



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

December 16, 2013

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

RE: Accent Hospice Care, Provider #131554

Dear Ms. Devinney:

On December 6, 2013, a follow-up visit of your facility, Accent Hospice Care, was conducted to verify corrections of deficiencies noted during the survey of September 13, 2013.

We were able to determine that the 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)** are now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;

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

After you have completed your Plan of Correction, return the original to this office by **December 30, 2013**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us 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: Kate Mitchell, CMS Region X Office



January 23, 2014

Bureau of Facility Standards
P.O. Box 83720
Boise, ID 83720-0009

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JAN 23 2014

FACILITY STANDARDS

Dear Nicole Wisenor

Enclosed is our response to your letter dated January 14, 2014. In your letter, you have asked that we send you copies of the forms we would use to make said corrections. Because we use an electronic medical record (EMR), we do not use an actual form, but use the applications within our EMR system. We have printed out the completed forms to show how these corrections will look in our EMR. Please note that we were not able to print out forms for the specific patients mentioned in the letter as they have either passed away or they have been discharged from service. We did however, print out information on other patients who are still on service and were a part of the original set of patients in question. If you have any questions regarding this matter, please feel free to contact me at 208-854-7036.

Sincerely,

Nicole R. DeVinney
Administrator
Accent Hospice Care

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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131554	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/06/2013
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 000}	INITIAL COMMENTS The following deficiencies were cited during the follow up survey of your hospice agency on 12/02/13 through 12/06/13. Surveyors conducting the follow up were: Gary Gules, RN, HFS, Team Leader Libby Doane, RN, BSN, HFS Acronyms used in this report include: A-fib - Atrial Fibrillation BPH - Benign Prostatic Hyperplasia CAD - Coronary Artery Disease CHF - Congestive Heart Failure cm - centimeter COPD - Chronic Obstructive Pulmonary Disease CNA - Certified Nurse Aide CRNC - Clinical Registered Nurse Coordinator DCS/SW - Director of Clinical Services/Social Worker DME - Durable Medical Equipment HTN - Hypertension IDG - Interdisciplinary Group mg - milligram OT - Occupational Therapy PCG - Primary Care Giver POC - Plan of Care prn - as needed PT - Physical Therapy RN - Registered Nurse SW - Social Worker UTI - Urinary Tract Infection	{L 000}			
{L 543}	418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by	{L 543}	L543 Please refer to L545, L547 and L552	01/15/14	

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DEC 30 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 12/30/13

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 543}	Continued From page 1 the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure care followed a plan of care established by the IDG for 5 of 10 patients (#4, #5, #6, #8, and #9) whose records were reviewed. This resulted in a lack of direction to staff to enable them to provide consistent care. Findings include: 1. Refer to L545 as it relates to the agency's failure to ensure individualized POCs, which reflected patient goals and contained interventions based on comprehensive assessments, were developed. 2. Refer to L547 as it relates to the agency's failure to ensure POCs contained a detailed statement of the frequency of services necessary to meet patient needs. 3. Refer to L552 as it relates to the agency's failure to ensure the IDG revised POCs as needed. The failure to establish, follow, and update POCs resulted in a lack of consistency of care provided to patients.	{L 543}		
L 546	418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized	L 545	L 545	01/15/14

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L 545	<p>Continued From page 2</p> <p>written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure an individualized POC, which reflected patient goals and contained interventions based on comprehensive assessments, was developed for 3 of 10 patients (#5, #6, and #9) whose records were reviewed. The lack of an individualized and patient specific POC had the potential to allow the patient to receive inappropriate medication and other therapies that could result in negative health outcomes. Findings include:</p> <p>1. Patient #9's medical record documented a 76 year old female admitted to the agency on 11/01/13 with terminal diagnoses including stomach and intestinal cancer. Her medical record for the certification period of 11/01/13 through 1/29/14 was reviewed.</p> <p>The "Initial Comprehensive Assessment for [Patient #9]," dated 11/01/13, documented she was allergic to several medications, including acetaminophen. There was no documentation to indicate the type of reaction Patient #9 experienced with acetaminophen.</p> <p>A medication list, included as part of the POC and</p>	L 545	<p>An in-service will be conducted on 1/8/14 by the DCS/CRNC discussing how to properly document if a patient is allergic to a medication (what type of reaction does the patient have), what procedure to follow when a patient is given a new medication, how to properly document where they obtained the patient's allergy information (i.e. family, patient, H&P), what our company policy is on medication errors and how to properly document this in our EMR system. The CRNC along with the RNCM, will ensure that all known allergies are documented on the initial and all subsequent Physician Certification of Terminal Illness Orders and Standing Medication Update Orders, which includes all standing medication orders.</p> <p>We are also requiring the pharmacy to give a medication information pamphlet to each new hospice patient for every hospice covered medication when they come on service and the first time a new hospice covered medication is dispensed to that patient.</p>	

