Bristol Hospice – Pierce, L.L.C Certificate of Need Application

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 4:35 pm, Jan 31, 2022

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Washington State Department of Health

Hospice Agency Certificate of Need Application Packet

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Application submission must include:

- One electronic copy of your application, including any applicable attachments – no paper copy is required.
- A check or money order for the review fee of $21,968 payable to Department of Health.

Include copy of the signed cover sheet with the fee if you submit the application and fee separately. This allows us to connect your application to your fee. We also strongly encourage sending payment with a tracking number.

Mail or deliver the application and review fee to:

Mailing Address:

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

Other Than By Mail:

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, Washington 98501

Contact Us:
Certificate of Need Program Office 360-236-2955 or FSLCON@doh.wa.gov.

Application Instructions

The Certificate of Need Program will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310.

General Instructions:

- Include a table of contents for application sections and appendices/exhibits
- Number **all** pages consecutively
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- **Provide a detailed listing of the assumptions you used for all of your utilization and financial projections, as well as the bases for these assumptions.**
- Under no circumstance should your application contain any patient identifying information.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.
- If any of the documents provided in the application are in draft form, a draft is only acceptable if it includes the following elements:
  a. identifies all entities associated with the agreement,
  b. outlines all roles and responsibilities of all entities,
  c. identifies all costs associated with the agreement,
  d. includes all exhibits that are referenced in the agreement, and
  e. any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

Do not skip any questions in this application. If you believe a question is not applicable to your project, explain why it is not applicable.

Answer the following questions in a manner that makes sense for your project. In some cases, a table may make more sense than a narrative. The department will follow up in screening if there are questions.

Program staff members are available to provide technical assistance (TA) at no cost to you before submitting your application. While TA isn't required, it's highly recommended and can make any required review easier. To request a TA meeting, call 360-236-2955 or email us at FSLCON@doh.wa.gov.

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CN22-33

Certificate of Need Application
Hospice Agency

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and WAC 246-310, rules and regulations adopted by the Washington State Department of Health. I attest that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer Vice President of Mergers and Acquisitions Staci Beltran Email Address Staci.beltran@bristolhospice.com	Date 1/30/2022 Telephone Number 385-228-5955
Legal Name of Applicant Bristol Hospice – Pierce, L.L.C. Address of Applicant 206 North 2100 West, Ste. 202 Salt Lake City, UT 84116	Provide a brief project description ☒ New Agency ☐ Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $30,000
Identify the county proposed to be served for this project. Note: Each hospice application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must submitted for each county separately. Pierce County	

Applicant Description

Answers to the following questions will help the department fully understand the role of the applicant(s). Your answers in this section will provide context for the reviews under Financial Feasibility (WAC 246-310-220) and Structure and Process of Care (WAC 246-310-230).

1. Provide the legal name(s) and address(es)of the applicant(s).
   Note: The term "applicant" for this purpose includes any person or individual with a ten percent or greater financial interest in the partnership or corporation or other comparable legal entity as defined in WAC 246-310-010(6).

   Bristol Hospice – Pierce, L.L.C.
   206 N 2100 W, Ste 202, Salt Lake City, UT 84116

   The legal name of the applicant is Bristol Hospice – Pierce, L.L.C. which is a subsidiary of Bristol Hospice L.L.C. Throughout the application Bristol Hospice – Pierce, L.L.C. will be referred to as "Bristol Hospice".

2. Identify the legal structure of the applicant (LLC, PLLC, etc.) and provide the Unified Business Identifier (UBI).

   Bristol Hospice – Pierce, L.L.C. is a Limited Liability Company (LLC). UBI: 604 864 903. See **Exhibit 1**.

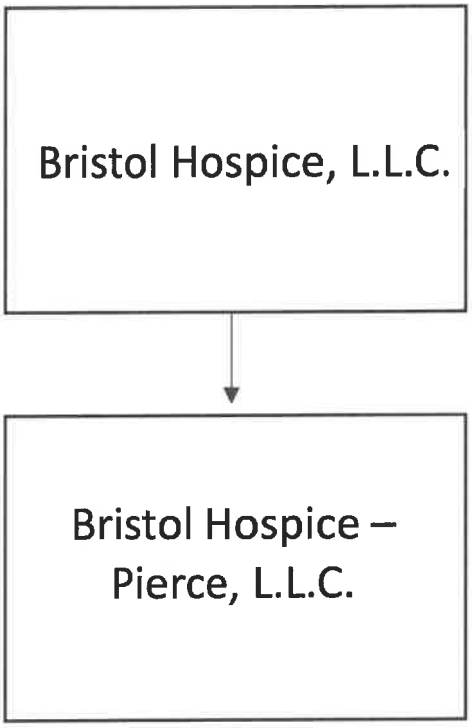
3. Provide the name, title, address, telephone number, and email address of the contact person for this application.

   Staci Beltran
   Vice President of Mergers and Acquisitions
   206 N 2100 W, Ste 202, Salt Lake City, UT 84116
   385-228-5955
   Staci.Beltran@bristolhospice.com

4. Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).

   No consultants have been engaged.

5. Provide an organizational chart that clearly identifies the business structure of the applicant(s).



6. Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant or its affiliates with overlapping decision-makers. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:
    - Facility and Agency Name(s)
    - Facility and Agency Location(s)
    - Facility and Agency License Number(s)
    - Facility and Agency CMS Certification Number(s)
    - Facility and Agency Accreditation Status
    - If acquired in the last three full calendar years, list the corresponding month and year the sale became final
    - Type of facility or agency (home health, hospice, other)

    See **Exhibit 2**.

Project Description

1. Provide the name and address of the existing agency, if applicable.

    Bristol Hospice – Pierce L.L.C. is not an existing facility in the State of Washington. This question is not applicable.

2. If an existing Medicare and Medicaid certified hospice agency, explain if/how this proposed project will be operated in conjunction with the existing agency.

   Bristol Hospice – Pierce L.L.C. is not an existing facility in the State of Washington. This question is not applicable.

3. Provide the name and address of the proposed agency. If an address is not yet assigned, provide the county parcel number and the approximate timeline for assignment of the address.

   Bristol Hospice – Pierce L.L.C.
   4160 6th Ave. SE, Suite 200
   Lacey, WA 98503

4. Provide a detailed description of the proposed project.

   Bristol Hospice is proposing to open a Medicare and Medicaid certified agency to fulfill the unmet Hospice needs of those suffering a life limiting illness in Pierce County, Washington. Bristol Hospice's mission is to "Embrace a Reverence for Life." Bristol Hospice will focus on, among other things, response time, individual patient and family needs, exceptional patient care, and accessibility to all.

5. Confirm that this agency will be available and accessible to the entire geography of the county proposed to be served.

   Bristol Hospice confirms that the agency will be available and accessible to all of Pierce County.

