BAYADA Comments Regarding Hospice of Iredell County, Inc. d/b /a Hospice and Palliative Care of Rowan (HPCRC) CON Project I.D. # F-011948-2

Criteria (3), (4) and (6) Comments Regarding HPCRC

Hospice of Iredell County, Inc. is an existing provider with three licensed hospices located in Iredell County. Each of these hospices currently serves small numbers of Rowan hospice patients. The HPCRC application proposes to add a new licensed location in Rowan County without genuinely improving patient choice to a new hospice provider. The aim of this austere proposal is simply to limit competition in the region.

HPCRC fails to provide its methodology with reasonable assumptions to demonstrate that the patient origin and utilization are realistic and achievable. Section C, Form C and Section Q assumptions do not provide adequate information to explain the projected ramp-up in patient utilization for the first three years of the proposed project. The following is a screen shot of the applicant's Form C explanation.

Form C: Utilization

- -New Admissions determined by reaching 44.5% of deaths served by third full year of operation (incremental increase)
- -ALOS at 78 days
- -Routine Home Care Days at 95% of days
- -GIP at 4.6% of days
- -Deaths are 88.7% of admissions
- -Live Discharges are 9.8% of admissions

The applicant fails to provide an adequate methodology and assumptions for the projected numbers of hospice admissions and deaths for each of the first three years of the proposed project. HPCRC has no rationale for the Year 1, Year 2 and Year 3 projections for hospice admissions and the numbers of patients served; these are simply contrived numbers.

HPCRC provides no mathematical basis for the increases in admissions for Years 1, 2 and 3 to explain why it is reasonable to expect that its proposed project can bring the percentage of deaths served up to the statewide median in 2024. The applicant fails to demonstrate that it has the resources and capabilities to extend its services outside of Iredell County. Hospice of Iredell currently has three hospice offices serving minimal numbers of Rowan patients. Adding a fourth hospice location would be of no real benefit to the citizens of Rowan County. As documented in the 2020 SMFP and page 8 of the application, Hospice of Iredell County has three existing licensed hospices in Iredell County as follows:
HOS0387 Hospice of Iredell County, Inc.
HOS1338 Hospice of Iredell County, Inc.
HOS3187 Gordon House Hospice

These three existing hospices are all in relatively close proximity to the population of Rowan County. There have been no regulatory limitations as to the numbers of Rowan patients that could have been served by the three Hospice of Iredell entities. Even so, the 2020 SMFP demonstrates that these hospices only served a **combined total of 9 Rowan Hospice admissions**. The historical data shows that Hospice of Iredell lacks the commitment to aggressively compete to serve Rowan County patients.

The utilization projections for the proposed Rowan Hospice project do not include any volumes projections for the numbers of hospice patients to be served by:

- HOS0387 Hospice of Iredell County, Inc.
- HOS1338 Hospice of Iredell County, Inc.
- HOS3187 Gordon House Hospice

Without knowing the future projected volumes of Rowan patients for these existing Hospices of Iredell and Gordon House for Years 1, 2 and 3, it is not reasonable to accept the applicant's projections for the proposed Rowan Hospice project.

The applicant provides no basis as to why the projected Average Length of Stay (ALOS) would be 78 days for Years 1, 2 and 3. The ALOS in Year 1 should be far less than 78 days as projected for the subsequent years because there are very few carry over patients from the start up period into Year 1. Further, patients admitted the last two months of Year 1 could not utilize 78 days of care within two months.

Based on these deficiencies, the HPCRC application should be found nonconforming to CON Criteria 3, 4 and 6:

- The application fails to properly demonstrate the need for the proposed project because the utilization projections are not based on reasonable and adequately supported assumptions.
- HPCRC does not demonstrate that the proposed project is an effective alternative due to the unreliable utilization projections and resulting flawed financial projections.
- The proposed project would unnecessarily duplicate existing hospice services in Rowan County that are currently serving some Rowan County patients.

Criterion (5) Comments Regarding HPCRC

The applicant fails to provide an adequate methodology and assumptions for the projected numbers of hospice admissions, average length of stay and total days of care. Based on these unreliable operational projections the financial proforma are unreasonable.

Revenue projections for the proposed project are flawed due to the incorrect presentation of the Routine Home Care reimbursement rates in Form F-3. Rather than a projected **average rate per day** for each payor category for Routine hospice home care, the applicant erroneously provides the same range of rates of $190.17 (1 to 60) and $150.32 (61+) for each payor.

No documentation is provided to show that all payors will reimburse at the same rates.
Yet, Form F.3 unreasonably assumes that:

- All payors are projected to reimburse $1,001.88 per day for inpatient care.
- All payors are projected to reimburse $444.54 per day for respite.
- All payors are projected to reimburse $56.97 per hour for continuous care

The Form H projections for administrator, office support and accounting positions are incomprehensible because the projected numbers of FTEs for these staff positions have been omitted. The application provides unreliable salary figures with incomplete staffing assumptions. Based on these errors and omissions, the total salary projections for this project for Years 1, 2 and 3 are invalid. HPCRC provides such incomplete staffing information that the CON analyst is unable to check the applicant's math.

Expense projections for rent and utilities of only $11,400 per year are unreliably low. The "management fee" amounts are understated and incorrect for Years 2 and 3 because they are based on much higher projected numbers of patient days as compared to Year 1.

For these reasons, the HPCRC application fails to reasonably demonstrate financial feasibility as required by CON Review Criterion 5.

Criterion (7) Comments Regarding HPCRC

The Form H projections for administrator, office support and accounting positions are incomprehensible because the projected numbers of FTEs for these staff positions have been omitted. The application provides unreliable salary figures with incomplete staffing assumptions. HPCRC provides such incomplete staffing information that the CON analyst is unable to check the applicant's math.

Thus, the HPCRC application does not conform to Review Criterion 7 regarding the adequacy of staff resources.

Criterion (13c) Comments Regarding HPCRC

HPCRC fails to provide adequate access for Medicaid patients based on comparison to the existing Trellis and Novant Hospices. The applicant fails to explain why it projects to serve only **1% Medicaid patients.** Both existing licensed hospice offices located in Rowan County currently serve at least **5 percent Medicaid patients.**

	Trellis Pts	Trellis %	Novant Pts	Novant %
Medicare	289	87.0%	330	86.4%
Medicaid	17	5.1%	19	5.0%
Insurance	20	6.0%	22	5.8%
Self Pay	6	1.8%	8	2.1%
Other	0	0.0%	3	0.8%
Totals	332	100.0%	382	100.0%

Sources: Trellis Rowan Hospice and Novant Rowan Hospice 2020 LRA

Therefore, the applicant did not demonstrate that the medically underserved groups will have adequate access to the proposed home health services. As seen in previous CON reviews (e.g. Mecklenburg 2012 Home Health Review) for new home health agencies, applicants that projected substandard access for Medicaid patients were found to be nonconforming to Criterion (13c). Consequently, the application is not conforming to this criterion.

Criterion (18a) Regarding HPCRC

HPCRC fails to enhance competition because the applicant has three existing hospices located in nearby Iredell County that are currently serving some Rowan patients. The application fails to demonstrate adequate administrative and support to ensure quality care due to errors and omissions in the staffing table Form H. The applicant projects an unacceptably low access to Medicaid patients as discussed in the Criterion (13c) comments.

HPCRC fails to conform to Criterion (18a) because the proposal does not adequately demonstrate that it will promote cost-effective services. The applicant's projected utilization is not based on reasonable and adequately supported assumptions. The discussions regarding analysis of need and projected utilization found in Criterion (3) are incorporated herein by reference.

BAYADA Comments Regarding Adoration Home Health & Hospice CON Project I.D. # F-011949-2

Criteria (3), (4) and (6) Comments Regarding Adoration

Adoration Home Health & Hospice (Adoration) proposes a new hospice home care agency in Rowan County. With no prior hospice experience in North Carolina, the applicant projects to provide a minimal and substandard scope of hospice services to the population. The applicant's utilization projections as described in Section Q are not conservative or reasonable. Adoration rejects the hospice methodology that is included in the 2020 State Medical Facilities Plan and substitutes its own unproven methodology and assumptions for projecting patient origin and utilization.

Adoration's patient origin projections are unreasonable due to overstated numbers of patients from Stanly County. The following table shows the applicant's Year 3 projections.

Projected Patient Origin

2. (a) **Complete the following table for the proposed new hospice office identified in Section A, Question 7.**

Projected Patient Origin

County	Third Full Fiscal Year (FY) 09/01/2023 to 08/31/2024	
	# of New (Unduplicated) Admissions	% of Total
Rowan	149	57%
Stanly	114	43%
Total	263	100%

These projections for the patient admissions from Stanly County are unreasonable and excessive because Adoration has no home health, home care or other potential referral sources located in Stanly County. Adoration unreasonably projects to serve an extraordinarily high number of patients from Stanly County as compared to the projected admissions from Rowan County.

Projected Admissions	YR 1	YR 2	YR 3
Rowan	109	112	149
Annual Growth %		2.75%	33.04%
Stanly	25	76	114
Annual Growth %		204.00%	50.00%

Some of the reasons that the Adoration projections are inaccurate include:

- Page 93 of the application erroneously states that the projected need for hospice is based on the percentage of deaths to be served by hospice that is higher than the statewide percentage that is used in the 2020 SMFP methodology and assumptions.

- The application mistakenly uses an inaccurate and overstated **1.48** ratio of admissions to deaths for Stanly County which overstates the expected numbers of admissions. Table 13A of the 2020 SMFP (page 337) shows that Stanly County hospice experienced a total of 285 admissions and 281 deaths for a ratio of **1.01.**

The absence of referral sources for potential patients residing in Stanly County is a critical issue because Adoration fails to justify its outrageous projected percentages of additional deaths as seen on page 94 of the application. This is the step in the methodology where Adoration projects to serve 25%, 40% and 60% of the "additional deaths in need." The 25%, 40% and 60% projections are unsupported because Adoration lacks adequate referral sources to capture such large market share.

Several times in the application, Adoration discusses its parent company BrightSpring's acquisition of Advance Home Care offices in North Carolina. The 2019 home health data for the Advanced Home Care offices that were recently acquired by the applicant's parent company, BrightSpring, show very few home health patients from Stanly County. As seen in the following chart these two home health agencies served by the related company **served only 10 home health patients that reside in Stanly County.**

As of 6-12-2020

Chapter 12: Home Health Data by County of Patient Origin - 2019 Data

Lic. #	Name	Facility County	Resident County	<18	18-64	65-74	75+	Total
HC0308	Atrium Health At Home Stanly	Stanly	Stanly	0	179	199	313	691
HC0270	Kindred at Home	Rowan	Stanly	0	162	158	329	649
HC0514	Stanly County Home Health Agency	Stanly	Stanly	135	64	34	97	330
HC0486	BAYADA Home Health Care, Inc.	Cabarrus	Stanly	0	34	62	110	206
HC0929	Encompass Health Home Health	Randolph	Stanly	0	18	20	41	79
HC0906	Advanced Home Care	Gaston	Stanly	0	4	2	2	8
HC1901	Interim HealthCare of the Triad, Inc.	Mecklenburg	Stanly	1	1	3	2	7
HC0787	Kindred at Home	Mecklenburg	Stanly	0	1	0	4	5
HC0358	BAYADA Home Health Care, Inc.	Davidson	Stanly	0	0	2	1	3
HC3966	PHC Home Health	Mecklenburg	Stanly	0	0	0	3	3
HC0281	Advanced Home Care, Inc.	Cabarrus	Stanly	0	2	0	0	2
HC0357	BAYADA Home Health Care, Inc.	Rowan	Stanly	0	0	0	2	2
HC1038	Atrium Health At Home Charlotte	Mecklenburg	Stanly	1	0	0	0	1
HC0521	Piedmont Home Care	Davidson	Stanly	0	0	0	1	1
HC0496	Well Care Home Health, Inc.	Davie	Stanly	0	0	0	1	1
			Stanly Totals	137	465	480	906	1,988

BrightSpring's actual home health utilization of 10 patients represents **0.5% market share** of the total numbers of 1998 home health patients. This 0.5% market share in Stanly County is a more logical basis for the expected Stanly County market share for the proposed Adoration Hospice. If this same 0.5% market share for home health is applied to the total 334 Median Projected 2021 Hospice Deaths for Stanly County as depicted in the 2020 SMFP (Table 13B Columns I), then Adoration would be projected to serve 0.5% times 334 which equals **1.67 patients from Stanly County**. This analysis demonstrates that Adorations' projections for Stanly County for Year 1 = 25 patients, Year 2 = 76 patients and Year 3 = 114 patients are not credible.

Based on these multiple deficiencies the Adoration application should be found nonconforming to CON criteria 3, 4 and 6:

- The application fails to properly demonstrate the need for the proposed project because the patient origin projections are not credible and the utilization projections are not reasonable.
- Adoration fails to show that the proposed project is an effective alternative due to the unreliable utilization projections and flawed financial projections.
- The proposed project would unnecessarily duplicate existing hospice services in Stanly County where there are established providers

Criterion (5) Comments Regarding Adoration

The applicant fails to provide an adequate methodology and assumptions for the projected numbers of hospice admissions and total days of care. Based on these unreliable operational projections the financial proforma are unreasonable

Revenue projections for the project are flawed. The applicant unreasonably projects its average length of stay (ALOS) to be 63 days in PY 3. This projection is much less than the national average of approximately 76 days as published by National Hospice and Palliative Care Organization Facts and Figures. Thus, the Adoration revenue projections are inaccurate.

Therapy services and medication expenses are omitted from the Forms F.5 even though these are essential to the scope of services in accordance with the Medicare Conditions of Participation. Adoration gives the impression that these services will be provided in the CON narrative but no funds are included in the operating budget. Pages 106 and 107 of the financial assumptions include no discussion of therapy services and medications. Based on these omissions, the projected operating expenses in Form F.4 are understated and inaccurate.

For Year 3 of the project, Adoration projects an average cost per day of only $128 which is derived from:

- Substandard salaries of $67,626 for its RN positions;
- Unrealistically low 20 percent for taxes and benefits; and
- Underreported expense projections for central office overhead.