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L 545	<p>Continued From page 4 which had last been changed 10/26/13.</p> <p>RN visits notes, dated 11/19/13 and 11/22/13, documented the catheter was intact and Patient #6's urine was light yellow with thick sediment in the collection bag;</p> <p>On 11/26/13, the RN documented she changed the catheter using sterile technique. She documented Patient #6 tolerated the procedure well and that the catheter was draining cloudy yellow urine. She also documented she provided teaching to Patient #6 and caregiver related to cleaning the catheter insertion site and checking for kinks and twists in the catheter tubing.</p> <p>On 11/29/13, the RN documented the catheter was draining dark yellow urine and there was "mucous" noted in the tubing. There was no documentation to indicate the physician had been notified of the cloudy urine or mucous in the catheter.</p> <p>The POC, dated 11/20/13, did not contain goals or interventions related to the catheter. In addition, notes from IDG meetings held on 11/13/13 and 11/27/13 were reviewed. Neither contained documentation indicating the catheter had been discussed. There was no documentation to indicate the heavy sediment, cloudy urine, or mucous in the catheter tubing had been discussed during the IDG meetings or that the POC had been updated accordingly.</p> <p>The RN case manager reviewed the record and was interviewed on 12/04/13 beginning at 12:45 PM. She confirmed the POC did not contain documentation related to the catheter. She stated the POC was reviewed during the IDG</p>	L 545	<p>L545 Continued from page 4 On the initial assessment, the admitting nurse will do a literal head to toe examination of the patient to determine if there are issues including: Skin Integrity, Cardiac Circulatory, Communication, Elimination, Neurology, Nutrition Hydration, Respiratory Oxygenation, Self Esteem Mental Status, Coordination of Care, Nursing Related Observation and Nursing Summary. All findings will be documented in the Initial Comprehensive Assessment and the POC will be updated accordingly to their findings. The RN CM will thoroughly examine the patient's skin integrity weekly to ensure that there are no skin breakdown issues. All issues will be thoroughly documented in the clinical chart and an e-mail will be sent to the CRNC, DCS and Medical Director notifying them of findings. The CRNC or the DCS will review the POC within 24 hours of the e-mail to determine if the POC has been updated correctly.</p>	

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ACCENT HOSPICE CARE

1867 SOUTH MILLENNIUM WAY, SUITE 100
MERIDIAN, ID 83646

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L 545	<p>Continued From page 5</p> <p>meetings, but could not explain why the lack of documentation related to the catheter had not been addressed on the POC.</p> <p>Care of Patient #6's catheter was not included on the POC.</p> <p>3. Patient #5's medical record documented a 67 year old female who was admitted for hospice services on 11/01/13. She died on 12/03/13. Her terminal diagnosis was metastatic cancer of unknown origin.</p> <p>a. Patient #5's initial assessment on a form titled "General Clinical Chart Details," dated 11/01/13 but not timed, stated she had a rash on her chest from previous radiation therapy.</p> <p>The agency's Medical Director was interviewed on 12/05/13 beginning at 3:45 PM. He stated Patient #5 had an order for Silvadene ointment which her caregiver used on the radiation burn on her chest.</p> <p>The form for Patient #5 titled "Hospice Certification and Plan of Treatment," dated 11/04/13, did not mention the radiation burn. The plan noted the medications Patient #5 was taking. Silvadene was not listed on the plan.</p> <p>The CRNC was interviewed on 12/04/13 beginning at 1:15 PM. She reviewed Patient #5's medical record and confirmed the POC did not include the radiation burn or the Silvadene.</p> <p>b. The agency's Medical Director was interviewed on 12/05/13 beginning at 3:45 PM. He stated, prior to Patient #5's admission, virtually every bony prominence had wounds and</p>	L 545		

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L 545	<p>Continued From page 6</p> <p>paper thin skin. He stated her wounds had not healed when she was admitted. He stated a surgical wound on Patient #5's lumbar spine had not healed.</p> <p>Patient #5's "Hospice Certification and Plan of Treatment," dated 11/04/13, did not specifically address the skin problems referred to by the physician. The plan did not direct nurses to physically examine Patient #5's skin with each visit.</p> <p>Patient #5's Initial nursing note by Nurse B, titled "General Clinical Chart Details," dated 11/01/13 but not timed, stated "Patient reports no skin issues at this time." No documentation was present that the nurse examined Patient #5's skin. Subsequent nursing notes on 11/05/13 and 11/12/13 also did not document if nurses examined her skin.</p> <p>The CRNC was interviewed on 12/04/13 beginning at 1:15 PM. She reviewed Patient #5's medical record and confirmed the POC did not address specific skin problems.</p> <p>c. The first nursing note to document skin issues was dated 11/19/13. A note by Nurse A, titled "General Clinical Chart Details," dated 11/19/13 but not timed, stated Patient #5 had "...a stage 2 pressure area located on her coccyx just to the right of it approximately 1 cm X 1.5 cm draining scant amount of clear fluid. Called [the Medical Director] for an order to treat with Silvadene, and dressed with a Duoderm thin bandage. Educated caregiver that bandage should be changed every 72 hours or until soiled."</p> <p>A note by Nurse B titled "General Clinical Chart</p>	L 545		