6. With the understanding that the review of a Certificate of Need application typically takes at least six to nine months, provide an estimated timeline for project implementation, below:

Event	Anticipated Month/Year
CN Approval	9/2022
Design Complete (if applicable)	N/A
Construction Commenced* (if applicable)	N/A
Construction Completed* (if applicable)	N/A
Agency Prepared for Survey	12/2022
Agency Providing Medicare and Medicaid hospice services in the proposed county.	1/2023

* If no construction is required, commencement of the project is project completion, commencement of the project is defined in WAC 246-310-010(13) and project completion is defined in WAC 246-310-010(47).

7. Identify the hospice services to be provided by this agency by checking all applicable boxes below. For hospice agencies, at least two of the services identified below must be provided.

Yes ☑Skilled Nursing	Yes ☑Durable Medical Equipment
Yes ☑Home Health Aide	Yes ☑ IV Services
Yes ☑Physical Therapy	Yes ☑Nutritional Counseling
Yes ☑Occupational Therapy	Yes ☑Bereavement Counseling
Yes ☑Speech Therapy	Yes ☑Symptom and Pain Management
Yes ☑Respiratory Therapy	Yes ☑Pharmacy Services
Yes ☑Medical Social Services	Yes ☑Respite Care
Yes ☑Palliative Care	Yes ☑Spiritual Counseling
☐ Other (please describe)	

8. If this application proposes expanding an existing hospice agency, provide the county(ies) already served by the applicant and identify whether Medicare and Medicaid services are provided in the existing county(ies).

   Bristol Hospice – Pierce L.L.C. is not an existing facility in the State of Washington. This question is not applicable.

9. If this application proposes expanding the service area of an existing hospice agency, clarify if the proposed services identified above are consistent with the existing services provided by the agency in other planning areas.

   Bristol Hospice – Pierce L.L.C. is not an existing facility in the State of Washington. This question is not applicable.

10. Provide a general description of the types of patients to be served by the agency at project completion (age range, diagnoses, special populations, etc).

    Bristol Hospice will provide Hospice services to those who are in the final phase of a terminal illness and would like to focus on comfort and quality of life, rather than curative care. Bristol Hospice's admission policy (**Exhibit 3**) prohibits discrimination on the basis of race, income, ethnicity, sex, disability, age, pre-existing condition, physical, mental status and sexual identity. All residents of the service area, including low-income persons, racial and ethnic minorities, women, persons with disabilities, and other underserved groups are welcomed at Bristol Hospice. Bristol Hospice serves patients in a broad array of setting including but not limited to Home, Assisted Living Facilities, Skilled Nursing Facilities, Nursing Homes, Board and Cares, and Adult Family Homes. There is no reason that Bristol Hospice would not accept a patient who qualifies and is wanting to elect their Hospice Benefit. Bristol Hospice would expect to see a wide range of ages, diagnosis, and special populations. If the patient is hospice eligible and would like to receive services but is uninsured and/or unfunded, Bristol Hospice provides

charity care. The charity care policy can be found in **Exhibit 4**. If the patient does not qualify for hospice services, Bristol Hospice as an Advanced Illness Management Program (AIM). More information on AIM is provided in **Exhibit 5**.

11. Provide a copy of the letter of intent that was already submitted according to WAC 246-310-080 and WAC 246-310-290(3).

    See **Exhibit 6**.

12. Confirm that the agency will be licensed and certified by Medicare and Medicaid. If this application proposes the expansion of an existing agency, provide the existing agency's license number and Medicare and Medicaid numbers.

    IHS.FS._____

    Medicare #:_____

    Medicaid #:_____

    Bristol Hospice - Pierce, LLC confirms that the agency will be licensed and certified by Medicare and Medicaid. Bristol Hospice – Pierce, L.L.C. is not an existing facility in the State of Washington.

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. WAC 246-310-290 provides specific criteria for hospice agency applications. Documentation provided in this section must demonstrate that the proposed agency will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing agencies proposing to expand. For any questions that are not applicable to your project, explain why.

1. For existing agencies, using the table below, provide the hospice agency's historical utilization broken down by county for the last three full calendar years. Add additional tables as needed.

COUNTY	Identify Year	Identify Year	Identify Year
Total number of admissions			
Total number of patient days			
Average daily census			

Bristol Hospice – Pierce L.L.C. is not an existing facility in the State of Washington. This question is not applicable.

2. Provide the projected utilization for the proposed agency for the first three full years of operation. For existing agencies, also provide the intervening years between historical and projected. Include all assumptions used to make these projections.

COUNTY	2023	2024	2025
Total number of admissions	110	158	205
Total number of patient days	6,833	9,815	12,735
Projected average daily census	19	27	35

See **Exhibit 7** for the assumptions used to make these projections.

3. Identify any factors in the planning area that could restrict patient access to hospice services.

. Although Bristol Hospice has a robust human resources department that has navigated the current climate of healthcare recruiting, Bristol Hospice has identified that recruiting and retaining healthcare workers could potentially restrict some access to hospice services. Below is an outline of the steps Bristol would take to ensure that it would have the appropriate level of staff to run its agency.

As a fundamental matter, Bristol Hospice is committed to hiring passionate and qualified professionals to our teams without regard to race, retaliation, marital status, color, creed, gender, sexual orientation, pregnancy, childbirth, age, disability, national origin, or status with regard to public assistance and promotes the full realization of an inclusive employment policy.

As soon as each new hire completes their initial paperwork, they begin their 90-day onboarding period which includes a thorough review and education of Bristol Hospice's policies, procedures, mission, standards of care, job specific training, safety, and compliance. To maintain consistency and excellence, we utilize a learning management system to properly administer, document, and update many of these trainings in addition to interdisciplinary job shadowing, and competency checklist completion.

We have a dedicated team of Talent Acquisition experts who carefully source, interview, and onboard these professionals. The Talent Acquisition team is comprised of 8 members including one Director, one Supervisor, three Senior Leaders, and three Specialists. Two of our Talent Acquisition professionals have active Registered Nurse Licenses and bring a unique perspective to our clinical recruiting processes, and the majority of our team members individually have over five years of Talent Acquisition experience.
We believe that through strategically collaborating with our clinical and administrative teams and leaders, we can identify specific strengths and experiences needed in each individual new hire. This customized approach helps

us build well-rounded teams where strengths are celebrated and opportunities for growth are identified and supported. We believe that by investing in our Talent Acquisition and Retention teams and strategies, we will support our mission to provide the best possible care to patients and their families and retain staff in order to provide continuity for our patients. We support this ongoing commitment by:

- Analyzing Talent Acquisition and Retention trends locally and nationally and adjusting our practices based on current market trends.
- Investing in state-of-the-art recruitment software that enables us to:
    - Engage in "active sourcing" in addition to attracting active candidates through traditional job postings;
    - Target candidates with key industry experience and skillsets that meet the needs of our teams, patients, and their families;
    - Participate in all key national search engines as well as take advantage of specific industry networking events and job fairs to promote our opportunities; and
    - Create virtual and in-person hiring events within the communities we serve and increase the pool of potential candidates by offering paid training opportunities.

- Utilizing state of the art labor market wage analysis software, which enables the company to:
    - Pay competitively in the market.
    - Analyze our internal compensation to remain competitive as well as prevent any internal compensation equity issues.
    - Effectively monitor compensation and review diversity within our company and the communities the company serves.

