to educate Patient #11's family in order to prevent hospitalization.	L 544			
L 550	418.58(c)(5) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (6) Medical supplies and appliances necessary to meet the needs of the patient. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure DME was identified on patient POTs and supplied in accordance with patient need for 8 of 11 patients (#2, #3, #5, #7, #8, and #11) whose records were	L 550	1. In service training and education was conducted by the DCS/SW on 9/27/13, 10/4/13 and 10/9/13 with 100% of the RN CM's in attendance. In-Service content addressed the requirement of the plan of care to include all services necessary for the palliation and management of the terminal illness and related conditions including medical supplies and appliances necessary to meet the needs of the patient. 2. These actions will ensure that DME is included in the patients POT and supplied in accordance with their needs.		

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(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 550	<p>Continued From page 43 reviewed. This resulted in patient needs being left unmet and unnecessary patient injuries occurring. Findings include:</p> <p>1. Patient #11's 9/12/12 initial Hospice Certification and Plan of Treatment documented she was a 57 year old female with pulmonary disease (end stage COPD). Her record did not include documentation that DME was provided in accordance with her identified needs as follows:</p> <p>a. Her DME Order Details note, dated 9/6/13 documented she required DME which included a shower hose and an over bed table. However, Patient #11's record did not include documentation that she received the DME. Her 9/12/12, 12/11/12, 2/12/13, 4/13/13, and 5/09/13 Hospice Certification and Plan of Treatment forms all continued to document she needed the shower hose and an over bed table.</p> <p>b. Her DME Order Details note, dated 9/06/13 documented she required DME which included a shower chair. However, Patient #11's record did not include documentation that she received the DME as follows:</p> <p>Patient #11's 9/12/12 Hospice Certification and Plan of Treatment form continued to document she needed the shower chair.</p> <p>An 11/16/12 RN visit note stated "Patient needs shower curtain and shower chair..."</p> <p>An 11/27/12 RN visit note documented Patient #11 had fallen after her bath, had hit her head and was bleeding. The note documented she hit head head above her right eye and the area was swollen. She also had a 4 cm cut on her left shin</p>	L 550	<p>3. At time of admission patient needs are initially assess and continually re-assessed throughout the duration of treatment. The supplies and appliances are provided as soon as the need is identified. The RN CM's are responsible for ordering an/or verifying the ordering of and delivery of any needed medical supplies or equipment. The items are identified that the patient already has and uses is indicated in the clinical chart (with the words "patient owns") under the heading "Body Systems Activity Musculoskeletal Finding" in the section labeled "Patient Used Mobility Equipment and Devices." The DME orders section in the clinical chart will be created at admission. If applicable, when the first ordered equipment and/or supplies are delivered to the patient. Each item will be listed with the actual word "delivered" to indicate actual delivery to and receipt of such item by the patient. Any subsequent equipment and/or supplies will be added by updating the current DME orders (as opposed to creating a new order) in order to keep the full list in one area of documentation including the item, delivery date, and word "delivered" to indicate actual delivery to and receipt of such item by the patient. Any needs will be discussed with the Entire IDG Team and documented in the time correlated IDG Comprehensive Assessment. The Primary IDG Team will review and document needs, refusals, and reassessments of needs.</p>		

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1067 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83048		
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L 550	<p>Continued From page 44 and a dark bruise on her left inner knee. The note stated "We discussed getting a shower rug, shower chair and shower curtain again." The note stated "Floor was probably wet due to missing shower curtain."</p> <p>A subsequent Hospice Aide Visit note documented the shower curtain was hung and a non-slip mat was placed on 11/29/12. However, no information regarding Patient #11 receiving a shower chair was present.</p> <p>An 11/30/12 RN visit note stated "Now has shower chair, bath mat, bath rug and shower curtain." However, Patient #11's 12/11/12, 2/12/13, 4/13/13, and 5/09/13 Hospice Certification and Plan of Treatment forms all continued to document she needed the shower chair.</p> <p>c. A physician's Face to Face Visit note, dated 2/14/13 stated "...her nebulizer is not functioning..." Documentation regarding when the nebulizer was replaced could not be found in Patient #11's record.</p> <p>d. The Assessment summary section of her 5/09/13 Hospice Certification Certification and Plan stated she used a 4 wheel walker, but needed a new one as Patient #11's was "old and rickety." Documentation that the walker had been replaced could not be found in Patient #11's record.</p> <p>The DCS/SW was interviewed on 9/12/13 beginning at 10:15 AM. He confirmed there was no documentation to indicate the DME needs identified above had been provided.</p>	L 550	<p>Addendum: 4. The completion date for correction will 11/15/2013. 5. The Fiance/HR Director and the Administrative Assistant OR QD will perform monthly audits to compare the list of actual delivered DME equipment with that of the requested list in the clinical chart. 6. Finance/HR Director and the Administrative Assistant OR QD will be responsible for implementing this acceptable plan of correction.</p>		

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1867 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646	
(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 550	Continued From page 45 DME had not been supplied in accordance with Patient #11's needs. 2. The Patient Used Mobility Equipment and Devices section of Patient #3 RN Case Manager visit note dated 6/11/13, documented he used DME which included a recliner and a shower seat. However, Patient #3's 8/18/13 Hospice Certification and Plan of Treatment did not include the recliner or the shower chair. The DCS/SW was interviewed on 9/12/13 beginning at 10:50 AM. He confirmed the DME was not included on the POT. DME was not included on Patient #3's POT. 3. The Patient Used Mobility Equipment and Devices section of Patient #8 RN Case Manager visit note dated 6/25/13, documented he used DME which included an electric scooter. However, Patient #8's 7/11/13 Hospice Certification and Plan of Treatment did not include the electric scooter. The DCS/SW was interviewed on 9/12/13 beginning at 10:50 AM. He confirmed the DME was not included on the POT. DME was not included on Patient #8's POT.	L 550		
	4. The Patient Used Mobility Equipment and Devices section of Patient #7 RN Case Manager visit note dated 7/26/13, documented she used DME which included an electric scooter. However, Patient #7's 7/26/13 Hospice Certification and Plan of Treatment did not include the electric scooter.			

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L 550	<p>Continued From page 46</p> <p>The DCS was interviewed on 9/11/13 beginning at 2:15 PM. He confirmed the DME was not included on the POT.</p> <p>DME was not included on Patient #7's POT.</p> <p>5. Patient #2's 8/29/12 RN Case Manager notes documented in the Patient Used Mobility Equipment and Devices section that Patient #2 required a walker, recliner, wheelchair, shower seat, bedside commode, adjustable bed, toilet seat riser, bed rails, and an exercise bike. Patient #2's 5/01/13, 5/15/13, 5/22/13, 5/29/13, 6/12/13, 6/25/13, 7/03/13, 7/17/13, 7/24/13, 7/31/13, 8/07/13, 8/14/13, 8/21/13, 8/28/13, 8/28/13 and 9/04/13 RN Case Manager notes documented he required the same equipment listed in the 8/29/13 note and included a transfer pole.</p> <p>However, his 8/06/13 and 8/05/13, Hospice Certification and Plan of Treatment stated he required a walker, a wheelchair, a suction machine and a shower chair. The recliner, bedside commode, adjustable bed, toilet seat riser, bed rails, and the transfer pole were not included in Patient #2's POTs.</p> <p>Additionally, Patient #2's 5/01/13, 5/15/13, 5/22/13, 5/29/13, 6/12/13, 6/25/13, 7/03/13, 7/17/13, 7/24/13, 7/31/13, 8/07/13, 8/14/13, 8/21/13, 8/28/13, 8/28/13 and 9/04/13 RN Case Manager notes documented in the Patient Used Mobility Equipment and Devices section that a new shower chair was ordered on 5/15/13. Patient #2's record did not include information regarding when or if he had received the new chair.</p>	L 550			

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L 550	<p>Continued From page 47</p> <p>The DCS/SW was interviewed on 9/12/13 beginning at 10:50 AM. He confirmed the DME was not included on the POT.</p> <p>DME was not included in the POT or supplied in accordance with Patient #2's needs.</p> <p>6. Patient #5's Initial Comprehensive Assessment, dated 5/23/12, stated she required a quad cane, a lift recliner, a wheelchair, a shower seat, a bedside commode, a toilet seat riser, grab bars, a grabber/reacher, and a wedge pillow for her bed.</p> <p>Additionally, her RN Case Manager visit notes, dated 5/02/13, 5/09/13, 5/24/13, 5/30/13, 6/03/13, 6/10/13, 6/17/13, 6/20/13, 6/29/13, 7/05/13, 7/11/13, 7/18/13, 7/25/13, 8/01/13, 8/08/13, 8/15/13, 8/22/13, and 8/29/13, stated she required a quad cane, a lift recliner, a wheelchair, a shower seat, a bedside commode, a toilet seat riser, grab bars, a grabber/reacher, and a wedge pillow for her bed.</p> <p>However her 3/28/13, 5/27/13, and 7/13/12 Hospice Certification and Plan of Treatment only included the quad cane.</p>	L 550			
	<p>Further, Patient #5's 7/11/13 Face to Face Visit Details note stated Patient #5 had peripheral edema, which "has become a very large problem." The note stated "I think she would be a candidate for a sequential pressure lymphedema pump. I will see if [company name] can set her up with that."</p>				
	<p>No additional information regarding the status of the pump (if she received it, if it was effective, etc.) was present in Patient #5's record.</p>				

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L 550	Continued From page 48	L 550		
L 555	<p>The DCS/SW was interviewed on 9/12/13 beginning at 10:15 AM. He confirmed there was no documentation to indicate the DME needs identified above had been reconciled. He also confirmed the POT did not include all DME for Patient #5.</p> <p>DME had not been included in the POT or supplied in accordance with Patient #5's needs.</p> <p>418.56(e)(2) COORDINATION OF SERVICES</p> <p>[The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-]</p> <p>(2) Ensure that the care and services are provided in accordance with the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on interview and medical record review it was determined the hospice failed to ensure care and services were provided in accordance with the POT for 1 of 11 patients (#10) whose records were reviewed. This failure had the potential to adversely affect coordination of care and quality of patient care. Findings include:</p>	L 555	<p>1. In-service training and education was conducted by the DCS/SW on 9/27/13, 10/4/13, 10/9/13 and 10/16/13 with 100% of required staff in attendance. The education covered the requirement of the POT to be individualized to each patient and care and services needed will be systematically communicated and integrated between all members of the primary IDG Team. 2. These actions will ensure that the agency maintains a system of communication ensuring aide services are provided in accordance with the POT. 3. Cares and services will be reviewed, every 14 days, with the Entire IDG team. Cares and Services needed will be reviewed with the Entire IDG Team and documented by the Primary IDG Team RNCM to ensure they are provided in accordance with the POT. 4. Completion date will be 11/15/2013.</p>	
	<p>Patient #10 was a 78 year old female who was admitted to the hospice on 3/12/13. She revoked hospice services on 6/20/13. Her diagnoses included COPD, lung cancer, and depression.</p> <p>The RN note titled General Clinical Chart Details, dated 3/12/13, stated Patient #10 "...will have nursing and an aide to begin with." The nursing note stated care was coordinated with the</p>			

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646		
(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 555	Continued From page 49 DCS/SW, Chaplain, hospice aide, Medical Director, and the patient. However, the form Assignment Details, dated 3/12/13, which listed all staff who were to provide care to Patient #10, did not list the aide. The aide documented 1 visit to Patient #10, on 3/15/13. She also documented Patient #10 refused aide services on 3/25/13, 3/27/13, and 4/01/13. No aide visits were attempted after 4/01/13 until 6/05/13. Twelve nursing visits were documented between 3/15/13 and 6/05/13. None of the nursing notes documented Patient #10 refused aide services or that aide services were not being provided. Each nursing note used the same language to document coordination of care had occurred with the DCS/SW, Chaplain, hospice aide, Medical Director, and the patient. However, the notes did not document what was discussed. Between 3/15/13 and 6/05/13, none of the 6 IDG meeting notes included the status of the hospice aide. The DCS/SW was interviewed on 9/12/13 beginning at 10:50 AM. He confirmed coordination of care between team members was not documented.	L 555	5. Addendum: The DCS or CRNC OR QD will ensure that during the initial Primary IDG Team Meeting the POT accurately reflects the services and frequency of visits that the hospice Aide will provide to the patient. In addition, the DCS/SW or Administrator OR QD will attend each IDG Team meeting ensuring that all Aide Services are being provided in accordance with the POT. The CRNC OR QND will ensure that during their weekly audit of 100% of all patient records that hospice aide services are being provided in accordance with the POT. 6. The CRNC OR QND will ensure that Hospice Aide Services are being provided in accordance with the POT during their 100% weekly review of all clinical charts. The DCS/SW or Administrator OR QD will ensure on-going Hospice Aide visits are being met by attending the the Entire IDG team meeting. The DCS or CRNC OR QD will ensure that hospice Aide visit frequencies and services are accurately reflected during the initial primary IDG Team meeting.		
L 557	418.56(e)(4) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in	L 557			

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L 557	Continued From page 50 accordance with the hospice's own policies and procedures, to-] (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the hospice failed to maintain a system of communication and integration to ensure information was shared between all disciplines providing care for 7 of 11 Patients (#1, #2, #3, #5, #8, #10, and #11) whose records were reviewed. This failure resulted in a lack of coordination of care. Findings include: The DCS/SW was interviewed on 9/12/13 at 10:15 AM. He stated the agency's EMR system would automatically populate information from one visit to the next without staff actually making an entry in the patient's medical record. He stated staff were not always vigilant in correcting that error. The following examples contained documentation of care coordination that had not actually occurred:	L 557	1. In-service training and education was conducted by the DCS/SW on 10/18/13 with the RN CM's. The Coordination of Care Section in the clinical chart will now reflect who was directly involved in the discussion regarding the patient's care, and the date that this discussion took place, as opposed to a comprehensive list of all disciplines who have been involved with the patients coordination of care since their admission to hospice. 2. This action on the part of the RN CM will ensure that the documentation accurately reflects what care was provided and who provided said care as reflected on the POT. 3. Cares and services for all disciplines will be reviewed, every 14 days, with the Entire IDG Team. After this review the RN CM will document (coordination of care) that all disciplines are providing care and services in accordance with the POT. 4. Completion date will be 11/15/2013. ADDENDUM: 5. The DCS or CRNC or QD will ensure that upon admission, the cares and services accurately reflects the services and cares needed by the patient/family. In addition, the DCS/SW or Administrator OR QD will attend each IDG Team Meeting ensuring that all care and services are being provided in accordance with the POT. The CRNC or QND, will ensure that during their weekly audit of 100% of all patient records, that all agency disciplines are providing the care and services, and that these care and services have been documented (Coordinator of Care) in accordance with the POT.	
	a. Patient #1 was a 81 year old female admitted to the hospice on 7/12/13 with a terminal diagnosis of COPD. Her medical record for the certification period of 7/12/13 through 10/09/13 was reviewed. Coordination of care with the IDG and members of Patient #1's family was documented in the RN visit notes, but had not actually occurred. Examples include, but were not limited to, the following:			

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L 557	<p>Continued From page 51</p> <p>-RN visit notes dated 7/18/13, 7/25/13, 8/01/13, and 8/15/13 documented care was coordinated with the DCS/SW, Medical Director, patient, daughter, and granddaughter in the Coordination of Care section of the RN visit notes.</p> <p>b. Patient #2 was an 80 year old male admitted to the hospice on 3/09/12 with the terminal diagnosis of Parkinson's disease. His medical record for the certification period of 8/06/13 through 8/04/13 was reviewed. Coordination of care with the IDG and members of Patient #2's family was documented in the RN visit notes, but had not actually occurred. Examples include, but were not limited to, the following:</p> <p>- RN visit notes dated 5/08/13, 5/22/13 and 6/12/13 documented care was coordinated with the DCS/SW, Medical Director, patient, and wife in the Coordination of Care section of the RN visit notes.</p> <p>c. Patient #3 was a 90 year old male admitted to the hospice on 5/25/2012 with a terminal diagnosis of sigmoid colon cancer. His medical record for the certification period of 8/18/13 through 10/16/13 was reviewed. Coordination of care with the IDG and members of Patient #3's family was documented in the RN visit notes, but had not actually occurred. In addition, the RN documented care had been coordinated with the Chaplain, but Chaplain services were not included in the POT. Examples include, but were not limited to, the following:</p> <p>- RN visit notes, dated 6/11/13, 7/17/13 and 8/06/13, documented care was coordinated with the DCS/SW, Chaplain, Medical Director, patient, and wife in the Coordination of Care section of</p>	L 557	<p>6. The CRNC or QND will ensure that all disciplines are providing care and services in accordance with the POT during their 100% weekly review of all clinical charts. The DCS/SW or Administrator OR QD will ensure on going cares and services are provided, in accordance with the POT, by attending each Entire IDG Team Meeting. The DCS/SW or CRNC OR QD will ensure that care and services are accurately reflected during the initial Primary IDG Team Meeting.</p>		