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L 545	<p>Continued From page 7</p> <p>Details," dated 11/21/13 at 11:10 AM, stated Patient #5's husband called and requested a nursing visit. The note stated Patient #5 had a large piece of tape to the right buttocks and no Duoderm was in place. The note stated the caregiver had removed the Duoderm and had torn some of the skin which started bleeding. The note stated the nurse removed a gauze dressing over the wound and it started to bleed again. The note stated the nurse stopped the bleeding and cleansed the pressure sore area with wound cleanser. The note stated the nurse placed Duoderm over the pressure area on Patient #5's coccyx and then placed a non-stick pad over the excoriated area that was still slowly bleeding. The note stated Nurse B told Patient #5's caregiver not to use the Silvadene any more.</p> <p>Subsequent nursing notes on 11/25/13, 11/26/13, and 11/27/13 documented the wounds were treated by cleansing them with water or wound cleanser and applying Duoderm and/or a non-stick dressing. No orders to treat the wound were documented.</p> <p>The wounds worsened until a note by Nurse A titled "General Clinical Chart Details," dated 11/29/13 at 4:00 PM, stated "Coccyx wound necrotic with sloughing skin approximately 5 cm X 3 cm...Patient has skin tear on bilateral buttocks. Left side approximately 4 cm X 4 cm and right side approximately 3 cm X 4 cm. Both sides bleeding bright red blood, appears to be sheared." However, physician notification of the worsening wounds was not present and no orders to treat the wound were documented. Both the 11/29/13 and 11/30/13 nursing note documented the wounds were treated by cleansing them with water or wound cleanser and applying Duoderm</p>	L 545		

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L 545	<p>Continued From page 3</p> <p>electronically signed by the Medical Director on 11/13/13 and 11/26/13, included acetaminophen 650 mg suppositories to be taken rectally every 6 to 8 hours as needed for pain or fever. The medication list documented the acetaminophen had been ordered by the Medical Director on 11/12/13.</p> <p>The DCS/SW reviewed the record and was interviewed on 12/04/13 at 3:00 PM. He confirmed Patient #9 was allergic to acetaminophen. He stated acetaminophen had been ordered by mistake by the RN case manager, which allowed it to populate the medication list. He stated acetaminophen had been delivered to Patient #9's home but had been intercepted by the RN case manager prior to Patient #9 using it. He stated this had not been documented or tracked via an incident report. He confirmed there was no documentation to indicate the Medical Director had been notified of the error.</p> <p>Patient #9's POC contained a medication she had a documented allergy to.</p> <p>2. Patient #6's medical record documented an 86 year old male admitted to the agency on 9/12/13 with terminal diagnoses including acute respiratory failure, COPD, renal failure and CAD. His medical record for the certification period of 9/12/13 through 12/10/13 was reviewed.</p> <p>A nursing visit note, dated 11/15/13, documented Patient #6 was incontinent of bowel and bladder and wore briefs. The note documented Patient #6 had a history of urinary retention related to BPH and a history of UTIs. The note also documented Patient #6 had a foley catheter,</p>	L 545	<p>L545 Continued from page 3</p> <p>Upon admission, an informational e-mail about the patient will be sent to all of the staff and the Pharmacy. This e-mail will include the patient's name, DOB, their terminal diagnosis, any allergies that they have, where they are located and which staff members will be taken care of them and what their frequencies will be.</p> <p>All medication errors or adverse reactions will be documented by the RNCM in the Clinical Notes and on a QAPI Incident Report form.</p> <p>The RNCM will notify, via e-mail, the CRNC, DCS and Medical Director in regards to any changes in condition that the patient may experience and they will update the POC accordingly as well as document these changes in the clinical notes. The CRNC or DCS will review the POC within 24 hours of receiving the e-mail to ensure that the POC was updated accordingly. The CRNC or DCS will print out and discuss during IDG all the e-mails they received in regards to any changes to the patient's condition.</p>	

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L 545	Continued From page 8 and/or a non-stick dressing. The "Plan of Care dated 12/01/2013 for [Patient #5]" did not direct specific care for Patient #5's pressure ulcer or other wounds on her buttocks. Also, an order clarifying the use of Silvadene was not present on the POC or elsewhere in the medical record. The CRNC was interviewed on 12/04/13 beginning at 1:15 PM. She reviewed Patient #5's medical record and confirmed the POC was not individualized and did not include Patient #5's wounds or the use of Silvadene.	L 545			
L 547	418.56(c)(2) 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:] (2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the POC contained a detailed statement of the frequency of services necessary to meet patient needs for 3 of 10 patients (#5, #6, and #8) whose records were reviewed. This resulted in incomplete documentation of aide frequencies and inattention to patient and family needs.	L 547	L547 As of 1/15/2014, the nursing staff will review all of the patient's within their case load to ensure that all frequencies are updated to reflect each patient's individual needs. The CRNC or DCS will review the Hospice Assignments to ensure that the RNCM has made the appropriate changes necessary. Our Hospice Aide assignments are in a separate area within the EMR and they are included in the contents of the clinical records which were made	01/15/14	