The applicant's low cost projections do not represent an effective alternative based on these deficiencies.

Substandard RN Salaries

Adoration's projected salaries of $67,626 for Registered Nurse positions in Project Year 2023-24 are substandard because the website salaries.com reports the current year (2020) median salary for a hospice staff nurse (RN) in North Carolina at $72,600.

	Annual $
Salaries.com RN Median Salary in NC for 2020	**$72,600**
Adoration Projected Salary 2023-24	**$67,626**
Variance	**-$4,974**

Unrealistically Low Benefits

The Adoration application fails to disclose that it holds down its taxes and benefits costs to 20 percent for its direct care staff by assigning most direct care positions to "PRN" status. The initials PRN stand for the Latin phrase pro re nata, which means "as the situation demands." The drawbacks to PRN positions are threefold: the lack of a consistent salary, the possibility of having to work shifts no one else wants such as weekend shifts, and the lack of benefits. If a person is terminated from a PRN job or needs an extended leave, there are no unemployment or disability benefits.

Underreported Central Office Expense

Adoration incorrectly allocates its expected central office overhead for the proposed project based on its historical experience that includes no existing hospice home care operations in North Carolina. Adoration application page 9 provides:

"Section A. Question 9(a) Identify all existing and approved hospice offices located in North Carolina that are owned or operated by the applicant or a related entity by completing the following table." Adoration's response is provided as follows:

Not applicable, as Adoration does not currently own or operate any existing or approved hospices in North Carolina.

The above statement is inconsistent with the Adoration Financial Assumptions page 107 N) that reads as follows:

Central Office Overhead expense is based upon the historical central office overhead expenses for Adoration's other Home Health and Hospice Facilities (6.483% of non-central office overhead operating expenses).

It is unreasonable for an applicant to assume that central office overhead for home health offices would be a reasonable basis for projecting hospice home care because the scope of services are dissimilar. Unlike home health agencies, hospice provides four levels of care, its billing processes are different, and accreditation for hospice is separate and distinct from home health. Therefore, it is unreasonable for the multi-office home health company in North Carolina (previously Advanced Home Care) to assume that its existing home health central office can simply implement hospice home care using its existing processes and resources.

Even though Adoration's parent company, BrightSpring, has recently acquired hospices in other states, the application fails to explain where it will actually provide a central office in 2022 to 2024 to support its proposed hospice project in North Carolina. Will this "central office" be located in Tennessee, Texas, Mississippi or somewhere else?

For these reasons, the Adoration application fails to reasonably demonstrate financial feasibility as required by CON Review Criterion 5.

Criterion (7) Comments Regarding Adoration

Pages 9 and 10 of the application discuss the applicant's claim of **24 hrs /7 days per week** availability of services. This 24/7 level of service and responsiveness appears to be based on the experience of much larger Adoration hospices in Mississippi, Tennessee, Texas, and Ohio that have an average daily census of approximately 725 patients. Having 24/7 coverage at the proposed hospice would require at least 168 weekly paid hours which translates **to 4.2 FTEs for RN positions**.

Form H shows only:
1.7 RN FTEs in Year 1
2.7 RN FTEs in Year 2
3.8 RN FTEs in Year 3

Furthermore, the Adoration staffing model does not include a Clinical Manager position with the capability to provide on-call back up for the RN staff. Consequently, the proposed Adoration staffing levels are insufficient to cover the registered nurse visits, travel and on-call responsibilities 24/7 for the projected utilization in Rowan and Stanly Counties. Consequently, Form H for RN positions and the projected operating expenses in Form F.4 are severely understated.

Criterion (8) Comments Regarding Adoration

Adoration includes no budgeted expenses for contract physical therapy, occupational therapy or speech therapy services. Adoration Form F.5 assumptions on pages 106 and 107 do not have any line items that include therapy services. Therefore, the proposed project cannot provide comprehensive assessments of all types of patients as is required by the Medicare Hospice Conditions of Participation. Expenses for medications are also omitted from the financial proforma and assumptions. Therefore, the applicant does not adequately demonstrate that it will make available or otherwise make arrangements for the provision of the necessary ancillary and support services or that the proposed services will be coordinated with the existing health services. As seen in previous CON reviews (e.g. Radbourne Manor Village Project ID # F-11095-15), an application that does not include sufficient information to adequately document how the services will be made available fails to conform to Criterion (8).

Consistent with previous Agency decisions, the Amedisys application does not conform to Review Criterion 8 that requires a demonstration of the availability of ancillary and support services.

Criterion (13c) Comments Regarding Adoration

Adoration fails to provide adequate access for Medicaid patients based on comparison to the existing Trellis and Novant Hospices. The applicant does not adequately explain why it projects to serve only **2% Medicaid patients**. Both existing licensed hospice offices located in Rowan County currently serve at least **5 percent Medicaid patients**.

	Trellis Pts	Trellis %	Novant Pts	Novant %
Medicare	289	87.0%	330	86.4%
Medicaid	17	5.1%	19	5.0%
Insurance	20	6.0%	22	5.8%
Self Pay	6	1.8%	8	2.1%
Other	0	0.0%	3	0.8%
Totals	332	100.0%	382	100.0%

Sources: Trellis Rowan Hospice and Novant Rowan Hospice 2020 LRA

Therefore, the Adoration application fails demonstrate that the medically underserved groups will have adequate access to the proposed home health services. As seen in previous CON reviews (e.g. Project ID # F-10012-12 in the Mecklenburg 2012 Home Health Review) an applicant that projected substandard access for Medicaid patients was found to be nonconforming to Criterion (13c). Consequently, the Adoration application is not conforming to this Criterion.

Criterion (18a) Comments Regarding Adoration

The Adoration proposal fails to enhance competition due to inadequate staffing and the lack of therapy services to ensure quality care. Adoration fails to conform to Criterion (18a) because the proposal does not adequately demonstrate that it will promote cost-effective services. Adoration projects to provide unacceptably low access to Medicaid patients as discussed in the Criterion (13c) comments. The applicant's projected utilization is not based on reasonable and adequately supported assumptions. The discussions regarding analysis of need and projected utilization found in Criterion (3) are incorporated herein by reference.

BAYADA Comments Regarding PruittHealth Hospice CON Project I.D. # F-011952-20

Criteria (3), (4) and (6) Comments Regarding PruittHealth Hospice

The PruittHealth methodology and assumptions for both its projected patient origin and utilization are unreasonable and lack adequate support. The projected hospice utilization is grossly overstated because the applicant unreasonably assumes that it can capture market share in multiple counties where no unmet need is shown in the 2020 SMFP and where existing hospices are more than adequately serving the need for hospice home care.

Projected Patient Origin

2. (a) Complete the following table for the proposed new hospice office identified in Section A, Question 7.

Projected Patient Origin

County	Third Full Fiscal Year (FY) 10/01/2023 to 09/30/2024	
	# of New (Unduplicated) Admissions	% of Total
Rowan	170	55.3%
Cabarrus	35	11.3%
Guilford	35	11.3%
Forsyth	31	10.2%
Union	20	6.5%
Mecklenburg	17	5.4%
Total	308	100.0%

Table 13B of 2020 SMFP shows the projected surpluses for hospice home care services for Cabarrus, Guilford, Forsyth Union and Mecklenburg Counties.

2020 SMFP Table 13B

	Column K Surplus (Deficit)
Cabarrus	226
Mecklenburg	240
Union	396
Forsyth	163
Guilford	334

In spite of the hospice surpluses, PruittHealth unreasonably forecasts it will serve 109 patients from these counties with surpluses in its third year Clearly, the PruittHealth proposal aims to take hospice market share in the contiguous counties as opposed to concentrating on serving the patients in counties with projected hospice deficits.

PruittHealth projects to serve unreasonably large 44.7% of total hospice patients from Cabarrus, Guilford, Forsyth, Union and Mecklenburg Counties where no hospice deficits exist. This unreasonably high percentage of patients from these other counties is inconsistent with established hospice home care offices in North Carolina that typically range between 10 to 15 percent of patients from outside of their home county.

PruittHealth's projections of patients originating from Cabarrus, Guilford, Forsyth, Union and Mecklenburg Counties are not adequately supported due to the omission of supporting documentation. Page 37 of the application specifically asks for supporting documentation for the patient origin projections. The applicant response is **"Not applicable."**

Instead of documentation, PruittHealth speculates that its projected patient origin for its proposed Salisbury Hospice would be located closer to patients in Rowan, Cabarrus, Guilford, Forsyth, Union and Mecklenburg Counties than its existing Wilkes Hospice. However, PruittHealth's CON certificate for its Wilkes Hospice does not include Cabarrus, Guilford, Forsyth, Union and Mecklenburg Counties in its defined service area. Furthermore, PruittHealth fails to demonstrate that its existing hospice located in North Wilkesboro (Wilkes County) can legitimately provide a full scope of hospice services to patients who located over 70 miles away in portions of Mecklenburg, Guilford and Union Counties.

The PruittHealth application fails to provide adequate documentation that its proposed hospice can support a full scope of hospice services in its entire geographic service area as required by licensure rules. The applicant's 60 circle radius map on page 118 of the application does not reflect everyday traffic congestion and travel times. PruittHealth is unable to explain how it will provide adequate supervision and timely hospice services to patients that are dispersed in an exceedingly large service area that encompasses a large segment of North Carolina's most overcrowded highways. Traffic congestion is notoriously bad between Concord (Cabarrus County) and Charlotte (Mecklenburg County) as documented by frequent new articles. Travel times of over 1 hour from Salisbury, NC to most of Union and Guilford Counties do not support PruittHealth's proposal to provide a full scope of hospice services to patients in these distant regions.

PruittHealth's assumptions to admit large numbers of hospice patients from Cabarrus, Guilford, Forsyth, Union and Mecklenburg Counties are unreasonable based on **its own historical data**. Hospice admissions to PruittHealth Hospice in these counties **are rapidly declining** with a **-22.13%** Compound Annual Growth Rate.

Pruitt Health Hospice Patients

	2016	2017	2018	2019	**CAGR**
Cabarrus	41	37	23	20	**-21.28%**
Mecklenburg	10	6	14	12	**6.27%**
Union	33	25	12	3	**-55.04%**
Forsyth	20	18	16	20	**0.00%**
Guilford	40	26	26	13	**-31.23%**
Combined	144	112	91	68	**-22.13%**

The applicant attempts to obscure this trend by averaging the numbers of patients served for the three previous years for its projections.

PruittHealth fails to adequately explain the statement on page 55 of the application.

> There are no alternative methods of meeting the needs for the proposed project because the existing hospice offices operated by PruittHealth Hospice In North Carolina are not close enough to Rowan County to offer extensive hospice services.

As seen in the table below, the existing PruittHealth Hospice, located in Wilkes County, has apparently been providing less than "extensive" hospice services to Rowan County patients for multiple years.

Rowan Hospice Patients					
	2016	2017	2018	2019	CAGR
PruittHealth	36	40	25	25	-11.45%
Sources: Table 13B 2018 to 2021 SMFPs					

The decline in hospice services provided by PruittHealth demonstrates that Rowan patients and physicians are less receptive of this substandard service. Consequently, the proposed PruittHealth Hospice in Rowan County lacks credibility and merit.

The application also fails to explain why the proposed hospice is unwilling to serve any patients from Stanly County, where a hospice deficit actually exists within reasonable proximity to Rowan County.

Based on these multiple deficiencies, the PruittHealth application should be found nonconforming to CON Criteria 3, 4 and 6:

- The application fails to properly demonstrate the need for the proposed project because the patient origin projections are not credible and the utilization projections are not reasonable.
- PruittHealth fails to show that the proposed project is an effective alternative due to the unreliable utilization projections and flawed financial projections.
- The proposed project would unnecessarily duplicate existing hospice services in Cabarrus, Mecklenburg, Union, Forsyth and Guilford Counties where existing providers are fulfilling the need for hospice services.

Criterion (5) Comments Regarding PruittHealth Hospice

The applicant fails to provide an adequate methodology and assumptions for the projected numbers of hospice admissions, average length of stay and total days of care. Based on these unreliable operational projections the financial proforma are unreasonable. Revenue projections for the proposed project are incomplete and unreliable due to the incorrect presentation of the reimbursement rates in Form F-3. The application contains no reimbursement rates for Medicaid patients for Respite, Inpatients, and Continuous Care. These omissions demonstrate that PruittHealth has no real commitment to serve Medicaid patients on par with existing hospice providers in Rowan County.

For these reasons, the PruittHealth application fails to demonstrate financial feasibility as required by CON Review Criterion 5.

Criterion (13c) Comments Regarding PruittHealth Hospice

PruittHealth Hospice fails to provide adequate access for Medicaid patients based on comparison to existing Rowan hospices. The applicant unreasonably projects to serve only **1% Medicaid patients**. In contrast, both existing licensed hospice offices located in Rowan County currently serve at least **5 % Medicaid patients**.

	Trellis Pts	Trellis %	Novant Pts	Novant %
Medicare	289	87.0%	330	86.4%
Medicaid	17	5.1%	19	5.0%
Insurance	20	6.0%	22	5.8%
Self Pay	6	1.8%	8	2.1%
Other	0	0.0%	3	0.8%
Totals	332	100.0%	382	100.0%

Sources: Trellis Rowan Hospice and Novant Rowan Hospice 2020 LRA

Therefore, PruittHealth did not demonstrate that the medically underserved groups will have adequate access to the proposed home health services. As seen in previous CON reviews (e.g., Mecklenburg 2012 Home Health Review) for new home health agencies, applicants that projected substandard access for Medicaid patients were found to be nonconforming to Criterion (13c). Consequently, the application is not conforming to this criterion.

Criterion (18a) Comments Regarding PruittHealth

PruittHealth fails to enhance competition because the proposal lacks ancillary and therapy services to ensure quality care. The application does not conform to Criterion (18a) because the proposal does not adequately demonstrate that it will promote cost-effective services and enhance access. The applicant's projected utilization is not based on reasonable and adequately supported assumptions. The discussions regarding analysis of need and projected utilization found in Criterion (3) are incorporated herein by reference. The application projects to provide unacceptably low access to Medicaid patients as discussed in the Criterion (13c) comments. Furthermore, PruittHealth's quality assurance in Rocky Mounty measures failed to comport with CMS requirements.