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L 557	<p>Continued From page 52 the RN visit notes.</p> <p>d. Patient #8 was an 88 year old male admitted to the hospice on 7/11/13 with a terminal diagnosis of Parkinson's disease. His medical record was reviewed for the certification period of 7/11/13 through 10/08/13. Coordination of care with the IDG and Patient #8 was documented in the RN visit notes, but had not actually occurred. In addition, the RN documented that care had been coordinated with the Chaplain, but Chaplain services were not included in the POT. Examples include, but were not limited to, the following:</p> <ul style="list-style-type: none"> - RN visit notes, dated 8/01/13, 8/27/13 and 9/10/13 documented care was coordinated with the DCS/SW, Chaplain, Medical Director and patient in the Coordination of Care section of the RN visit notes. <p>e. Patient #5 was 73 year old female admitted to hospice services 8/01/13 with a terminal diagnosis of COPD. Coordination of care with the IDG was not accurately documented. Examples include, but were not limited to, the following:</p> <p>The Staff Assignments section of Patient #5's POT, dated 5/27/13, documented she was to receive the following services: Social Services, Case Management, hospice aide, Medical Director, volunteer services, and Chaplain services.</p> <p>Her record contained a Chaplain visit note, dated 8/01/2013, documenting a high school volunteer had arrived during the visit.</p> <p>However, the General Clinical Chart Details, dated 8/01/13, documented care was coordinated</p>	L 557			

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L 557	<p>Continued From page 53</p> <p>with the DCS/SW, hospice aide, patient, Medical Director, family, caregiver and other. No other documentation of coordination between the Case Manager and the Chaplain or Volunteer Coordinator was present.</p> <p>Patient #5's record contained Chaplain visit notes that documented there were two Chaplain visits in July 2013 and 3 visits in August 2013.</p> <p>The General Clinical Chart Details, dated 7/06/13, 7/11/13, 7/18/13, and 7/25/13 documented care was coordinated with the DCS/SW, hospice aide, patient, Medical Director, family, caregiver and other. No other documentation of coordination between the Case Manager and the Chaplain or Volunteer Coordinator was present.</p> <p>Additionally, Patient #5's record contained visit notes, dated 7/01/13, 7/15/13, and 7/26/13. The Spiritual Concerns section of the note was blank on all three notes.</p> <p>The General Clinical Chart Details, dated 8/01/13, 8/08/13, 8/15/13, 8/22/13, and 8/29/13 documented care was coordinated with the DCS/SW, hospice aide, patient, Medical Director, family, caregiver and other. No other documentation of coordination between the Case Manager and the Chaplain or Volunteer Coordinator was present.</p> <p>Additionally, Patient #5's record contained visit notes, dated 8/12/13, 8/19/13, and 8/26/13. The Spiritual Concerns section of the note was blank on all three notes.</p> <p>f. Patient #11 was a 57 year old female admitted to the hospice on 9/12/12 with a terminal</p>	L 557		

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L 557	<p>Continued From page 54</p> <p>diagnosis of COPD. Her medical record for the certification period of 9/12/12 through the time of her death on 5/24/13 was reviewed. Coordination of care with the IDG and Patient #11 was documented in the RN visit notes, but had not actually occurred. Examples include, but were not limited to, the following:</p> <p>- RN visit notes dated 2/15/13, 3/02/13, 5/21/13 and 5/23/13 documented care was coordinated with the DCS/SW, Chaplain, Medical Director, and patient in the Coordination of Care section of the RN visit notes.</p> <p>g. Patient #10 was a 78 year old female admitted to the hospice on 3/12/13 with a terminal diagnosis of COPD. Her medical record was reviewed from the SOC date through the certification period of 6/10/13 through 9/07/13. Coordination of care with the IDG and members of Patient #10's family was documented in the RN visit notes, but had not actually occurred. Examples include, but were not limited to, the following:</p> <p>- RN visit notes dated 5/ 3/13, 5/ 9/13, 5/21/13 and 5/24/13 documented care was coordinated with the SW, Chaplain, hospice aide, patient and husband in the Coordination of Care section of the RN visit notes.</p> <p>An RN note, dated 5/24/13, documented "Husband has not been as verbally abusive in the last few weeks as he usually is, but she remains nervous and anxious some of the time." The RN documented care was coordinated with the SW, Chaplain, hospice aide, patient and nephew in the Coordination of Care section of the RN visit notes.</p>	L 557			

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L 557	Continued From page 55 Patient #10's medical record did not contain any documentation of DCS/SW intervention during the month of May. Additionally, her POT, dated 3/12/13, documented there was no Chaplain assigned to her case. In an interview on 9/12/13 at 10:15 AM, the DCS/SW confirmed the coordination of care notes were populated from one visit to the next and the RN was not actually speaking to all members of the IDG team and family at each visit.	L 557		
L 559	Care was not coordinated as documented. 418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT This CONDITION is not met as evidenced by: Based on staff interview and review of agency policies, QAPI documents and meeting minutes, it was determined the hospice failed to ensure a QAPI program was fully developed, implemented, and maintained. This resulted in the agency's inability to monitor its services and improve the quality of patient care and services based on relevant data. Findings include: 1. Refer to L561 as it relates to the failure of the agency to ensure the QAPI program was capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services. 2. Refer to L563 as it relates to the failure of the	L 559	Please see plan of correction for sections L561, L563, L566, L571, and L574.	

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L 559	Continued From page 56 agency to ensure the QAPI program used quality indicator data, including patient care, and other relevant data, in the design of its program. 3. Refer to L566 as it relates to the failure of the agency to ensure the QAPI program focused on high risk, high volume, and problem-prone areas. 4. Refer to L571 as it relates to the failure of the agency to ensure performance improvement projects were developed and implemented. 5. Refer to L574 as it relates to the failure of the agency to ensure the governing body assumed responsibility for implementing and maintaining the QAPI program. The cumulative effective of these systemic practices resulted in the inability to assess quality and improve performance.	L 559		
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 QAPI documents, it was determined the hospice failed to ensure the QAPI 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 determine whether or not its services were meeting patients' needs. Findings include:	L 561	L 561 A new policy was developed on 11/4/13 with regards to the QAPI program. The frequency and detail of the data collected was approved by the Governing Body. Data collected is based on incidence, prevalence and severity of the problem and includes the following quality indicators: 1.) Symptom Management 2.) Care Planning and Delivery 3.) Infection Control 4.) Incidence and Occurrence Tracking of potential adverse and sentinel events (Adverse events are defined as any action or inaction by a hospice that causes harm to a hospice patient). All data collected is reported to the Administrator or Administrative Designee, via a written report or EMR. If a written report is required for the electronic QAPI software system, the Administrator or Administrative Designee, will enter that information into the system. The Governing Body meets every quarter, or	11/4/13

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L 581	<p>Continued From page 57</p> <p>The agency policy Organizational Performance Improvement Plan, not dated, stated "The primary goals of the organizational Performance Improvement Plan are to continually and systematically plan, design, measure, assess and improve performance of critical focus areas relative to palliative outcomes and Hospice services." The plan stated the focus would be on 4 components which included symptom management, care planning and delivery, infection control and incidence and occurrence tracking. The plan stated data was to be collected from 31 separate data sources, which included but were not limited to the following:</p> <ul style="list-style-type: none"> - Outcomes of processes or services, including adverse events. - Infection control surveillance and reporting. - Medication use, including adverse reactions/errors. - Timeliness of assessment and evaluation of services. - Appropriateness of treatment. - Patient treatment plan toward end of life quality goal setting. - Assessment of the efficacy of treatment administered. - Patient/family education. - Infection control practices. - The appropriateness and effectiveness of pain management and control. - Significant medication errors. - Significant adverse drug reactions. - Appropriateness of pain management. <p>However, a specific plan to measure the items was not documented.</p> <p>When interviewed on 9/11/13 beginning at 10:50</p>	L 561	<p>L 561 Continued from page 57</p> <p>as needed, to review data reports. The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, reflect the scope, complexity, and past performance of the hospice's services and operations. The improvement project is determined through the following methodology:</p> <ol style="list-style-type: none"> 1.) Analyze all aggregated summary reports generate by the ERM or QAPI software system. 2.) Identify and prioritize any areas of weakness or high risk. 3.) Develop and implement a strategy to minimize the risk of the problem areas. 4.) Take appropriate actions aimed to improve the problem areas. 5.) Monitor and track the progress of the performance improvement project by comparing previous and current summary reports. <p>The Governing Body then reports their findings and recommendations to the appropriate staff. The Governing Body designates what actions are to be taken and who will be responsible for implementing any changes necessary. The Administrator is ultimately responsible for overseeing the entire QAPI Program.</p>		

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L 561	Continued From page 58 AM, the Administrative Director stated a plan that included specific quality indicators for the agency to monitor in order to evaluate its practices had not been developed. She stated the agency's EMR automatically gathered data regarding 1 quality indicator and transmitted it to CMS. She stated the quality indicator measured the amount of pain the patient stated on admission versus the amount of pain the patient stated 48 hours later. She stated this was an automated process and no agency practices were evaluated to determine what impact the agency had on levels of pain experienced by patients. She stated this data was not used to improve the agency's processes. She stated she could not provide documentation of any quality indicators that had been monitored in the past year that were part of the agency's internal QAPI program.	L 561		
L 563	The facility failed to ensure a plan had been developed to collect quality indicator data in order to demonstrate measurable improvement related to palliative outcomes and hospice services. 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.	L 563	L 563 A new policy was developed on 11/4/2013 in regards to Accent Hospice's QAPI program. Data is collected, using several sources. These sources include Active Patient Records, Clinical Assessments, Family Surveys, IDT meetings, Clinical Staff. The frequency and detail of the data collected was approved by the Governing Body on 10/23/13. Data collected is based on the incidence, prevalence, and severity of the problem and includes the following quality indicators: Symptom Management (i.e. pain, dyspnea, nausea, constipation, diarrhea, depression, insomnia, anxiety), infection control (i.e. UTI, Respiratory tract, non-surgical wound, IV site, or other indicated type of infection), Care Planning and Delivery, Incidence and Occurrence Tracking (i.e. falls, non-falls, skin tears, laceration, bruise, medication adverse reaction such as allergy, respiratory distress, overly sedated or other specified reaction, medication error or count discrepancy, motor vehicle accident, was the event sentinel (i.e. suicide, assault, homicide, or other crime). The nurses are responsible for gathering the information. They are also responsible for entering the information into the EMR, filling out all of the QAPI reports and getting said information	11/4/13
	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 QAPI program used quality indicator data, including patient care, and other relevant data, in the design of its program. This prevented the agency from developing a program which contained enough information to evaluate its services. Findings			

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1867 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646	
(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 563	Continued From page 59 include: The agency policy Organizational Performance Improvement Plan, not dated, stated "The primary goals of the organizational Performance Improvement Plan are to continually and systematically plan, design, measure, assess and improve performance of critical focus areas relative to palliative outcomes and Hospice services." The plan stated the focus would be on 4 components which included symptom management, care planning and delivery, infection control and incidence and occurrence tracking. The plan stated data was to be collected from 31 separate data sources, which included but were not limited to the following: - Infection control surveillance and reporting. - Medication use, including adverse reactions/errors. - Timeliness of assessment and evaluation of services. - Appropriateness of treatment. - Patient treatment plan toward end of life quality goal setting. - Documentation of patient progress. - Assessment of the efficacy of treatment administered. - Patient/family education. - Infection control practices. - The appropriateness and effectiveness of pain management and control. - Significant medication errors. - Significant adverse drug reactions. - Appropriateness of pain management.	L 563	L 563 Continued from page 59 turned into the Administrator or Administrative Designee in a timely manner. If a written report is required for the electronic QAPI software system, the Administrator or Administrative Designee, enters that information into the system. The Governing Body meets every quarter, or as needed, to review data reports. The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's services and operations. The improvement project is determined through the following methodology: 1.) Analyze all aggregated summary reports generated by the EMR or QAPI software system. 2.) Identify and prioritize any areas of weakness or high risk. 3.) Develop and implement a strategy to minimize the risk of the problem areas. 4.) Take appropriate actions aimed to improve the problem areas. 5.) Monitor and track the progress of the performance improvement project by comparing previous and current summary reports. The Administrator is ultimately responsible for overseeing the entire QAPI program.	
	However, a plan to use specific quality indicator data to monitor these items was not documented.			

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L 563	Continued From page 60 When interviewed on 9/11/13 beginning at 10:50 AM, the Administrative Director stated the agency had not gathered quality indicator data in the past year for an internal QAPI program. She also stated the agency had not used quality indicator data in the design of its program. The facility failed to ensure quality indicator data was collected and utilized.	L 563	A new QAPI policy was created on 11/4/2013 specifying the proced for implementing action taken to correct the deficient practice. The agency shows measurable improvements by using Aggregated reports and graphs generated by EMR and QAPI software system.	11/4/13
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 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 agency document Organizational Performance Improvement Plan, not dated, did not include direction to staff to focus on high risk, high volume, and problem-prone areas. The document provided general direction to staff as to how a plan could be developed. However, an actual plan that focused on high risk, high volume, and problem-prone areas and included specific quality indicators for staff to monitor, had not been developed. When interviewed on 9/11/13 beginning at 10:50	L 566	The Governing Body meets every quarter, or as needed, to review data reports. The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, will reflect the scope, complexity, and past performance of the hospice's services and operations. The improvement project were determined through the following methodology: 1.) Analyze all aggregated summary reports generated by the EMR or QAPI software system. 2.) Identify and prioritize any areas of weakness or high risk. 3.) Develop and implement a strategy to minimize the risk of the problem areas. 4.) Take appropriate actions aimed to improve the problem areas. 5.) Monitor and track the progress of the performance improvement project by comparing previous and current summary reports.	

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L 566	Continued From page 61 AM, the Administrative Director confirmed the agency had not developed a plan that focused on high risk, high volume, and problem-prone areas. She also stated the agency had not used quality indicator data in the design of its program, including data to measure high risk, high volume, and problem-prone areas.	L 566	L 566 Continued from page 61 The Governing Body then reports their findings and recommendations to the appropriate staff. The Governing Body designates what actions are to be taken and who will be responsible for implementing any changes needed. The Administrator is ultimately responsible for overseeing the entire QAPI program.		
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 QAPI documents, it was determined the hospice failed to ensure performance improvement projects were development and implemented. This resulted in missed opportunities for improvement. Findings include: The policy Organizational Performance Improvement Plan, not dated, did not define performance improvement projects nor did it state the agency would develop and implement them. A specific plan to evaluate the agency, including the utilization of performance improvement projects, was not documented. When interviewed on 9/11/13 beginning at 10:50 AM, the Administrative Director confirmed the policy did not address performance improvement projects. She confirmed the agency had not	L 571	L 571 Correction to deficiency L571 was achieved on Friday, October 25, 2013. The Governing Body at Accent Hospice met and discussed what project they would like to choose for their annual QAPI project (see attached Governing Body minutes dated 10-25-13). After much discussion, it was decided that Accent Hospice would be tracking the patient's falls and the circumstances surrounding the falls. The procedure for our QAPI project will be as follows: Each RNCM has been given a QAPI binder containing pre-printed QAPI forms to be completed in the event of a fall. This form is titled "Incident/Occurrence Report Form and Definition/Instruction Sheet" (see attached Incident/Occurrence Report Form and Definition/Instruction Sheet) and it will contain general patient information date and time of occurrence, witness (if any), type of incident/occurrence and where it occurred	10/25/13	

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L 571	Continued From page 62 developed a plan that included performance improvement projects. She stated the agency had not conducted any performance improvement projects in the past year.	L 571	L571 Continued from page 62 possible contributing factors such as environmental, progression of the disease, gait disturbances, assistive devices or lack thereof, medications, and whether the occurrence was a sentinel event, description of occurrence, result of the occurrence, analysis of causative factors, and/or errors made, interventions implemented and follow up, any other pertinent comments, and any previous safety teaching or staff training which may relate to the occurrence.		
L 574	418.58(e)(1) EXECUTIVE RESPONSIBILITIES The facility failed to ensure performance improvement projects were developed, implemented and maintained. 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 QAPI documents and governing body meeting minutes, it was determined the hospice failed to ensure the governing body assumed responsibility for implementing and maintaining the QAPI program. This resulted in a lack of direction to staff and the failure of the agency to develop and maintain a comprehensive QAPI program. Findings include: 1. A plan to measure the effectiveness of agency practices, including specific quality indicators and directions for the gathering and use of data, had not been developed or implemented. When interviewed on 9/11/13 beginning at 10:50 AM, the Administrative Director stated she was part of the "Leadership Team" that functioned as the governing body for the agency. She stated a specific QAPI plan had not been developed or	L 574	When completed, this form is turned into the Administrator or Administrative Designee no later than 24 hours after the incident is reported to the RNCM. All data is entered into the QAPI computer program by the Administrator or Administrative Designee. All falls/incidents are reported by the RNCM at the next IDG meeting and any changes to the POC pertaining to the incident are discussed and noted on the Incident/Occurrence Form. Every quarter, the Governing Body meets and reviews the Aggregated Summary Report generated by Deyta. They evaluate the data and discuss any changes that need to be implemented to improve the quality of patient care and safety. The Governing Body's findings and actions to correct the identified problem areas are presented to the appropriate staff at the following IDG meeting.		

