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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	021500	A. BUILDING ______ B. WING ______	C 02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAT-SU REGIONAL HOSPICE	**950 EAST BOGARD ROAD, SUITE 132 WASILLA, AK 99654**

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L 000	INITIAL COMMENTS The following deficiencies were noted during an unannounced Medicare/Medicaid complaint investigation AK #2514 conducted 2/24-25/14. Sample size 4. STATE OF ALASKA Department of Health and Social Services Division of Health Care Services 4501 Business park Blvd. Ste. 24, Bldg L Anchorage, Alaska 99503	L 000		
L 530	418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring.	L 530		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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L 530	Continued From page 1 This STANDARD is not met as evidenced by: Based on medical record review, policy review and interview the hospice agency failed to ensure new medication orders were reconciled with initial and/or on-going medication list in 4 of 4 patients (#s 1; 2; 3; and 4) for whom medications were reviewed. As a result these patients were placed at risk for adverse events related to medication interactions, lack of medications, or, inappropriate dosage of medications. Findings: All medical records and policy and procedure reviews were completed between 2/24-25/14. Patient #1 Patient #1 was admitted to the hospice agency with a primary diagnosis of metastatic prostate cancer. Record review of Patient #1's 485 (Initial Plan of Treatment and Certification) for the certification period of 12/27/13 to 3/26/14 revealed Patient #1 was to receive the following medications: Colace 100 mg daily (reason-constipation); Fentanyl Transdermal patch 75 mcg.hr, 1 every 72 hours(reason- pain); Miralax, 17 gram, 1, daily (reason-constipation); Oxycodone 30 mg 1, every 4 hours/prn [as needed] (reason-pain); Percocet 10-325 mg, 1 every 4 hours/prn (reason-pain); Senna, 176 mg/5 ml, 1 daily (reason-constipation).	L 530		

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L 530	Continued From page 2	L 530		

Review of the physician orders, dated 12/17/13, revealed the physician had prescribed Morphine Sulfate (MS) 20mg/ml at 0.5-1 ml by mouth every hour as needed for pain and shortness of breath. The physician's order also included Lorazepan 2 mg/ml at 0.5 ml by mouth every hour as needed for agitation. These orders were sent to the hospice agency on 12/27/13; however, these medications were not included in the initial Medication Profile or any other medication list thereafter.

Medical review of a Client Coordination Note Report, dated 1/1/14, confirmed the Patient's spouse was giving liquid morphine to the Patient.

Additional medical record review of a Client Coordination Note Report, dated 1/2/14, revealed the Patient's spouse had increased the Patient's Fentanyl patch from 75-100 mcg/hour. The increase in the dose of the pain patch was not reconciled in the Patient's Medication Profile.

Review of physician orders on 2/24-25/14 for Patient #s 2; 3; and 4 revealed there were also changes in these patients' medications that had not been reconciled on the medical record Medication Profiles.

Review of the agency's P&P "Medications", dated

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L 530	Continued From page 3 7/10, revealed "Agency will implement a standardized method for creating an accurate list of medications at admission/entry, on-going and transfer/discharge. The comprehensive assessment includes a review of all current prescription medications, sample medications, over-the-counter (OTC) medications, oxygen, vitamins, prescribed ointments, herbal/dietary supplements and nutrition supplements will be listed on the Medication Profile." During an interview on 2/25/14 at 9:30 am the Director of Nurses (DON) confirmed patient #s 1; 2; 3; and 4 had medication changes that had been ordered by their physicians electronically, and that the nursing staff had not included these changes in the medical record Medication Profile. The DON said the problem was the agency's computer system used for physician orders was not the same system used for patients' data collection in the agency's patient electronic medical record. Therefore, because two different computer systems were in use, nurses would forget to include the medication changes in the patients' medical record. The surveyor asked would Medication Profiles not being updated place patients at a higher risk for not receiving correct medications or the correct dosages of medications? The DON confirmed it did place patients at a higher risk for medication errors.	L 530		
L 539	418.56(a)(1) APPROACH TO SERVICE DELIVERY (1) The hospice must designate an interdisciplinary group or groups composed of	L 539		