Additionally, we know that staffing in the healthcare industry is facing more and more challenges recently and we've enhanced our benefit offerings to minimize outside stressors that can impact work performance and patient care, including:

- An Employee Assistance Program that provides mental health, and financial counselling services.
- Paid Time Off that starts accruing on an employee's first day, as well as paid holidays.
- Employer sponsored Medical, Dental, and Vision insurance with plan options that meet the individual needs of our team members.
- Long-Term and Short-Term Disability Insurance.
- Employer Sponsored Life Insurance.
- Identity Theft Protection.
- Cellphone and Mileage Reimbursement.
- 401k with an Employer Match.

We've also taken the following additional steps to remain competitive and support our teams during these challenges, including:

- Supporting personal and professional development through tuition reimbursement and in-service training to help meet the level of experience and education needed for each role.
- Establishing flexible work arrangements where available (remote/hybrid).
- Providing hiring & retention incentives (bonuses, pay incentives, referral programs, etc.).
- Continuing to monitor and respond to employee feedback (open communication, provide a safe workplace, proactive focus group meetings to address challenges).
- Developing a travel nurse and leadership team to address staffing shortages and provide additional respite support to our teams.
- Continuing COVID pay beyond the expiration of the federal mandates.

4. Explain why this application is not considered an unnecessary duplication of services for the proposed planning area. Provide any documentation to support the response.

   Bristol Hospice is able to justify that the proposed project does not constitute an unnecessary duplication of services. The data provided by the Department of Health in its 2021 Hospice Need Methodology (**Exhibit 8**) proves for itself that the current providers are not able to meet the need. Without knowing the focus of each of the organizations, we can only assume that the listed providers have constraints as the need study is showing that there are 3 new agencies needed.

5. Confirm the proposed agency will be available and accessible to the entire planning area.

   Bristol Hospice confirms it will be available and accessible to the entire planning area.

6. Identify how this project will be available and accessible to under-served groups.

   Bristol Hospice has put resources in place to serve all community members, including those that are underserved. This includes, but is not limited to, language translation services, continued education to staff, dedicated Community Liaisons that provide outreach, and specialty programs such as Bright Moments for Alzheimer's and Dementia, We Honor Veterans, and Sweet Dreams. See **Exhibit 9** for information on these programs.

   Bristol believes that the Hispanic population could be better served by a provider that offers programming and access to this population such as Bristol Hospice.

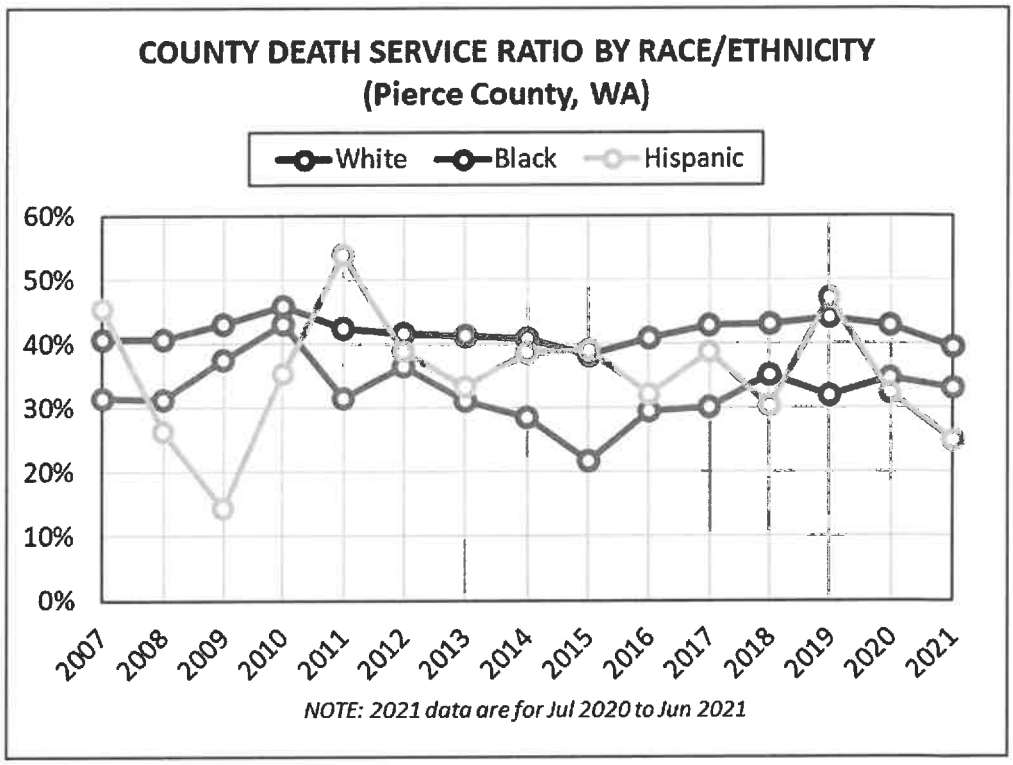
   Medicare claims data shows that there are disparities in hospice use amongst minority groups in Pierce County, WA. Both Black and Hispanic populations have

had lower death service ratios regularly for the past decade and half, with the Hispanic Population reaching above average only a few times during this time period. In 2021, there was a dip in the death service ratio for both Black and Hispanic populations. Barriers for these groups include, language, religion, family culture, and/or limited resources.

DEATH SERVICE RATIO BY RACE/ETHNICITY

Pierce County, WA

Year	All	White	Black	Hispanic
2007	40%	41%	32%	45%
2008	40%	41%	31%	26%
2009	42%	43%	38%	14%
2010	45%	46%	43%	35%
2011	42%	42%	32%	54%
2012	41%	42%	37%	39%
2013	40%	41%	31%	33%
2014	40%	41%	29%	39%
2015	37%	38%	22%	39%
2016	40%	41%	30%	32%
2017	42%	43%	30%	39%
2018	42%	43%	35%	30%
2019	43%	44%	32%	47%
2020	41%	43%	35%	32%
2021	38%	40%	33%	25%



Source: "HealthPivots DataLab." *HealthPivots DataLab*, https://datalab.healthpivots.com/.

Bristol Hospice would implement a Spanish speaking specialty program in Pierce County to serve the Spanish speaking community. Bristol Hospice's affiliate company Bristol Hospice – Miami-Dade LLC has implemented this program in their location and has had great success serving and educating the Spanish Speaking Community.

Examples of the support and education that would be provided:

- Bristol Hospice would recruit and retain Spanish Speaking staff. It would be intended that Spanish Speaking patients be paired with Spanish Speaking staff members.
- All consents would be available in Spanish.
- All Marketing Materials would be available in Spanish.
- Bereavement Programs would be available in Spanish.
- Education materials would be created in Spanish.
- Bristol Hospice would engage with local Spanish Community groups such as the Alzheimer's Association and YMCA Spanish Speaking support groups, the Latino Community Fund, and local Spanish Speaking religious groups.

See **Exhibit 10** for materials in Spanish.