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L 574	Continued From page 63 implemented for at least 1 year. She stated no quality indicators had been developed and no data had been gathered for the agency's internal quality program. The governing body failed to ensure a specific quality plan had been developed. 2. Six Leadership Team Meeting minutes were documented between 9/26/12 and 8/06/13. Each of these minutes stated a goal was to "...decrease discharges, for other than death, by 50 percent by December 31, 2014." This was the only specific quality indicator mentioned in the minutes. No data for this item was documented in the minutes. Also, the minutes did not mention a specific QAPI program at the agency. No other documentation of governing body oversight of the QAPI program was present. The Administrative Director, interviewed on 9/11/13 beginning at 10:50 AM, confirmed documentation of the governing body activities was not present and available for review. The governing body did not oversee the QAPI program.	L 574	L571 Continued from page 63 The Governing Body will continue to meet quarterly and annually to evaluate the effectiveness of the project, the actions taken and ensure that all of the Hospice Conditions of Participation are being met. The Administrator will oversee the QAPI program to ensure that the Governing Body is participating in obtaining and evaluating all of the QAPI data. Everything listed for the QAPI program will be a continuous on-going process as we have to continuously gather data. However, Accent Hospice began implementing this process starting on October 25, 2013. The nursing staff was given an in-service review on October 30, 2013, to review all of the QAPI paperwork and to ensure the paperwork would be filled out correctly and that no one had any questions. L574 On 11/4/2013, a new policy was developed regarding the agency's QAPI program. The Governing Body met on 10/23/13 to review data reports generated by the EMR and QAPI software system. The improvement project was determined by analyzing all of the aggregated summary reports generated by the EMR or QAPI software system. They identified and prioritized any	11/4/13	
	3. Adverse patient events and medical errors were not identified and tracked. Incident reports noted falls that had occurred in the past year but there was no documentation that these events were evaluated to determine their causes or what actions could be taken to prevent future falls. Also, no tracking of these events was documented, (i.e. the number of falls by month to determine whether trends could be identified, etc.). Besides falls, no other adverse events were documented.				

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83648
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L 574	Continued From page 64 The Administrative Director, interviewed on 9/11/13 beginning at 10:50 AM, confirmed adverse patient events were not identified, evaluated, and tracked. The facility failed to ensure the governing body assumed responsibility for implementing and maintaining the QAPI program.	L 574	L574 Continued from page 64 areas of weakness or high risk. A project was developed and a strategy was implemented to minimize the risk of problem areas, appropriate actions were taken to improve the problem areas, monitor and track the progress of the performance improvement project by comparing previous and current summary reports. The Governing Body reported their findings on 10/30/13 to the appropriate staff. The agencies annual project is based on incidents/occurrences. The Governing Body is requiring the RNCM to fill out the incident/occurrence reports. The Governing Body will continue to meet quarterly to compare previous and current aggregated summary reports generated by the QAPI software program. The Administrator is ultimately responsible for overseeing the entire QAPI program.	
L 577	418.60 INFECTION CONTROL This CONDITION is not met as evidenced by: Based on staff interview and review of infection control 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. This resulted in potential negative impacts to the health and safety of all hospice patients. Findings include:			
	1. Refer to L578 as it relates to the agency's failure to ensure an infection control program was defined, implemented, and maintained.			
	2. Refer to L580 as it relates to the agency's failure to ensure development and implementation of a program for the surveillance, identification, and prevention of infectious diseases.			

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L 574	Continued From page 64 The Administrative Director, interviewed on 9/11/13 beginning at 10:50 AM, confirmed adverse patient events were not identified, evaluated, and tracked.	L 574			
L 577	418.60 INFECTION CONTROL The facility failed to ensure the governing body assumed responsibility for implementing and maintaining the QAPI program. This CONDITION is not met as evidenced by: Based on staff interview and review of infection control 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. This resulted in potential negative impacts to the health and safety of all hospice patients. Findings include:	L 577	Accent Hospice has initiated an HAI (Health Care Associated Infection Control Plan.) ACTION: In-Service Training and Education was conducted on 10-16-13. HAI Infection Control was implemented and staff was educated on Infection Control Protocols, Policies and Procedures. An in-service was held on 10-16-13, educating the staff on the HAI Binder and where to locate, infection control protocols. The Staff was 100% in attendance. The staff was given an Infection Control Test and the results were discussed and each Staff Member received a completion certificate which was placed in their Personal Employee File. PLAN: HAI Infection Control Education will be on-going monthly and will be held after IDG will all staff present to receive monthly updates from the CDC, as well as guest speakers and on-going infection control. The CRNC (Clinical Registered Nurse Coordinator) will ensure that all Medical Team Staff and those in direct contact with Patients, Patient Families		
	1. Refer to L578 as it relates to the agency's failure to ensure an infection control program was defined, implemented, and maintained. 2. Refer to L580 as it relates to the agency's failure to ensure development and implementation of a program for the surveillance, identification, and prevention of infectious diseases.				

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L 577	Continued From page 65 3. Refer to L581 as it relates to the agency'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 L582 as it relates to the agency's failure to ensure the hospice provided infection control education to employees/contract staff, patients and families. The cumulative effect of these systemic practices resulted in an incomplete and ineffective hospice infection control program.	L 577	HAI Plan Continued- and Patient Caregivers, will be giving the proper Education and ensure that the POC will reflect this education. TITLE OF RESPONSIBLE PERSON: The C.R.N.C.(Clinical Registered Nurse Coordinator) will be responsible to ensure the on-going infection control education and training. The DCS will also be involved with the C.R.N.C., in assuring that the education is scheduled for the IDG Team and Staff. The C.R.N.C. Clinical Registered Nurse Coordinator will Provide on-going monthly education and training		
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 infection control 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:	L 578	on the following dates: November 27, 2013 December 11, 2013 January 8, 2014 February 19, 2014 March 19, 2014 April 16, 2014 May 14, 2014 June 25, 2014 July 23, 2014 August 20, 2014 September 24, 2014 October 22, 2014 November 19, 2014 December 17, 2014		
	1. The policy Healthcare Associated Infection (HAI) Control Plan, undated, stated "The administration of Accent Hospice shall delegate				

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L 578	<p>Continued From page 66</p> <p>the oversight and management of the infection prevention & control to RN case managers."</p> <p>The DCS/SW was interviewed on 9/12/13 at 2:30 PM. He confirmed the RN Case Managers were not involved in the development and maintenance of an infection control program. He stated no one provided oversight of the infection control program for the hospice.</p> <p>2. The policy Healthcare Associated Infection (HAI) Control Plan, undated, stated the hospice would reduce the risk of HAI's for patients, families, staff and volunteers through the following activities:</p> <p>a. "Surveillance - Identification of baseline information about the frequency and type of HAI's [sic] - Identification of clusters of significant deviations from endemic levels - Investigation as needed - Monitoring of hand washing"</p> <p>There was no documentation to indicate the definition of "investigation as needed." In an interview on 9/12/13 at 2:30 PM the DCS/SW confirmed no surveillance activities were being performed and the hospice had not developed a method for investigating possible HAIs.</p> <p>b. "Prevention - Educating patient/families, staff and volunteers about infection control guidelines - Identification of risks for acquiring and spreading of infections - Risks are prioritized"</p> <p>The policy did not define situations for which</p>	L 578	<p>ACTION: Oversight and Management of the infection prevention and control to RN Case Managers will be Provided by the Clinical Registered Nurse Coordinator.</p> <p>The C.R.N.C will train staff on a monthly on-going basis, on the dates provided and will include the RN Case Managers in developing and maintaining the infection control program.</p> <p>The Oversight Management by the Clinical Registered Case Manager will reduce the risks of HAI's for patients, families, staff and volunteers through the following:</p> <p>ACTION: Surveillance will be maintained by the C.R.N.C. The HAI Binder available to all staff is now updated with the Infection Control Forms which detail the Patients at risk of infectious disease and the oversight management of each Patient will be discussed and updated in the POC during IDG.</p> <p>DESCRIPTION: The new Infection Control Reporting Form has been developed and all Staff has been educated and trained on use of form. The In-Service Training Date for usage of the Infection Control Reporting Form was completed on 10-18-13 and a sign in sheet is noted in the In-Service Sign In Book. The Sign-In In-Service book is located in the C.R.N.C. Office.</p> <p>PLAN: The Infection Control Reporting Form includes Patient general information, Responding Factors, Suspected Site of Infection, Sign and Symptoms of Infection, Action taken by the R.N.C.M. Implementation to the P.O.C and update in I.D.G. Medical Director Oversight and Follow up Actions as well as Secondary Follow up Dates.</p>		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131554	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2013
NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646		
(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 578	<p>Continued From page 67</p> <p>patient and families would receive infection control education. There was no documentation of what the education would consist of. There was no documentation to indicate how risks would be prioritized and what the prioritization would be based on.</p> <p>c. "Clinical Controls:</p> <ul style="list-style-type: none"> - Identification of patient/families and/or staff and volunteers with communicable or potentially communicable infections - Implementation of appropriate infection control measures - Educating hospice staff and volunteers about prevention & control - Limiting unprotected exposure to pathogens - Limiting the spread of infection associated with patient care procedures - Limiting the spread of infection associated with medical equipment use - Improving staff compliance with hand hygiene" <p>The DCS/SW was interviewed at 2:30 PM on 9/12/13. He confirmed the hospice was not tracking or monitoring any of the above clinical controls. In addition, the hospice policy Reporting of Communicable Diseases, undated, contained a list of Nationally Notifiable Infectious Diseases from 2008. The Administrative Director confirmed in an interview on 9/12/13 at 9:30 AM that the policy had not been reviewed since 2008 and the hospice did not have a current list of Nationally Notifiable Infectious Diseases.</p> <p>d. "Administrative Controls:</p> <ul style="list-style-type: none"> - Ensuring appropriate education of infection control... - Directing, encouraging healthcare worker adherence to recommended infection control 	L 578	<p>All Registered Nurse Case Managers have the necessary educational information to pass on to their Patients. The prioritizing risks are well outlined in the Infection Control Reporting Form.</p> <p>Clinical Controls are in place to identify communicable or potentially "at risk" patients and their potential for infectious diseases. The C.R.N.C. will implement appropriate infection control measures through oversight of the R.N.C.M.</p> <p>EDUCATION: The Clinical Registered Nurse Coordinator will educate the hospice staff and volunteers on an on-going basis regarding prevention and control. Education will continue on limiting exposure to pathogens and limiting the spread of infection associated with patient care procedures and will be provided in on-going training. See education in-service dates previously listed.</p> <p>IMPLEMENTATION: The C.R.N.C will provide hand hygiene for all hospice staff on November 8, 2013.</p> <p>COMPLIANCE: The Hospice is now in compliance with the HAI Infection Control Protocols, education and training and is updated weekly by the Centers For Disease Control. The Staff is emailed and updated weekly on the Nationally Notified Infectious Diseases and has been registered with the Centers for Disease Control as of October 25, 2013.</p>		

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L 578	Continued From page 68 practices...."	L 578			
L 580	In an interview with the DCS/SW at 2:30 PM on 9/12/13, he confirmed that hospice administration did not currently provide infection control education. He also confirmed administration was not monitoring staff in infection control competencies. The hospice did not maintain and infection control program. 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 infection control 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: The policy Healthcare Associated Infection (HAI) Control Plan, undated, stated "infection control	L 580	The Hospice is currently providing and maintaining infection control. ADDENDUM: The CRNC or qualified designee are supervised by the Governing Body and specifically the Administrator. The CRNC or qualified designee are gathering data through in-services training, trends of suspected infections as specified on the QAPI Infection Control Reporting form found in the QAPI binder which all hospice RNCM have in their hospice forms binder. The Hospice has implemented and will continue to maintain and coordinate an agency-wide program. SURVEILLANCE: Oversight Management will be the responsibility of the Clinical Registered Nurse Coordinator. The Hospice has initiated and implemented the HAI Binder and protocols as well as the Infection Control Reporting Form. This form is the safety coordination and safety risk assessment form for all communicable diseases. The Infection Control Form will be filled out by the R.N.C.M. and discussed with the I.D.G. team and reflected in the P.O.C. The HAI protocols will be an integral part of the hospices quality assessment and performance improvement program. The STANDARD has been met by the review of infection control policies and documents. The Infection Control Policy and been defined and will be maintained with the Medical Director, D.C.S., C.R.N.C. case oversight and management. DESCRIPTION: The hospice staff is well educated	11/15/13	

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FACILITY STANDARDS

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L 580	Continued From page 69 management decisions shall be made using data regarding institutional experience/epidemiology, trends in community and institutional HA's [sic], local, regional and national epidemiology, and emerging infectious disease threats. The policy also stated "Continuous review of infection control education" will be performed as a performance improvement project related to the infection control program. The DCS/SW was interviewed on 9/12/13 at 2:30 PM. He stated that no data had been collected or analyzed in relation to infection control practices or trends in accordance with the policy. In addition, he stated there had been no ongoing infection control education provided to staff in the past year, and no performance improvement projects had been completed in relation to infection control. He also stated there was no documentation to indicate the infection control program had been evaluated for effectiveness, or revised in any way to meet the needs of patients families and employees. 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	to detect, monitor and prevent future infections. ACTION: The D.C.S. has been educated and informed of the policy changes and has been provided a new Clinical Registered Nurse Oversight Manager to ensure that the infection protocol and changes are implemented, maintained and all hospice staff is educated on a regular basis. This education will be on-going and will provide performance improvement projects for all direct care staff. Employee incentives will be provided to encourage the hospice staff to prevent infections and follow HAI and C.D.C. guidelines.	
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	L 581		

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L 581	<p>Continued From page 70</p> <p>communicable disease problems; and (ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.</p> <p>This STANDARD is not met as evidenced by: Based on interview and review of infection control policies, it was determined the hospice failed to maintain an agency wide program for the surveillance, identification, prevention, control and investigation of infectious and communicable diseases. This failure had the potential to expose patients and staff to communicable disease. Findings include:</p> <p>The policy Healthcare Associated Infection (HAI) Control Plan, undated, stated that surveillance would be performed by "identification of baseline information about the frequency and type of HAIs...Identification of clusters or significant deviations from endemic levels...Investigation as needed...Monitoring hand washing practices of direct care staff."</p> <p>The DCS/SW was interviewed on 9/12/13 at 1:25 PM. He stated the hospice was not actively performing infection control surveillance and did not have a method for identifying infectious and communicable disease problems. He stated the hospice did not monitor staff handwashing in accordance with hospice policy. He confirmed there was no documentation to indicate baseline information about the frequency and type of HAIs had been performed.</p> <p>The hospice did not perform surveillance for the identification of infectious and communicable diseases.</p>	L 581	<p>ACTION: A plan has been implemented and the appropriate actions are being followed by the hospice staff. These changes are expected to result in improvement in education, prevention and maintenance of disease prevention.</p> <p>DESCRIPTION: The C.R.N.C. has reviewed infectious disease control policies and maintain an agency-wide program for the surveillance, prevention, control and investigation of infectious and communicable disease. The patients and staff have been educated on exposure and reporting of communicable disease. The QUAPI program will now have viable information from the Infection Control Reporting Form and C.R.N.C reporting and P.O.C updates to identify baselines of patients "at-risk". This information will also include monitoring to prevent deviation from epidemic levels, and the monitoring of hand washing practices of "Direct Care Staff."</p>	11/15/13

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L 582	<p>418.60(c) EDUCATION</p> <p>The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.</p> <p>This STANDARD is not met as evidenced by: Based on interview, record review, review of personnel files and policies, it was determined the hospice failed to provide infection control to employees, contracted providers, patients and family members. This systemic failure had the potential to negatively impact patient safety. Findings include:</p> <p>1. The hospice failed to provide infection control education to employees and contracted personnel as follows:</p> <p>a. The policy Information and Training, undated, stated infection control training would be provided to staff during orientation and would contain, at a minimum, "An explanation of the organization exposure plan, and the means by which staff can obtain a copy of the written plan...Information on the types, basis for selection, proper use, location, removal, handling, decontamination and disposal of personal protective equipment...Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated and that the vaccine and vaccination will be offered free of charge...Information on the appropriate actions to take and person to contact in an emergency involving blood or other potentially infectious materials...An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident."</p>	L 582	<p>COMPLETION: The completion dates are as follows:</p> <p>HAI Infection Control In-Service and Training Completed on 10-18-13. Hand Washing training for all Staff will be November 8, 2013.</p> <p>MONITORING: The C.R.N.C. will provide on-going training to all direct staff as well as all new hires going forward.</p> <p>ACTION: The Clinical Registered Nursing Coordinator will provide updated training on infection control and exposure plans. The written plan is implemented and available to all staff. The Forms are located in the HAI Education Binder and under the supervision of the C.R.N.C. Information on all types and basis for selection, proper use, location, removal, handling, contamination and disposal of personal and protective equipment. Staff has been educated and received Certification on HAI Protocol.</p> <p>The Staff will be given the option of receiving the Hepatitis B vaccine free of charge. The C.R.N.C. will oversee and administer the Vaccine each to "direct staff employee". The shot will be provided on November 8, 2013. The C.R.N.C. will educate the Staff on the benefits of being vaccinated. Training on Blood Bourne Pathogens and risks of training has been provided to all staff in the infection control training.</p>	
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L 582	<p>Continued From page 72</p> <p>The policy did not address orientation for contract staff or whether ongoing infection control training was to be provided to staff.</p> <p>The policy Tuberculosis Training Program Outlines, undated, stated tuberculosis training would be provided during orientation and at least annually.</p> <p>Personnel files were reviewed with the Director of Finance and Human Resources on 9/11/13 at 11:15 AM. Only two employee personal files, Staff A and Staff B, contained documentation of infection control training in 2013. There was no documentation to indicate any other staff had been trained in infection control during orientation, or that any annual training had been provided in accordance with the policy.</p> <p>The DCS/SW was interviewed on 9/12/13 beginning at 1:25 PM. He confirmed there was no documentation to indicate the hospice had provided infection control education at staff orientation in accordance with the Information and Training policy. In addition, he stated the hospice did not provide ongoing infection control education to staff members. He stated the training documented in Staff A and Staff B's personnel files was part of the annual 12 hours required of CNAs and was not offered to other staff.</p> <p>The hospice did not provide infection control education to employees.</p> <p>b. Personnel files were reviewed with the Director of Finance and Human Resources on 9/11/13 at 11:15 AM. There were no personnel</p>	L 582	<p>ACTION: All Staff will be oriented on HAI and Infection Control. All Contract Staff will be included in HAI and Infection Control Training.</p> <p>ACTION: Tuberculosis Training will also be provided by the Clinical Registered Nurse Coordinator annually.</p> <p>COMPLETION: Tuberculosis Training will be given on November 8, 2013.</p>	