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L 547	<p>Continued From page 9 Findings include:</p> <p>1. Patient #6's medical record documented an 86 year old male admitted to the agency with terminal diagnoses including acute respiratory failure, COPD, renal failure and CAD. His medical record for the certification period of 9/12/13 through 12/10/13 was reviewed.</p> <p>The POC, signed by the Medical Director on 9/13/13, documented Patient #6 was to receive hospice aide services to assist with personal care, home making and to promote comfort per RN assignment. The POC did not include aide visit frequencies.</p> <p>IDG meeting notes dated 11/13/13 and 11/27/13 documented hospice aide visits were being made twice a week. There was no documentation to indicate the POC was reviewed and updated to reflect the visit frequency noted during IDG.</p> <p>The RN case manager reviewed the record and was interviewed on 12/04/13 beginning at 12:45 PM. She confirmed the POC did not include hospice aide visit frequencies. She confirmed the aide was visiting Patient #6 twice a week.</p> <p>Aide visit frequencies were not included on the POC.</p> <p>2. Patient #5's medical record documented a 67 year old female who was admitted for hospice services on 11/01/13. She died on 12/03/13. Her terminal diagnosis was metastatic cancer of unknown origin.</p> <p>a. Patient #5's "Hospice Certification and Plan of Treatment," dated 11/04/13, listed the visit</p>	L 547	L 547 Continued from page 9 available to the appropriate authority or legally authorized person.	

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L 547	<p>Continued From page 10</p> <p>frequency for the Chaplain as 2 visits per month, the nurse as 1 visit per week, and social services as 1 visit per month. The plan for each discipline also stated "7 prn visit(s) every 7 days."</p> <p>The CRNC was interviewed on 12/04/13 beginning at 1:15 PM. She reviewed Patient #5's medical record and stated the agency wrote plans for 7 prn visits per week for all disciplines for all patients so staff could visit patients if they wanted to.</p> <p>As Patient #5's condition worsened, the visit frequency for nurses did not change. A note by Nurse A, titled "General Clinical Chart Details," dated 11/19/13 but not timed, stated Patient #5 had a stage 2 pressure area located on her coccyx. Nursing visits were also documented on 11/21/13, 11/25/13, 11/26/13, and 11/27/13.</p> <p>A form for Patient #5, dated 11/28/13 and titled "Assignment Details," again directed the visit frequency for the the nurse as 1 visit per week. The plan did not reflect Patient #5's increasing needs. Subsequent nursing visits were documented on 11/29/13, 11/30/13, 12/01/13, and 12/02/13.</p> <p>The CRNC was interviewed on 12/04/13 beginning at 1:15 PM. She reviewed Patient #5's medical record and confirmed the visit frequency did not change in relation to Patient #5's needs.</p> <p>The agency did not increase Patient #5's visit frequency in relation to her needs.</p> <p>3. Patient #8's medical record documented a 68 year old male who was admitted for hospice services on 11/14/13. He was currently a patient</p>	L 547			

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L 547	Continued From page 11 as of 12/04/13. His terminal diagnosis was coronary atherosclerosis. Patient #8's form "Assignment Details," effective 11/14/13, listed the visit frequency for the Chaplain as 2 visits per month, the nurse as 1 visit per week, social services as 1 visit per month, and the aide as 1 visit per week. The plan for each discipline also stated "7 pm visit(s) every 7 days." The CRNC was interviewed on 12/04/13 beginning at 1:15 PM. She stated agency practice was to specify 7 pm visits for all disciplines so they could visit a patient at any time. The agency did not individualize Patient #8's visit frequency.	L 547			
L 552	418.56(d) REVIEW OF THE PLAN OF CARE The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure the IDG revised the POC as needed for 4 of 10 patients (#4, #5, #6 and #9) whose medical records were reviewed. This prevented the IDG from directing the care of the patient. Findings include:	L 552	L552 The RNCM will review and revise patient's individualized POC every IDG (q 2 weeks) and/or if there is a change in patient's condition. The RNCM will e-mail the CRNC, the DCS and the Medical Director as to any changes in the patient's condition. The CRNC or DCS will review the POC within 24 hours of receiving the e-mail to ensure that the appropriate changes were made to the POC. The CRNC or DCS will print out and discuss during IDG all the e-mails they received in regards	01/15/14	