For all of these reasons, the PruittHealth application does not conform to this Criterion (18a)

Criterion 20 Comments Regarding PruittHealth

PruittHealth's experience of operating existing hospices in North Carolina fails to demonstrate conformity to Criterion 20 and Policy GEN-3.

On February 28, 2018, a complaint investigation by CMS of PruittHealth in Rocky Mounty, NC documented that the agency failed to comply with nursing standards of practice by **writing prescriptions and cutting and pasting the physician signature onto the prescriptions** and by **changing the dates on the Certifications of Terminal Illness (CTI).**

A copy of the QCOR Hospice Compliant investigation is included in Attachment A.

BAYADA Comments Regarding Continuum Care of North Carolina LLC (CCNC) CON Project I.D. # F-011945-20

Criteria (3), (4) and (6) Comments Regarding CCNC

The CCNC utilization projections are unreasonable due to overstated admissions and excessive days of care. As a proposed new hospice provider in North Carolina, CCNC lacks sufficient in-state resources and an existing referral base of physicians and healthcare providers to achieve the "Projected Percent of Unserved Hospice Deaths Served" for Rowan and Stanly Counties. These projections are unreasonable because:

- CCNC irrationally expects to achieve exceedingly high admissions and an average length of stay 77.7 days in its first year of operation.
- CCNC does not have an existing base of referring physicians and patients from home health and home care offices that can support the overly aggressive Year 1 ramp up. Consequently there is no initial potential for a surge of 144 hospice patients that will enable CCNC to achieve skyrocketing admissions during the initial months of operation.
- The statewide median average length of stay for North Carolina is not calculated based on new hospices that are in their initial ramp up periods of operation. Consequently there is no justification for assuming that CCNC will have a high of 77.7 ALOS in its first two years.
- Hospice admissions that occur during the last two months of the first year of operation cannot squeeze 77.7 days of care into the two months of the calendar. Thus, patients that are admitted in these last two months will have days of care that carry over into the next year. Furthermore, in CCNC's first year of operation it will not have any patients that were admitted from the previous year. Thus the CCNC projection of 77.7 ALOS is unreliable for the first year and not credible in the second year. .
- Years 2 and 3 projections are based on CCNC's grossly overinflated volumes in Year 1. The implausible upsurge of utilization in Year 1 means that the entire trajectory of growth for subsequent years is not credible.
- CCNC's projected days of care in Years 1, 2 and 3 are overstated and unreasonable based on exaggerated admissions multiplied by the unreliable projected average length of stay.

Based on these multiple deficiencies, the CCNC application should be found nonconforming to CON criteria 3, 4 and 6:

- The application fails to properly demonstrate the need for the proposed project because the patient projections are overstated and the utilization projections are not reasonable.
- CCNC fails to show that the proposed project is an effective alternative due to the unreliable utilization projections and flawed financial projections.
- The proposed project represents unnecessary duplication of existing hospice services because the CCNC project is not justified.

Criterion (5) Comments Regarding CCNC

CCNC fails to provide a sound methodology based on reasonable assumptions for the project. The numbers of hospice admissions, average lengths of stay and total days of care are overstated and unreliable. Based on these unreliable operational projections the financial proforma are unreasonable.

Revenue projections for the proposed project are based on overstated average length of stay days. Therefore the blended reimbursement rates that are based on 77.7 days are inaccurate. The applicant fails to show the assumptions and calculations for determining the blended rates.

For these reasons, the application is not conforming to this criterion.

Criterion (18a) Comments Regarding CCNC

The application fails to conform to Criterion (18a) because the proposal does not adequately demonstrate that it will promote cost-effective services. CCNC's projected utilization is not based on reasonable and adequately supported assumptions. The discussions regarding analysis of need and projected utilization found in Criterion (3) are incorporated herein by reference.

BAYADA Comments Regarding Carolina Caring (formerly Catawba Regional Hospice) CON Project I.D. # F-011956-20

Criteria (3), (4) and (6) Comments Regarding Carolina Caring

Carolina Caring is an existing hospice provider with licensed offices and inpatient facilities located in Catawba County. Each of these hospices currently serves small numbers of Rowan hospice patients. The Carolina Caring application proposes to add a new licensed location in Rowan County without genuinely improving patient choice to a new hospice provider.

Historically a portion of Carolina Caring's admissions and days of care provided to Rowan patients has been to the existing inpatient hospice facilities located in Catawba County (HOS3144 and HOS4445). Rowan patients that have need for inpatient hospice can continue to choose to be admitted to these existing Carolina Caring inpatient hospice facilities. It is unreasonable for the applicant to assume that the proposed hospice home project will shift **all Rowan patient admissions** to the proposed new hospice because some patients will likely continue to need inpatient hospice services in existing hospices including Carolina Caring in Catawba County.

The overstated inpatient hospice days of care for the proposed project lack adequate support. While Carolina Caring has excess inpatient hospice capacity in Catawba County, this does not justify the proposed new hospice home care in Rowan achieving high numbers of inpatient days of care. Rowan hospice patients have access to existing inpatient facilities within their home county and in multiple adjoining counties.

The applicant's patient projections are unreasonable because Carolina Caring irrationally expects to achieve high admissions and an average length of stay (ALOS) of 71.7 days in its first year of operation. This is unreasonable because there will be no patient days carried over from the previous year. Also, hospice admissions that occur during the last two months of the first year of operation cannot squeeze 71.7 days of care into the two months of the calendar. Patients that are admitted in these last two months of Year 1 will have some days of care that carry over into the next year. However it is still unreasonable for the applicant to assume that its ALOS will rise to 71.7 days because its admissions will still be ramping up. Thus the Carolina Caring projection of 71.7 ALOS is unreliable for the first year and in the second year.

Years 2 and 3 projections are based on the applicant's overstated volumes in Year 1. The overstated and unreliable utilization in Year 1 means that the projected growth path for subsequent years is not credible. Carolina Caring's projected days of care in Years 1, 2 and 3 are overstated and unreasonable based on exaggerated admissions multiplied by the unreliable projected average length of stay.

The applicant chose not to provide copies of its License Renewal Applications for its existing hospices in Catawba County that would be serving some Rowan patients in future years. Nor did the applicant disclose its future utilization projections for these existing hospices to provide a reasonable basis for the projections in its proposed project.

Based on these deficiencies, Carolina Caring should be found nonconforming to CON Criteria 3, 4 and 6:

- Carolina Caring fails to properly demonstrate the need for the proposed project because the utilization projections are not based on reasonable and adequately supported assumptions.
- Carolina Caring does not demonstrate that the proposed project is an effective alternative due to the unreliable utilization projections and resulting flawed financial projections.

- The proposed project would unnecessarily duplicate its own existing hospices that are currently serving some Rowan County patients.

Criterion (5) Comments Regarding Carolina Caring

Carolina Caring fails to provide an adequate methodology and assumptions for the projected numbers of hospice admissions, average length of stay and total days of care. Based on these unreliable operational projections the financial proforma are unreasonable.

Revenue projections for the proposed project are flawed due to the applicant's assumption that its historical experience for the distribution of days of care in Catawba County (with one hospice home care office plus two inpatient hospices) would be a predictor for the proposed Rowan project. The proposed new hospice office will have no inpatient capacity within Rowan County that is owned and operated by Carolina Caring. The proposed hospice days of care for inpatient hospice are overstated causing the revenue projections to be excessive and unreasonable.

The application omits the methodology for calculating the Medicare reimbursement rates for routine home care that are derived from an unknown set of assumptions applied to the 1-60 days rate and the 60+ rate. Reimbursement rates are projected to increase for Years 2 and 3 based on the applicant's undisclosed assumptions. Rather than providing these mathematical calculations and assumptions, the applicant provides its hypothetical "blended rates" on page 122 in Section Q. Thus, the Carolina Caring revenue projections are unreliable.

For these reasons, the application is not conforming to Criterion (5).

Criterion (18a) Comments Regarding Carolina Caring

The application does not conform to Criterion (18a) because the proposal fails to demonstrate cost-effective services. Carolina Caring's projected utilization is not based on reasonable and adequately supported assumptions. The discussions regarding analysis of need and projected utilization found in Criterion (3) are incorporated herein by reference.

BAYADA Comments Regarding PHC Hospice CON Project I.D. # F-011956-20

Criteria (3), (4) and (6) Comments Regarding PHC Hospice

Personal Home Care of North Carolina, LLC (PHC Hospice), as a new proposed provider of hospice services, lacks sufficient resources and referral base to achieve the projected utilization.

As an existing home health provider, Personal Home Care of North Carolina, LLC is located in Charlotte and has provided minimal home health services to Rowan and Stanly residents. In recent years, Personal Home Care of North Carolina, LLC has experienced a decline in home health referrals and market share for patients from Rowan and Stanly Counties.

Home Health Patients Served by Personal Home Care of North Carolina, LLC

	2017	2018	**2019**
Rowan County Patients	27	22	**4**
Rowan Market Share	0.73%	0.54%	**0.10%**
Stanly County Patients	17	14	**3**
Stanly Market Share	0.87%	0.70%	**0.15%**

Sources: 2019, 2020, and 2021 SMFP Table 12A Home Health Patient Origin Tables

Personal Home Care of North Carolina, LLC holds less than 3 percent market share in its home county Mecklenburg as well as all of the counties in Health Service Area III.

PHC Home Health			
	PHC Patients	Total HH Pts	Market Share
Mecklenburg	496	17,668	2.81%
Union	10	3,783	0.26%
Gaston	180	6,726	2.68%
Cabarrus	89	5,350	1.66%
Lincoln	39	2,710	1.44%
Iredell	53	4,813	1.10%
Rowan	4	4,154	0.10%
Stanly	3	1,988	0.15%

Source: 2021 SMFP Table 12A Home Health Patient Origin

Such an anemic home health presence in this market shows that PHC is ill prepared to support patients and families with its proposed hospice services.

PHC utilization projections are unreasonable based on overstated admissions and excessive days of care. As a proposed new hospice provider in North Carolina, PHC lacks an existing referral base of physicians and healthcare providers in these counties to achieve the "Projected Percent of Unserved Hospice Deaths Served" for Rowan and Stanly Counties. Most of the applicant's letters of support are from individuals that are located outside the proposed service area of Rowan and Stanly Counties.

The PHC utilization projections are unreasonable because:

- For both Rowan and Stanly Counties, the application unreasonably assumes 70% market share in Year 1, 100% market share in Year 2, and 100% in Year 3 of projected deficits for hospice deaths (page 106 of PHC application).
- PHC fails to adequately explain why its market share percentage assumptions for Rowan and Stanly are the same when its proposed hospice office would be located in Rowan County.
- As seen in the Home Health patient origin data in Table 12A of the 2021 SMFP, PHC home health services reported minimal market share based on 4 patients (0.10% market share) for Rowan County and 3 patients (0.15% market share) for Stanly County. Table 12A, Home Health Data by County of Patient Origin is available on-line **https://info.ncdhhs.gov/dhsr/mfp/publications.html#por.**
- According to the SMFP 2019, 2020 and 2021 data, PHC home health utilization for its combined numbers of patients from Rowan and Stanly Counties has declined from 44 patients in 2017 to only 7 patients in 2019 for an -84% decline.
- PHC does not have an existing referral based of referring physicians and patients that can support the overly aggressive Year 1 ramp up for a surge of 152 hospice patients
- The application fails to adequately justify its assumption of 80 average length of stay (ALOS).
- PHC irrationally projects to achieve exceedingly high admissions and an average length of stay of 80 days in its first year of operation.
- Years 2 and 3 projections are based on PHC's overinflated volumes in Year 1. The unbelievable ramp of utilization in Year 1 means that the growth trend for subsequent years is not credible.
- PHC's projected days of care in Years 1, 2 and 3 are overstated and unreasonable based on exaggerated admissions multiplied by the unreliable projected average length of stay.
- The PHC assumptions for hospice inpatient days of care is based on an inaccurate and overstated 3.1% assumption.

Based on these multiple deficiencies, PHC should be found nonconforming to CON Criteria 3, 4 and 6:

- The application fails to properly demonstrate the need for the proposed project because the patient projections are overstated and the utilization projections are not reasonable.
- PHC fails to show that the proposed project is an effective alternative due to the unreliable utilization projections and flawed financial projections.
- The proposed project represents unnecessary duplicate of existing hospice services because the PHC project is not justified.

Criterion (5) Comments Regarding PHC Hospice

PHC's projected hospice admissions, average lengths of stay and total days of care are overstated and unreliable. The application includes unreasonable and excessive hospice inpatient days of care in Years 1, 2 and 3 that cause its revenue projections to be excessive.

Revenue projections for the proposed project are based on the overstated 80 day (ALOS) average length of stay. PHC unreasonably projects the highest ALOS of any CON applicant in this review or any previous Hospice CON review. Thus its projections for net revenue per day and net revenue per admission are unreasonable.

For these reasons the PHC application does not conform to Criterion (5).

Criterion (18a) Comments Regarding PHC Hospice

The application does not conform to Criterion (18a) because the proposal fails to demonstrate cost-effective services. PHC's projected utilization is not based on reasonable and adequately supported assumptions. The discussions regarding analysis of need and projected utilization found in Criterion (3) are incorporated herein by reference.

Attachment A

S&C QCOR

Hospices in North Carolina with a Deficiency Cited on a Complaint Investigation

There are 80 Hospices in North Carolina. CMS cited 21.3% of them for a Deficiency in the last three years. Please click on the survey report for the detailed citation.