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L 582	<p>Continued From page 73</p> <p>files for contracted staff present. The Director of Finance and Human Resources stated the hospice did not keep personnel files on contracted staff because they were so infrequently used. She stated the last time contracted staff had been used was "two or three years ago." She confirmed contracted staff did not receive infection control training through the hospice agency.</p> <p>The hospice did not provide infection control education to contracted staff.</p> <p>2. The hospice failed to educate patients and family members in infection control as follows:</p> <p>The policy Infection Control - Patient/Family Education," undated, stated that hospice patients will be assessed for knowledge related to infection control guidelines and "When appropriate, the patient, family or caregiver may receive verbal and written information on Standard Precautions."</p> <p>The policy did not specify the situations when it would be "appropriate" to instruct a patient or family member in infection control practices. The policy did not include who will be assessing the patient/family for infection control knowledge.</p> <p>The policy also did not include the specific education patients and or families would receive, listing only topics of possible education, such as "Hand hygiene" or Transmission of Infections."</p> <p>The DCS/SW was interviewed on 9/12/13 at beginning at 2:30 PM. He stated the patient population served by the hospice was "low risk" in relation to infectious disease and did not require "a lot of education." He confirmed there was no</p>	L 582	<p>ACTION: The C.R.N.C. will maintain direct oversight of the R.N.C.M. to ensure the Patients are receiving education. The C.R.N.C. will assure that the hospice patients are being assessed for knowledge related to infection control guidelines.</p> <p>DESCRIPTION: When appropriate the patient, family or caregiver may receive verbal and or written communication and or information regarding Standard Precautions.</p> <p>PLAN: The patient will be provided by the R.N.C.M. the appropriate education/documentation on Infection Control.</p> <p>MONITORING/TRACKING The C.R.N.C. will maintain education and training of the new initiated HAI Infection Control and provide on-going training. The date provided for "Hand Hygiene" will be provided November 8, 2103.</p>	

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L 582	Continued From page 74 specific education that was provided to patients and families regarding infection control. He stated education should be documented in the clinical record but confirmed there was no tracking done by the hospice to ascertain if this was being done.	L 582			
L 594	418.64(c) MEDICAL SOCIAL SERVICES Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services. This STANDARD is not met as evidenced by: Based on staff interview and medical record review, it was determined the agency failed to ensure medical social services were provided based on patients' and families' needs. This affected the care of 3 of 11 patients (#7 and #10, #11) whose records were reviewed. The failure to provide services based on needs had the potential to result in unmet needs. Finding include: 1. Patient #7 was a 73 year old female admitted to hospice care on 7/26/13. She revoked her hospice benefit on 8/12/13. Her diagnoses included COPD and congestive heart failure. The Admission Note Details form, dated 7/26/13 by the RN, stated the patient lived in an assisted	L 594	1. DCS/SW attended an In-service on October 30, 2013, conducted by Adult Protection. This in-service included a thorough review of the definition of a vulnerable adult and their need to be free from abuse, neglect and exploitation. 2. These combined actions will ensure that Social Work Services are based on the patients psychosocial assessment and the patients and family needs are adequately met thus insuring patient safety 3. During the Entire IDG Team Meeting, which is held every 14 days, Social Work Services will be reviewed to ensure they are adequately meeting the patient and families needs. 4. Completion date for correction will be 11/15/2013. Addendum: 5. The CRNC or Administrator QD will ensure that upon admission the social work services being offered adequately meets the needs of the patient and family. This will take place during the initial Primary IDG Team Meeting. In addition, the CRNC or Administrator OR QD will attend the Entire IDG Team Meeting ensuring that social work services are being offered in accordance with the patient and family needs.		

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L 594	<p>Continued From page 75</p> <p>living facility. The form stated Patient #7's son was being released from prison after 15 years and she needed help to find a place where he could live with her when he got out. He was to be released on 8/15/13.</p> <p>A form labeled Assignment Details, dated 7/26/13, directed the DCS/SW to visit Patient #7 once a month.</p> <p>A Social Assessment, dated 7/31/13, stated Patient #7 was "...looking for a home to move into together [with her son] around the middle of August." The assessment did not mention the son's prisoner status or assess Patient #7's ability to find a home. No specific social service needs were identified. No other visits by the DCS/SW were documented.</p> <p>No change to the POT for the SW was documented after his visit. A document labeled Plan of Care for [Patient #7], dated 7/31/13, stated the DCS/SW was to perform non-specific tasks such as "Aid in connecting patient/family and community resources and services" and "Assess level of need."</p> <p>The DCS/SW was interviewed on 9/11/13 beginning at 2:15 PM. He confirmed Patient #7's Social Assessment did not address her living situation or her son coming to live with her. He confirmed a specific plan to address her unique situation had not been developed.</p> <p>Needed social services were not assessed for or provided to Patient #7.</p> <p>2. Patient #10 was a 78 year old female who was admitted to the hospice on 3/12/13. She revoked</p>	L 594	<p>during her monthly review of clinical records, will ensure that social work services are meeting the patient and/or families needs. 6. The CRNC or Administrator OR QD will ensure that social work services are being provided to meet patient and family needs.</p>	

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L 594	Continued From page 76 hospice services on 6/20/13. Her diagnoses included COPD, lung cancer, and depression. A nursing note, dated 4/02/13 at 1:30 PM, stated Patient #10's "...husband was in quite a foul mood, [was] reported that yesterday he had gone into an uncontrollable rage, shouting and swearing with foul language. He has been talking about 'putting patient in a nursing home so someone can teach her how to take her medicine.' Patient confirms this. She adds, 'Sometimes he just gets so violent!'...RN noted a shotgun sitting propped against a bookcase near his chair so asked, 'Is he capable of getting so angry that he would grab a gun?' and she replied that yes, she thought he might with enough anger...patient's husband has a gun in every room...when asked about the situation, she replied 'I don't know what to do.'" A nursing note, dated 4/30/13 at 1:30 PM, stated Patient #10's "Husband is present today and patient is clearly very nervous and fearful...patient informed [the nurse] that [the husband] had been especially ugly this morning. He has been calling her names, telling her she is 'just a dirty bitch,' and in fact threatened to kill her."	L 594			
	A nursing note, dated 5/14/13 at 4:20 PM, stated Patient #10's oxygen saturation level was 92%. The note stated the nurse assisted Patient #10 to put her oxygen on. The note stated "After 10 minutes there was no improvement noted in sats so RN checked the tubing. It had been disconnected at the swivel, the 2 ends held up straight and tied in a knot. Patient said [her husband] did that." The RN corrected the problem and Patient #10's oxygen saturation level improved slightly.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131554	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2013
NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1867 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646		
(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)	(X6) COMPLETION DATE	
L 594	Continued From page 77 A specific plan to address the abuse identified in Patient #10's medical record was not documented. The RN who wrote the above visit notes was interviewed on 5/13/13 beginning at 1:20 PM. She stated Patient #10's husband called her a "filthy bitch" and confirmed she was afraid for Patient #10's safety. A Social Assessment, dated 3/22/13, included a question "How is the caregiver coping with role?" The answer stated the husband "Seems to be well spoken reporting that he is doing 'ok with everything.'" Social service visit notes were dated 4/04/13, 4/05/13, 4/15/13, 4/25/13, and 5/30/13. These included: a. The 4/04/13 visit note did not mention caregiver problems. b. The 4/05/13 visit note stated the DCS/SW spoke with a relative of the patient for an hour. It stated the relative wanted the patient to take immediate action regarding her husband. The note did not state what the issues were between Patient #10 and her husband. No specific action was documented by the DCS/SW. The note stated "SW offers education and input regarding realistic options that may be available to pt regarding these matters." c. The 4/15/13 note did not mention caregiver problems. d. The 4/25/13 note documented a telephone call by the DCS/SW to the family member. It stated Patient #10 had an attorney and would be moving	L 594			

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83846	
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L 594	<p>Continued From page 78 sometime around mid May. No actions by the DCS/SW were documented.</p> <p>e. The last DCS/SW note, dated 5/30/13, stated the visit "...focuses on monitoring pt for feelings of depression and loneliness as well as providing pt with social support and companionship." The note did not mention if Patient #10 was depressed. The note did not mention caregiver issues.</p> <p>The DCS/SW was interviewed on 9/12/13 beginning at 10:50 AM. He stated Patient #10 was a "classic case of battered woman syndrome" and he encouraged her to get away from her husband. He confirmed the visit notes did not document actions taken to address caregiver issues or Patient #10's depression.</p> <p>Needed social services were not provided to Patient #10.</p> <p>3. Patient #11 was a 57 year old female admitted to hospice services on 9/12/12 with a terminal diagnosis of COPD. Social work services were not provided in a way to meet Patient #11's needs as follows:</p> <p>a. The Initial RN assessment note dated 9/12/12 documented Patient #11 was living with a grown daughter who "does Meth and could take narcotics." The RN documented Patient #11 was keeping her clonazepam (or Klonopin, a medication to treat anxiety) at the home of another daughter to keep it safe. The RN documented she instructed Patient #11 to do the same with Tylenol #3, which contains codeine. The note documented family was willing to care for Patient #11, but there was "possible drug</p>	L 594		

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L 594	Continued From page 79 diversion and lack of caregivers." The POT dated 9/12/12, signed by the RN on 9/12/12 and the physician on 9/16/12, did not contain interventions related to the possible diversion of medications by Patient #11's daughter. The first IDG meeting held after Patient #11 was admitted to hospice was documented on 9/19/12. There was no documentation to indicate the risk of diversion had been addressed in the IDG meeting. The only documentation for the IDG meeting was "keep monitoring pt and educating pt and family." On 10/12/12 the RN documented Patient #11's daughter was in jail and would not be released for at least 90 days. A DSC/SW visit note dated 12/05/12 documented Patient #11 talked for several minutes about the upcoming release of her daughter from jail. The DCS/SW documented Patient #11 stated she did not want her daughter to live with her because of the potential for medication diversion. There was no documentation to indicate interventions were taken by the hospice to ensure Patient #11 would be in a safe living situation.	L 594		
	The POT for the following certification period of 12/11/12 through 3/10/13 was signed by the physician on 11/29/12 and the RN on 11/30/12. There was no documentation on the POT to address the risk for diversion, except a notation that there was "no comfort kit in home due to diversion from family and friends."			
	During a visit on 12/14/12, the RN documented Patient #11's new bottle of Klonopin was missing			

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L 594	Continued From page 80 and she was using medication out of the old bottle from October. The RN documented Patient #11's daughter had been released from jail and the RN suspected the daughter had taken the pills. The RN documented Patient #11 denied she gave her daughter any pills. There was no documentation to indicate the POT had been altered to ensure Patient #11's medications were not diverted. An IDG Comprehensive Assessment Details note, dated 12/26/12, documented "Patient is missing her Clonopin [sic] from 12/21/2012. She has called the office to get it refilled and called [RN's name] on the 24th to get it filled. She denies her daughter [daughter's name] took it. She has a verbal agreement with me and hospice agency since her daughter got out of jail on the 8th of Dec. that she will only get 28 tabs a week and if they disappear then 'consequences' are that she waits until the next refill before she gets more. It has been 2 weeks and this is the 2nd week that medications finally disappeared. [Physician's name] is aware and agrees to go with consequences of missing drugs. When SW gets back will do a written contract with patient and have her sign it."	L 594			
	The DCS/SW's next visit note was documented on 1/21/13. There was no documentation to indicate a contract had been discussed with Patient #11. An RN visit note dated 12/21/12 documented the number of Klonopin administered to Patient #11 had been decreased because "this is what we do for patients at risk of diversion" by family members. The RN documented even though Patient #11's daughter was not living with her, she				

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L 594	<p>Continued From page 81</p> <p>was still diverting medications without Patient #11 being aware. The RN also documented she would not be refilling the Tylenol #3 because of the diversion and because Patient #11 was "not really using them." There was no documentation to indicate how often Patient #11 had been using Tylenol #3 or that Patient #11 was involved in the decision to stop using Tylenol #3.</p> <p>An RN visit note dated 12/28/12 documented Patient #11 thought her daughter had taken some of her Tylenol #3. The RN documented she "went over our agreement about missing narcotics again today" and if medications were missing again the police would be called.</p> <p>An RN visit note dated 1/08/13 documented Patient #11's daughter had stolen the rest of her Tylenol #3 but had not taken the Klonopin because Patient #11 had hidden it in her pillow. The RN documented she notified the DCS/SW and Administrative Director and they directed her to file a report with the police. The RN documented Patient #11 refused to file charges against her daughter. She documented she informed Patient #11 that if any more Klonopin were missing she would not get any more until her refill date.</p>	L 594			
	<p>An IDG Comprehensive Assessment Details note, dated 1/08/13, documented that Patient #11 was "having the medications stolen by her daughter....Police were notified but they can't do anything unless [sic] the patient files charges."</p> <p>An IDG Comprehensive Assessment Details note, dated 1/23/13, documented "Should we be concerned about 3 tabs clonopin [sic] that showed up from her daughter, that [were] not part</p>				

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L 594	<p>Continued From page 82</p> <p>of her supply-green. Also, she borrowed clonopin [sic] from another resident in the building when she ran out the first time. She also has 3 boxes of Spiriva, which [physician's name] D/C'd with another person's name on the labels that she is going to use." There was no documentation to indicate whether Patient #11 was allowed to keep the medications that came from an unknown source. There was no documentation by the IDG group to address the issue of Patient #11 obtaining medications from unknown sources.</p> <p>An RN note dated 2/08/13 stated Patient #11's daughter was out of jail as of 12/08/12. She "Takes mom's clonopin [sic] or any narcotics. Patient has been reluctant to press charges against [daughter] so far. Medications are delivered on Wednesday of every week #28 tabs. Patient knows that if she runs out before then that she goes without." In addition, the note stated "Medications are missing today. Patient is aware of the consequences and refuses to press charges against her daughter who is currently in the bathroom with the shower on. She does not want me to wait and talk to [daughter] either. No refills of Clonopin [sic] before Wed. 02/13/2013."</p> <p>An RN note on 2/12/2013 documented Patient #11 had been admitted to the hospital on 2/09/13. The note stated Patient #11 had run out of her Klonopin on "Saturday some time after her daughter...took them" and had suffered a panic attack, became hypoxic and called 911. Patient #11 was discharged from the hospital on 2/11/13. The note also documented Patient #11's daughter, who had taken her medication, had overdosed and was admitted to the hospital. Because Patient #11's daughter was in the hospital, and Patient #11 had filed a police report,</p>	L 594		
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L 594	<p>Continued From page 83</p> <p>the RN documented she would call and get her Klonopin refilled. There was no documentation to indicate the event had been investigated to determine if withholding medication from Patient #11 contributed to her admission to the hospital. The incident was not addressed in IDG meeting notes.</p> <p>During an interview on 9/12/13 beginning at 10:15 AM, the DCS/SW reviewed Patient #11's record and confirmed the event had not been discussed during IDG meetings. The DCS/SW stated as he reviewed the EMR "We did not discuss the theft of her medications or how we could have prevented it from happening."</p> <p>Social work services were not provided to prevent the diversion of Patient #11's medications.</p> <p>b. The admission note documented by the RN on 9/12/12 stated Patient #11 lived with her daughter in an apartment.</p> <p>In a General Clinical Chart Details note dated 10/12/12, the RN documented Patient #11's daughter was now in jail for at least 90 days and was suspected of taking her mother's medications "as none have disappeared since she left." There was no documentation to indicate a change in the POT due to Patient #11 living alone. The IDG meeting note dated 10/17/12 did not include any documentation to indicate the issue had been addressed, the note only stated "Klonopin will be filled at [name of pharmacy]."</p> <p>In a General Clinical Chart Details note, dated 11/27/12, the RN documented Patient #11 had called the hospice to say she had fallen after her</p>	L 594		

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L 594	<p>Continued From page 84</p> <p>bath, had hit her head, and wanted a nurse to assess her. The RN documented Patient #11 had hit her head above her right eye and had sustained a 4 cm cut to her left shin, which Patient #11 had dressed with bandaids.</p> <p>An IDG Comprehensive Assessment Details note dated 4/30/13, stated "patient has become unsafe by herself as she forgets to plug in or check Oxygen tubing to see if connected and working. She may forget to take Oxygen off to smoke. She does not take her medications if not set out for her. She did not eat for a whole day. Or take medications for 3 days. She needs supervision. Has PCS available but will not use it, she is afraid of???? [sic] Cries. Wants to think about it. A meeting with family and hospice SW Monday, what happened?" There was no documentation on the IDG note to indicate what interventions were taken by the hospice to keep Patient #11 safe.</p> <p>An RN visit note for 5/09/13 documented Patient #11 had spent the night in the hospital after family members had decided they could not stay with her. She was readmitted to hospice the following day. The note documented family had requested to take her to the ED because there was no one to care for Patient #11 at the time. The note also documented Patient #11 had moved to a family member's home and would remain there until the end of her life.</p> <p>During an interview on 9/12/13 beginning at 10:15 AM, the DCS/SW reviewed Patient #11's record and confirmed she had been admitted to the hospital. He stated the nurse who had been the Case Manager for Patient #11 at that time no longer worked for the agency, so he was unable</p>	L 594		