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L 539	Continued From page 4 individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. This STANDARD is not met as evidenced by: Based on record review, policy review and interview the hospice agency failed to ensure care and service needs were adequately coordinated for 1 patient (#1) of 4 patients for whom care and services were reviewed. The failed practice placed the patient and family at risk of not receiving the support required to meet their end of life needs: Findings: All medical records and policy and procedure reviews were completed between 2/24-25/14. Patient #1 Patient #1 was admitted to the hospice agency with a primary diagnosis of metastatic prostate cancer. Record review of Patient #1's 485 (Initial Plan of Treatment and Certification) for the certification period of 12/27/13 to 3/26/14 revealed Patient #1 was to receive the following medications: Colace 100 mg daily (reason-constipation); Fentanyl Transdermal patch 75 mcg.hr, 1 every 72 hours(reason- pain); Miralax, 17 gram, 1, daily (reason-constipation); Oxycodone 30 mg 1, every	L 539		

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L 539	Continued From page 5 4 hours/prn [as needed] (reason-pain); Percocet 10-325 mg, 1 every 4 hours/prn (reason-pain); Senna, 176 mg/5 ml, 1 daily (reason-constipation). Additional review of the 485 revealed the Patient was to receive the following services: SN 1time a week for1week, 2 times a week for 2 weeks, 1 time a week for 13 weeks, with 3 prn visits for Shortness of Breath (SOB), pain or anxiety. Effective 12/29/13, MSW (medical social worker) at1 time a week for 1 week; hospice volunteer prn; and chaplain to evaluate. Review of the documented nursing visits for the first week of service (12/27/13-1/3/14) revealed nursing staff had made a home visit on the 12/27/13 for the admit assessment; a nursing home visit was made on 12/31/13 because the patient's spouse called upset because the Patient was experiencing more pain. The next nurse home visit was on 1/2/14 late in the afternoon after the Patient's spouse called because she did not think the medication she was giving was addressing the Patient's pain. She requested more guidance on how to administer the Patient's pain medications. The spouse expressed she was frustrated and angry that she was unable to get the liquid Methadone. The last nurse home visit was on 1/4/14 at the time of the Patient's death. Review of the Client Coordination Note Reports	L 539		

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L 539	Continued From page 6 Review of a Client Coordination Note Report, dated 1/1/14, revealed the Patient's spouse called "stating that Patient has now become semi-conscious and unable to swallow. She is needing guidance on use of medication. We discussed use of the liquid morphine and as long as this controls his pain we should be just fine. She verbalized understanding. She remembers that she could crush the oxycodone if she needed to as well." Review of a Client Coordination Note Report, dated 1/2/14, revealed the patient's spouse had called the hospice agency that morning and was not able to get her questions answered for obtaining liquid Methadone instead of crushing the pill form of Methadone to address the Patient's uncontrolled pain.The spouse was not able to talk with a nurse at the time of the call. A second note Client Coordination Note Report, dated 1/2/14, revealed at 9:50 am an on-call hospice nurse called the patient's spouse back. "Called [name omitted] after she called office to ask about medications. She is expressing frustration and says she in very upset that she has not received any liquid Methadone yet and no one had called her 1st thing this morning. She says she has given husband crushed Methadone at 1615 yesterday and again early this am. She has given 2 doses of the Oxycodone, crushed. She has the liquid Morphine she has not used.	L 539		