CMS Certification Number	Facility Name	Address	City	Accrediting Organization	Date of CMS Survey	Reason for Survey	Immediate Jeopardy Situation?	
341500	HOSPICE & PALLIATIVE CARE CHARLOTTE REGION	7845 LITTLE AVENUE	CHARLOTTE	ACCREDITATION COMMISSION FOR HEALTH CARE INC.	02/27/2018	COMPLAINT INVESTIGATION	N	Read Survey Report
341501	CAREPARTNERS HOSPICE & PALLIATIVE CARE SERVICES	21 BELVEDERE ROAD	ASHEVILLE	JOINT COMMISSION	07/16/2020	COMPLAINT INVESTIGATION	N	Read Survey Report
341501	CAREPARTNERS HOSPICE & PALLIATIVE CARE SERVICES	21 BELVEDERE ROAD	ASHEVILLE	JOINT COMMISSION	01/30/2019	COMPLAINT INVESTIGATION	N	Read Survey Report
341506	WAKE FOREST BAPTIST HEALTH CARE AT HOME HOSPICE-WI	126 EXECUTIVE DRIVE, SUITE 110	WILKESBORO	COMMUNITY HEALTH ACCREDITATION PROGRAM	08/16/2018	FULL SURVEY AFTER COMPLAINT	N	Read Survey Report
341508	HOSPICE AND PALLIATIVE CARE OF CABARRUS COUNTY	5003 HOSPICE LANE	KANNAPOLIS	STATE AGENCY	07/29/2019	COMPLAINT INVESTIGATION	N	Read Survey Report
341515	LOWER CAPE FEAR HOSPICE CARE	1414 PHYSICIANS DRIVE	WILMINGTON	ACCREDITATION COMMISSION FOR HEALTH CARE INC.	07/17/2019	COMPLAINT INVESTIGATION	N	Read Survey Report
341523	TRANSITIONS LIFECARE	250 HOSPICE CIRCLE	RALEIGH	ACCREDITATION COMMISSION FOR HEALTH CARE INC.	02/14/2019	COMPLAINT INVESTIGATION	N	Read Survey Report
341529	HOSPICE OF ROCKINGHAM CO INC	2150 NC HIGHWAY 65	REIDSVILLE	ACCREDITATION COMMISSION FOR HEALTH CARE INC.	10/31/2017	COMPLAINT INVESTIGATION	N	Read Survey Report
341530	FOUR SEASONS COMPASSION FOR LIFE	571 SOUTH ALLEN ROAD	FLAT ROCK	STATE AGENCY	08/06/2019	COMPLAINT INVESTIGATION	N	Read Survey Report
341549	HARRIS PALLIATIVE CARE AND HOSPICE	81 MEDICAL PARK LOOP, SUITE 204	SYLVA	STATE AGENCY	11/20/2019	COMPLAINT INVESTIGATION	N	Read Survey Report
341550	HAYWOOD HOSPICE AND PALLIATIVE CARE	43 BOWMAN DRIVE	WAYNESVILLE	STATE AGENCY	06/15/2018	COMPLAINT INVESTIGATION	N	Read Survey Report
341550	HAYWOOD HOSPICE AND PALLIATIVE CARE	43 BOWMAN DRIVE	WAYNESVILLE	STATE AGENCY	03/20/2018	COMPLAINT INVESTIGATION	N	Read Survey Report
341560	AMEDISYS HOSPICE	3320 US 1 HIGHWAY, SUITE C	FRANKLINTON	STATE AGENCY	12/17/2019	COMPLAINT INVESTIGATION	N	Read Survey Report
341569	LIBERTY HOME CARE LLC	2550 SOUTH 41ST STREET	WILMINGTON	STATE AGENCY	09/18/2019	COMPLAINT INVESTIGATION	N	Read Survey Report
341569	LIBERTY HOME CARE LLC	2550 SOUTH 41ST STREET	WILMINGTON	STATE AGENCY	04/17/2019	COMPLAINT INVESTIGATION	N	Read Survey Report

S&C QCOR

Hospices in North Carolina with a Deficiency Cited on a Complaint Investigation

There are 80 Hospices in North Carolina. CMS cited 21.3% of them for a Deficiency in the last three years. Please click on the survey report for the detailed citation.

CMS Certification Number	Facility Name	Address	City	Accrediting Organization	Date of CMS Survey	Reason for Survey	Immediate Jeopardy Situation?	
341569	LIBERTY HOME CARE LLC	2550 SOUTH 41ST STREET	WILMINGTON	STATE AGENCY	01/10/2019	COMPLAINT INVESTIGATION	N	Read Survey Report
341576	COMMUNITY HOME CARE & HOSPICE	2800 BREEZEWOOD AVENUE, SUITE 100	FAYETTEVILLE	ACCREDITATION COMMISSION FOR HEALTH CARE INC.	12/12/2019	COMPLAINT INVESTIGATION	N	Read Survey Report
341581	KINDRED HOSPICE	122 E SAINT JAMES STREET	TARBORO	STATE AGENCY	05/02/2018	COMPLAINT INVESTIGATION	N	Read Survey Report
341589	COMMUNITY HOME CARE OF VANCE COUNTY	152 ZEB ROBINSON ROAD	HENDERSON	ACCREDITATION COMMISSION FOR HEALTH CARE INC.	04/20/2020	COMPLAINT INVESTIGATION	N	Read Survey Report
341591	PRUITTHEALTH HOSPICE - ROCKY MOUNT	301 S CHURCH STREET, SUITE 135	ROCKY MOUNT	STATE AGENCY	02/28/2018	COMPLAINT INVESTIGATION	N	Read Survey Report
341596	AMEDISYS HOSPICE CARE	56 THREE HUNTS DRIVE BUILDING 3	PEMBROKE	STATE AGENCY	10/30/2019	COMPLAINT INVESTIGATION	N	Read Survey Report

<< Prev 1 2 Next >>

Last updated on 10/02/2020 with all surveys since 10/01/2017

Go To: Hospices with Complaint Investigations

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	341560	A. BUILDING ______ B. WING ______	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMEDISYS HOSPICE	3320 US 1 HIGHWAY, SUITE C, FRANKLINTON, NC, 27525

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

L0513

37615

Based on clinical record review, nurse practitioner interview, and staff interview, the agency failed to assist in transferring the patient to the patient and nurse practitioner's preferred level of care for 1 of 3 patients (#1). Findings include:

Patient #1 was admitted on 9/12/19 with prostate cancer, chronic obstructive pulmonary disease (COPD) and diabetes. The Plan of Care (POC) for 9/12/19-12/10/19 included orders for skilled nursing (SN) to visit weekly for 13 weeks, and medical social worker (MSW) to visit 1 time for an evaluation, then weekly. The MSW (#2) evaluation on 9/16/19 confirms "Patient shared not having any family members or supports. Patient reported that his neighbor is a [sic] emergency contact individual."

A note from the nurse practitioner visit on 10/11/19 was reviewed. The cover sheet to the hospice agency stated, "He [patient] has progressed with cancer ...Due to his social situation along with disease and transfusion dependent because of cancer, he was willing to have hospice with trf [transfer] to hospice house when necessary. Dr ___ and ____ [nurse practitioner] feels like he will need hospice home by the end of next week at the latest. Maybe sooner." The patient was also seen by the physician on 10/11/19. The note stated, "I anticipate that his health will continue to decline and he would need to be transferred to hospice home in the near future."

A communication note by the MSW (#2) on 10/22/19 stated, "SW [social worker] communicated with ___ [RN at cancer center] in reference to patient agreed to transfer to ___ Hospice Home due to patient decline. SW informed RN anout [sic] protocols to transfer and being approved to be appropriate for hospice home with facility."

MSW #2 made a joint visit RN #3 on 10/24/19. The visit note stated, "SW and Case manager attempted to encourage patient to participate in assistance [sic] living facility ...Patient was adamant about not wanting to participate in transitioning to assistant [sic] living facility. Patient reported only having interests for hospice home. Patient reported cancer doctor and nurse believes he is appropriate for hospice home ..."

On 10/24/19 RN #3 conducted a visit. The visit note stated "PRN visit made to update pt on status of ALF [assisted living facility] placement. Pt refused to go to ALF of any kind. He wants to go to hospice home because he's heard thats [sic] where he needs to be from outside influences."

A note on 10/29/19 by RN #3 stated, "Visited pt after receiving email from chaplain that pt passed out and fell ...Once again expressed growing concerns about pt safety being alone in home.

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 reverse for further 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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Bed at ALF in _______ [city name] still available but pt does not want to go ...Providers from cancer center have visited pt and expressed concerns he is not in the hospice home run by __________ Hospice. Numerous members of _____ [hospice agency] staff have repeatedly told pt and cancer center why pt is not eligible for placement there."

A note from the agency director of operations (#1) on 10/29/19 stated, "___NP from cancer center called to discuss a hospice home for patient. He feels hospice home is the best and safest option. Reviewed that patient had an ALF bed in _ [city name] but refused after meeting with him last week. He believed pt will pass in the next few weeks .... [NP] insisted that he hospice home was the only option ...Info was faxed to _______ [hospice home] for review."

On 10/30/19, MSW #2 conducted a visit. The note stated, "SW assist case manager with home visit due to safety concerns. SW and CM [case manager] provided presences [sic] and support for patient. SW contacted several transportation companies to request for assisting patient to assistance [sic] living facility. SW explained to patient about options to transfer to assistance [sic] living facility of having adult protective serviced contacted due to safety concerns." The MSW note also stated, "Patient had old fecal matter embedded on back of head in his hair ...Patient appeared confused. Delusional." RN #3 note on 10/30/19 stated, "HHA phoned office to report she had found pt on floor covered in feces and confused. Spoke with SW and manager and decided pt needed to be transferred to ALF so he wouldn't be alone. This was the second fall in two days. Pt passed out and fell both times ...Pt was wearing O2 but still breathing with pursed lips and respirations were labored. Pt was very weak and took three people to get him up and back into recliner. Spoke with pt about going to ALF and pt agreed he wasn't well enough to stay alone ...Pt not thrilled about going but explained to him how dangerous his living situation was and APS would have to get involved." Pt transferred to ALF.

On 10/30/19, in the evening, the ALF called for visit. RN #11 visited at approximately 7:00 p.m. The note revealed BP 230/200, "Pulse weak 54 bpm, oxygen saturation not registering on pulse ox. Oxygen increased to 4 lpm, resident reaching out into air. Conversation nonsensical." Transferred to ED.

A coordination note on 10/31/19 by the agency director of operations (#1) stated, "_____Hospital MSW and Dr adamant that pt not return to facility. He was to go to the hospice home. Patient was discharged from this agency at that time.

Interview with the director of operations #1 on 12/16/19 at 3:25 p.m. confirmed the only referral to the hospice home was on 10/29/19. An interview with medical social worker #2 on 12/16/19 at 3:50 p.m. confirmed that she did not make referral to hospice home. MSW stated, "The cancer center would have made that referral." An interview with RN #3 on 12/16/19 at 4:08 p.m. confirmed she never talked with the hospice home. "The office staff would have done that."

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 reverse for further 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	341560	A. BUILDING ______ B. WING ______	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMEDISYS HOSPICE	3320 US 1 HIGHWAY, SUITE C, FRANKLINTON, NC, 27525

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

Interview was conducted with Nurse Practitioner (NP) from the cancer center was conducted on 12/16/19 at 12:15 pm. The NP stated the patient "would have been best served in a 24-hour hospice facility ...My nurse tried to get ____ (hospice agency) to refer him (to hospice home) but got push back." The NP stated transfer to an inpatient unit was delayed. The NP also stated the hospice "Did not respect my clinical judgement" when he asked for inpatient hospice.

L0549

37615

Based on clinical record review and staff interview, the plan of care failed to include all medications for 1 of 3 patient (#1). Findings include:

Patient #1 was admitted on 9/12/19 with prostate cancer, chronic obstructive pulmonary disease, and diabetes. The Plan of Care (POC) for 9/12/19-12/10/19 included orders for skilled nursing (SN) to visit weekly for 13 weeks. The initial assessment conducted by the agency director on 9/12/19 revealed patient was on oxygen 2 liters nasal cannula. The POC did not include oxygen.

An interview with the Director of Operations #12 on 12/17/19 at approximately 1:00 p.m. confirmed the Plan of Care did not contain oxygen.

L0555

37615

Based on clinical record review and staff interview, the agency failed to follow the plan of care for physician notification related to oxygen saturations outside ordered parameters for 1 of 3 patients (#3). Findings include:

Patient #3 was admitted on 3/28/19 with respiratory failure, shortness of breath, dependence on supplemental oxygen and chronic obstructive pulmonary disease (COPD). The Plan of Care (POC) for 3/28/19-6/25/19 included orders for skilled nursing (SN) to visit 2 times for 1 week, 3 times per week for 2 weeks, 2 times per week for 10 weeks, and 1 time per week for 1 week. The POC also stated, "Hospice nurse to obtain O2 sats [oxygen saturation] via pulse oximeter for baseline and prn. Report to MD for O2 sats <85 [less than 85%]." A visit was conducted by LPN #8 on 3/29/19. The visit note revealed the following respiratory findings:
" Abnormal breath sounds
" Abnormal breath patterns
" Apnea
" Requires oxygen
" Periods of apnea
" Diminished breath sounds in the lower lobes

The visit note stated, "Pt very weak, O2 via NC [nasal cannula] with O2 sats 56%...Patient is increasingly having trouble

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

FORM CMS-2567 (02/99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	341560	A. BUILDING ______ B. WING ______	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMEDISYS HOSPICE	3320 US 1 HIGHWAY, SUITE C, FRANKLINTON, NC, 27525

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

breathing. Pt gets SOB [short of breath] with minimal exertion and uses accessory muscles during breathing ...Talked with ____ RN and request for respiratory [respiratory therapy] to come and evaluate equipment and do family teaching. SN also asked family to turn on air conditioner, room very hot and pt agreed. Decline is evident by weight at 65 lbs, increase SOB decreased sats 56 with O2 sat 4-5 litters [sic]." The LPN left prior to respiratory therapist arriving. The patient's family sought care from the emergency department.

There was no evidence that the physician was notified of the assessment and the oxygen saturation outside of ordered parameters.
An interview with LPN #8 was conducted on 12/17/19 at approximately 1:30 p.m. The LPN stated that "a piece of equipment was not working" and she had called to have respiratory therapy make a home visit. The interview confirmed the physician was not notified of the low oxygen saturation levels.