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L 594	Continued From page 85 to question her. As the DCS/SW reviewed Patient #11's EMR, he stated the IDG meeting notes had documented the safety issues identified above. He was unable to find evidence the agency had immediately taken measures assist and protect her.	L 594			
L 603	Social work services were not provided to ensure Patient #11 was safe. 418.72 PHYS, OCCUPNL THERAPY & SPEECH-LANG PATHOLOGY This CONDITION is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure therapy services were offered and provided as indicated by patient need. This resulted in the potential for patient physical therapy, occupational therapy and speech therapy needs to be unmet. Findings include: 1. Refer to L604 as it relates to the agency's failure to ensure therapy services were provided. The cumulative effect of the lack of therapy services resulted in the inability of the agency to meet patients' therapy needs.	L 603	Physical, Occupational, Speech- Language has been added to the Election Of Benefits to reflect that therapy services are part of the hospice benefits. At the time of admission the R.N. or CRNC will assess the patients needs . The CRNC will sustain compliance and be responsible for implementing therapy when patient is in need, or when ordered by physician. Will monitor and track at every IDG. The Election of Benefits upon admission will be discussed in full with each patient by the admitting R.N. or CRNC. Family or patient will be asked or told that Pt, OT , or Speech services are available or have been ordered by physician.	09/15/2013 11/01/2013 Ongoing	
L 604	418.72 PHYS, OCCUPNL THERAPY & SPEECH-LANG PATHOLOGY Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.	L 604	H.R. has contacted Therapy agencies, will meet to update all contracts. Will request current licensures and background checks on all therapist before any therapist see patients in their residence. Therapist will read and understand our Hospice Philosophy and Mission Statement. This will be filed in therapist file kept by H.R.	10/15/13 Ongoing	

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L 604	<p>Continued From page 86</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and patient and facility record review, it was determined the agency failed to ensure therapy services were provided. This failure directly impacted 8 of 11 patients (#1 - #5, #8 - #9 and #11), whose records were reviewed and had the potential to impact all patients of the agency who had or developed therapy needs. This failure had the potential to lead to unnecessary trauma and additional medical complications for patients receiving care from the facility. Findings include:</p> <p>1. The agency's Hospice Request for Certification in the Medicare Program (Form CMS-417), signed by the Administrative Director on 9/13/13 documented the agency provided physical therapy, occupational therapy and speech-language pathology services by arrangement. However, evidence that therapy services were available was not found.</p> <p>On 9/10/13 at 2:00 PM, the Director of Finance presented a contract for PT and OT services dated 9/17/07. She stated to her knowledge PT and OT services had never been provided by the agency. She stated the last time SLP services had been provided was on 9/17/11. She also stated the agency did not have documentation of licensure for therapists.</p> <p>Between 9/10/13 and 9/13/13, surveyors attempted to phone the therapy company listed in the contract 7 times. Each time the surveyor got a busy signal.</p> <p>On 9/10/13 at 11:25 AM, the DCS stated the agency had never had a patient who required PT or OT services. He stated SLP services had last</p>	L 604	<p>Director of H.R. will make sure contracts are current with all therapy agencies used. H.R. will make sure all therapist have a current licensures and background checks are completed before any therapist enters residence of patient.</p> <p>CRNC/DCS will notify HR that therapist is needed for patient care. HR will make arrangement with therapy agency. .</p> <p>DCS has educated the RN casemanagers on the need to provide patients with therapy if needed, must have Dr order.</p>	<p>10/15/2013</p> <p>Ongoing</p> <p>10/23/2013</p>	

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L 604	<p>Continued From page 87 been provided 2.6 years ago.</p> <p>The agency did not provide PT and OT services.</p> <p>2. Staff E and F were RN Case Managers for the agency.</p> <p>Staff E was interviewed on 9/13/13 beginning at 8:25 AM. He stated no therapy services were offered to patients.</p> <p>Staff F was interviewed on 9/13/13 beginning at 1:20 PM. She stated no therapists were on staff at the agency and available to provide services to patients.</p> <p>Case Managers were not aware the agency provided therapy services.</p> <p>3. The agency's admission packet, which was given to patients was reviewed. The admissions packet did not include information regarding the availability of therapy services.</p> <p>Further, patient records were reviewed. The records documented potential therapy needs, which had not been addressed as follows:</p> <p>a. Patient #1's records included an Initial Hospice Certification and Plan of Treatment which documented her SOC on 7/12/13. The plan documented Patient #1 was an 81 year old female with COPD. The functional limitations section of the plan documented she used a 4 wheeled walker when ambulating and had difficulty standing from low seating. The plan stated in the safety/security section "Fall Risk (Unsteady [sic] and numbness in feet. Able to Comprehend and Follow Safety Instructions</p>	L 604		

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L 604	<p>Continued From page 88 (Requires reminders) [sic]..."</p> <p>The plan did not include documentation that therapy services were considered or discussed with Patient #1.</p> <p>Additionally, Patient #1's record documented continued mobility concerns. Examples include, but were not limited to the following:</p> <p>RN Case Manager visit notes dated 7/12/13, 8/01/13, 8/08/13, 8/15/13, 8/23/13, and 8/29/13 stated "Alteration in Endurance, Poor Coordination and Balance (Patient is unstable on her feet, uses four wheeled walker)."</p> <p>However, her record did not include documentation that therapy services were considered or discussed with Patient #1.</p> <p>b. Patient #2's records included an Initial Hospice Certification and Plan of Treatment which documented his SOC on 3/09/12. The plan documented Patient #2 was a 80 year old man with Parkinson's Disease.</p> <p>Patient #2's 3/09/12 plan stated he used a walker for ambulation, "but has had multiple falls in the past week...is unable to help self out of bed in the middle of the night when he has to go to the restroom. Also needs assistance while showering due to his disease process...stopped the exercise class that pt was attending to help with strength and mobility due to no improvement is noticed [sic]..." The summary section of the plan also documented Patient #2 "fell this morning in the kitchen causing pain to the left wrist..."</p>	L 604		
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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1067 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83548
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(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
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L 604	<p>Continued From page 89</p> <p>The plan did not include documentation that therapy services were considered or discussed with Patient #2.</p> <p>Additionally, Patient #2's record documented continued concerns. Examples include, but were not limited to the following:</p> <ul style="list-style-type: none"> - An IDG Comprehensive Assessment Detail note, dated 3/22/12 stated he "continues to have multiple falls and balance issues...very unsteady and high fall risk; patient denies falls at this time." - A fall event was documented on 8/15/12. The note stated Patient #2 used an exercise bike daily to help from becoming too stiff, that he did not ambulate much and usually used a wheelchair. The note stated Patient #2 had attempted to get off of the bike by himself and had fallen, landing on his back and hitting his head on a dresser. The note stated "Skilled nurses visiting the patient will assist family and other caregivers in gentle passive ROM exercises to assist with the stiffness that afflicts patient, especially in the morning." - An RN Case Manager visit note, dated 8/20/12 stated "he has not been able to walk lately; wife states in the last 2 weeks there has been a deterioration in ambulation..." - A physician's Face to Face Visit Detail note, dated 5/17/13 stated "This man has had an obvious decline...more choreiform type movements [rapid, jerky movements]. He is getting weaker and transferring is getting more difficult..." - An IDG Comprehensive Assessment Detail 	L 604		
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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1057 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83848
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(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
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L 604	<p>Continued From page 80 note, dated 7/10/13 stated he was having "intermittent issues with inability to move his extremities..."</p> <p>- An IDG Comprehensive Assessment Detail note, dated 7/24/13 stated he "has more issues with impaired mobility..."</p> <p>A Hospice Certification and Plan of Treatment dated 8/10/13 stated "Complete full assist with ADL's [sic]. He is bed bound much of the day..."</p> <p>Patient #2's record documented ongoing concerns. However, his record did not include documentation that therapy services were considered or discussed with Patient #2.</p> <p>Patient #2's 3/9/12 plan also stated he "has episodes of choking while drinking thin liquids..."</p> <p>The plan did not include documentation that therapy services, including SLP services, were considered or discussed with Patient #2.</p> <p>Additionally, Patient #2's record documented continued concerns. Examples include, but were not limited to the following:</p> <p>- An RN Case Manager visit note, dated 8/29/12 stated "Speech somewhat thick and slurred d/t disease process. Pt is able to make needs known most of the time but has problems sometimes if speech is more slurred and thick than usual..."</p> <p>- An IDG Comprehensive Assessment Detail note, dated 6/15/13 stated "He is finding it harder to talk, often cannot be understood..."</p>	L 604		

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1867 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646
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(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
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L 604	<p>Continued From page 91</p> <p>- A physician's Face to Face Visit Detail note, dated 5/17/13 stated "This man has had an obvious decline. More difficulty swallowing..."</p> <p>- An IDG Comprehensive Assessment Detail note, dated 7/24/13 stated he "has increased problems swallowing pills just in the last few weeks..."</p> <p>A Hospice Certification and Plan of Treatment dated 8/10/13 stated "Now virtually unable to talk and can barely feed himself..."</p> <p>Patient #2's record documented ongoing concerns and increased difficulty in dining and communicating. However, his record did not include documentation that therapy services, including SLP services, were considered or discussed with Patient #2.</p> <p>c. Patient #3's records included an Initial Hospice Certification and Plan of Treatment which documented his SOC on 5/11/12. The plan documented Patient #3 was an "89 year old man with colon cancer with possible metastasis to the right kidney. he [sic] is able to ambulate with the help of a walker and slight assist..." The plan stated in the safety/security section "Fall Risk, Plan Of Care Identified as Fall Risk Factor."</p> <p>The plan did not include documentation that therapy services were considered or discussed with Patient #3.</p> <p>Additionally, Patient #3's record documented continued fall risk concerns. Examples include, but were not limited to the following:</p> <p>- An IDG Comprehensive Assessment Detail</p>	L 604		
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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1057 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646		
(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 604	<p>Continued From page 92</p> <p>note, dated 6/12/13 stated he was "very unsteady and high fall risk; patient denies falls at this time."</p> <p>- An IDG Comprehensive Assessment Detail note, dated 6/26/13 stated he was "very unsteady on his feet."</p> <p>- An IDG Comprehensive Assessment Detail note, dated 8/07/13 stated he "had a fall over this last weekend. He denies injury. He continues to get weaker."</p> <p>- An RN Case Manager note documented Patient #3 fell on 8/12/13 while leaning over to pick up pine needles and sticks. The fall resulted in a knot on his left buttock and the note documented Patient #3 reported being "pretty sore."</p> <p>- An IDG Comprehensive Assessment Detail note, dated 8/21/13 stated "Has had falls every other week for at least the last 2 weeks with minor injuries. Continues with his altered judgement..."</p> <p>- An IDG Comprehensive Assessment Detail note, dated 9/04/13 stated "Patient has had a fall or accident every week for the last several week. Has not had any major injuries. Poor judgement and stubborn determination are primary reasons for this."</p> <p>Patient #3's record documented ongoing concerns and increasing falls. However, his record did not include documentation that therapy services were considered or discussed with Patient #3.</p> <p>d. Patient #4's 8/18/13 Hospice Certification and Plan of Treatment documented his SOC on</p>	L 604			

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(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 604	<p>Continued From page 93</p> <p>10/28/11. The plan documented he was a 94 year old man with a terminal diagnosis of "Debility unspecified."</p> <p>The 8/18/13 plan stated Patient #4 required minimal assistance for ambulation, used a cane, had increased unsteadiness, limped on his left leg and was at risk for falls due to fatigue and not always using his cane. The note also documented Patient #4 had edema in both legs which was uncomfortable, had right hip and left knee "problems and he almost fell" during the RN's visit.</p> <p>The plan did not include documentation that therapy services were considered or discussed with Patient #4.</p> <p>Additionally, Patient #4's record documented continued fall risk concerns. Examples include, but were not limited to the following:</p> <ul style="list-style-type: none"> - RN Case Manager notes dated 8/20/13, 8/27/13 and 9/03/13 documented Patient #4 did not always use his cane and relied on furniture to catch himself when he was off balance. The notes documented he used a 4 wheel walker in hallways. The notes stated "Patient is at risk for falls due to fatigue and not always using his cane." <p>Patient #4's record documented ongoing concerns. However, his record did not include documentation that therapy services were considered or discussed with him.</p> <p>Additionally, the diagnoses section of Patient #4's 8/18/13 plan included "Dysphagia leading to inadequate nutritional intake (inability or</p>	L 604		

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L 604	<p>Continued From page 04 unwillingness to take food or fluids..." and documented he had lost 30 pounds in the past 6 months "etiology unknown as he says he is eating..."</p> <p>The plan did not include documentation that therapy services, including SLP services, were considered or discussed with Patient #4.</p> <p>Further, the Nutrition and Hydration section of Patient #4's RN Case Manager notes dated 8/20/13, 8/27/13 and 9/3/13 stated "No Problem." No information related to his diagnosis of dysphagia or his weight loss was present.</p> <p>Patient #4's record did not include documentation that therapy services, including SLP services, were considered or discussed with Patient #4.</p> <p>e. Patient #6's records included an Election of Hospice Benefits form dated 6/01/12, a revocation statement dated 6/15/12, an Election of Hospice Benefits form dated 7/13/12, a revocation statement dated 1/26/13, an Election of Hospice Benefits form dated 1/27/13, and a revocation statement dated 8/28/13.</p> <p>Her 6/27/13 Hospice Certification and Plan of Treatment documented she was a 72 year old female with COPD. The plan stated she required maximum assistance, had left side hemiplegia, required 1 person assistance and a quad cane for ambulation, assistance with transfers and assistance with dressing. The plan stated she had altered endurance and "has no activity tolerance at all," poor coordination and balance and gait disturbance.</p> <p>The plan did not include documentation that</p>	L 604		
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L 604	<p>Continued From page 95</p> <p>therapy services were considered or discussed with Patient #5.</p> <p>Additionally, Patient #5's record documented continued concerns. Examples include, but were not limited to the following:</p> <ul style="list-style-type: none"> - An RN Case Manager note dated 7/08/13 documented Patient #5 fell and landed on her right side. - A physician's Face to Face Visit Details note dated 7/11/13 documented Patient #5 had developed "severe" edema in her legs, resulting in "her ability to move and manage at home very difficult, especially when she has to get up to go to the bathroom frequently in the morning. Last week when after [sic] she had gone to the bathroom, she got up and then had a fall landing..." The note documented her right hip was still tender. The note stated the physician "will also check with the physical therapist, [therapist's name], who works for [facility name] and see if we could have him help us with this. I am unable to perform manual lymphedema treatment. He possibly could." <p>However, the IDG note, dated 7/11/13 did not include information regarding the physical therapist referral.</p> <ul style="list-style-type: none"> - RN Case Manager notes dated 7/18/13 documented continued edema. Her IDG notes, dated 7/24/13 stated compression stockings would be tried. Information regarding the physician's 7/11/13 referral to PT was not included in the IDG note. - An RN Case Manager notes dated 7/26/13 and 	L 604		

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83846
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L 604	<p>Continued From page 96</p> <p>8/01/13 documented her edema remained the same. An IDG note, dated 8/07/13 documented Patient #5 refused to wear the compression stockings, so her left leg was being wrapped with an Ace wrap.</p> <p>- An RN Case Manager note dated 8/08/13 documented Patient #5's edema remained the same.</p> <p>- An RN Case Manager note dated 8/28/13 documented Patient #5 fell, sliding off of her bed and landing on her buttocks.</p> <p>However, beyond the physician's 7/11/13 note, Patient #5's record did not include documentation that therapy services were considered or discussed with her.</p> <p>f. Patient #8's records included an Initial Hospice Certification and Plan of Treatment which documented his SOC on 7/11/13. The plan documented Patient #8 was an 88 year old male with Parkinson's Disease.</p> <p>The 7/11/13 plan stated "He demonstrates increased stiffness in his upper and lower extremities with right sided upper extremity tremors which is somewhat controlled by medications. Patient has increased difficulty with basic every day activity of daily living r/t [related to] decreased and unequal upper distal extremity grasp. Patient finds it difficult to hold simple objects such as a razor, turning a door knob to open a door [sic]. Patient c/o [complaints of] Vertigo [sic] when moves his head to look up, and then back down, and dizziness when ambulating, and concerned that he may fall because of it [sic]. Patient decreased sensation in his lower</p>	L 604		
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L 604	<p>Continued From page 97</p> <p>extremities r/t his disease, and not able to ambulate as well as he used too..."</p> <p>The functional limitations section of the plan stated he used a 4 wheeled walker for ambulation, had gait disturbance, and poor coordination and balance. The plan also documented he required assistance with bathing and toileting.</p> <p>The plan did not include documentation that therapy services were considered or discussed with Patient #8.</p> <p>Additionally, Patient #8's record documented continued mobility concerns. Examples include, but were not limited to, the following:</p> <ul style="list-style-type: none"> - RN Case Manager visit notes dated 7/11/13, 7/16/13, 8/1/13, 8/08/13, 8/13/13, 8/20/13, 8/27/13, 9/03/13, 9/10/13 stated "Poor Coordination and Balance (Vertigo when looking up or ambulating), Gait Disturbance (Vertigo/unsteady gait)." - The RN Case Manager visit notes dated 8/01/13 and 8/06/13 also stated Patient #8's caregiver was "having to help patient more in shower and dressing patient r/t stiffness..." 	L 604		
	<ul style="list-style-type: none"> - The RN Case Manager visit notes dated 8/13/13 stated Patient #8 was walking outside and became tired. He "went to sit down on a Rubbermaid garbage can that was laying sideways on the ground, rolled off of the garbage can and on to the ground. Patient reports no injuries, C/O increased stiffness today and muscle pain generalized...had to call someone to help get patient off of the ground. Patient to [sic] 			