7. Provide a copy of the following policies:

- Admissions policy
- Charity care or financial assistance policy
- Patient Rights and Responsibilities policy
- Non-discrimination policy

Suggested additional policies include any others believed to be directly related to patient access (death with dignity, end of life, advanced care planning)

Please see **Exhibit 11** for a copy of our polices.

8. If there is not sufficient numeric need to support approval of this project, provide documentation supporting the project's applicability under WAC 246-310-290(12). This section allows the department to approve a hospice agency in a planning area absent numeric need if it meets the following review criteria:
   - All applicable review criteria and standards with the exception of numeric need have been met;
   - The applicant commits to serving Medicare and Medicaid patients; and
   - A specific population is underserved; or
   - The population of the county is low enough that the methodology has not projected need in five years, and the population of the county is not sufficient to meet an ADC of thirty-five.

     Note: The department has sole discretion to grant or deny application(s) submitted under this subsection.

Pierce County showed numeric need for 3 additional providers.

B. Financial Feasibility (WAC 246-310-220)

Financial feasibility of a hospice project is based on the criteria in WAC 246-310-220.

1. Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:
   - Utilization projections. These should be consistent with the projections provided under the Need section. **Include all assumptions.**
   - Pro Forma revenue and expense projections for at least the first three full calendar years of operation using at a minimum the following Revenue and Expense categories identified at the end of this question. **Include all assumptions.**
   - Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. **Include all assumptions**.
   - For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the projections. For incomplete years, identify whether the data is annualized.

Revenue **Expenses**

Medicare, including Managed Care	Advertising
Medicaid, including Managed Care	Allocated Costs
Private Pay	B & O Taxes
Other, [TriCare, Veterans, LNI, etc.] detail what is included	Depreciation and Amortization
Non-operating revenue	Dues and Subscriptions
	Education and Training
	Employee Benefits
	Equipment Rental
	Information Technology/Computers
Deductions from Revenue:	Insurance
(Charity)	Interest
(Provision for Bad Debt)	Legal and Professional
(Contractual Allowances)	Licenses and Fees
	Medical Supplies
	Payroll Taxes
	Postage
	Purchased Services (utilities, other)
	Rental/Lease
	Repairs and Maintenance
	Salaries and Wages (DNS, RN, OT, clerical, etc.)
	Supplies
	Telephone
	Travel (patient care, other)
	Other, detail what is included

Please see **Exhibit 12** for the forecasted P&L's and balance sheets.

2. Provide the following agreements/contracts:
   - Management agreement.
   - Operating agreement
   - Medical director agreement
   - Joint Venture agreement

   Note, all agreements above must be valid through at least the first three full years following completion or have a clause with automatic renewals. Any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

The only contracts applicable are the Medical director agreement and Operating agreement. Please see **Exhibit 13** for our contracts.

3. Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site.

   If this is an existing hospice agency and the proposed services would be provided from an existing main or branch office, provide a copy of the deed or lease agreement for the site. If a lease agreement is provided, the agreement must extend through at least the third full year following the completion of the project. Provide any amendments, addendums, or substitute agreements to be created as a result of this project to demonstrate site control.

   If this is a new hospice agency at a new site, documentation of site control includes one of the following:

   a. An executed purchase agreement or deed for the site.
   b. A draft purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.
   c. An executed lease agreement for at least three years with options to renew for not less than a total of two years.
   d. A draft lease agreement. For Certificate of Need purposes, draft agreements are acceptable if the draft identifies all entities entering into the agreement, outlines all roles and responsibilities of the entities, identifies all costs associated with the agreement, includes all exhibits referenced in the agreement. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

   Please see **Exhibit 14** which includes a lease agreement.

4. Complete the following table with the estimated capital expenditure associated with this project. Capital expenditure is defined under WAC 246-310-010(10). If you have other line items not listed in the table, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate.

Item	Cost
a. Land Purchase	$
b. Utilities to Lot Line	$
c. Land Improvements	$
d. Building Purchase	$
e. Residual Value of Replaced Facility	$
f. Building Construction	$
g. Fixed Equipment (not already included in the construction contract)	$
h. Movable Equipment	$
i. Architect and Engineering Fees	$
j. Consulting Fees	$
k. Site Preparation	$
l. Supervision and Inspection of Site	$
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	
1. Land	$
2. Building	$
3. Equipment	$
4. Other	$
n. Washington Sales Tax	$
Total Estimated Capital Expenditure	**$**

Because Bristol Hospice will be leasing the costs listed above are not applicable. Below is a schedule for Capital Expenses and Equipment.

Schedule for Capital Expenses and Equipment

Item	Expense	
IT Equipment	$	15,000.00
Furniture for Office	$	10,000.00
Initial Inventory of Supplies	$	5,000.00
	$	**30,000.00**

5. Identify the entity responsible for the estimated capital costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.

   The entity responsible is Bristol Hospice – Pierce, L.L.C.

6. Identify the amount of start-up costs expected to be needed for this project. Include any assumptions that went into determining the start-up costs. Start-up costs should include any non-capital expenditure expenses incurred prior to the facility opening or initiating the proposed service. If no start-up costs are expected, explain why.

   The capital costs and the forecasted schedules include all start up costs expected.

7. Identify the entity responsible for the estimated start-up costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.

   All costs in the capital expenditures and forecasted P&L's will fall under the Bristol Hospice – Pierce, L.L.C. entity.

8. Explain how the project would or would not impact costs and charges for healthcare services in the planning area.

   The project will have a total of $30,000 of capital impact in the question above and will produce the jobs shown in the FTE calculation.

   Hospice provides stabilizing support to families and provides assistance to those who are alone without family support. The overall healthcare operating costs within Pierce County will be reduced from these unmet admissions being admitted to Bristol Hospice.

   The hospice benefit is a Medicare benefit paid by the Federal program directly. Many beneficiaries are duel eligible beneficiaries of both Medicaid and Medicare. Bristol Hospice services will reduce the costs for these Medicaid beneficiaries for the county by providing supportive services and reducing acute admissions.

9. Explain how the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges for health services in the planning area.

   The provision of hospice services is covered by Medicare, Medicaid or commercial insurance. Our financial analysis shows that the reimbursement for services is adequate to cover the cost of the provision of services. Bristol would not be charging patients or referral sources for any services. The capital costs of the

project due to the nature of hospice serves being provided where the patient lives are minimal and do not add any cost that would affect the planning area.

10. Provide the projected payer mix by revenue and by patients by county as well as for the entire agency using the example table below. Medicare and Medicaid managed care plans should be included within the Medicare and Medicaid lines, respectively. If "other" is a category, define what is included in "other."

Payer Mix	Percentage of Gross Revenue	Percentage by Patient
Medicare	98%	98%
Medicaid	1%	1%
Other Payers (list in individual lines)	1%	1%
Total	100%	100%

11. If this project proposes the addition of a county for an existing agency, provide the historical payer mix by revenue and patients for the existing agency. The table format should be consistent with the table shown above.

    This question is not applicable as this project does not propose an addition of a county for an existing agency.

12. Provide a listing of equipment proposed for this project. The list should include estimated costs for the equipment. If no equipment is required, explain.