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L 552	<p>Continued From page 12</p> <p>1. Patient #5's medical record documented a 67 year old female who was admitted for hospice services on 11/01/13. She died on 12/03/13. Her terminal diagnosis was metastatic cancer of unknown origin.</p> <p>Patient #5's medical record contained a note by Nurse A, titled "General Clinical Chart Details" and dated 11/19/13 but not timed, that stated Patient #5 had a stage 2 pressure area located on her coccyx. A note by Nurse B titled "General Clinical Chart Details," dated 11/21/13 at 11:10 AM, stated "Patient #5's husband called and requested a nursing visit. The note stated Patient #5 had skin tears near the pressure sore from the caregiver's attempt to remove a wound dressing.</p> <p>The "IDG Comprehensive Assessment Details," dated 11/27/13 but not timed, documented the IDG met and discussed Patient #5 on that date. The IDG note did not mention wound care.</p> <p>The "Plan of Care dated 12/01/2013 for [Patient #5]" was generated from the IDG meeting. The POC did not address wound care.</p> <p>The CRNC was interviewed on 12/04/13 beginning at 1:15 PM. She reviewed Patient #5's medical record and confirmed the IDG did not revise the POC to address her wounds.</p> <p>The IDG did not revise Patient #5's POC to address her individual needs.</p> <p>2. Patient #4's medical record documented an 88 year old female admitted to the agency on 11/14/12 with terminal diagnoses including cardiovascular disease, CHF, A-fib, and HTN. Her medical record and POC for the certification</p>	L 552	<p>L552 Continued from page 12 to any changes to the patient's condition. The CRNC will review the IDG notes 48 hours after IDG to ensure the IDG notes reflect any changes to the patient's cares and any discussions that took place during the IDG meeting.</p>	

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L 552	<p>Continued From page 13 period of 11/09/13 through 1/07/13 was reviewed. Her POC was not individualized to meet her needs as follows:</p> <p>a. The POC, dated 10/31/13, documented goals and interventions related to the use of oxygen that were instituted 5/07/13. The interventions included "Collaborate with physician, obtain order for oxygen/suction prn" and "Instruct PCG in oxygen use." However, documentation in the medical record indicated the interventions were no longer appropriate for Patient #4 as follows:</p> <ul style="list-style-type: none"> - The "DME Order Details" section of of Patient #4's POC documented on 9/15/13 a DME supplier "picked up oxygen concentrator and [tanks]. Patient was not using them and requested that they be taken." - RN visit notes dated 11/18/13 and 11/26/13 documented Patient #4 was not using oxygen. <p>The RN case manager reviewed the record and was interviewed on 12/04/13 beginning at 12:45 PM. She confirmed Patient #4 had not been using oxygen. She confirmed the POC had not been updated to reflect Patient #4's current condition.</p> <p>b. Patient #4's POC, dated 10/31/13, documented interventions related to the management of "cardiac/circulatory function and fluid volume alteration" that had been initiated 1/28/13. The interventions included assessing edema by monitoring weight gain, elevating edematous areas, and apply knee high compression stockings to lower extremities. The POC did not include information related to how the RN was to monitor weight gain and lower</p>	L 552			

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L 552	<p>Continued From page 14</p> <p>extremity edema and what parameters should be reported to the physician.</p> <p>RN visit notes, dated 11/18/13 and 11/26/13, documented Patient #4's weight had been obtained during a visit on 11/12/13. No weights were taken during the respective visits. In addition, both notes documented Patient #4 had "trace" edema to both ankles.</p> <p>The RN visit note dated 11/18/13 documented Patient #4 had not been wearing her compression stockings, but kept her feet elevated during the day.</p> <p>The RN case manager reviewed the record and was interviewed on 12/04/13 beginning at 12:45 PM. She stated Patient #4 no longer wore compression stockings because she no longer had edema to her lower extremities. She also stated that because Patient #4 did not have edema, she had decided to only weigh Patient #4 once a month. She confirmed the POC had not been updated to reflect Patient #4's current condition.</p> <p>Patient #4's POC was not updated to reflect her current condition.</p> <p>3. Patient #9's medical record documented a 76 year old female admitted to the agency on 11/01/13 with terminal diagnoses including stomach and intestinal cancer. Her medical record for the certification period of 11/01/13 through 1/29/14 was reviewed. Patient #9's POC documented she received nursing, aide, SW, and Chaplain services. The "Hospice Aide Assignment," dated 11/01/13, documented aide visits were to occur three times a week.</p>	L 552		

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L 552	<p>Continued From page 15</p> <p>An IDG meeting note, dated 11/13/13, documented Patient #9's husband had requested "...some extra time or visit from CNA so he can go shopping for groceries and a few other things that patient needs." There was no further documentation in the IDG meeting note to indicate a change had been made in response to Patient #9's husband's request for more aide visits.</p> <p>On 11/20/13, an order was taken by the RN for aide visits to be increased to daily. The Medical Director signed the order on 11/22/13. However, aide visits were not completed daily in accordance with the order as follows:</p> <p>Hospice aide visits were documented on 11/20/13, 11/21/13, 11/25/13, 11/26/13, 11/27/13 and 11/29/13 until the time of the survey on 12/02/13.</p> <p>The DCS/SW and CRNC reviewed the record and were interviewed on 12/04/13 beginning at 3:00 PM. The DCS/SW confirmed aide visits were not provided daily in accordance with the Medical Director's order. He stated the RN case manager responsible for Patient #9 had stopped working for the hospice around the time the order was written. He stated she had not communicated the change in frequencies to the hospice aide or updated the POC to reflect the increase in visits.</p> <p>The POC was not updated to reflect the change in aide frequencies.</p> <p>4. Patient #6's medical record documented an 86 year old male admitted to the agency on 9/12/13</p>	L 552			