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1067 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646
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(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 604	<p>Continued From page 98</p> <p>weak to help much...[care giver's name] reports she had to dress and bath patient completely now. Patient not able to provide much help."</p> <p>- The RN Case Manager visit note dated 8/27/13 stated Patient #8's caregiver had been out of town. The note documented Patient #8 was concerned while the caregiver was gone "because his stiffness prevents him getting [sic] out of bed on his own, so he slept in his recliner" when the caregiver was gone.</p> <p>- The RN Case Manager visit notes dated 9/03/13 and 9/10/13 stated Patient #8 was "exhibiting increased tremoring in left and right upper extremities..."</p> <p>Patient #8's record documented ongoing concerns, increased stiffness and tremors, increased need for assistance, and a fall. However, his record did not include documentation that therapy services were considered or discussed with Patient #8.</p> <p>- Additionally, RN Case Manager visit notes dated 7/11/13, 7/18/13, 8/01/13, 8/06/13, 8/13/13, 8/20/13, 8/27/13, 9/03/13 and 9/10/13 documented Patient #8 experienced "Dysphagia (Chokes on food occasionally)...Difficulty Chewing (Unable to open mouth as wide or chew as good)."</p> <p>- The RN Case Manager visit notes dated 9/03/13 and 9/10/13 stated Patient #8's caregiver reported "patient having more difficulty opening his mouth wide enough to be able to eat certain things he used to like eating..."</p> <p>Patient #8's record documented ongoing</p>	L 604		

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L 604	<p>Continued From page 89</p> <p>concerns and increased difficulty in dining. However, his record did not include documentation that therapy services, including SLP services, were considered or discussed with Patient #8.</p> <p>g. Patient #9's records included an Initial Hospice Certification and Plan of Treatment which documented his SOC on 7/30/13. The plan documented Patient #9 was an 79 year old male with end stage dementia. The plan stated he required minimal assistance.</p> <p>Patient #9's record documented decrease in mobility as follows:</p> <ul style="list-style-type: none"> - An RN Case Manager note dated 8/02/13 documented Patient #9 tripped of a hose while getting gasoline and fell, resulting in a sore hip and irritating his left elbow, which had been injured in the past. - An RN Case Manager note dated 8/09/13 documented "Gait Disturbance (unsteady at times)." - An RN Case Manager note dated 8/16/13 documented "Gait Disturbance (unsteady on his feet most of the time)." The note stated "No falls this week but his precarious gait and altered decision making continue to create safety issues." - RN Case Manager notes dated 8/22/13, 8/30/13, and 9/06/13 documented "Alteration in Endurance (can't work like he used to), Gait Disturbance (unsteady on his feet most of the time)." The note stated "He is unsteady on his feet most of the time, and states that he 	L 604		
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131854	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2013
NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1867 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646		
(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 604	<p>Continued From page 100 'stumbles around quite a bit'..."</p> <p>However, his record did not include documentation that therapy services were considered or discussed with Patient #9.</p> <p>h. Patient #11's records included an Election of Hospice Benefits form dated 9/12/12, a revocation statement dated 2/09/13, an Election of Hospice Benefits form dated 2/12/13, a revocation statement dated 5/07/13, and an Election of Hospice Benefits form dated 5/09/13.</p> <p>Her 9/12/12 initial Hospice Certification and Plan of Treatment documented she was a 67 year old female with pulmonary disease (end stage COPD). The plan stated she required minimal assistance with ambulation but required supervision, used a scooter and a 4 wheel walker and experienced gait disturbance. The plan also stated she had a history of fall and multiple visits to the emergency room. The plan stated was at risk for falls and had recently tripped over her oxygen tubing and fell.</p> <p>However, the 9/12/13 plan did not include documentation that therapy services were considered or discussed with Patient #11.</p> <p>Patient #11's 12/11/12, 2/12/13, and 4/13/13 Hospice Certification and Plan of Treatment documented continued fall risk. However, none of the plans included documentation that therapy services were considered or discussed with Patient #11.</p> <p>Additionally, her 5/09/13 Hospice Certification and Plan of Treatment documented she required maximum assistance for bathing and needed a</p>	L 604			

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83846		
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L 604	Continued From page 101 shower hose. The plan stated she required moderate assistance for ambulation and used a 4 wheel walker, but needed a new one as Patient #11's was "old and rickety." The plan stated she "Exhausts with any exertion," and had poor coordination and balance. The plan did not include documentation that therapy services were considered or discussed with Patient #11. Staff E, an RN Case Manager, was interviewed on 9/13/13 beginning at 8:25 AM. He stated he did not evaluate patients for therapy services. Staff F, an RN Case Manager, was interviewed on 9/13/13 beginning at 1:20 PM. She stated she did not evaluate patients for therapy services.	L 604			
L 617	Patients' potential needs for therapy services were not evaluated by the agency. 418.76(c)(3) COMPETENCY EVALUATION (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. This STANDARD is not met as evidenced by: Based on review of personnel files and staff interview, it was determined the hospice failed to ensure aide competency evaluations were performed by a registered nurse for 4 of 4 CNAs (Staff A-D) whose personnel files were reviewed. This allowed CNAs to care for patients without first proving competency in patient care techniques. Findings include: CNA personnel files were reviewed with the	L 617	L617: 1. All Currently employed CNA's completed competency evaluations performed by hospice staff RN's, bringing all staff into compliance with this requirement. 2. This action will result in ensuing all CNA's caring for patients are competent in providing patient care techniques. 3. CNA competency evaluations will now be completed at hire and updated annually with on-site visits to ensure that CNA's provide competent care in accordance with each patient's established POT. 4. The completion date for correction will be 11/15/2013. Addendum: 5. The CRNC or DCS/SW OR QD will ensure all CNA's are evaluated by an RN OR CRNC OR QND at hire and annually. 6.The Finance/HR Director OR QD will be responsible for maintaining these competencies in each staff's employee file.		

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L 617	<p>Continued From page 102</p> <p>Director of Finance and Human Resources on 9/11/13 at 11:15 AM. Competency evaluations were missing for the following:</p> <p>Staff A, CNA, hire date 1/07/13 Staff B, CNA, hire date 4/20/12 Staff C, CNA, hire date 8/01/13 Staff D, CNA, hire date 6/26/13</p> <p>The Director of Finances and Human Resources confirmed the personnel records lacked evidence of an RN competency evaluation. She stated the DCS/SW handled all evaluations.</p> <p>The DCS/SW was interviewed on 9/12/13 beginning at 1:25 PM. He stated that he did not perform CNA competency evaluations because he was not an RN. He confirmed the CNAs did not have competency evaluations performed by an RN. He confirmed that without an RN evaluating CNA competency, it was difficult to determine if the CNA was able to perform all patient care tasks assigned.</p> <p>The agency did not perform competency evaluations for CNA staff.</p>	L 617		
L 632	<p>418.76(h)(2) SUPERVISION OF HOSPICE AIDES</p> <p>(2) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of personnel files, it was determined the hospice failed to ensure annual on-site visits were made to assess</p>	L 632	<p>All currently employed CNAs completed competency evaluations performed by hospice staff RNs, bringing all staff into compliance with this requirement. CNA competency evaluations will now be completed at hire and updated annually with on-site visits to ensure that CNAs provide competent care in accordance with each patient's established POT. The DCS will ensure all CNAs are evaluated by an RN at hire and annually. The Finance/HR Director will be responsible for maintaining these competencies in each staff's personnel file.</p>	10/15/13

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L 632	<p>Continued From page 103</p> <p>care provided by 4 of 4 CNAs (A-D) whose personnel files were reviewed. This led to a lack of aide oversight and a lack of clarity as to whether aides were performing tasks in accordance with POTs. Findings include:</p> <p>Personnel files were reviewed with the Director of Finance and Human Resources on 9/11/13 at 11:15 AM. The following CNA's personnel files lacked evidence of an annual on-site visit:</p> <p>Staff A, CNA, hire date 1/07/13 Staff B, CNA, hire date 4/20/12 Staff C, CNA, hire date 6/01/13 Staff D, CNA, hire date 6/26/13</p> <p>The Director of Finances and Human Resources confirmed the personnel records lacked evidence of an annual onsite visit from the RN. She stated the DCS/SW handled all evaluations.</p> <p>The DCS/SW was interviewed on 9/12/13 beginning at 1:25 PM. He stated that he did not perform CNA competency evaluations because he was not an RN. He confirmed there was no documentation to indicate on-site visits had been performed by an RN. He confirmed that without and RN evaluating CNA competency, it was difficult to determine if the CNA was able to perform all patient care tasks assigned in accordance with POTs.</p> <p>The agency did not perform on-site assessments of CNA staff.</p>	L 632		
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L 648	418.100 ORGANIZATIONAL ENVIRONMENT	L 648	Please see plan of correction for section L651.	
	This CONDITION is not met as evidenced by:			

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L 648	Continued From page 104 Based on staff interview and review of meeting minutes, agency policies, QAPI documents, infection control documents, and personnel 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 agency's operations. This resulted in the inability of the agency to provide necessary services and systems. Findings include:	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: Based on staff interview and review of medical records and infection control documents, it was determined the governing body failed to assume full responsibility for the management of the hospice, the provision of all hospice services, and continuous quality assessment and performance	L 651	1. A Governing Body meeting will be held on 11/15/2013 where 100% of the Governing Body will be in attendance. During this meeting the Medicare COP's will be reviewed ensuring that all members of the Governing Body are aware of their specific duties and what areas they will be performing oversight as it relates to staff and patient responsibilities. The cumulative effect of the corrections and resolutions of these systemic problems assures the ability of the hospice to provide services consistent with accepted standards of practice. 3. The combined direction and oversight of the Governing Body, the Hospice Administrator, CRNC and the Medical Director will ensure that all staff are clinically supervised and that all patient and families needs are met effectively. Quarterly meetings of the Governing Body will include a review of the agencies policies and procedures, infection control, care and services provided		

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L 651	<p>Continued From page 105</p> <p>Improvement. This resulted in a lack of oversight of the agency and of the services provided. Findings include:</p> <p>1. The governing body did not specify a system for the oversight of nursing services at the agency.</p> <p>The policy Lines of Authority/Use of Organizational Chart, undated, stated the DCS/SW oversee the RN Case Managers, LPNs, Social Worker/Bereavement Coordinator, CNAs, Chaplain/Assistant Bereavement Coordinator and the Volunteer Coordinator.</p> <p>The policy Responsibilities/Supervision of Clinical Services, undated, stated the DCS was responsible for supervision of clinical care.</p> <p>The agency job description for the DCS/Director of Nursing stated "The DCS position is for a licensed RN (Registered Nurse) with hospice experience (additional management experience is advantageous, but must at least have previous hospice RN/Case Management experience."</p> <p>In an interview on 9/09/13 at 2:30 PM, the DCS identified himself as an MSW. He confirmed he did not have an RN license nor had he worked as an RN Case Manager. He stated he supervised nursing services, Social Work services, Chaplain services and hospice aide services. He stated he did not supervise nursing clinical care but he relied on the RN Case Managers to provide nursing oversight. He stated there was no formal process for this and no nurse was designated as in charge of other nurses. He stated that if the RN Case Managers require further direction they could consult the Medical Director.</p>	L 651	<p>by all including the Medical Director, Quality Assessment and performance improvement and personnel Files. This will ensure the Governing Body's responsibility for the management of the hospice, including direction and oversight of all agency operations. 4. The completion date for correction will be 11/15/2013.</p> <p>ADDENDUM: 5/6. The CRNC OR QND and the DCS/SW will be responsible for nursing oversight and the Hospice Administrator for the day to day operation of the entire agency operation.</p>		

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L 651	<p>Continued From page 106</p> <p>The DCS was not qualified for his position per agency policy and nursing staff were not clinically supervised.</p> <p>2. Refer to L500 Condition of Participation: Patient Rights and related standard level deficiencies as they relate to the governing body's failure to ensure patients and their representatives were informed of their rights and that patient rights were upheld and promoted.</p> <p>3. Refer to L536 Condition of Participation: Interdisciplinary Group, Care Planning, and Coordination of Services and related standard level deficiencies as they relate to the governing body's failure to ensure patient-specific plans of care, containing measurable outcomes, were developed, revised, and followed for each patient.</p> <p>3. Refer to L559 Condition of Participation: Quality Assessment and Performance Improvement and related standard level deficiencies as they relate to the governing body's failure to ensure a QAPI program was fully developed, implemented, and maintained.</p> <p>4. Refer to L577 Condition of Participation: Infection Control and related standard level deficiencies as they relate to the governing body's failure to ensure a comprehensive infection control program was developed, implemented and maintained.</p> <p>5. Refer to L603 Condition of Participation: Physical Therapy, Occupational Therapy and Speech-Language Pathology and the related standard level deficiency as they relate to the governing body's failure to ensure therapy</p>	L 651		

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L 651	Continued From page 107 services were offered and provided as indicated by patient need. 6. Refer to L661 as it relates to the governing body's failure to ensure employees were oriented to the hospice philosophy. 7. Refer to L663 as it relates to the governing body's failure to ensure written policies and procedures were developed which described a method of assessment of staff competencies. 8. Refer to L664 Condition of Participation: Medical Director and the related standard level deficiency as they relate to the governing body's failure to ensure the medical director provided sufficient oversight necessary to ensure patients' health, safety, nursing, social work, therapy and counseling needs were met. 9. Refer to L670 Condition of Participation: Clinical Records and the related standard level deficiencies as they relate to the governing body's failure to ensure clinical records included comprehensive, timely information which was readily available. 10. Refer to L708 as it relates to the governing body's failure to ensure inpatient respite care was available.	L 651			
L 661	The cumulative effect of these systemic problems resulted in the inability of the agency to provide hospice services consistent with accepted standards of practice. 418.100(g)(1) TRAINING (1) A hospice must provide orientation about the	L 661	L 661 At hire, all staff are given an orientation manual which includes our hospice philosophy. Orientation		

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L 661	Continued From page 108 hospice philosophy to all employees and contracted staff who have patient and family contact. 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 orientation about the hospice philosophy was provided to 7 of 8 employees (Staff A, C, D, E, F, G, and H) whose personnel files were reviewed. The hospice also failed to have a process for orienting contract staff. This failure resulted the potential for staff to lack the understanding of hospice philosophy necessary for caring for hospice patients. Findings include: Personnel files were reviewed with the Director of Finance and Human Resources on 8/11/13 at 11:15 AM. The following employees lack documentation of orientation to the hospice philosophy: - Staff A, CNA, hired 1/07/13 - Staff C, CNA, hired 6/01/13 - Staff D, CNA, hired 6/25/13 - Staff E, RN, hired 5/28/13 - Staff F, RN, hired 4/27/12 - Staff G, RN, hired 5/01/13 - Staff H, DCS/SW, hired 1/28/11 The Director of Finance and Human Resources confirmed there was no documentation in the above listed employee files to indicate they had received an orientation to the hospice philosophy.	L 661	HR has discussed with Staff the Hospice Philosophy & Mission Statement A orientation checklist was created by H.R for all employees as well as Contracted staff . The HR and Finance Director will be responsible for maintaining all personnel files which includes record of this orientation as well as all licensures and in services . H.R . will maintain Checklist on a biweekly schedule .	10/30/13	
L 663	418.100(g)(3) TRAINING (3) A hospice must assess the skills and competence of all individuals furnishing care,	L 663	CRNC will implement and be responsible for Competency assessments. CPR certification training conducted and all employees who required certifications are now current. A Policy has been created addressing	11/01/2013 09/25/2013	

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L 663	Continued From page 109 including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months. This STANDARD is not met as evidenced by: Based on 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. The hospice failed to ensure current CPR certification was maintained for 8 of 10 employees (Staff A, B, C, D, F, and H) whose personnel files were reviewed. It also failed to ensure assessment of the skills and competencies of 3 of 3 employees (B, F, H) 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: 1. Personnel files were reviewed with the Director of Finance and Human Resources on 9/11/13 at 11:15 AM. a. The following personnel files lacked competency assessments: - Staff B, CNA, hired 4/20/12 - Staff F, RN, hired 4/27/12 - Staff H, DCS/SW, hired 1/28/11 The Director of Finance and Human Resources stated all evaluation were conducted and documented by the DCS/SW. The DCS/SW was	L 663	CPR certification training was conducted and all employees who required certifications are now current. A policy has been created addressing agency in-service training education. All staff needing Competency assessment have been completed. The policy outlines that competency assessment will be done at hire by the DCS/CRNC. All individuals will have a competency annually to assure that individuals who have contact with patients and families are competent to complete required care and services. The H.R. Finance Director will be responsible for maintaining all personnel files which include record of staff competency assessments and current CPR Certifications.	09/25/2013 Ongoing 10/15/2013