    This was provided under the Capital Expenses and is listed below.

Schedule for Capital Expenses and Equipment

Item	Expense	
IT Equipment	$	15,000.00
Furniture for Office	$	10,000.00
Initial Inventory of Supplies	$	5,000.00
	$	**30,000.00**

13. Identify the source(s) of financing (loan, grant, gifts, etc.) and provide supporting documentation from the source. Examples of supporting documentation include: a letter from the applicant's CFO committing to pay for the project or draft terms from a financial institution.

    Please see **Exhibit 15** for a letter from our CFO.

14. If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

This question is not applicable Bristol Hospice will be using cash from its balance sheet to fund this project.

15. Provide the most recent audited financial statements for:
    - The applicant, and
    - Any parent entity responsible for financing the project.

    Please see **Exhibit 16** for the most recent audited financial statements.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

Projects are evaluated based on the criteria in WAC 246-310-230 for staffing availability, relationships with other healthcare entities, relationships with ancillary and support services, and compliance with federal and state requirements. Some of the questions within this section have implications on financial feasibility under WAC 246-310-220.

1. Provide a table that shows FTEs [full time equivalents] by category for the county proposed in this application. All staff categories should be defined.

   Please see **Exhibit 12 second sheet of the excel file** that shows FTE's by category.

2. If this application proposes the expansion of an **existing** agency into another county, provide an FTE table for the entire agency, including at least the most recent three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years. All staff categories should be defined.

   This question is not applicable as this projected does not propose the expansion of an existing agency.

3. Provide the assumptions used to project the number and types of FTEs identified for this project.

   Please see **Exhibit 12 second sheet of the excel file** for the assumptions used to project the FTE's.

4. Provide a detailed explanation of why the staffing for the agency is adequate for the number of patients and visits projected.

   Bristol Hospice uses similar staffing ratios across the country. Bristol started in 2006 and has robust experience in operating hospice agencies. It has found that these ratios are optimal for serving the patient population and providing frequent visits and quality care.

5. Provide the name and professional license number of the current or proposed medical director. If not already disclosed under 210(1) identify if the medical director is an employee or under contract.

   Bristol Hospice's Medical Director is Dr. Sabine VonPreyss, Family Medicine, 1164551338.

6. If the medical director is/will be an employee rather than under contract, provide the medical director's job description.

   This is not applicable as the medical director will be under contract.

7. Identify key staff by name and professional license number, if known. If not yet known, provide a timeline for staff recruitment and hiring (nurse manager, clinical director, etc.)

   Key staff will be recruited if awarded the CON. The recruitment process will begin upon being awarded with start dates of January of 2023. The individuals hired will align with our 2023 FTE table provided in **Exhibit 12 second sheet of the excel file.**

8. For existing agencies, provide names and professional license numbers for current credentialed staff.

   This is not applicable.

9. Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.

   Bristol Hospice has a strong clinical structure with engaged flexible team members that can support the healthcare needs in cases of emergency or shortage. Bristol is supported by a centralized national recruiting team that has a strong history of hiring healthcare employees within 15 to 20 days of posting a position, which is far below the national average. Bristol recruits on over 150 websites as well as hospice specific niches and organizations. Applicants can apply via their phone or other personal device to easily join the Bristol Hospice team.

   All staff are vetted through extensive background checks including local and national databases as well as the government LEIE exclusion list. New hires go through at least 2 rounds of interviews to ensure they have the temperament to provide this sacred level of service to the community.

Once hired all staff must complete a rigorous training program to ensure skills are ready for the Bristol Hospice level of quality. This training includes all state and federal required trainings as well as custom Bristol Hospice coursework and best practices. Technology and in person training are both utilized to ensure a well-rounded curriculum. Each new member will receive preceptor guidance for the first weeks or months, if necessary, to build competency. Every staff member is measured on performance-based indicators that are based upon electronic quantitative quality data that is stored in our clinical tracking systems. The systems gather charting information and provide feedback to clinical managers to know where to coach and guide staff. For those that are not providing high quality per the quantitative measures they will be trained to provide higher quality and put on disciplinary action if they fail to meet requirements.

Bristol Hospice offers favorable benefits packages to hire and retain talent including Health, 401k, vision, dental, and tuition assistance. It allows all employees to apply for new jobs that are posted including any of the affiliated companies of Bristol Hospice L.L.C. allowing incredible opportunities for advancement nationally. Bristol Hospice encourages staff to continue to receive additional licensure and or education on an ongoing basis. Bristol Hospice rewards and recognizes those that get advanced degrees or further education certificates.

Volunteers are managed by dedicated volunteer coordinator and are critical component to meeting community needs. Bristol Hospice provides training to all volunteers, which ensures that volunteers are ready to serve the community appropriately. This is done similarly to hired staff in a multi-pronged approach with in-person and technological support. Bristol Hospice recruits volunteers from all over the community including schools, universities, retirement organizations, current employee contacts or recommendations, local volunteer boards, and online boards. The volunteers go through a rigorous background check and Bristol Hospice loves to work alongside community constituents to serve its patients.

10. Identify your intended hours of operation and explain how patients will have access to services outside the intended hours of operation.

Bristol Hospice general office hours are from 0800 to 1700; our actual operations are 24/7/365. There are always staff that are required to work after hours, weekends and holidays to meet patient needs. Further, it does not rely solely on third party answering services after office hours. All calls are routed to Bristol Hospice hired and trained on-call RN's for resolution. This is done through advanced technology that can track down available staff. Even if all staff are on visits, a call will NEVER go to voicemail. A live clinically trained person will answer 100% of the time to address any need. Our lights are always on. We dispatch

trained staff at any hour of the day and night and our goal is to arrive within 30 minutes of any needed after hours visit.

11. For **existing** agencies, clarify whether the applicant currently has a method for assessing customer satisfaction and quality improvement for the hospice agency.

    This question is not applicable as the project is not proposing expansion of an existing agency.

12. For **existing** agencies, provide a listing of ancillary and support service vendors already in place.
    This question is not applicable as the project is not proposing expansion of an existing agency.

13. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project.

    This question is not applicable as the project is not proposing expansion of an existing agency.

14. For **new** agencies, provide a listing of ancillary and support services that will be established.

    Bristol uses the following support services partners and services for ancillary needs:

    - Durable Medical Equipment
    - Pharmacy
    - Medical Supplies
    - Physical Therapy
    - Dietitian
    - X-Ray
    - Laboratory
    - Ambulance or medical transport
    - Biowaste disposal
    - Inpatient care

15. For **existing** agencies, provide a listing of healthcare facilities with which the hospice agency has documented working relationships.

This question is not applicable as the project is not proposing expansion of an existing agency.

16. Clarify whether any of the existing working relationships would change as a result of this project.

This question is not applicable as the project is not proposing expansion of an existing agency.

17. For a **new** agency, provide the names of healthcare facilities with which the hospice agency anticipates it would establish working relationships.

Please see **Exhibit 17** for a list of healthcare facilities Bristol Hospice would anticipate it would establish working relationships.

18. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)
    a. A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a hospice care agency; or
    b. A revocation of a license to operate a health care facility; or
    c. A revocation of a license to practice a health profession; or
    d. Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

Bristol Hospice does not have any facility or practitioner associated with this application who has had any of the actions listed.

19. Provide a discussion explaining how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services. WAC 246-310-230

Across all of Bristol Hospice affiliated companies, year to date we have served over 2,000 different referral sources. This includes referrals from Assisted Living Facilities, Hospitals, Skilled Nursing Facilities, and Physicians. Each of these referral sources exhibited confidence in Bristol Hospice to promote continuity and unwarranted fragmentation in services. Bristol Hospice takes pride in providing care for each patient on an individual level based on their specific needs and

disease process. Bristol Hospice will develop relationships with the entire continuum of care in Peirce County including:

- Local government agencies providing guidance to the community such as the Are Agency of Aging
- Local chapters of AARP
- Local chapter of National Hospice and Palliative Care Organization
- Local Home Health Agencies
- Local Nursing Homes
- Local chapter of the Alzheimer's Association
- Local Veterans Association. Bristol has participated in the Honors flight and some affiliated companies are We honor Veterans level 4.
- Local insurance providers such as Asuris Northwest Health, Molina Healthcare, Bridgespan, Coordinated Care, Lifewise Health Plan of Washington, Kaiser Permanente, and Regence BlueSheild.
- Local Senior Centers and Community Centers
- Local Senior Olympics
- Local Emergency Preparation & Disaster Recovery with Local Fire/EMS/Police Departments
- Local radio and television news stations
- Local support groups and grief discussions
- Local groups that support Diversity and Inclusion such as Zoo Walk, Memory Café, Tacoma Traumatic Brain Injury Group, Tacoma Caregiver Matters, Hearing Loss Association of Tacoma, DadsMOVE, Northwest Parkinson's Foundation, Kinship Caregiving, Northwest Parkinson's Foundation

20. Provide a discussion explaining how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230.

    Bristol Hospice would serve the health care system in the same manner as the other current Hospice agencies in the planning area, and would provide excellent post-acute care for those in need. Additionally, Bristol Hospice would be available as a resource for the area's existing health care system and would actively engage to streamline communication serving not only the health care system but the community as a whole.

21. The department will complete a quality of care analysis using publicly available information from CMS. If any facilities or agencies owned or operated by the applicant reflect a pattern of condition-level findings, provide applicable plans of correction identifying the facility's current compliance status.

    Bristol Hospice does not reflect a pattern of condition-level findings.

22. If information provided in response to the question above shows a history of condition-level findings, provide clear, cogent and convincing evidence that the applicant can and will operate the proposed project in a manner that ensures safe and adequate care, and conforms to applicable federal and state requirements.

    This is not applicable as Bristol Hospice does not have a history of condition-level findings.

D. Cost Containment (WAC 246-310-240)

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

1. Identify all alternatives considered prior to submitting this project. At a minimum include a brief discussion of this project versus no project.

   Bristol Hospice considered the potential of acquiring an existing agency or doing a joint venture but the opportunity of doing so did not present itself. Bristol Hospice felt that since the county showed need through the Department of Health's study it would pursue the project.

2. Provide a comparison of the project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected alternatives. Factors to consider can include, but are not limited to: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.

   Bristol Hospice has a long history of providing exceptional hospice care across the country. Bristol now operates 47 locations across 14 states including: AZ, CA, OR, HI, UT, CO, TX, GA, NV, WI, MI, WA, LA and FL. It employs a diverse skilled workforce to meet the needs of its patients with more than 2,300 employees. As such, Bristol Hospice would be able to lean on hundreds of Hospice professionals that have seen or experienced any and all imaginable hospice circumstances. The ability to back fill any issues with access to the broad Bristol platform is invaluable to ensure the community of Pierce County will get 24/7 consistent service every time, every day and every year. This depth and breadth of experience and service will be put to excellent use in Pierce County.

   Each Bristol Hospice program operates out of a community office, which is typically staffed with an Executive Director ("ED") who is responsible for the overall operations of their location. The ED oversees all staff and is responsible for identifying and contracting with Medical Directors and Associate Medical Directors to serve its patients. The Director of Patient Care Services ("DPCS") is the leading force in all clinical matters. The DPCS reports to the ED but is responsible for overseeing all matters relating to patient care including supervision of RNs, LPNs, CNAs and other disciplines that provide direct care

to patients. The number of employees in each facility is based on the census with a constant watch to ensure that there is sufficient staff to provide its expected level of quality care. Office functions such as billing, A/P, contract management, payroll and HR are standardized and provide consistent compliant services. These services have been time tested and have been proven to provide reliable quality care that currently is not in Washington.

The Bristol Hospice local offices are individualized hospice operations that are supported by a national office. Each hospice program provides custom tailored hospice services to meet the physical, psychosocial, and spiritual needs of our patients and their families/caregivers. An interdisciplinary group of professionals and volunteers develops an individualized plan of care which includes, as appropriate, the following services: nursing, physicians, home health aides, counseling, spiritual support, therapy, dietary, durable medical equipment, supplies, volunteer services and bereavement services. All departments receive robust support from the national support services. Every chaplain has hundreds of chaplains standing behind them in the Bristol Hospice family. This is true for every other discipline. That said, the local leader is free to give the local touch necessary to ensure we are giving Washington residents Washington care.

Bristol Hospice patients are diverse in ethnic background and religious practices. The Bristol Hospice team develops programs and hires its clinical team to meet the various cultures of its patients at the local level. It goes the extra mile to ensure that the culture is understood and respected by the staff working with patients in each location. Bristol Hospice understands each patient brings unique clinical, cultural and spiritual needs and that as a national hospice system, programs and staffing recognize the importance of this and strive to accommodate these personal and regional variations. Its key leadership consistently travels to its locations and frequently engages community leaders, clinicians, and our patient base to ensure we tailor our programs to meet the special needs of the patients. Bristol Hospice's boutique hospice model provides a community focused approach which also incorporates a sophisticated national infrastructure to ensure that its programs meet all relevant legal and accreditation standards while incorporating best practices in CHAPs accreditation standards and the Hospice Conditions of Participation. Members of the Bristol parent company's advisory board are also on the CHAP board and review compliance and survey performance nationally. These members are in **Exhibit 18** and show the depth and breadth of support that is backing the Bristol Hospice model of care.

Bristol Hospice focuses on providing customized care which meets and/or exceeds national standards for quality care delivery yet is tailored for the specific needs of each patient. In addition to each individualized patient care plan, Bristol Hospice produces an individualized service plan for each location, to ensure that all services are tailored to the communities it serves. This care

model is customized prior to its entry into new markets to ensure its success in becoming a valued part of the community. Bristol Hospice leadership personally visit the community to best understand the cultural and care needs so that tailor core programs can be tailored to meet the community's needs. Frequent additional visits once the hospice is open, ensure that Bristol Hospice is truly a community hospice.