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L 552	<p>Continued From page 16 with terminal diagnoses including acute respiratory failure, COPD, renal failure and CAD. His medical record for the certification period of 9/12/13 through 12/10/13 was reviewed.</p> <p>A nursing visit note, dated 11/15/13, documented Patient #6 was incontinent of bowel and bladder and wore briefs. The note documented Patient #6 had a history of urinary retention related to BPH and a history of UTIs. The note also documented Patient #6 had a foley catheter, which had last been changed 10/26/13.</p> <p>RN visits notes, dated 11/19/13 and 11/22/13, documented the catheter was intact and Patient #6's urine was light yellow, but thick sediment was noted in the collection bag.</p> <p>On 11/26/13, the RN documented she changed the catheter using sterile technique. She documented Patient #6 tolerated the procedure well and that the catheter was draining cloudy yellow urine. The RN also documented she provided teaching to Patient #6 and his caregiver related to cleaning the catheter insertion site and checking for kinks and twists in the catheter tubing.</p> <p>On 11/29/13, the RN documented the catheter was draining dark yellow urine and there was "mucous" noted in the tubing. There was no documentation to indicate the physician had been notified of the cloudy urine or mucous in the catheter.</p> <p>The POC, dated 11/20/13, did not contain goals or interventions related to the catheter. In addition, notes from IDG meetings held on 11/13/13 and 11/27/13 were reviewed. Neither</p>	L 552			

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L 552	Continued From page 17 contained documentation indicating the catheter had been discussed. There was no documentation to indicate the heavy sediment, cloudy urine, or mucous in the catheter tubing had been discussed during the IDG meetings. The RN case manager reviewed the record and was interviewed on 12/04/13 beginning at 12:45 PM. She stated the cloudiness and mucous in the urine was actually sediment, and normal for Patient #6. She confirmed the POC did not contain documentation related to the catheter. She stated the catheter was discussed during IDG but confirmed there was no documentation.	L 552			
L 554	418.58(e)(1) COORDINATION OF SERVICES The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to- (1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care was coordinated and the IDG maintained responsibility for directing, coordinating and supervising care for 3 of 10 patients (#3, #4, and #9) whose records were reviewed. This resulted in missed opportunities to alter the POC in response to patient and family needs. Findings include:	L 554	L554 We have developed a new System of Communication and Coordination of Care protocol that ensures the continuity of care for patients when an employee either leaves the company or goes on vacation. If there are any changes or concerns regarding the patient, the RNCM is to send an e-mail to the CRNC, DCS, Administrative Assistant, and Administrator immediately letting them know of the changes. The CRNC and DCS will review the patient's chart to ensure that the appropriate changes have been made and that the	01/15/14	

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L 554	Continued From page 18 1. Patient #3's medical record documented a 72 year old female admitted to the agency on 10/01/13 with terminal diagnoses including COPD, acute bronchitis, HTN, and renal failure. Her medical record for the certification periods of 10/01/13 through 11/29/13 and 11/30/13 through 1/28/14 were reviewed. The agency failed to coordinate care and the IDG failed to direct and supervise her care as follows: a. An RN note, documented on 10/01/13, stated Patient #3 had been unable to bear weight and ambulate on her left foot since before she had been discharged from a long term care facility (prior to admission to hospice) and that Patient #3's caregivers had been using a mechanical lift for all transfers. The RN documented Patient #3 had profound weakness, no activity tolerance, and was non ambulatory. A DCS/SW visit note, dated 10/28/13, documented Patient #3 stated "she would simply [sic] like to be able to stand and then walk without becoming anxious." The DCS/SW documented he reviewed "positive affirmations" with Patient #3 and her daughter "with the hope that she will be once again able to stand and then ambulate without becoming anxious." The DCS/SW noted the POC had been updated to include this goal. There was no documentation to indicate a PT evaluation had been discussed by the DCS/SW with Patient #3 and her daughter. The POC, dated 10/28/13, documented Patient #3's goal of wanting to be able to stand and ambulate. Interventions to reach this goal were documented as "Assist in coping with limits imposed by illness" and "Provide opportunities for	L 554	L 554 Continued from page 18 appropriate parties have been notified. The CRNC or DCS will print out and discuss during IDG all the e-mails they received in regards to any changes to the patient's condition.		