L0672

37615

Based on clinical record review and staff interview, the agency failed to document the death assessment in 1 of 3 records reviewed (#3). Findings include:

Patient #3 was admitted on 3/28/19 with respiratory failure, shortness of breath, dependence on supplemental oxygen and chronic obstructive pulmonary disease (COPD). The Plan of Care (POC) or 3/28/19-6/25/19 included orders for skilled nursing (SN) to visit 2 times for 1 week, 3 times per week for 2 weeks, 2 times per week for 10 weeks, and 1 time per week for 1 week. On 4/29/19 RN #6 made a home visit. Temperature was 97, pulse 58, respirations 22, blood pressure 86/62, and oxygen saturation 74%. The visit note stated, "Did death occur during this visit? No." On 4/29/19 the chaplain and MSW conducted Bereavement Visits.

RN #6 was unavailable for an interview. An interview was conducted with the chaplain on 12/17/19 at 1:00 p.m. The chaplain confirmed the RN was in the home when the patient died. An interview with Director of Operations #12 confirmed the death "had not been entered into the system.

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

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 341596
(X2) MULTIPLE CONSTRUCTION: A. BUILDING ______ B. WING ______
(X3) DATE SURVEY COMPLETED: 10/30/2019

NAME OF PROVIDER OR SUPPLIER: AMEDISYS HOSPICE CARE
STREET ADDRESS, CITY, STATE, ZIP: 56 THREE HUNTS DRIVE BUILDING 3, PEMBROKE, NC, 28372

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

L0501

28783

Based on review of complaint log, policy review, policy review, caregiver interview and staff interview the agency failed to document and investigate complaint for 1 of 1 patient [#1]. The findings include:

"Policy: RI-006A ... Effective Date 1/1/06 ... Topic: Patient Grievances and Complaints ... Date(s) Revised: 02/2017 ... Purpose ... To Ensure that appropriate action will be taken to address all patient/caregiver complaints ... To provide a mechanism for receiving, reviewing, and resolving patient/caregiver complaints ... A grievance is a formal or informal written or verbal complaint that is made to any hospice employee ... The agency will maintain records of grievances/complaints and their outcomes ..."

Review of the complaint log on 10/28/19 revealed no evidence that the agency received a complaint regarding Patient #1.

Interview with the caregiver for Patient #1 conducted on 10/29/19 at 7:08 p.m. to 7:35 p.m. revealed, "I called and left messages for __________ [Name of Director of Clinical Operations] to call me about what had happened, but she never called me back until I called corporate ... When I talked to __________ [Name of Director of Clinical Operations] she said they should have handled things differently. But she never talked with anyone to investigate what happened, so that she could put measures in place so that this doesn't happen to someone else."

Interview conducted with the Director of Clinical Operations on 10/30/19 at 1:12 p.m. revealed, "No, I did not receive a complaint ... ________ [Name of Caregiver of Patient #1] called my AVP [Area Vice President] ... I never got a complaint form, so I don't know what was written ... She told ________ [Name of AVP] that she was not pleased with the care that ________ [Name of Patient #1] received when she was dying ... She felt like more could have been done ... ________ [Name of AVP] asked me to reach out to her [caregiver] and check on her ... She told me she was upset about how ______ [Name of Patient #1] had passed and she did not want that to happen to her husband ... I did tell her that she could call me at any time ... I went back and looked at who was on call ... I don't have that documented anywhere."

L0512

28783

Based on clinical record review, caregiver and staff interviews the agency failed to manage the patient's pain and symptoms related to the terminal diagnosis and related conditions; and failed to ensure that what mattered to the patient regarding pain control and comfort was provided for 1 of 1 patient [#1]. Findings included:

Patient #1 was a 72-year-old admitted to Hospice on 7/23/19. The patient had a terminal diagnosis of Malignant Neoplasm of Unspecified Part of Left Bronchus or Lung [Cancer of the lungs] which had spread to the brain.

A review of the physician's orders/plan of care [POC] for the certification period 7/23/19 to 10/20/19 revealed SN [skilled nursing] was ordered. The SN visit frequency was 1 time per week for 1 week, 1 time per week every 2 weeks for 11 weeks and 3 PRN [as needed] visits for symptom management.

SN orders included, "PULSE OX [pulse oximeter/used to measure oxygen level] PRN SX [symptom] MANAGEMENT ... NOTIFY MD IF BELOW 80% [notify doctor if oxygen level below 80%] ... HOSPICE RN [registered nurse] TO EVALUATE PATIENT, DISEASE PROCESS, SYMPTOMS, AND OTHER CONDITIONS ... HOSPICE NURSE TO OBSERVE AND ASSESS NEUROLOGICAL STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS ... SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PHYSICIAN FOR EARLY INTERVENTION ... HOSPICE NURSE TO ASSESS EFFECTIVENESS OF CARDIOPULMONARY SYMPTOM RELIEF MEASURES INCLUDING OXYGEN TREATMENT AND COMFORT MODALITIES ..."

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Medications on the POC for the certification period 7/23/19 to 10/20/19 included the following:

-Ativan 1 tablet every 6 hours PRN [as needed] "Reason ... ANXIETY/AGITATION ... Instructions ... TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR ANXIETY OR TERMINAL AGITATION ..."

-Levsin 1 tablet every 6 hours "Reason ... TERMINAL SECRETIONS ... Instructions ... TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR EXCESSIVE ORAL SECRETIONS ..."

-Morphine Concentrate 20 milligrams/milliliter 0.25 to 1 ml [milliliter] "Reason ... PAIN/SOB [shortness of breath] ... Instructions ... TAKE 0.25 TO 1 ML EVERY 1 TO 2 HOURS AS NEEDED FOR PAIN OR SOB ..."

The start of care visit was conducted by a registered nurse, #1E on 7/23/19. The Election of Benefit Statement was signed on 7/23/19 by Patient #1 and #1E. The Election of Benefit revealed, "Hospice Philosophy ... I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions ... The focus of hospice care is to provide comfort and support to both me and my family/caregivers ... Right to choose an attending physician ... I do not wish to choose an attending physician and understand that the hospice medical director or designee will provide any physician services required by my plan of care ... I acknowledge that my choice for an attending physician is ... ______ [Name of Hospice Agency Medical Director] ..."

The "PATIENT/ FAMILY INFORMED CONSENT" was signed on 7/23/19 by Patient #1 and #1E. The consent revealed, "I choose to receive hospice care from ______ [Name of Hospice Agency] ... and acknowledge and agree to the following ... I acknowledge receipt of the Patient information Booklet that contains written information on the topics listed below ... Topics discussed included ... Procedure for filing a grievance or complaint ... Medication and treatment procedure including the patient's right to pain management & medication safety ... Hospice Philosophy: I understand that hospice provides palliative, not curative care, to meet the physical emotional and spiritual needs of the patient and family. I understand that hospice focuses on the relief of pain and symptoms ... My attending physician is: ______ [Name of Medical Director] ... Hospice Services: I understand hospice services will be provided by the Hospice Interdisciplinary team, my chosen attending physician and providers contracted by Hospice. The Hospice Interdisciplinary team consist of nurse, physicians ... home health aides ... Hospice services are available on a scheduled and as needed basis, twenty-four hours a day, seven days a week ... Patient and Family Role with Hospice ... I ... understand that the hospice team is not intended to take the place of the family, but rather to support the primary caregiver and family in caring for the patient ..."

A document dated 7/23/19 and titled "WHAT MATTERS TO ME" included the name of Patient #1. The document indicated that what mattered to Patient #1 was "Pain Free ... Comfort ... Staying home ..."

Interview with #1E conducted on 10/29/19 at 4:04 p.m. revealed, "I asked [asked what mattered] the patient and the caregiver ... This [What Matters to Me Document] is kind of a guide for the plan of care ... This [Pain Free, Comfort, Staying home] was the patient's wishes." Interview confirmed it was the patient's wishes to be pain free, comfortable and to remain home.

Hospice Aide was ordered after the start of care. Hospice Aide services began the week of 8/4/19. A Hospice Aide visit was conducted by #4E on 8/16/19 at 12:27 p.m. to 1:39 p.m.

The Hospice IDG [interdisciplinary group] Comprehensive Assessment and Plan of Care Update Report for Patient #1 indicated an IDG meeting was conducted on 8/16/19. There was no indication in the Hospice IDG meeting notes that the patient's caregiver called [8/16/19] regarding a decline in the patient's condition and a need for a SN visit.

Review of the IDG Meeting Agenda revealed the meeting was held on 8/16/19 at "1:45-1745." Signatures of those in attendance included, the Medical Director, the Business Office Specialist/Scheduler [#3E], Director of

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Clinical Operations, and the RN Case Manager [#5E] for Patient #1. There was not a signature noted for the Clinical Manager [#8E], who was present, as reported by the Director of Clinical Operations on 10/30/19 at approximately 2:30 p.m.

Client Episode Coordination Notes Report revealed a call was placed by the caregiver of Patient #1 on 8/16/19 at 5:07 p.m. The coordination note revealed, "... CG [caregiver] ... REPORTS THAT PATIENT HAS HAD A SIGNIFICANT CHANGE SINCE YESTERDAY ... INCREASED AGITATION ... REQUESTS NURSE VISIT ... CALL TO ON CALL NURSE _______ [Name of #2E] ... RN WHO WILL MAKE VISIT ..."

SN visit notes revealed #2E conducted a visit to Patient #1 on 8/16/19 at 6:21 p.m. to 7:17 p.m. #2E documented, "INDICATE REASON FOR VISIT AND PROBLEMS/CONCERNS REPORTED ... DECLINE IN STATUS ... WAS CURRENT NEUROLOGIC/EMOTIONAL/COGNITIVE STATUS ASSESSED ... YES ... CURRENT NEUROLOGIC/EMOTIONAL/COGNITIVE STATUS ... DETERIORATING ... ABNORMAL NEUROLOGIC FINDINGS ... HEADACHE ... SEIZURES ... PATIENT'S MENTAL STATUS ... ORIENTED TO PERSON ... RESTLESS ... AGITATED ... LETHARGIC ... DOES DROWSINESS SIGNIFICANTLY AFFECT THE PATIENT ... YES ... DROWSINESS SCORE ... 0-10 ... 10 ... DROWSINESS SCORE REPORTED BY ... CAREGIVER ... PATIENT REPORTED GOAL DROWSINESS SCORE ... 0-10 ... 5 ... WHAT IS WORST LEVEL IN THE LAST 24 HOURS FOR DROWSINESS ... 10 ... WAS PAIN/COMFORT ASSESSED ... YES ... PATIENT'S RESPONSE: *ARE YOU UNCOMFORTABLE BECAUSE OF PAIN ... NO ... PAIN REPORTED BY ... CAREGIVER-ASSISTED ... IS PATIENT UNDER 18 OR NOT ABLE TO ANSWER ... PATIENT UNABLE TO VERBALIZE ... WAS A DETAILED PAIN ASSESSMENT COMPLETED ... YES ... FREQUENCY OF PAIN INTERFERING WITH PATIENT'S ACTIVITY OR MOVEMENT ... ALL OF THE TIME ... HOW DOES THE PATIENT DESCRIBE THE CHARACTER OF PAIN ... ACHING ... INDICATE DURATION OF PATIENT'S PAIN ... CONTINUOUS ... WERE MEDICATIONS RECONCILED DURING THIS VISIT ... YES ... PROVIDE DETAIL OF RECONCILIATION ... PT ONLY TAKING COMFORT MEDICATIONS ... IS PATIENT ABLE TO SELF-ADMINISTER MEDICATIONS ... NO ... PERSON(S) AUTHORIZED TO ADMINISTER MEDICATION ... CAREGIVER ... REASON FOR VISIT ... PATIENT CARE DUE TO UNEXPECTED STATUS CHANGE ... NARRATIVE ... PRN VISIT DUE TO CAREGIVER COMPLAINT OF A DECLINE IN STATUS ... THE CAREGIVER STATES THAT PATIENT HAS STARTED CHOKING WITH JUST SIPS OF WATER AND STATING THAT IT WAS DIFFICULT FOR HER TO SWALLOW. THIS RN NOTICED A LUMP IN THE THROAT THAT WAS NOT THERE LAST WEEK PER CAREGIVER. WHEN ASKED PATIENT IS SHE IN PAIN SHE STATES NOT REALLY. SPEECH IS VERY FAINT AND VERY SLOW. DIFFICULT FOR THIS RN TO UNDERSTAND. CAREGIVER STATES THAT PATIENT WAS HAVING A COMPLETE CONVERSATION YESTERDAY SO THIS IS A MAJOR DECLINE. CAREGIVER STATES SHE LEAVES A COOL RAG ON HER HEAD BECAUSE OF PAIN ... EDUCATED CAREGIVER ON ADMINISTRATION OF COMFORT MEDS [medications] AT THIS TIME ... DUE TO RAPID DECLINE I ANTICIPATE PATIENT IS ACTIVELY DYING. INCREASING VISITS TO DAILY ..."

Interview with the caregiver for Patient #1 conducted on 10/29/19 at 7:08 p.m. to 7:35 p.m. revealed, "It [patient's decline] started Friday [8/16/19] ... I originally called at 10 a.m. ... I spoke with ________ [Name of #3E] ... I'm pretty sure it was ________ [Name of #3E] ... The aide [#4E] came that day [8/16/19] ... when she got there that day [8/16/19] she called the office and told them she [Patient #1] had declined ... When the aide called, her regular nurse ... ________ [Name of #5E] was in the office at the time ... She [#5E] had no clue as to what was going on ... She [#5E] would have come but no one told her what was going on ... I called back at 5:00 [p.m. 8/16/19] because no one had come all day [8/16/19] ... I think they didn't realize how fast things were going ... _________ [Name of #6E] was on call that night [8/16/19] but she couldn't come because they had her doing an admission, so they sent _________ [Name of #2E] ... _________ [Name of #2E] came sometime after 6 [p.m.] ... When _________ [Name of #2E] left, she [Patient #1] had calmed down ..."