Bristol's goal is to provide the best possible patient experience and has developed programs to address specific patient conditions that go above the CMS conditions of participation:

- Namaste Program Services
  - The Namaste program addresses the unique emotional and physical needs of individuals, their caregivers, and families. As a leader in the hospice community, Bristol Hospice stands true to its company values and mission of Embracing a Reverence for Life.
- Bright Moments
  - Bright Moments is a program specifically designed for patients with end-state dementia. It is based on the belief that more can be done for dementia and Alzheimer's patients. Bright Moments provides innovative tools to help support these patients, as well as their family, staff, and physicians.
- Sweet Dreams
  - The Sweet Dreams program addresses the unique emotional and physical needs of individuals, their caregivers, and families by providing services after 5 PM per the care plan. The goals of this program are to reduce nighttime agitation and enhance bedtime rituals to allow for comfort and quality sleep. As a leader in the hospice community, Bristol stands true to its company values and mission of Embracing a Reverence for Life.

3. If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):
   - The costs, scope, and methods of construction and energy conservation are reasonable; and
   - The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

   This project will not involve construction.

4. Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

Having sufficient hospice services available in the community promote cost effectiveness in the delivery of health services as it reduces the amount of rehospitalizations that occur when patients do not have access healthcare in the home. Bristol Hospice strives to be available for a hospice conversation within 1 hour of the referral and admit the patient within 4 hours of the referral. This level of speed is critical in reducing unnecessary hospitalizations and EMS use as the patient can then have access to clinical staff 24/7 to address health concerns.

Hospice Agency Superiority

In the event that two or more applications meet all applicable review criteria and there is not enough need projected for more than one approval, the department uses the criteria in WAC 246-310-290(11) to determine the superior proposal.

Multiple Applications in One Year

In the event you are preparing more than one application for different planning areas under the same parent company – regardless of how the proposed agencies will be operated – the department will require additional financial information to assess conformance with WAC 246-310-220. The type of financial information required from the department will depend on how you propose to operate the proposed projects. Related to this, answer the following questions:

1. Is the applicant (defined under WAC 246-310-010(6)) submitting any other hospice applications under either of this year's concurrent review cycles? This could include the same parent corporation or group of individuals submitting under separate LLCs under their common ownership.

   If the answer to this question is no, there is no need to complete further questions under this section.

   The application is not submitting any other hospice applications.

2. If the answer to the previous question is yes, clarify:
   - Are these applications being submitted under separate companies owned by the same applicant(s); or
   - Are these applications being submitted under a single company/applicant?
   - Will they be operated under some other structure? Describe in detail.

   Not applicable.

3. Under the financial feasibility section, you should have provided a pro forma balance sheet showing the financial position of **this project** in the first three full calendar years of operation. Provide pro forma balance sheets for the **applicant,** assuming approval of this project showing the first three full calendar years of operation. In addition, provide a pro forma balance sheet for the **applicant**

assuming approval of **all proposed projects** in this year's review cycles showing the first three full calendar years of operation.

Not applicable.

4. In the event that the department can approve more than one county for the same applicant, further pro forma revenue and expense statements **may** be required.
   - If your applications propose operating multiple counties under the same license, provide combined pro forma revenue and expense statements showing the first three full calendar years of operation assuming approval of all proposed counties.
   - If your applications propose operating multiple counties under separate licenses, there is no need to provide further pro forma revenue and expense statements.

   Not applicable.

Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310

Certificate of Need Program 'Frequently Asked Questions'

Commonly Referenced Rules for Hospice Projects:

WAC Reference	Title/Topic
246-310-010	Certificate of Need Definitions
246-310-200	Bases for findings and action on applications
246-310-210	Determination of Need
246-310-220	Determination of Financial Feasibility
246-310-230	Criteria for Structure and Process of Care
246-310-240	Determination of Cost Containment
246-310-290	Hospice services—Standards and need forecasting method.

Certificate of Need Contact Information:
Certificate of Need Program Web Page
Phone: (360) 236-2955
Email: FSLCON@doh.wa.gov

Licensing Resources:
In-Home Services Agencies Laws, RCW 70.127
In-Home Services Agencies Rules, WAC 246-335
Hospice Agencies Program Web Page

Exhibit 1

UNITED STATES OF AMERICA

The State of Washington

Secretary of State

I, STEVE R. HOBBS, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF FORMATION

to

BRISTOL HOSPICE - PIERCE, L.L.C.

A **WA LIMITED LIABILITY COMPANY**, effective on the date indicated below.

Effective Date: 01/18/2022
UBI Number: 604 864 903

Given under my hand and the Seal of the State of Washington at Olympia, the State Capital

Steve R. Hobbs, Secretary of State

Date Issued: 01/18/2022

FILED
Secretary of State
State of Washington
Date Filed: 01/18/2022
Effective Date: 01/18/2022
UBI No: 604 864 903

This Box For Office Use Only

Office of the Secretary of State
Corporations & Charities Division

Physical/Overnight address
801 Capitol Way S
Olympia, WA 98501-1226
Tel: 360.725.0377

Mailing Address
PO Box 40234
Olympia, WA 98504-0234
www.sos.wa.gov/corps

□ **Filing Fee $180**

□ **To Expedite Filing Add $50**

Certificate of Formation
Limited Liability Company
RCW 23.95 and RCW 25.15

All fields required unless otherwise specified

(1) Do you already have a UBI Number? (Check one) □ Yes ■ No If Yes, provide UBI # _____

If No, a new UBI# will be issued to you upon successful completion of the filing.

(2) ENTITY NAME: Bristol Hospice - Pierce, L.L.C.

If designation is not provided, it will be defaulted to LLC

For name requirements review the following RCW(s): RCW 23.95.305

Does the entity have a name reserved? (Check one) □ Yes ■ No

If Yes, provide the Name Reservation Number and Name If No, provide only the name

Reservation Number: _____

Name: _____

(3) PERIOD OF DURATION : Please check **ONE** of the following

■ This Company shall have a perpetual duration (default) □ This Company shall have a duration of _____ years.

□ This Company shall expire on _____

(4) EFFECTIVE DATE: Please check **ONE** of the following:

■ Date of filing □ Specify a date _____ cannot be more than 90 days following received date

Work Order #: 2022011400035037 - 1
Received Date: 01/14/2022
Amount Received: $230.00

(5) REGISTERED AGENT:

Is the Registered Agent a Commercial Registered Agent? ■ Yes ☐ No

If Yes, provide the name of the Commercial Registered Agent: Registered Agent Solutions, Inc.

A Commercial Registered Agent is an entity or individual that is registered with the Office of the Secretary of State to receive legal documents on behalf of a corporation. A Commercial Registered Agent has the entities/individual's address on record with the office.

A Registered Agent consent is still required for a Commercial Registered Agent located below.

If No, please continue below

Please complete ONE type of Registered Agent below. Be sure to include the name below the checked box. Then continue to provide the required street address. Mailing address if needed.

☐ **Individual**	☐ **Entity**	☐ **Office or Position**
First and last name of a Non-commercial Registered Agent. (Any person not registered as a Commercial Registered Agent.)	Name of a Non-commercial Registered Agent. (Any business not registered as a Commercial Registered Agent.)	List the Office or Position serves as agent. (Only if using the specific office or position as the registered agent, no matter who holds the position like: Secretary, Member or Treasurer.)