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L 554	<p>Continued From page 19</p> <p>enriching and worthwhile activities and experiences." There were no interventions related to the physical aspects of achieving Patient #3's goal, such as a PT or OT evaluation.</p> <p>IDG meeting notes, dated 10/30/13 and 11/13/13, were reviewed. Neither note contained documentation to indicate the updated POC had been addressed in IDG meetings.</p> <p>A DCS/SW note, dated 11/25/13, documented Patient #3 reported she was still feeling anxious and had not been able to stand or walk, but had identified a new goal of being able to walk at her grandson's wedding in August of 2014. The DCS/SW encouraged her to review positive affirmations that will "hopefully aide her meeting these goals." There was no documentation to indicate a PT or OT evaluation had been discussed with Patient #3.</p> <p>An IDG meeting note, dated 11/27/13, did not contain documentation to indicate Patient #3's goal of being able to walk by August 2014 had been addressed.</p> <p>The DCS/SW and CRNC reviewed the record and were interviewed together on 12/04/13 at 3:00 PM. The DCS/SW stated Patient #3 had been receiving PT services while admitted to a long term care facility, prior to admission to hospice. He stated she had not met her goals with PT during that time, so it was decided by the IDG that PT would not be resumed when Patient #3 was admitted to hospice. He confirmed there was no documentation of this. He stated Patient #3 had been informed the hospice offered PT services, but a PT evaluation had not been specifically discussed with her. He confirmed</p>	L 554			

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L 554	<p>Continued From page 20</p> <p>there was no documentation in the IDG notes to indicate Patient #3's goal of standing and walking had been addressed, or whether a PT evaluation would be appropriate for Patient #3.</p> <p>IDG did not coordinate care in order to facilitate Patient #3 achieving her goals.</p> <p>b. An RN visit note, dated 11/18/13, documented Patient #3's daughter stated Patient #3's Medicaid benefits had ended and she would no longer have help caring for Patient #3 other than what she could pay for privately. The RN also documented the loss of Medicaid benefits and caregiver help in another visit note, dated 11/21/13.</p> <p>A DCS/SW visit was made to Patient #3 on 11/25/13. There was no documentation to indicate the loss of Medicaid benefits and caregiver help had been addressed during the visit.</p> <p>An IDG meeting note dated 11/27/13 was reviewed. There was no documentation to indicate the loss of Medicaid benefits and caregiver help had been addressed by the IDG.</p> <p>The DCS/SW and CRNC were interviewed together on 12/04/13 beginning at 3:00 PM. Both stated they were unaware Patient #3 had lost her Medicaid benefits and caregiver help. The DCS/SW stated the RN who had documented the notes on 11/18/13 and 11/21/13 had recently stopped working for the agency and had not communicated the issue to the nurse assuming care for Patient #3 or the IDG prior to leaving.</p> <p>Information related to a decrease in caregiver</p>	L 554			

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PRINTED: 12/16/2013
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 R 12/06/2013
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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L 554	<p>Continued From page 21</p> <p>assistance was not coordinated among IDG members.</p> <p>2. Patient #9's medical record documented a 76 year old female admitted to the agency on 11/01/13 with terminal diagnoses including stomach and intestinal cancer. Her medical record for the certification period of 11/01/13 through 1/29/14 was reviewed. Patient #9's POC documented she received nursing, aide, SW, and Chaplain services.</p> <p>The "Hospice Aide Assignment," dated 11/01/13, documented aide visits were to occur three times a week.</p> <p>An IDG meeting note, dated 11/13/13, documented Patient #9's husband had requested "...some extra time or visit from CNA so he can go shopping for groceries and a few other things that patient needs." There was no further documentation in the IDG meeting note to indicate a change had been made in response to Patient #9's husband's request for more aide visits.</p> <p>On 11/20/13, the RN made a visit to Patient #9's home after her husband called and asked for a visit. The RN documented Patient #9's husband felt overwhelmed and "in over his head." The RN documented Patient #9 was getting weaker and was "obtunded most of the time." The RN documented aide visits would be increased to daily.</p> <p>An order was taken by the RN on 11/20/13 for aide visits to be increased to daily. The Medical Director signed the order on 11/22/13. However, aide visits were not completed daily in</p>	L 554			

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L 554	<p>Continued From page 22 accordance with the order as follows:</p> <p>Hospice aide visits were documented on 11/20/13, 11/21/13, 11/25/13, 11/26/13, 11/27/13 and 11/29/13 until the time of the survey on 12/02/13.</p> <p>The DCS and CRNC reviewed the record and were interviewed on 12/04/13 beginning at 3:00 PM. The DCS confirmed aide visits were not provided in accordance with the order taken on 11/20/13. He stated the RN case manager responsible for Patient #9 had stopped working for the hospice around the time the order was written. He stated the RN had not communicated the change in frequencies to the hospice aide, or the RN case manager who assumed care of her patients, prior to leaving.</p> <p>Care was not coordinated to ensure aide visits were performed to meet the needs of Patient #9 and family.</p> <p>3. Patient #5's medical record documented a 67 year old female who was for hospice services on 11/01/13. She died on 12/03/13. Her terminal diagnosis was metastatic cancer of unknown origin.</p> <p>A note by Nurse A, titled "General Clinical Chart Details," dated 11/19/13 but not timed, stated Patient #5 had "...a stage 2 pressure area located on her coccyx just to the right of it approximately 1 cm X 1.5 cm draining scant amount of clear fluid. Called [the Medical Director] for an order to treat with Silvadene, and Duoderm thin dressing. Cleaned affected area with with [normal saline] and applied generous amount of Silvadene and dressed with a Duoderm thin bandage."</p>	L 554		