Interview with #5E conducted on 10/30/19 at 9:54 a.m. revealed, "Yes I was in the office when the aide called on Friday [8/16/19] ... That Friday was our meeting for IDG's [interdisciplinary group meetings] ... I was in this office between 1 and 1:30 [p.m.] and I was here until the meeting was over around 4 or 5 o'clock ... The only thing that _____ [Name of Clinical Manager] said to me that day was that she [Patient #1] would get a visit on Saturday [8/17/19] ... The notes in the IDG notes are based on my last visit with the patient ... I was in ______ [Name of City] that morning [8/16/19] but no one called me to ask me to go ... She lived between ______ [Name of City] and ______ [Name of City], so I could have seen her [Patient #1] ..."

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Interview conducted with #4E on 10/30/19 at 9:58 a.m. to 10:23 a.m. revealed, "... Yes, I remember ______ [Name of Patient #1] ... That Friday [8/16/19] when I got there ________ [Name of caregiver for Patient #1] was a little bit edgy. She was telling me that the night before she had a bad night. When I got there, she told me she had called the office around 10 or 11 [a.m. on 8/16/19] to tell them that ______ [Name of Patient #1] was declining ... I got up and looked at the patient ... She was just laying there ... I thought she had already passed ... I went out of the room and called ________ [Name of Hospice Agency] ... ________ [Name of #3E] answered the phone and my exact words was ________ [Name of caregiver for Patient #1] stated that she called the office about 10 or 11 and she said that there was a serious decline from the night before ... ______ [Name of #3E] told me to hold on ... _____ [Name of Director of Clinical Operations] gets on the phone ... I told her that ________ [Name of Patient #1] needed a nurse out there and she [caregiver for Patient #1] said that she had called earlier ... _____ [Name of Director of Clinical Operations] told me to hold on ... ______ [Name of #3E] gets back on the phone and tell me that ______ [Name of Clinical Manager] said there will be no nurse coming out today because they don't have nobody to send out there ... I got off the phone and told her that they said that they don't have a nurse to come out today ... I apologized. She said to me would I get you in trouble if I told them I need a nurse right now, I told her no ma'am. She then stated she would wait until 5:00 o'clock ... maybe the on-call nurse would come out ... ________ [Name of RN/#5E] told me that no one ever told her that her patient was declining, and she said she was in the office that day [8/16/19] for IDG."

Interview with Interview with the Business Office Specialist/Scheduler [#3E] conducted on 10/30/19 at 12:08 p.m. revealed, "I ... work in the office ... I answer the phones and do scheduling ... I'm over the CNA'S with their schedules ... I remember her [caregiver for Patient #1] calling [8/16/19] ... I'm not sure that I talked to her ... I talked with the aide [#4E] ... She [#4E] was calling because _____ [Name of Patient #1] needed a nursing visit ... ________ [Name of the Director of Clinical Operations] asked me if I was talking to ________ [Name of Hospice Aide/#4E] on the phone, and she said ... she wanted to talk to her ... I got back on the phone with ______ [Name of Hospice Aide/#4E] and told her that _________ [Name of Clinical Manager/#8E] said that we did not have a RN to send out at the moment ... She said it would be tomorrow [8/17/19] when she got a nursing visit ..."

Interview with the Clinical Manager [#8E] conducted 10/30//19 at 12:25 p.m. to 12:34 p.m. revealed, "... Coordination notes should be put in when a family calls requesting a visit ... We call the primary nurse to let them know that they need to go see the patient right away ... There are times that those calls don't get documented ... It's not an official process but it's one that we strive for in our office ... Every interaction should be documented ... Yes, she [caregiver of Patient #1] called that day [8/16/19] ... I don't recall saying that we were short staff ... I know the practice is to notify the primary nurse ... that is what I would have done ... If I didn't document, it ... I can't argue with __________ [Name of #5E] that I called her [#5E]."

Interview conducted on 10/30/19 at 12:37 p.m. with the RN [#2E] who conducted the visit on the evening of 8/16/19 revealed, "I educated her [caregiver] on how to administer the Morphine. She gave her a dose while I was there ... I was on-call ... triage must have called me to make the visit [8/16/19] ... At that point I felt she needed daily visits, just to keep an eye on them."

Interviews confirmed the hospice agency failed to provide effective pain management and symptom control in a timely manner for Patient #1 on 8/16/19.

A scheduled SN visit was conducted on 8/17/19 at 1:02 p.m. by #9E. #9E documented, "... Narrative ... PT ... VITALS WNL [within normal limits] BUT PT ACTIVELY DECLINING ... NO SIGNS AND SYMPTOMS OF PAIN ... NO P.O. [oral/by mouth] INTAKE ... NO URINARY OUTPUT SO FAR THIS DAY ... BED BOUND ... DEPENDENT ON CG [caregiver] ... DAILY VISITS CONTINUED DUE TO ACTIVE DECLINE ... ENCOURAGE CG TO CALL AS NEEDED ..."

Client Episode Coordination Notes Report revealed #10E, a registered nurse made an entry on 8/17/19 at 9:49 p.m. Review of the entry [8/17/19 at 9:49 p.m.] revealed, "NAME OF CALLER _____ [Name of caregiver for Patient #1] ... PURPOSE OF CALL ... PROBLEM/CONCERN IDENTIFIED ... O2 85% PULSE 116, PT

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LETHARGIC, NO ORAL INTAKE TODAY ... ACTION TAKEN: EMOTIONAL SUPPORT PROVIDED ... COMFORT MEDS REVIEWED ... END OF LIFE SIGNS AND SYMPTOMS REVIEWED ... SN VISIT MADE: DECLINED ... ______ [Name of caregiver for Patient #1] DECLINED VISIT ... STATES SHE KNOWS DEATH IS NEAR AND JUST WANTED REASSURANCE THAT SHE IS DOING EVERYTHING CORRECT ... ENCOURAGED TO CALL 24/7 FOR ANY NEEDS OR CONCERNS ..."

Client Episode Coordination Notes Report revealed #10E made another entry on 8/18/19 at 12:56 a.m. Review of the entry [8/18/19 at 12:56 a.m.] revealed, "NAME OF CALLER _____ [Name of caregiver for Patient #1] ... PURPOSE OF CALL ... PROBLEM/CONCERN IDENTIFIED ... PT CONTINUES TO DECLINE. PULSE 138 O2 [oxygen] IN THE 70S ... ACTION TAKEN: REVIEWED END OF LIFE AND WHAT TO EXPECT. ENCOURAGED TO CALL 24/7 WITH ANY NEEDS OR CONCERNS ... SN VISIT MADE: _______ [Name of RN #6E] ... COMMENTS: FAMILY REPORTS THEY HAVE BEEN GIVING 1ML OF MORPHINE EVERY HOUR ALONG WITH ATIVAN 1MG Q 6 [1 milligram every 6 hours] WITH NO SYMPTOM RELIEF ..."

Interview with the caregiver for Patient #1 conducted on 10/29/19 at 7:08 p.m. to 7:35 p.m. revealed, "When I called that night [8/17/19] I told them her heart rate was up and her oxygen was dropping. There was no oxygen in the home for her and she had lung cancer. I asked the nurse if I should put my husband's oxygen on her, she said not to because at this point it may agitate her more. I never declined a visit. I know I repeatedly said I needed somebody to help me. The nurse taking the call was trying to get someone to come out. She could hear her moaning. She was moaning all night. No one ever came. When I saw that no one was coming I started videoing her. I called back around 7:00 the next morning [8/18/19] because she started to have seizures. They told me to put the secretion medicine in her mouth to help with the foaming. I didn't know how to administer the secretion medicine. When ________ [Name of RN #6E] came she [Patient #1] was taking her last breath."

The caregiver of Patient #1 called and left a message on 10/30/19 at 8:48 a.m. to clarify what happened when she called on 8/17/19. She indicated the very first call [8/17/19 at 9:49 p.m.], she called to make sure the dosage of Morphine 1 milliliter was right. She confirmed that she declined the nurse visit [8/17/19 at 9:49 p.m.]. She indicated that the second time she called [8/18/19 at 12:56 a.m.] she requested a nurse to come out to visit."

Interview conducted on 10/30/19 at 11:04 a.m. with #6E revealed, "I spoke to ______ [Name of Caregiver] when I got the call it was around 1:00 a.m. [8/18/19] ... We [caregiver of patient #1 and #6E] talked about her comfort medications ... I know she had Morphine and I think she had Ativan ... I messaged the doctor [Medical Director] and I didn't get a response back ... No, I didn't call him ... I always text ... I let her know that I would see her 1st thing in the morning and if she needed anything to call back ... I believe I texted Dr. _______ [Name of Medical Director] ... If I'm not mistaken ... she was maxed out on the amount of medication [Morphine] we could give ... I'm not sure why I didn't go out because I didn't document the call ... I told her [caregiver for Patient #1] that as soon as he messaged me back, I would call her to let her know it there were any changes ..."

Interview with #10E conducted on 10/30/19 at 11:13 a.m. to 11:15 a.m. revealed, "I work for _________ [Name of Hospice Agency] I am the after-hours coordinator ... she [caregiver of Patient #1] told me that she did not want a visit when she called [8/17/19 at 9:49 p.m.] ... She called me again at 12:56 a.m. [8/18/19] ... She only called me twice ... ________ [Name of #6E] was supposed to make the visit ... The nurse is to call the patient and let them know what time they will be there."

Interview confirmed the hospice agency failed to provide effective pain management and symptom control for Patient #1. The agency also, failed to ensure that what mattered to Patient #1, to be pain free and comfortable, was achieved.

L0554

28783

Based on clinical record review, policy review, caregiver and staff interviews the Hospice agency failed to coordinate nursing visits in a timely manner for 1 of 1 patient requesting a nursing visit [#1]; failed to

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coordinate with the Medical Director for 1 of 1 patient [#1] in need of pain and symptom relief; and failed to coordinate needed support to the caregiver in the hours proceeding the patient's death for 1 of 1 patient [#1]. Findings included:

"Policy: TX-012 ... Effective Date 1/1/06 ... Topic: Core Services-Nursing Service ... Date Revised ... 10/2018 ... Applicable Services ... Hospice ... Nursing services ensure that the nursing needs of the patient are met as identified in the initial, comprehensive, and updated assessments ... Operational Guidelines ... 1. The primary registered nurse is the case manager. The case manager will be designated in the hospice patient POC [plan of care]. The Case management includes ... d. Coordination of services given by other health care providers ... and ensure continuous assessment of the patient's/family's needs and the implementation of the POC ... e. Documentation of all activities and findings ... g. the observation and assessment of signs and symptoms and the reporting to the physician of reactions to treatments, including drugs and changes in the patient's physical or emotional condition ..."

Patient #1 was a 72-year-old, admitted to Hospice on 7/23/19. The patient had a terminal diagnosis of Malignant Neoplasm of Unspecified Part of Left Bronchus or Lung [Cancer of the lungs] which had spread to the brain.

A review of the physician's orders/plan of care [POC] for the certification period 7/23/19 to 10/20/19 revealed SN [skilled nursing] was ordered. The SN visit frequency was 1 time per week for 1 week, 1 time per week every 2 weeks for 11 weeks and 3 PRN [as needed] visits for symptom management.

SN orders included, "PULSE OX [pulse oximeter/used to measure oxygen level] PRN SX [symptom] MANAGEMENT ... NOTIFY MD IF BELOW 80% [notify doctor if oxygen level below 80%] ... HOSPICE RN [registered nurse] TO EVALUATE PATIENT, DISEASE PROCESS, SYMPTOMS, AND OTHER CONDITIONS ... HOSPICE NURSE TO OBSERVE AND ASSESS NEUROLOGICAL STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS ... SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PHYSICIAN FOR EARLY INTERVENTION ... HOSPICE NURSE TO ASSESS EFFECTIVENESS OF CARDIOPULMONARY SYMPTOM RELIEF MEASURES INCLUDING OXYGEN TREATMENT AND COMFORT MODALITIES ..."

Medications on the POC for the certification period 7/23/19 to 10/20/19 included the following:

-Ativan 1 tablet every 6 hours PRN [as needed] "Reason ... ANXIETY/AGITATION ... Instructions ... TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR ANXIETY OR TERMINAL AGITATION ..."

-Levsin 1 tablet every 6 hours "Reason ... TERMINAL SECRETIONS ... Instructions ... TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR EXCESSIVE ORAL SECRETIONS ..."

-Morphine Concentrate 20 milligrams/milliliter 0.25 to 1 ml [milliliter] "Reason ... PAIN/SOB [shortness of breath] ... Instructions ... TAKE 0.25 TO 1 ML EVERY 1 TO 2 HOURS AS NEEDED FOR PAIN OR SOB ..."

The start of care visit was conducted by a registered nurse, #1E on 7/23/19. The Election of Benefit Statement was signed on 7/23/19 by Patient #1 and #1E. The Election of Benefit revealed, "Hospice Philosophy ... I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions ... The focus of hospice care is to provide comfort and support to both me and my family/caregivers ... Right to choose an attending physician ... I do not wish to choose an attending physician and understand that the hospice medical director or designee will provide any physician services required by my plan of care ... I acknowledge that my choice for an attending physician is ... ______ [Name of Hospice Agency Medical Director] ..."

The "PATIENT/ FAMILY INFORMED CONSENT" was signed on 7/23/19 by Patient #1 and #1E. The consent revealed, "I choose to receive hospice care from ______ [Name of Hospice Agency] ... and acknowledge and agree to the following ... I acknowledge receipt of the Patient information Booklet that contains written information on the topics listed below ... Topics discussed included ... Procedure for filing a grievance or complaint ... Medication and

treatment procedure including the patient's right to pain management & medication safety ... Hospice Philosophy: I understand that hospice provides palliative, not curative care, to meet the physical emotional and spiritual needs of the patient and family. I understand that hospice focuses on the relief of pain and symptoms ... My attending physician is:________ [Name of Medical Director] ... Hospice Services: I understand hospice services will be provided by the Hospice Interdisciplinary team, my chosen attending physician and providers contracted by Hospice. The Hospice Interdisciplinary team consist of nurse, physicians ... home health aides ... Hospice services are available on a scheduled and as needed basis, twenty-four hours a day, seven days a week ... Patient and Family Role with Hospice ... I ... understand that the hospice team is not intended to take the place of the family, but rather to support the primary caregiver and family in caring for the patient ..."