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L 663	<p>Continued From page 110</p> <p>interviewed on 9/12/13 at 1:26 PM. He confirmed there was no documentation to indicate competency assessments had been performed on the three employees that had provided services for greater than one year. In addition, he confirmed there was no established method or policies outlining how to assess staff competencies. He also stated that no inservice training had been provided to staff within the last 12 months.</p> <p>The hospice did not assess for competency or provide inservice training for staff.</p> <p>b. The following personnel files lacked documentation of current CPR certification:</p> <ul style="list-style-type: none"> - Staff A, CNA, hired 1/07/13 - Staff B, CNA, hired 4/20/12 - Staff C, CNA, hired 6/01/13 - Staff D, CNA, hired 6/25/13 - Staff F, RN, hired 4/27/12 - Staff H, DCS/SW, hired 1/28/11 <p>The Director of Finance and Human Resources confirmed the above listed employee files did not contain a current CPR certification. She confirmed that current CPR certification was a requirement for employment and this was included in the CNA, RN and MSW job descriptions.</p> <p>Hospice employees did not maintain CPR certification as required by job descriptions.</p>	L 663		
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L 664	<p>418.102 MEDICAL DIRECTOR</p> <p>This CONDITION is not met as evidenced by:</p>	L 664	<p>1. A Governing Body meeting will be held on November 13, 2013 reviewing with the Medical Director his responsibilities as it relates to providing sufficient oversight necessary to ensure patients needs are met.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131654	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/13/2013
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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83846
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(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
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L 664	<p>Continued From page 111</p> <p>Based on record review and interview, it was determined the Medical Director failed to ensure sufficient oversight was provided necessary to ensure patient needs were met. This resulted in the lack of direction to staff to ensure the patient's health, safety, social work, and therapy needs were met. Findings include:</p> <p>1. Refer to L669 as it relates to the Medical Director's failure to ensure patient needs were met.</p>	L 664	<p>In addition, the Medical Directors Job description and Services Agreement will be reviewed. 2. The cumulative result of these actions will ensure that Medical Director provides direction and oversight of care and services ensuring that patients health, safety, social work, and therapy needs are met. 3. The procedure for implementing this plan will be that a member of the Governing Body will attend each Entire IDG Team Meeting ensuring that the Medical Director is providing direction and oversight of care and services to the Entire IDG Team. In addition, at least yearly, the Medical Directors Performance will be reviewed by the Governing Body ensuring that he is providing adequate direction and oversight of care and services to the Entire IDG Team as well as to the patients and families served by the hospice. 4. Completion Date will be 11/15/2013. 5. The Medical Directors performance will be monitored at each Each Entire IDG Team Meeting by a member of the Governing Body. As previously stated the Medical Directors performance will be evaluated and re-viewed at least yearly by the Governing Body.</p> <p>6. The members of the Governing Body will ensure that the Medical Director is providing adequate direction and oversight to both staff and patients.</p>	
L 669	<p>418.102(d) MEDICAL DIRECTOR RESPONSIBILITY</p> <p>The medical director or physician designee has responsibility for the medical component of the hospice's patient care program.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the Medical Director failed to ensure sufficient oversight was provided meet patient needs. This failure directly impacted 10 of 11 patients (#1 - #5, and #7 - #8) whose records were reviewed and had the potential to impact all patients receiving care from the agency. This resulted in a lack of leadership to ensure plans were developed and implemented to address patients' health, safety, nursing, social work, and therapy needs. Findings include:</p> <p>1. The policy Medical Director Job Description, not dated, stated "The Job description for the Medical Director may include, but is not limited to, the following:</p> <p>-Reviewing patient's medical eligibility</p>	L 669	<p>Please see plan of correction for section L664.</p>	

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1867 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646		
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L 669	<p>Continued From page 112</p> <p>-Acting as a leader & medical resource to the Hospice Interdisciplinary team."</p> <p>The policy did not specifically state what "Acting as a leader & medical resource" meant. The policy did not address oversight of physician, nursing, social work, therapy, and counseling provided to patients.</p> <p>The DCS/SW was interviewed on 9/27/13 beginning at 3:30 PM. He confirmed the Medical Director job description did not specify the Medical Director's duties.</p> <p>The Medical Director's duties were not specified.</p> <p>2. Refer to L533 as it relates to the Medical Director's failure to ensure comprehensive assessments were updated in response to changes in patients' conditions.</p> <p>3. Refer to L536 Condition of Participation: Interdisciplinary Group, Care Planning, and Coordination of Services and related standard level deficiencies as they relate to the Medical Director's failure to ensure patient-specific plans of care, containing measurable outcomes, were developed, revised, and followed for each patient.</p> <p>4. Refer to L594 as it relates to the Medical Director's failure to ensure medical social services were provided based on patients' and families' needs.</p> <p>5. Refer to L603 Condition of Participation: Physical Therapy, Occupational Therapy and Speech-Language Pathology and the related standard level deficiency as they relate to the Medical Director's failure to ensure therapy</p>	L 669			

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L 669	Continued From page 113 services were offered and provided as indicated by patient need.	L 669		
L 670	418.104 CLINICAL RECORDS This CONDITION is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure clinical records were complete and included comprehensive timely information which was readily available. This failure resulted in a lack of information being available on which to base care decisions. Findings include: 1. Refer to L674 as it relates to the agency's failure to ensure patient records included documentation of responses to medication. 2. Refer to L678 as it relates to the agency's failure to ensure timely authentication of patient record entries. 3. Refer to L685 as it relates to the agency's failure to ensure patient clinical records were readily available. The cumulative effect of these deficient practices resulted in the inability of the agency to ensure comprehensive patient information was available and that patient needs were being met.	L 670	Please see plan of correction for section L674.	
L 674	418.104(a)(3) CONTENT [Each patient's record must include the following:] (3) Responses to medications, symptom management, treatments, and services. This STANDARD is not met as evidenced by:	L 674	L674 A new position has been developed to assist the DCS with chart audits. This new position will be titled Clinical Registered Nurse Coordinator (CRNC). The DCS and the CRNC will be auditing 5 random charts a week. A chart audit consists	11/15/13

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L 674	<p>Continued From page 114</p> <p>Based on review of medical records and staff interview, it was determined the facility failed to ensure all medical records contained documentation of responses to medication, which led to a lack of clarity regarding treatment of 1 of 11 patients (#8) whose records were reviewed. This failure resulted in the potential for a missed opportunity to alter a patient's POT. Findings include:</p> <p>1. Patient #8 was an 68 year old male admitted to the hospice on 7/11/13 for the terminal diagnosis of Parkinson's. His medical record for the certification period of 7/11/13 through 10/08/13 was reviewed.</p> <p>A Physician Order, dated 8/21/13 and signed by the RN Case Manager on 8/21/13 and the physician on 8/22/13, documented an order for Nystatin powder to be applied topically to affected areas as needed. There was no documentation in the medical record as to why the Nystatin powder had been ordered or where the powder would be applied. In addition, there was no documentation to indicate whether or not the Nystatin powder had been effective.</p> <p>The RN Case Manager was interviewed on 9/13/13 at 8:20 AM. He stated the Nystatin powder had been for a yeast infection Patient #8 had developed in his groin area. He confirmed there was no documentation in the medical record to indicate Patient #8 had a yeast infection, when he had developed it, or whether the infection was causing him pain. The RN Case Manager stated the yeast infection "cleared up" after Patient #8 used the Nystatin powder. He confirmed there was no documentation in the medical record of Patient #8's response to</p>	L 674	<p>L 674 Continued from page 114 of the patient's response to medications, symptom management, treatments and services. The charts will be audited to ensure that the patient's plan of treatment is sufficient. The CRNC and/or the DCS will be required to fill out the chart audit paperwork titled "Comprehensive Documentation Review" to show what areas the RNCM needs to improve upon and what areas they are in compliance with. (Please see sample of Comprehensive Documentation Review (4 pages)).</p>	
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L 674	Continued From page 115 treatment with the Nystatin powder. He agreed that this led to a lack of clarity related to Patient #8's course of treatment.	L 674			
L 679	<p>Patient #8's medical record did not contain response to medications.</p> <p>418.104(b) AUTHENTICATION</p> <p>All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the timely authentication of patient record entries for 10 of 11 patients (#1 - #5 and #7 - #11) whose records were reviewed. This resulted in the potential for a lack of comprehensive information being available to the IDG on which to base POT decisions. Findings include:</p> <p>1. The Entries into Clinical Records policy, undated, stated "Documentation in the clinical record will be timely, detailed, accurate and reflect the care or services provided...All entries will reflect the date care, treatment and/or services was provided, including the month, date and year, time and authentication...Clinical staff shall complete all required documentation at least by the end of each work week..."</p> <p>The policy did not include a nationally accepted current standard of practice which allowed for the weekly documentation.</p> <p>When asked, during an interview on 9/11/13 at</p>	L 679	<p>1. The policy entries into the Clinical Records was updated to reflect that documentation must be authenticated by midnight or an e-mail must be sent to the DCS by that time, explaining valid reasons why this standard can't be met. 2. This action will ensure that all records are complete, with timely authentication, so information is available for all to accurately and appropriately base care decisions. 3. The DCS conducted an in-service on 10/23/2013 to review the policy and standard, ensuring all staff understood this policy and the consequences of not being in compliance. 4. The completion date for this correction will be 11/15/2013. 5/6. The Hospice Administrator will perform on-going monthly audits and those out of compliance will receive appropriate progressive discipline.</p>		

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L 679	<p>Continued From page 116</p> <p>9:45 AM, the DCS stated clinical staff were required to complete documentation by midnight of the date of service.</p> <p>However, patient clinical records did not demonstrate clinical entries were completed within the 24 hour time frame as follows:</p> <p>a. Patient #1's 7/18/13 POT documented she was to receive care which included RN Case Manager visits once per week. Her record did not consistently include evidence of timely visit note authentication. Examples include, but were not limited to, the following:</p> <ul style="list-style-type: none"> - An RN Case Manager note documented a visit was made on 7/15/13 to assess concerns with Patient #1's skin. The note was not authenticated until 8/14/13. - An RN Case Manager note documented a visit was made on 8/05/13 to follow up on Patient #1's pain levels. The note was not authenticated until 8/14/13. - An RN Case Manager note documented a visit was made on 8/23/13. The note stated Patient #1 had experienced no acute changes since the prior week's visit. The note was not authenticated until 8/28/13. <p>b. Patient #2's 6/06/13 POT documented he was to receive care which included RN Case Manager visits once per week and hospice aide visits 3 times per week. His record did not consistently include evidence of timely visit note authentication. Examples include, but were not limited to, the following:</p>	L 679			

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L 679	<p>Continued From page 117</p> <ul style="list-style-type: none"> - A hospice aide note documented a visit was made on 8/09/13 and Patient #2 was provided with personal care. The note was not authenticated until 8/12/13. - An RN Case Manager note documented a visit was made on 8/15/13. The note stated Patient #2 had experienced a decrease in ability to walk and increased depression and frustration. The note was not authenticated until 8/29/13. - A hospice aide note documented a visit was made on 8/20/13 and Patient #2 was provided with personal care. The note was not authenticated until 8/22/13. c. Patient #3's 6/19/12 POT documented he was to receive care which included RN Case Manager visits once per week and Social Services visits once monthly. His record did not consistently include evidence of timely visit note authentication. Examples include, but were not limited to, the following: <ul style="list-style-type: none"> - A Social Services note documented a visit was made on 6/28/13. The note stated Social Worker visits would continue at least 1 time per month. The note was not authenticated until 6/30/13. - An RN Case Manager note documented a visit was made on 7/02/13. The note stated Patient #3 had been friendly for the last several visits. The note was not authenticated until 7/07/13. - A Social Services note documented a visit was made on 8/30/13. The note stated Social Worker visits would continue at least 1 time per month. The note was not authenticated until 9/02/13. 	L 679			

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L 679	<p>Continued From page 118</p> <ul style="list-style-type: none"> - An RN Case Manager note documented a visit was made on 8/28/13. The note stated Patient #3's POT would continue as written. The note was not authenticated until 9/03/13. d. Patient #4's 7/09/13 POT documented he was to receive care which included RN Case Manager visits once a week. His record did not consistently include evidence of timely visit note authentication. Examples include, but were not limited to, the following: <ul style="list-style-type: none"> - An RN Case Manager note documented a visit was made on 8/06/13. The note stated weekly visits would continue. The note was not authenticated until 8/14/13. e. Patient #5's 7/26/13 POT documented she was to receive care which included RN Case Manager visits 2 times per week and hospice aide visits 3 times per week. Her record did not consistently include evidence of timely visit note authentication. Examples include, but were not limited to, the following: <ul style="list-style-type: none"> - An RN Case Manager note documented a visit was made on 8/19/13. The note stated Patient #5's vitals were taken and an assessment was completed. The note was not authenticated until 8/22/13. - An hospice aide visit note documented a visit was made on 8/23/13. The note stated Patient #5 was assisted with a nebulizer treatments, skin care and to the bathroom. The note was not authenticated until 9/01/13. - An hospice aide visit note documented a visit was made on 8/27/13. The note stated Patient 	L 679			

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L 679	<p>Continued From page 119</p> <p>#5 was assisted with a nebulizer treatments, skin care and to the bathroom. The note was not authenticated until 8/29/13.</p> <p>f. Patient #7's record included an Admission Note dated 7/26/13. Her record did not consistently include evidence of timely visit note authentication. Examples include, but were not limited to, the following:</p> <ul style="list-style-type: none"> - An RN Case Manager note documented a visit was made on 7/26/13. The note stated Patient #7's POT would be developed. The note was not authenticated until 7/29/13. - A Social Assessment, dated 7/31/13, documented the initial social assessment was being completed. The social assessment note was not authenticated until 8/05/13. <p>g. Patient #8's 7/11/13 POT documented he was to receive care which included RN Case Manager visits once per week. His record did not consistently include evidence of timely visit note authentication. Examples include, but were not limited to, the following:</p> <ul style="list-style-type: none"> - An RN Case Manager note documented a visit was made on 7/15/13. The note stated Patient #8 seemed to be doing well. The note was not authenticated until 7/18/13. - An RN Case Manager note documented a visit was made on 8/01/13. The note stated Patient #8 was requiring more assistance with showering and dressing. The note was not authenticated until 8/12/13. <p>h. Patient #9's 7/30/13 POT documented he was</p>	L 679			

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L 679	<p>Continued From page 120</p> <p>to receive care which included RN Case Manager visits once per week and Social Service visits once per month. His record did not consistently include evidence of timely visit note authentication. Examples include, but were not limited to, the following:</p> <ul style="list-style-type: none"> - An RN Case Manager note documented a visit was made on 7/30/13. The note stated his vital signs were taken and he was dependent on his wife for all major concerns. The note was not authenticated until 8/01/13. - A Social Services note documented a visit was made on 8/02/13. The note stated the Social Worker would complete the visit with the nurse later that week. The note was not authenticated until 8/06/13. - An RN Case Manager note documented a visit was made on 8/16/13. The note stated he had a "precarious gait and altered decision making" which continued to "create safety issues." The note was not authenticated until 8/19/13. - A Social Services note documented a visit was made on 8/09/13. The note stated additional information was to be gathered by the Social Worker. The note was not authenticated until 8/12/13. - An RN Case Manager note documented a visit was made on 8/30/13. The note stated the POC would be continued. The note was not authenticated until 9/02/13. - An RN Case Manager note documented a visit was made on 9/06/13. The note stated the POT would be continued. The note was not 	L 679			

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L 679	Continued From page 121 authenticated until 9/09/13. i. Patient #10's 6/10/13 POT documented she was to receive care which included RN Case Manager visits 2 times per week. Her record did not consistently include evidence of timely visit note authentication. Examples include, but were not limited to, the following: - An RN Case Manager note documented a visit was made on 6/17/13. The note stated the POC would be continued. The note was not authenticated until 6/23/13. j. Patient #11's 5/09/13 POT documented he was to receive care which included RN Case Manager visits 2 times per week, hospice aide visits 2 times per week, and Social Service visits once per month. Her record did not consistently include evidence of timely visit note authentication. Examples include, but were not limited to, the following: - An RN Case Manager note documented a visit was made on 5/09/13. The note stated Patient #11 was able to comprehend and follow safety instructions. The note was not authenticated until 5/15/13. An interview was conducted with the DCS/SW and RN Staff F together on 9/13/13 beginning at 3:54 PM. They stated, if a nurse or the DCS/SW made a visit on a particular day and opened a visit note on that day, the note stayed open until it was closed. During this time, the author could return to the note and add or edit entries but these would not be dated or timed. For example, as noted above, an RN Case Manager visit note documented a visit was made to Patient #11 on	L 679		

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(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 679	Continued From page 122 5/09/13. The note was opened on that date but was not authenticated until 5/15/13. The DCS/SW and RN stated in a case such as this, the note could be edited or added to until it was closed on 5/15/13 and would not indicate when the entries were made or what had been changed. When asked about the patient records, during an interview on 9/13/13 at 11:45 AM, the DCS/SW stated staff were expected to authenticate entries in patient records on the day the entry was made. The medical record allowed persons to make changes without documenting those changes and did not ensure timely authentication of entries in patient records.	L 679		
L 685	418.104(f) RETRIEVAL OF CLINICAL RECORDS The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority. This STANDARD is not met as evidenced by: Based on record review, review of policies and staff interview it was determined the hospice failed to ensure the clinical record was readily available upon request for 6 of 11 patients (#1 - #5 and #10) whose records were reviewed. This failure resulted in incomplete medical records and a lack of direction to staff as to what constituted a legal medical record. Findings include: 1. The hospice utilized an electronic database for its medical record. A list of 4 patient medical records (#1, #2, #3, and #4) was given to the Administrative Director at approximately 2:00 PM on 9/09/13. At 3:50 PM the Administrative	L 685	L 685 On 10/15/2013, a policy titled "Content of the Clinical Record", was developed. The purpose of this policy is to outline the requirement and components of a clinical record in order to ensure a complete record is made readily available and provide a consistent direction to staff when printing a complete clinical record. These records will be available upon request by authorized individuals. Records will be printed out as quickly as technology allows this task to take.	10/15/13

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

PRINTED: 10/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131554	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2013
NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1867 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83848		
(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 685	<p>Continued From page 123</p> <p>Director had not been able to print a single record. She apologized and stated every item and visit note in the record had to be printed individually. She stated a procedure that included which items to print for a complete legal medical record and directions how to print the record had not been developed.</p> <p>On 9/10/13 at 8:00 AM, surveyors entered the hospice to find the Administrative Assistant printing records. She stated the Administrative Director was at home printing other records. The 4 medical records were given to surveyors at 10:30 AM on 9/10/13. At that time, the Administrative Director stated she had been up until 1:00 AM on 9/10/13 printing the records.</p> <p>Agency policies were reviewed. No policy defined the contents of a legal medical record or a procedure for staff to print the legal medical record.</p> <p>The Administrative Director was interviewed on 9/10/13 at 10:30 AM. She confirmed the agency had not developed a process to define the legal medical record and did not have a way to ensure the complete legal medical record was available in a timely manner.</p> <p>The agency had not developed a process to define medical records and make them readily available.</p> <p>2. Agency staff were asked to print copies of the medical record from the electronic medical record system on 9/09/13 through 9/12/13. The content of the record received by surveyors varied according to the staff member printing the records. Records were missing information.</p>	L 685			

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1857 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646		
(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 685	Continued From page 124 Examples include: a. Patient #10 was a 78 year old female who was admitted to the hospice on 3/12/13. She revoked hospice services on 6/20/13. The record was requested from the Administrative Assistant on 9/11/13. The record was printed and given to surveyors but did not contain nursing visit notes. At 2:00 PM on 9/11/13, the Administrative Director confirmed the visit notes were not printed as part of the medical record and printed them to complete Patient #10's medical record. She confirmed the agency did not have a procedure that provided direction to staff about printing medical records to consistently ensure the complete record was printed. The DCS/SW was interviewed about Patient #10 on 9/12/13 beginning at 10:50 AM. He then returned to his office and printed 5 General Admin Note Details for Patient #10's medical record. These were not part of the record that had been printed earlier. b. POTs were not included with the medical records for Patient #1, Patient #3, Patient #4, and Patient #5.	L 685			
L 708	Complete clinical records were not readily available. 418.108(b)(1)(i) INPATIENT CARE FOR RESPITE PURPOSES Inpatient care for respite purposes must be provided by one of the following: (1) A provider specified in paragraph (a) of this section.	L 708	1. The policy Admission for Respite Care was updated to include the name of Kindred Healthcare as the provider of inpatient respite care for our patients. In-service training and education was completed on 10/18/2013 to review the policy and process required to fulfill patients and families needs for respite care.		