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L 554	<p>Continued From page 23</p> <p>An order for Silvadene was not present in Patient #5's medical record.</p> <p>A note by Nurse B titled "General Clinical Chart Details," dated 11/21/13 at 11:10 AM, stated Patient #5's husband called and requested a nursing visit. The note stated he had attempted to remove the Duoderm from Patient #5 resulting in skin tears which started bleeding. The note stated the nurse stopped the bleeding and cleansed the pressure sore area with wound cleanser. The note stated the nurse placed Duoderm over the pressure area on Patient #5's coccyx and then placed a non-stick pad over the excoriated area that was still slowly oozing. The note stated Nurse B told Patient #5's caregiver not to use the Silvadene any more.</p> <p>An order for wound care was not present in Patient #5's medical record. A POC was not documented which specified wound care for Patient #5.</p> <p>Nurse B was interviewed on 12/05/13 beginning at 3:45 PM. She stated the Silvadene did not appear to be helping Patient #5 so she told the Patient #5's caregiver to stop using it. She stated Nurse A had not told her about the use of the Silvadene. She stated she was not aware of an order to apply Silvadene to Patient #5's pressure ulcer. She stated she did not notify the Medical Director of Patient #5's wounds and request orders for treatment.</p> <p>Nurse A, Nurse B, and the Medical Director did not coordinate to ensure consistent wound care was provided to Patient #5.</p>	L 554			

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{L 651} {L 651}	Continued From page 24 418.100(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 observation, staff interview, and review of medical records and agency policies, it was determined the agency's Governing Body failed to ensure the protection of personal health information at the agency for all patients of the agency. This resulted in the potential for patients' personal health information to be accessed by unauthorized persons. Findings include: 1. Refer to L680 as it relates to the failure of the Governing Body to ensure systems to protect personal health information on cell phones were developed, implemented, and monitored.	{L 651} {L 651}	L651 See L680	12/6/13	
L 680	418.104(e) PROTECTION OF INFORMATION The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department's rules regarding personal health information as set out at 45 CFR parts 160 and	L 680	L680 On 12/6/2013, the Governing Body met and a policy was developed to ensure the protection and security of all personal health information on cell phones and computers.	12/6/13	

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L 680	<p>Continued From page 25 164.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records and agency policies, it was determined the agency failed to ensure personal health information was safeguarded against loss and unauthorized use. This affected 1 of 10 patients (#5) and had the potential to affect all patients of the agency. The failure to protect personal health information resulted in the potential to compromise patients' privacy. Findings include:</p> <p>1. Patient #5's medical record documented a 67 year old female who was admitted for hospice services on 11/01/13. She died on 12/03/13. Her diagnosis was metastatic cancer of unknown origin.</p> <p>During an interview on 12/06/13 beginning at 11:30 AM, the CRNC stated iPhones were provided to employees of the agency. She demonstrated an application on her iPhone which contained Patient #5's full name and all of the medications by date and time that Patient #5 took while she was a patient. The CRNC also stated staff used their phones to text and email the Medical Director and each other to request orders and share patient specific information. She showed surveyors a text message to the physician on her iPhone which contained Patient #5's full name. The message stated Patient #5 had thrush and the CRNC had created an order for Nystatin swish and swallow 3 times a day.</p> <p>The CRNC opened her iPhone for the surveyor. She accessed the file without a password or the</p>	L 680	<p>L680 Continued from page 25 All company cell phones and computers will be password protected. A record of the passwords will be kept in a locked cabinet in the employee's file within the HR office. Only HR Director and Administrator will have access to this information.</p>	
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L 680	<p>Continued From page 26</p> <p>need to pass other security measures. The CRNC confirmed at the time that there were no security measures on her iPhone to prevent its unauthorized use by other persons.</p> <p>Patient #5's personal health information was not protected against unauthorized use.</p> <p>The Director of Finance was interviewed on 12/06/13 beginning at 12:50 PM. She stated she was responsible for providing agency issued cell phones to employees. She stated the agency initially encouraged staff to password protect the phones. She stated some staff had left the agency and had not provided the password to the agency to allow access to the phone. She stated the agency had stopped encouraging staff to password protect their phones. She also stated she was not aware of any measures to protect personal health information on the phones from unauthorized use.</p> <p>The Administrator was interviewed on 12/06/13 beginning at 12:30 PM. She stated the agency used iPhones to retain and send patients' personal health information. She stated the agency had not developed systems or policies to protect personal health information on cell phones or through texts and emails.</p> <p>The agency failed to ensure patients' personal health information was protected.</p>	L 680		