Hospice Aide was ordered after the start of care. Hospice Aide services began the week of 8/4/19. A Hospice Aide visit was conducted by #4E on 8/16/19 at 12:27 p.m. to 1:39 p.m.

The Hospice IDG [interdisciplinary group] Comprehensive Assessment and Plan of Care Update Report for Patient #1 indicated an IDG meeting was conducted on 8/16/19. There was no indication in the Hospice IDG meeting notes that the IDG coordinated care to ensure that the patient received a skilled nursing visit in response to a call from the caregiver the morning of 8/16/19 reporting a decline in the patient's condition.

Review of the IDG Meeting Agenda revealed the meeting was held on 8/16/19 at "1:45-1745." Signatures of those in attendance included, the Medical Director, the Business Office Specialist/Scheduler [#3E], Director of Clinical Operations, and the RN Case Manager [#5E] for Patient #1. There was not a signature noted for the Clinical Manager [#8E], who was present, as reported by the Director of Clinical Operations on 10/30/19 at approximately 2:30 p.m.

Review of the clinical record revealed no documentation to indicate that the caregiver of Patient #1 called the Hospice agency the morning of 8/16/19.

Client Episode Coordination Notes Report revealed a call was placed by the caregiver of Patient #1 on 8/16/19 at 5:07 p.m. The coordination note revealed, "... CG [caregiver] ... REPORTS THAT PATIENT HAS HAD A SIGNIFICANT CHANGE SINCE YESTERDAY ... INCREASED AGITATION ... REQUESTS NURSE VISIT ... CALL TO ON CALL NURSE ________ [Name of #2E] ... RN WHO WILL MAKE VISIT ..."

SN visit notes revealed #2E conducted a visit to Patient #1 on 8/16/19 at 6:21 p.m. to 7:17 p.m. #2E documented, "INDICATE REASON FOR VISIT AND PROBLEMS/CONCERNS REPORTED ... DECLINE IN STATUS ... WAS CURRENT NEUROLOGIC/EMOTIONAL/COGNITIVE STATUS ASSESSED ... YES ... CURRENT NEUROLOGIC/EMOTIONAL/COGNITIVE STATUS ... DETERIORATING ... ABNORMAL NEUROLOGIC FINDINGS ... HEADACHE ... SEIZURES ... PATIENT'S MENTAL STATUS ... ORIENTED TO PERSON ... RESTLESS ... AGITATED ... LETHARGIC ... DOES DROWSINESS SIGNIFICANTLY AFFECT THE PATIENT ... YES ... DROWSINESS SCORE ... 0-10 ... 10 ... DROWSINESS SCORE REPORTED BY ... CAREGIVER ... PATIENT REPORTED GOAL DROWSINESS SCORE ... 0-10 ... 5 ... WHAT IS WORST LEVEL IN THE LAST 24 HOURS FOR DROWSINESS ... 10 ... WAS PAIN/COMFORT ASSESSED ... YES ... PATIENT'S RESPONSE: *ARE YOU UNCOMFORTABLE BECAUSE OF PAIN ... NO ... PAIN REPORTED BY ... CAREGIVER-ASSISTED ... IS PATIENT UNDER 18 OR NOT ABLE TO ANSWER ... PATIENT UNABLE TO VERBALIZE ... WAS A DETAILED PAIN ASSESSMENT COMPLETED ... YES ... FREQUENCY OF PAIN INTERFERING WITH PATIENT'S ACTIVITY OR MOVEMENT ... ALL OF THE TIME ... HOW DOES THE PATIENT DESCRIBE THE CHARACTER OF PAIN ... ACHING ... INDICATE DURATION OF PATIENT'S PAIN ... CONTINUOUS ... WERE MEDICATIONS RECONCILED DURING THIS VISIT ... YES ... PROVIDE DETAIL OF RECONCILIATION ... PT ONLY TAKING COMFORT MEDICATIONS ... IS PATIENT ABLE TO SELF-ADMINISTER MEDICATIONS ... NO ... PERSON(S) AUTHORIZED TO ADMINISTER MEDICATION ... CAREGIVER ... REASON FOR VISIT ... PATIENT CARE DUE TO UNEXPECTED STATUS CHANGE ... NARRATIVE ... PRN VISIT DUE TO CAREGIVER COMPLAINT OF A DECLINE IN STATUS ... THE CAREGIVER STATES THAT PATIENT HAS STARTED CHOKING WITH JUST SIPS OF WATER AND STATING THAT IT WAS DIFFICULT FOR HER TO SWALLOW. THIS RN NOTICED A LUMP IN THE THROAT THAT WAS NOT THERE LAST WEEK PER CAREGIVER. WHEN ASKED PATIENT IS SHE IN PAIN SHE STATES NOT REALLY. SPEECH IS VERY FAINT AND VERY SLOW. DIFFICULT FOR THIS RN TO UNDERSTAND. CAREGIVER STATES THAT PATIENT WAS HAVING A COMPLETE CONVERSATION YESTERDAY SO THIS IS A MAJOR DECLINE. CAREGIVER STATES SHE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______
(X3) DATE SURVEY COMPLETED: 10/30/2019

NAME OF PROVIDER OR SUPPLIER: AMEDISYS HOSPICE CARE
STREET ADDRESS, CITY, STATE, ZIP: 56 THREE HUNTS DRIVE BUILDING 3, PEMBROKE, NC, 28372

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LEAVES A COOL RAG ON HER HEAD BECAUSE OF PAIN ... EDUCATED CAREGIVER ON ADMINISTRATION OF COMFORT MEDS [medications] AT THIS TIME ... DUE TO RAPID DECLINE I ANTICIPATE PATIENT IS ACTIVELY DYING. INCREASING VISITS TO DAILY ..."

Interview with the caregiver for Patient #1 conducted on 10/29/19 at 7:08 p.m. to 7:35 p.m. revealed, "It [patient's decline] started Friday [8/16/19] ... I originally called at 10 a.m. ... I spoke with ________ [Name of #3E] ... I'm pretty sure it was ________ [Name of #3E] ... The aide [#4E] came that day [8/16/19] ... when she got there that day [8/16/19] she called the office and told them she [Patient #1] had declined ... When the aide called, her regular nurse _______ [Name of #5E] was in the office at the time ... She [#5E] had no clue as to what was going on ... She [#5E] would have come but no one told her what was going on ... I called back at 5:00 [p.m. 8/16/19] because no one had come all day [8/16/19] ... I think they didn't realize how fast things were going ... _________ [Name of #6E] was on call that night [8/16/19] but she couldn't come because they had her doing an admission, so they sent _________ [Name of #2E] ... _________ [Name of #2E] came sometime after 6 [p.m.] ... When _________ [Name of #2E] left, she [Patient #1] had calmed down ..."

Interview with #5E conducted on 10/30/19 at 9:54 a.m. revealed, "Yes I was in the office when the aide called on Friday [8/16/19] ... That Friday was our meeting for IDG's [interdisciplinary group meetings] ... I was in this office between 1 and 1:30 [p.m.] and I was here until the meeting was over around 4 or 5 o'clock ... The only thing that _____ [Name of Clinical Manager] said to me that day was that she [Patient #1] would get a visit on Saturday [8/17/19] ... The notes in the IDG notes are based on my last visit with the patient ... I was in ________ [Name of City] that morning [8/16/19] but no one called me to ask me to go ... I could have seen her [Patient #1] ..."

Interview conducted with #4E on 10/30/19 at 9:58 a.m. to 10:23 a.m. revealed, "... Yes, I remember ______ [Name of Patient #1] ... That Friday [8/16/19] when I got there ________ [Name of caregiver for Patient #1] was a little bit edgy. She was telling me that the night before she had a bad night. When I got there, she told me she had called the office around 10 or 11 [a.m. on 8/16/19] to tell them that ______ [Name of Patient #1] was declining ... I got up and looked at the patient ... She was just laying there ... I thought she had already passed ... I went out of the room and called ________ [Name of Hospice Agency] ... ________ [Name of #3E] answered the phone and my exact words was ________ [Name of caregiver for Patient #1] stated that she called the office about 10 or 11 and she said that there was a serious decline from the night before ... ______ [Name of #3E] told me to hold on ... _____ [Name of Director of Clinical Operations] gets on the phone ... I told her that ________ [Name of Patient #1] needed a nurse out there and she [caregiver for Patient #1] said that she had called earlier ... _____ [Name of Director of Clinical Operations] told me to hold on ... ______ [Name of #3E] gets back on the phone and tell me that ______ [Name of Clinical Manager/#8E] said there will be no nurse coming out today because they don't have nobody to send out there ... I got off the phone and told her that they said that they don't have a nurse to come out today ... I apologized. She said to me would I get you in trouble if I told them I need a nurse right now, I told her no ma'am. She then stated she would wait until 5:00 o'clock [p.m.] ... maybe the on-call nurse would come out ... ________ [Name of RN/#5E] told me that no one ever told her that her patient was declining, and she [#5E] said she was in the office that day [8/16/19] for IDG."

Interview with the Business Office Specialist/Scheduler [#3E] conducted on 10/30/19 at 12:08 p.m. revealed, "... I work in the office ... I answer the phones and do scheduling ... I'm over the CNA'S with their schedules ... I remember her [caregiver of Patient #1] calling [8/16/19] ... I'm not sure that I talked to her ... I talked with the aide [#4E] ... She [#4E] was calling because _____ [Name of Patient #1] needed a nursing visit ... ________ [Name of the Director of Clinical Operations] asked me if I was talking to ________ [Name of Hospice Aide/#4E] on the phone, and she said ... she wanted to talk to her ... I got back on the phone with _______ [Name of Hospice Aide/#4E] and told her that _________ [Name of Clinical Manager/#8E] said that we did not have a RN to send out at the moment ... She said it would be tomorrow [8/17/19] when she got a nursing visit ..."

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(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______
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Interview with the Clinical Manager [#8E] conducted 10/30/19 at 12:25 p.m. to 12:34 p.m. revealed, "... Coordination notes should be put in when a family calls requesting a visit ... We call the primary nurse to let them know that they need to go see the patient right away ... There are times that those calls don't get documented ... It's not an official process but it's one that we strive for in our office ... Every interaction should be documented ... Yes, she [caregiver of Patient #1] called that day [8/16/19] ... I don't recall saying that we were short staff ... I know the practice is to notify the primary nurse ... that is what I would have done ... If I didn't document, it ... I can't argue with _________ [Name of #5E] that I called her [#5E]."

Interview conducted on 10/30/19 at 12:37 p.m. with the RN [#2E] who conducted the visit on the evening of 8/16/19 revealed, "I educated her [caregiver] on how to administer the Morphine. She gave her a dose while I was there ... I was on-call ... triage must have called me to make the visit [8/16/19] ... At that point I felt she needed daily visits, just to keep an eye on them."

Interviews confirmed the Hospice agency failed to coordinate a SN visit in a timely manner for Patient #1 on 8/16/19.

A scheduled SN visit was conducted on 8/17/19 at 1:02 p.m. by #9E. #9E documented, "... Narrative ... PT ... VITALS WNL [within normal limits] BUT PT ACTIVELY DECLINING ... NO SIGNS AND SYMPTOMS OF PAIN ... NO P.O. [oral/by mouth] INTAKE ... NO URINARY OUTPUT SO FAR THIS DAY ... BED BOUND ... DEPENDENT ON CG [caregiver] ... DAILY VISITS CONTINUED DUE TO ACTIVE DECLINE ... ENCOURAGE CG TO CALL AS NEEDED ..."

Client Episode Coordination Notes Report revealed #10E, a registered nurse made an entry on 8/17/19 at 9:49 p.m. Review of the entry [8/17/19 at 9:49 p.m.] revealed, "NAME OF CALLER _____ [Name of caregiver for Patient #1] ... PURPOSE OF CALL ... PROBLEM/CONCERN IDENTIFIED ... O2 85% PULSE 116, PT LETHARGIC, NO ORAL INTAKE TODAY ... ACTION TAKEN: EMOTIONAL SUPPORT PROVIDED ... COMFORT MEDS REVIEWED ... END OF LIFE SIGNS AND SYMPTOMS REVIEWED ... SN VISIT MADE: DECLINED ... _____ [Name of caregiver for Patient #1] DECLINED VISIT ... STATES SHE KNOWS DEATH IS NEAR AND JUST WANTED REASSURANCE THAT SHE IS DOING EVERYTHING CORRECT ... ENCOURAGED TO CALL 24/7 FOR ANY NEEDS OR CONCERNS ..."

Client Episode Coordination Notes Report revealed #10E made another entry on 8/18/19 at 12:56 a.m. Review of the entry [8/18/19 at 12:56 a.m.] revealed, "NAME OF CALLER _____ [Name of caregiver for Patient #1] ... PURPOSE OF CALL ... PROBLEM/CONCERN IDENTIFIED ... PT CONTINUES TO DECLINE. PULSE 138 O2 [oxygen] IN THE 70S ... ACTION TAKEN: REVIEWED END OF LIFE AND WHAT TO EXPECT. ENCOURAGED TO CALL 24/7 WITH ANY NEEDS OR CONCERNS ... SN VISIT MADE: _______ [Name of RN #6E] ... COMMENTS: FAMILY REPORTS THEY HAVE BEEN GIVING 1ML OF MORPHINE EVERY HOUR ALONG WITH ATIVAN 1MG Q 6 [1 milligram every 6 hours] WITH NO SYMPTOM RELIEF ..."

Interview with the caregiver for Patient #1 conducted on 10/29/19 at 7:08 p.m. to 7:35 p.m. revealed, "When I called that night [8/17/19] I told them her heart rate was up and her oxygen was dropping. There was no oxygen in the home for her and she had lung cancer. I asked the nurse if I should put my husband's oxygen on her, she said not to because at this point it may agitate her more. I never declined a visit. I know I repeatedly said I needed somebody to help me. The nurse taking the call was trying to get someone to come out. She could hear her moaning. She was moaning all night. No one ever came. When I saw that no one was coming I started videoing her. I called back around 7:00 the next morning [8/18/19] because she started to have seizures. They told me to put the secretion medicine in her mouth to help with the foaming. I didn't know how to administer the secretion medicine. When ________ [Name of RN #6E] came she [Patient #1] was taking her last breath."