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(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
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L 708	Continued From page 125 This STANDARD is not met as evidenced by: Based on staff interview and review of agency policies, it was determined the agency failed to ensure inpatient respite care was provided to patients. This had the potential to affect the families of all patients who received hospice care. This resulted in the lack of treatment options for families who required a break from caring for terminally ill patients. The policy Admission for Respite Care, not dated, stated "Hospice admits patients to _____ [blank space] Hospital for inpatient respite care." The policy stated the hospice provided respite care but did not specify how this would be done. Staff F, RN, a Case Manager, was interviewed on 9/10/13 beginning at 1:20 PM. She stated the agency did not provide respite care. She said patients and/or their families would have to arrange for such care through a private duty agency. Staff E, RN, another Case Manager, was interviewed on 9/13/13 beginning at 2:05 PM. She stated the agency did not provide respite care. She said patients and/or their families would have to arrange for such care through a private duty agency or other paid caregivers. On 9/10/13 at 2:00 PM, the Director of Finance was interviewed. She stated respite care had never been provided by the agency.	L 708	2. These actions ensure that respite care is available and provided as needed and that families of patients are given all treatment options. ADDENDUM: 3. The DCS/SW OR QD will ensure that families requesting respite care understand the process and are provided the services needed. The Finance/HR Director OR QD will be responsible to maintain a current contract with the respite care provider. 4. The completion date for correction will be 11/15/2013. 5. The DCS/SW or CRNC OR QD will ensure that during the initial Primary IDG Team Meeting the POT accurately reflects any potential need for Respite Care. In addition the DCS/SW or Administrator OR QD will attend each Entire IDG Team meeting ensuring that any potential respite situations are identified. The CRNC or QND will ensure that during their weekly audit of 100% of all patient records that any potential respite situations are identified and acted upon per agency policy. 6. The DCS/SW or CRNC OR QD will ensure that potential respite situations are identified during the initial Primary IDG Team meeting. The DCS/SW or Administrator OR QD will ensure any potential respite situations are identified at each Entire IDG Team Meeting.	
L 795	The agency did not provide respite care. 418.114(d)(1) CRIMINAL BACKGROUND CHECKS	L 795	The CRNC or QND will ensure that during ongoing weekly chart reviews potential respite situations are identified.	

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NAME OF PROVIDER OR SUPPLIER ACCENT HOSPICE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1057 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83646		
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L 795	<p>Continued From page 128</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on review of personnel records and interviews with staff, the hospice failed to ensure criminal background checks had been conducted for 3 of 8 employees (Staff C, E, and F) who had direct patient contact and whose personnel files were reviewed. This had the potential to allow staff with criminal records access to patients. Findings include:</p> <p>Employee personnel files were reviewed with the Director of Finance and Human Resources on 8/11/13 beginning at 11:15 AM. Personnel files were missing evidence of criminal background checks on staff, as follows:</p> <p>Staff C, CNA, whose hire date was 6/01/13 Staff E, RN, whose hire date was 5/28/13 Staff F, RN, whose hire date was 4/27/12</p> <p>The Director of Finance and Human Resources confirmed the above employees currently had direct contact with patients. She also confirmed the personnel files lacked criminal background checks.</p> <p>The hospice did not obtain criminal background checks on all hospice employees who had direct patient contact or access to patient records.</p>	L 795	<p>L 795</p> <p>All currently employed hospice staff now have completed background checks and the agency is in 100% compliance with this issue. All future employees who have direct patient contact or access to patient records will have had their fingerprints taken by the appropriate agency and their drug testing completed on their date of hire. If there is a problem with either one of these tests, the employee will be notified immediately and corrective action will be taken to fix the problem, up to and including termination, if necessary. The Finance/HR Director is responsible for ensuring this requirement is fulfilled and that the results are kept in the employee's personnel file.</p>	10/15/13	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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October 4, 2013

COPY

Cory Castagneto, Administrator
Accent Hospice Care
1857 South Millennium Way, Suite 100
Meridian, ID 83646-6349

RE: Accent Hospice Care, Provider #131554

Dear Mr. Castagneto:

On **September 13, 2013**, a complaint survey was conducted at Accent Hospice Care. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006076

Allegation #1: Respite care was not provided by the hospice.

Findings #1: An unannounced visit was made to the agency on 9/09/13 through 9/13/13. During the survey, facility and patient records were reviewed and staff and patient interviews were conducted with the following results:

The policy Admission for Respite Care, not dated, stated "Hospice admits patients to _____ {blank space} Hospital for inpatient respite care." The policy stated the hospice provided respite care but did not specify how this would be done.

An Registered Nurse (RN) Case Manager was interviewed on 9/10/13 beginning at 1:20 PM. She stated the agency did not provide respite care. She said patients and/or their families would have to arrange for such care through a private duty agency.

A second RN Case Manager was interviewed on 9/13/13 beginning at 2:05 PM. She stated the agency did not provide respite care. She said patients and/or their families would have to arrange for such care through a private duty agency or other paid caregivers.

On 9/10/13 at 2:00 PM, the Director of Finance was interviewed. She stated respite care had never been provided by the agency.

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The facility failed to provide respite care. Therefore, the allegation was substantiated and deficient practice was cited at 42 CFR 418.108(b)(1)(i).

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

Allegation #2: The hospice agency does not provide therapy services.

Findings #2: An unannounced visit was made to the agency on 9/09/13 through 9/13/13. During the survey, facility and patient records were reviewed and staff and patient interviews were conducted with the following results:

The agency's Hospice Request for Certification in the Medicare Program (Form CMS-417), signed by the Administrative Director on 9/13/13 documented the agency provided physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services by arrangement. However, evidence that therapy services were available was not found.

The agency's admission packet, which was given to patients was reviewed. The admissions packet did not include information regarding the availability of therapy services.

On 9/10/13 at 2:00 PM, the Director of Finance presented a contract for PT and OT services dated 9/17/07. She stated to her knowledge PT and OT services had never been provided by the agency. She stated the last time SLP services had been provided was on 9/17/11. She also stated the agency did not have documentation of licensure for therapists.

Between 9/10/13 and 9/13/13, surveyors attempted to phone the therapy company listed in the contract 7 times. Each time the surveyor got a busy signal.

On 9/10/13 at 11:25 AM, the Director of Clinical Services (DCS) stated the agency had never had a patient who required PT or OT services. He stated SLP services had last been provided 2.5 years ago.

Eleven patient records were reviewed. Eight of the 11 records documented potential therapy needs, which had not been addressed.

The 2 Registered Nurse (RN) Case Managers were interviewed on 9/13/13 beginning at 8:25 AM and on 9/13/13 beginning at 1:20 PM respectively. Both stated patients were not evaluated for therapy services and therapy services were not offered to patients. The RN Case Managers were not aware the agency provided therapy services.

The facility failed to provide therapy services as indicated by patient need. Therefore, the allegation was substantiated and deficient practice was cited at 42 CFR 418.72.

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Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: Drugs and biologicals were not routinely made available to patients due to a change in pharmacy provider.

Findings #3: An unannounced visit was made to the agency on 9/09/13 through 9/13/13. During the survey, facility and patient records were reviewed and staff and patient interviews were conducted with the following results:

Eleven medical records were reviewed. There was no documentation in the medical records to indicate medications were not available due to an issue with the pharmacy. In addition, the medical records contained a General Medication Note that documented an assessment of each patient's medications. The assessment included "patient allergies, patient co-morbidities, actual or potential drug interactions, drug cost, and whether drug therapies meet patient needs, are appropriate in route and dosing schedule, are redundant, or require changes for greater patient benefit."

In an interview on 9/13/13 at 2:30 PM, the Director of Clinical Services (DCS) stated a pharmacist assessed patient medications upon admission to hospice services and every other week during the Interdisciplinary Group (IDG) meetings. He stated the pharmacist noted medications that were not on the formulary and recommended substituting them for medications that were on the formulary and would be covered under hospice services. If a medication could not be substituted and was not covered by hospice services, the patient would be required to pay for it, but the medication would still be available to the patient.

On 9/10/13 beginning at 10:00 AM, a Registered Nurse (RN) visit was observed at the home of a patient. During the visit, the RN discussed the patient's medications and whether the patient had enough of each medication. After the RN left the home, the patient and his wife were interviewed. They stated they had never had a problem getting medications.

On 9/11/13 beginning at 9:30 AM, an aide visit was observed at the home a patient. During the visit, the patient's wife was interviewed. She stated she had never had a problem getting medications for her husband from the agency. She stated that if she had questions or concerns about medications, the hospice was quick to resolve the issue and change the medication or dose.

It could not be determined through the investigative process that drugs and biologicals were not routinely made available to patients. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The hospice agency did not complete medical record documentation in accordance with agency policy.

Findings #4: An unannounced visit was made to the agency on 9/09/13 through 9/13/13. During the survey, facility and patient records were reviewed and staff and patient interviews were conducted with the following results:

The agency's Entries into Clinical Records policy, undated, stated "Documentation in the clinical record will be timely, detailed, accurate and reflect the care or services provided...All entries will reflect the date care, treatment and/or services was provided, including the month, date and year, time and authentication...Clinical staff shall complete all required documentation at least by the end of each work week..."

The policy did not include a nationally accepted current standard of practice which allowed for the weekly documentation.

When asked, during an interview on 9/11/13 at 9:45 AM, the Director of Clinical Services (DCS)/Social Worker (SW) stated clinical staff were required to complete documentation by midnight of the date of service.

Eleven patient clinical records were reviewed. Ten of the 11 records did not demonstrate clinical entries were completed within the 24 hour time frame.

When asked about the patient records, during an interview on 9/13/13 at 11:45 AM, the DCS/SW stated staff were expected to authenticate entries in patient records on the day the entry was made.

An interview was conducted with the DCS/SW and a Registered Nurse (RN) together on 9/13/13 beginning at 3:54 PM. They stated, if a nurse or the DCS/SW made a visit on a particular day and opened a visit note on that day, the note stayed open until it was closed. During this time, the author could return to the note and add or edit entries but these would not be dated or timed. For example, one patient record included an RN Case Manager visit note which documented a visit was made to the patient on 5/09/13. The note was opened on that date but was not authenticated until 5/15/13. The DCS/SW and RN stated in a case such as this, the note could be edited or added to until it was closed on 5/15/13. The note would not indicate when the entries were made or what had been changed.

The medical record allowed persons to make changes without documenting those changes and did not ensure timely authentication of entries in patient records.

Additionally, one patient record included a 8/21/13 physician order, signed by the RN Case Manager on 8/21/13 and the physician on 8/22/13. The order stated Nystatin powder was to be

applied topically to affected areas as needed. There was no documentation in the medical record as to why the Nystatin powder had been ordered or where the powder would be applied and there was no documentation to indicate whether or not the Nystatin powder had been effective.

The RN Case Manager was interviewed on 9/13/13 at 8:20 AM. He stated the Nystatin powder had been for a yeast infection the patient had developed. He confirmed there was no documentation in the medical record to indicate the patient had a yeast infection, when the patient developed it, or whether the infection was causing the patient pain. The RN Case Manager stated the yeast infection "cleared up" after the patient used the Nystatin powder. He confirmed there was no documentation in the medical record regarding the patient's response to treatment with the Nystatin powder. The RN Case Manager agreed that this led to a lack of clarity related to the patient's course of treatment.

The facility failed to ensure records were authenticated in a timely fashion and that a patient's response to medications was documented. Therefore, the allegation was substantiated and deficient practice was cited at 42 CFR 418.104(a)(3) and 42 CFR 418.104(b).

Conclusion #4: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #5: The social worker is not completing the initial assessment within five days of the patient electing hospice services.

Findings #5: An unannounced visit was made to the agency on 9/09/13 through 9/13/13. During the survey, facility and patient records were reviewed and staff and patient interviews were conducted with the following results:

The agency's policy titled Initial Hospice Assessment, undated, stated "The Hospice interdisciplinary group, in consultation with the patient's physician, shall complete the comprehensive assessment no later than five (5) calendar days after the election of hospice care."

The Administrative Director was interviewed on 9/12/13 at 9:30 AM. She stated that each member of the Interdisciplinary Group (IDG) team did a separate assessment of the patient and then the members communicate by telephone to develop the treatment plan. She stated the hospice considered the IDG comprehensive assessment completed within 5 days as long as each member documented his or her assessment within that time period.

Eleven patient records were reviewed. Two of the 11 records did not include documentation that assessments were completed within the 5 day timeframe as follows:

A patient record documented the patient was admitted to hospice services on 7/30/13. A visit note dated 8/02/13 and signed by the Director of Clinical Services (DCS)/Social Worker (SW) on 8/06/13 stated the patient's wife preferred the SW to visit later in the week with the Registered

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Nurse (RN) and therefore, the assessment would be late.

A bereavement assessment and social assessment was performed by the DCS/SW on 8/09/13, ten days after the patient was admitted for hospice care.

A patient record documented the patient was admitted to hospice services on 9/12/12. The social assessment was performed by the DCS/SW on 9/28/12, 16 days after the SOC. In addition, the bereavement assessment, also dated 9/28/12, documented the DCS/SW was unable to contact the patient's primary caregiver and would follow up with her later to complete the assessment. There was no documentation in the medical record to indicate the bereavement assessment had been completed at a later time.

The DCS/SW was interviewed on 9/11/13 at 4:00 PM. He confirmed the assessments for both patients had not been completed within 5 calendar days of the patients' election of hospice.

The facility failed to ensure IDG comprehensive assessments were completed within 5 days of hospice election. Therefore, the allegation was substantiated and deficient practice was cited at 42 CFR 418.54(b).

Conclusion #5: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #6: Nursing services were not made available 24 hours a day, 7 days a week.

Findings #6: An unannounced visit was made to the agency on 9/09/13 through 9/13/13. During the survey, facility and patient records were reviewed and staff and patient interviews were conducted with the following results:

A Registered Nurse (RN) Case Manager was interviewed on 9/10/13 at 2:00 PM. She stated during normal business hours, or Monday through Friday from 8:00 AM to 5:00 PM, calls made to the hospice by patients were taken by an administrative assistant who then got in touch with the patient's respective RN Case Manager. She stated all calls made to the hospice after 5:00 PM or on weekends were directly forwarded to the phone of the on-call nurse. The RN Case Managers would take turns acting as the on-call nurse each week, which included 24 hours a day on weekends. She stated that each nurse knew when they were on-call and kept their phone nearby.

Eleven medical records were reviewed. The records contained visit notes that had resulted from patients calling the RN during the weekend or after regular business hours.

On 9/10/13 beginning at 10:00 AM, an RN visit was observed at the home of a patient. During the visit, the RN reiterated to the patient and his wife that nursing services were available 24/7 and to call if they needed anything. After the RN left the home, the patient and his wife were

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interviewed. Both stated they had never had any problems contacting nursing staff. They stated they did not frequently need assistance after hours but on the few occasions they had needed after hours assistance, they were able to contact the RN.

On 9/11/13 beginning at 9:30 AM, an aide visit was observed at the home a patient. During the visit, the patient's wife stated she had been told to call the agency any time day or night should she need assistance. She stated anytime she had called the agency, she received a response. She stated she had to call an RN to come to her home after business hours and on weekends and had always been able to reach an RN.

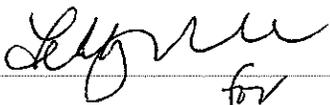
It could not be determined through the investigative process that nursing services were not available 24 hours a day, 7 days a week. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

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.

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 GUILLES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/pt