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L 539	Continued From page 7 He does have a 100 mcg Fentanyl patch on. Her understanding was that a liquid Methadone script was to be delivered today. She had called Geneva Woods and they told her they do not have a script and do not have the medications. [Name omitted] has put a call into Dr. [name omitted] at 0900. I told her I will call Dr. [name omitted] back now. She says it won't do any good, he won't call you back. I reviewed giving the crushed Methadone tablets and asked how many she has. She said she's not sure, it doesn't matter, because he's not absorbing it all when I only give it crushed. She says he is semiconscious and only moans or trys to talk when he needs to urinate. He might be in pain then, but she is not sure. I offered to come out, she declined. I offered to send [name omitted] MSW out, she responded with I'll just call her myself and hung up on me. [Name omitted], RN notified 1020: Called [name omitted] back with [name omitted], Administrator. She again expressed her frustration with [name omitted]. Again says that he is not getting the Methadone into his body by crushing it. I attempted to let her know that Geneva Woods does not have any liquid Methadone and per [name omitted]'s communication 90 Methadone [pills] only. She says she called them and they do have liquid Methadone and the point is we can't get Dr. [name omitted]. I told her we will keep trying to call him." Review of a nursing visit note, dated 1/2/14, at 5:21 pm, revealed "[Name omitted], wife, very tearful. Son at side, discussed use of Ativan for [Patient's] obvious anxiety. [Name omitted] verbalized understanding and say she will use tonight. She is very tired and Son says she does not rest even with his being there."	L 539		

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L 539	Continued From page 8 During an interview on 2/25/14 at 9:30 am and then again at 10:30 am with the Director of Nurses (DON), the surveyor questioned if there were issues with the coordination of care for this Patient and family. The DON said the Patient was admitted during a busy time of the year and that there were 3 nurses (1 on-call nurse and 2 hospice nurses) involved with evaluating and providing guidance to the Patient's wife concerning the Patient's anxiety and pain control. The DON said the regular hospice physician was on vacation during the time the Patient's spouse was trying to contact him. She said the hospice agency did have an on-call physician in place, but did not know if that was communicated to all of the staff and the Patient's family. During the time of the Spouse's concern pertaining to medications and pain control the primary hospice nurse had just come off from several days of vacation and had been called in on jury duty on 1/2/14 so she was not available to meet with the family until late in the evening on 1/2/14. The second hospice nurse was leaving on vacation on 1/1/14 and no other nursing staff went out to see the family during the day shift of 1/2/14. The DON said that looking back at the situation and how the Patient's spouse was handling the end of life care of the Patient, a nurse should have made a home visit between 12/27/14 - 12/31/13 instead of just calling the Patient's spouse. She also said on the morning of 1/2/14 the on-call nurse who had responded back to the Patient's spouse was not use to working with the	L 539		

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L 539	Continued From page 9 family and may not have been as aware of the Patient and family needs as the primary hospice nurse. In addition, the Inter-disciplinary Group (IDG) had not yet met to discuss coordination of service needs, which in a normal scenario would have happened during the IDG meeting. The DON said the Patient's spouse was given incorrect information concerning the liquid Methadone order that was supposed to have been at the local pharmacists. The DON said it may have been because the Patient's wife was referencing it as an order from the primary hospice physician when the order was obtained from the on-call physician. The DON also said the Patient's wife was very frustrated and angry because she had been calling the primary hospice physician and since he was on vacation he had not responded to her calls. When the surveyor asked if the accumulation of staff changes; medication changes and lack of medication changes being updated on the medication profile; physician on-call changes; pharmacy pick-up verses delivery changes; phone calls from staff instead of nurse home visits; could have contributed to a lack of coordination of care for the Patient and spouse? The DON confirmed after reviewing the events she felt it had. Review of the agency's policy and procedure "Care Planning Process, Coordination and Continuity" dated 7/10, revealed "The hospice will maintain a system of communication and integration in accordance with the hospice's own policies and procedures to: 1. Ensure the interdisciplinary group, through its designated	L 539		

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L 539	Continued From page 10 professionals, maintains responsibility for directing, coordinating, and supervising the care and services provided; and 2. Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in the home, outpatient settings, and in inpatient settings, irrespective whether the care or services are provided directly or under arrangement."	L 539		