The caregiver of Patient #1 called and left a message on 10/30/19 at 8:48 a.m. to clarify what happened when she called on 8/17/19. She indicated the very first call [8/17/19 at 9:49 p.m.], she called to make sure the dosage of Morphine 1 milliliter was right. She confirmed that she declined the nurse visit [8/17/19 at 9:49 p.m.]. She indicated that the second time she called [8/18/19 at 12:56 a.m.] she requested a nurse to come out to visit."

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Interview conducted on 10/30/19 at 11:04 a.m. with #6E revealed, "I spoke to ______ [Name of Caregiver] when I got the call it was around 1:00 a.m. [8/18/19] ... We [caregiver of patient #1 and #6E] talked about her comfort medications ... I know she had Morphine and I think she had Ativan ... I messaged the doctor [Medical Director] and I didn't get a response back ... No, I didn't call him ... I always text ... I let her know that I would see her 1st thing in the morning and if she needed anything to call back ... I believe I texted Dr. ______ [Name of Medical Director] ... If I'm not mistaken ... she was maxed out on the amount of medication [Morphine] we could give ... I'm not sure why I didn't go out because I didn't document the call ... I told her [caregiver for Patient #1] that as soon as he messaged me back ... I would call her to let her know it there were any changes ..."

Interviews confirmed #6E sent a text message to the Medical Director in the early morning hours and did not get a response back. #6E confirmed she did not attempt to call the Medical Director because she "always" text. Interview confirmed the Hospice agency failed to coordinate with the Medical Director concerning pain management for Patient #1. Interview further confirmed, that #6E did not conduct a visit to the home of Patient #1 when she received the call on 8/18/19 at around 1:00 a.m., leaving the dying patient and patient caregiver unsupported.

Interview with the Clinical Manager [#8E] conducted 10/30//19 at 12:25 p.m. to 12:34 p.m. revealed, "I was the clinical manager on duty the weekend that she [Patient #1] passed [8/18/19] ... I received a call from the on-call nurse [#6E] saying that she kept getting calls about ______ [Name of Patient #1] and that she didn't want to keep going back and forth to the house ... I told her if she's calling, she needed to make the visit ... I know she [#6E] was asked to go Saturday ... I believe triaged called and asked."

L0671

28783

Based on clinical record review, policy review, caregiver and staff interview the Hospice agency failed to document calls to the office and failed to document details of afterhours call for 1 of 1 patient requesting a nursing visit [#1]. The findings include:

"Policy: LD-006 ... Effective Date 1/1/06 ... Topic: Hours of Operation and On Call Service ... Date Revised ... 12/2018 ... Applicable Services ... Hospice ... Operational Guidelines ... 2. Nursing resources will be made available for patient needs during routine office hours Monday through Friday, from 8:00am to 5:00pm ... The guidelines during business hours are as follows ... a. Telephone calls to the agency during office hours are answered by agency staff ... b. Call are routed according to the patient/caregiver needs. staff will listen to the client's request and/or concerns and forward to the appropriate staff member in order to meet the patient needs ... c ... Documentation will be made on the coordination note ... 7. An after hours care coordination telephone log sheet is to be completed and retained ... either written or electronic ... The after hours care coordination telephone log will have at a minimum the following information ... Action Taken and the time ... Time call resolved ..."

"Policy: TX-012 ... Effective Date 1/1/06 ... Topic: Core Services-Nursing Service ... Date Revised ... 10/2018 ... Applicable Services ... Hospice ... Nursing services ensure that the nursing needs of the patient are met as identified in the initial, comprehensive, and updated assessments ... Operational Guidelines ... 1. The primary registered nurse is the case manager ... The Case management includes ... d. Coordination of services given by other health care providers ... and ensure continuous assessment of the patient's/family's needs and the implementation of the POC ... e. Documentation of all activities and findings ..."

Patient #1 was a 72-year-old, admitted to Hospice on 7/23/19. The patient had a terminal diagnosis of Malignant Neoplasm of Unspecified Part of Left Bronchus or Lung [Cancer of the lungs] which had spread to the brain.

A review of the physician's orders/plan of care [POC] for the certification period 7/23/19 to 10/20/19 revealed SN [skilled nursing] was ordered. The SN visit frequency was 1 time per week for 1 week, 1 time per week every 2

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weeks for 11 weeks and 3 PRN [as needed] visits for symptom management.

Hospice Aide was ordered after the start of care. Hospice Aide services began the week of 8/4/19.

Review of the clinical record revealed no documentation to indicate that the caregiver of Patient #1 called the Hospice agency the morning of 8/16/19 requesting a nursing visit.

A Hospice Aide visit was conducted by #4E on 8/16/19 at 12:27 p.m. to 1:39 p.m. There was no documentation in the Hospice Aide visit note that the Aide called the office to report a change in the patient's condition.

Interview with the caregiver for Patient #1 conducted on 10/29/19 at 7:08 p.m. to 7:35 p.m. revealed, "It [patient's decline] started Friday [8/16/19] ... I originally called at 10 a.m. ... I spoke with ________ [Name of #3E] ... I'm pretty sure it was ________ [Name of #3E] ... The aide [#4E] came that day [8/16/19] ... when she got there that day [8/16/19] she called the office and told them she [Patient #1] had declined ..."

Interview conducted with #4E on 10/30/19 at 9:58 a.m. to 10:23 a.m. revealed, "... When I got there, she [caregiver of Patient #1] told me she had called the office around 10 or 11 [a.m. on 8/16/19] to tell them that ______ [Name of Patient #1] was declining ... I ... called ________ [Name of Hospice Agency] ... ________ [Name of #3E] answered the phone and my exact words was ________ [Name of caregiver for Patient #1] stated that she called the office about 10 or 11 and she said that there was a serious decline from the night before ... ______ [Name of #3E] told me to hold on ... _____ [Name of Director of Clinical Operations] gets on the phone ... I told her that ________ [Name of Patient #1] needed a nurse out there and she [caregiver for Patient #1] said that she had called earlier ... _____ [Name of Director of Clinical Operations] told me to hold on ... ______ [Name of #3E] gets back on the phone and tell me that ______ [Name of Clinical Manager/#8E] said there will be no nurse coming out today because they don't have nobody to send out there ..."

Interview with the Business Office Specialist/Scheduler [#3E] conducted on 10/30/19 at 12:08 p.m. revealed, "... I work in the office ... I answer the phones and do scheduling ... I'm over the CNA'S with their schedules ... I remember her [caregiver of Patient #1] calling [8/16/19] ... I'm not sure that I talked to her ... I talked with the aide [#4E] ... She [#4E] was calling because _____ [Name of Patient #1] needed a nursing visit [8/16/19] ..."

Interview with the Clinical Manager [#8E] conducted 10/30/19 at 12:25 p.m. to 12:34 p.m. revealed, "... Coordination notes should be put in when a family calls requesting a visit ... We call the primary nurse to let them know that they need to go see the patient right away ... There are times that those calls don't get documented ... It's not an official process but it's one that we strive for in our office ... Every interaction should be documented ... Yes, she [caregiver of Patient #1] called that day [8/16/19] ... I don't recall saying that we were short staff ... I know the practice is to notify the primary nurse ... that is what I would have done ... If I didn't document, it ... I can't argue with __________ [Name of #5E] that I called her [#5E]."

Interviews confirmed the Hospice agency failed to document the caregiver's request for a SN visit on 8/16/19.

Client Episode Coordination Notes Report revealed #10E made another entry on 8/18/19 at 12:56 a.m. Review of the entry [8/18/19 at 12:56 a.m.] revealed, "NAME OF CALLER _____ [Name of caregiver for Patient #1] ... PURPOSE OF CALL ... PROBLEM/CONCERN IDENTIFIED ... PT CONTINUES TO DECLINE. PULSE 138 O2 [oxygen] IN THE 70S ... ACTION TAKEN: REVIEWED END OF LIFE AND WHAT TO EXPECT. ENCOURAGED TO CALL 24/7 WITH ANY NEEDS OR CONCERNS ... SN VISIT MADE: _______ [Name of RN #6E] ... COMMENTS: FAMILY REPORTS THEY HAVE BEEN GIVING 1ML OF MORPHINE EVERY HOUR ALONG WITH ATIVAN 1MG Q 6 [1 milligram every 6 hours] WITH NO SYMPTOM RELIEF ..."

Interview with the caregiver for Patient #1 conducted on 10/29/19 at 7:08 p.m. to 7:35 p.m. revealed, "When I called that night [8/17/19] I told them her heart rate was up and her oxygen was dropping. There was no oxygen in

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
341596	A. BUILDING ______ B. WING ______	10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMEDISYS HOSPICE CARE	56 THREE HUNTS DRIVE BUILDING 3, PEMBROKE, NC, 28372

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

the home for her and she had lung cancer. I asked the nurse if I should put my husband's oxygen on her, she said not to because at this point it may agitate her more. I never declined a visit. I know I repeatedly said I needed somebody to help me ... No one ever came ..."

The caregiver of Patient #1 called and left a message on 10/30/19 at 8:48 a.m. to clarify what happened when she called on 8/17/19. She indicated the very first call [8/17/19 at 9:49 p.m.], she called to make sure the dosage of Morphine 1 milliliter was right. She confirmed that she declined the nurse visit [8/17/19 at 9:49 p.m.]. She indicated that the second time she called [8/18/19 at 12:56 a.m.] she requested a nurse to come out to visit."

Interview conducted on 10/30/19 at 11:04 a.m. with #6E revealed, "I spoke to ______ [Name of Caregiver] when I got the call it was around 1:00 a.m. [8/18/19] ... We [caregiver of patient #1 and #6E] talked about her comfort medications ... I know she had Morphine and I think she had Ativan ... I messaged the doctor [Medical Director] and I didn't get a response back ... No, I didn't call him ... I always text ... I let her know that I would see her 1st thing in the morning and if she needed anything to call back ... I believe I texted Dr. _______ [Name of Medical Director] ... I'm not sure why I didn't go out because I didn't document the call ..."

Interviews confirmed the Hospice agency failed to document content of the call between the caregiver of Patient #1 and #6E regarding request for SN visit on 8/18/19.

Complaint Intake # NC 00156744/cmw

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

FORM CMS-2567 (02/99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	341591	A. BUILDING ______ B. WING ______	02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH HOSPICE - ROCKY MOUNT	301 S CHURCH STREET, SUITE 135, ROCKY MOUNT, NC, 27804

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
L0798	

37615

Based on North Carolina Board of Nursing Nurse Practice Rules, policy review, and agency documentation, the agency failed to comply with nursing standards of practice by writing prescriptions and cutting and pasting the physician signature onto the prescriptions and by changing the dates on the Certifications of Terminal Illness (CTI). Findings include:

"Components of Nursing Practice for the Registered Nurse", NCAC 36.0224 stated,
"(k) Accepting responsibility for self for individual nursing actions, competence and behavior is the responsibility of the registered nurse, which includes:
(1) having knowledge and understanding of the statutes and rules governing nursing;
(2) functioning within the legal boundaries of registered nurse practice;"

"Components of Nursing Practice for the Licensed Practical Nurse", NCAC 36.0225 stated,
"(i) Accepting responsibility for self for individual nursing actions, competence and behavior which includes:
(1) having knowledge and understanding of the statutes and rules governing nursing;
(2) functioning within the legal boundaries of licensed practical nurse practice"

A policy, "Medication Management for Hospice" (revised 1/12/15), was provided by the agency on 2/27/18 at approximately 11:00 a.m. by the administrator. The policy stated, "A licensed physician orders all medication."

Handwritten documentation from Employee #8 (assistant administrator) was provided by the agency on 2/27/18 at 9:00 a.m. The handwritten documentation from Employee #8 stated, "When I was hired back on 2/14/16 the term 'arts and crafts' floated the office. It was where the nurses had a copy of Dr. _______ signature and would paste it to the bottom of scripts to send to the pharmacy."

Handwritten documentation from RN #2 was provided by the

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agency on 2/27/18 at 9:00 a.m. The handwritten documentation from RN #2 stated, "I observed another nurse making a script to be faxed to pharmacy and attaching a copied signature of our Medical Director using the copy machine then faxing that to the pharmacy for needed comfort meds (medications). I felt this was acceptable since the pharmacist accepts a fax then later at Team IDG (Interdisciplinary Group) Dr. _____ would sign our hard copy ...I have needed to do this maybe five to ten times, the last six months."

Handwritten documentation from RN #6 (administrator) was provided by the agency on 2/27/18 at 9:00 a.m. The handwritten documentation from RN #6 stated, "I knew the term 'arts and crafts' was taking place in my office and I did nothing to stop this behavior. I don't remember when the term first started, but the nurses would paste a picture of Dr. ______ signature onto a typed prescription. They would do this to ensure they could get medications in a timely manner ...I am not aware of who all used Dr. ____ signature ...The signature sheet (with Dr. _____) signature was kept in our gray staff mail box at our old office ....I honestly don't remember playing 'arts and crafts' on any prescription bearing Dr. _______ name, but I can't say with 100% certainty that I never did. I want to be as honest as possible so if I had to guess I would say maybe 1-3 times."

RN #6 also stated, "I did occasionally change dates on CTIs probably 10-15 times to ensure our orders and dates were in compliance for our compliance audits ...We would get the patient list from the compliance auditors and check the dates on the CTIs and face to faces (documentation of physician visit). I would then change the physician date if it did not fall into compliance."

Handwritten documentation from RN #1 was provided by the agency on 2/27/18 at 9:00 a.m. The handwritten documentation from RN #1 stated, that she "made scripts (prescriptions), approximately 1 or 2 a month, for patients when I haven't been able to reach the doctor or if a patient was suffering and needed medication right then. I made scripts for emergencies ...I would do this for patient's needing comfort medicines like Morphine, Ativan, and Atropine. I also informed _______ (nurse's names) that this was an option when it was an emergency."

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