Phone: _____ Email: _____

Registered Agent Street Address (required)
(Must be a physical address No PO Box or PMB)

Country: United States **State:** Washington

Address : 3400 Capitol Blvd. SE

Suite 101

Zip: 98501 **City:** Tumwater

Registered Agent Mailing Address (optional)
☐ Check if mailing address is the same as street address

Country: United States **State:** Washington

Address : P.O. Box 1368

Zip: 98507 **City:** Olympia

CONSENT TO SERVE AS REGISTERED AGENT - REQUIRED FOR ALL TYPES

I hereby consent to serve as Registered Agent in the State of Washington for the named entity. I understand it will be my responsibility to accept service of process, notices, and demands on behalf of the entity; to forward mail to the entity; and to immediately notify the Office of the Secretary of State if I resign or change the Registered Office Address.

Brendan Wangel	Brendan Wangel, Asst. Secretary	1/13/2022
Signature of Registered Agent	Printed Name/Title	Date

Work Order #: 2022011400035037 - 1
Received Date: 01/14/2022
Amount Received: $230.00

(6) PRINCIPAL OFFICE: *The place where the entity's records are kept

Principal Office Street Address (Must be a physical address; No PO Box or PMB)	Mailing Address (*optional*) ■ Check if mailing address is the same as street address.
Address: 206 North 2100 West	Address:
Suite 202	
Zip: 84116 City: Salt Lake City	Zip: City:
State: UT Country: USA	State: Country:

Phone: (optional) 801-656-2769 Email: (optional) regulatory@bristolhospice.com

(7) RETURN ADDRESS FOR THIS FILING: *(Optional)*

This address will be sent document(s) regarding this specific filing in addition to document(s) being sent to the Registered Agent's street/mailing address.

Attention to: Email:

Address:

City State Zip

(8) EXECUTOR INFORMATION:

Name, address, and signature required. Attach additional sheets if necessary.

I herby certify, under penalty of law, that the above information is accurate and complies with the filing requirements of state law.

Name: Mekelle Andrezzi

Address: 206 No. 2100 W. Ste 202

City Salt Lake City State Ut. Zip 84116 Country U.S.A.

Mekelle Andrezzi — Mekelle Andrezzi/Natn'l Dir. licensing accreditation — 01/13/2022

Signature of Executor — Printed Name/Title — Date

Work Order #: 2022011400035037 - 1
Received Date: 01/14/2022
Amount Received: $230.00

WASHINGTON
Secretary of State
Corporations & Charities Division

Corporations and Charities Division
Physical/Overnight address:
801 Capitol Way S
Olympia, WA 98501-1226
Mailing address:
PO Box 40234
Olympia, WA 98504-0234
Tel: 360.725.0377
sos.wa.gov/corps

Congratulations:

You have completed the initial filing to create a new business entity. **The next step in opening your new business is to complete a Business License Application.** You may have completed this step already. The Business License Application can be completed online or downloaded at: http://www.bls.dor.wa.gov/

If you have any questions about the Business License Application, or would like a Business License Application package mailed to you, please call the Department of Revenue at 1-800-451-7985.

If you have questions about annual reports or registered agent requirements, please contact the Corporations Division at 360-725-0377 or visit our website at: http://www.sos.wa.gov/corps

REGISTERED AGENT SOLUTIONS, INC.
P.O. BOX 1368
OLYMPIA WA 98507

IMPORTANT

To keep your filing status active and avoid administrative dissolution, you must:

1. **File an Initial Report** within 120 days of the date your corporation or limited liability company (LLC) was filed. The date of filing is stated on your certificate. Please go online to file your initial report at www.sos.wa.gov/ccfs

2. **File an Annual Report** each year before the anniversary of the filing date for the entity. The registered agent will be sent notice of the Annual Report requirement. It is the corporation or LLC's responsibility to file the report on time even if no notice is received.

3. **Maintain a Registered Agent** and registered office in this state. You must file a statement of change or designation of registered agent if there are any changes in your registered agent, agent's address, or registered office address. Failure to file changes with the Corporations Division will result in misrouted mail, and possibly lead to administrative dissolution.

If you have questions please contact our office at: corps@sos.wa.gov 360-725-0377, or visit our website www.sos.wa.gov/corps

Exhibit 2

Legal Name	D/B/A	Address	NPI	License #	PTAN	Accred. Status	Date of Sale (If applicable)	Facility Type	Surveys	#
Angelic Heart Hospice, Inc.	Bristol Hospice - Mid Michigan	10801 Saginaw St., Suite C, Grand Blanc, MI. 48430	1245629955	1041000146	231650	CHAP accred.	9/10/2021	Hospice	Not surveyed under Bristol	
Bristol Hospice - Bend, L.L.C.	N/A	563 SW 13th Street, Suite 101, Bend, OR 97702-3156	1356916845	16-1092	pending	pending	N/A	Hospice	New program/ not surveyed	
Bristol Hospice - Eugene, L.L.C.	N/A	1077 Gateway Loop, Ste B Springfield, OR 97477	1568962033	16-1076	381568	CHAP accred.	N/A	Hospice	CHAP POC & Letter	1
Bristol Hospice, L.L.C.	Bristol Hospice - Thurston	135 South 336th Street, Federal Way, WA 98003	1932781721	HIS.FS.61211200	pending	pending	N/A	Hospice	New program/ not surveyed	
Bristol Hospice - Green Bay, L.L.C.	N/A	2450 Velp Avenue, Suite 101, Green Bay, WI. 54303-6593	1356928154	2057	pending	CHAP accred.	N/A	Hospice	New program/ not surveyed	
Bristol Hospice - Madison, L.L.C.	N/A	206 E Olin Avenue, Ste 101, Madison, WI. 53713	1992382733	2058	pending	CHAP accred.	N/A	Hospice	New program/ not surveyed	
Bristol Hospice - California, L.L.C.	N/A	374 E. Yosemite Ave., Suite 200 Merced, CA 95340-9100	1487603452	550000358	551501	CHAP accred.	N/A	Hospice	CHAP POC & Letter	2
Bristol Hospice - Georgia, L.L.C.	N/A	2849 Paces Ferry Road, Ste 380 Atlanta, GA 30339-3769	1558663872	033-0357-H	111711	CHAP accred.	N/A	Hospice	State Survey/ Letter	3
Bristol Hospice - Hawaii, L.L.C.	N/A	55 Merchant Street, Suite 2900 Honolulu, HI 96813	1811045594	W54162393-01	121508	CHAP accred.	N/A	Hospice	CHAP POC & Letter	4
Bristol Hospice - Miami Dade, LLC	N/A	5201 Blue Lagoon Drive, Ste 570 Miami, FL 33126-2075	1679011720	50370981	101558	CHAP accred.	N/A	Hospice	CHAP POC & Letter	5
Bristol Hospice - Oregon, L.L.C.	N/A	10365 SE Sunnyside Road, Ste 340 Clackamas, OR 97015-5751	1063780351	16-1056	381559	CHAP accred.	N/A	Hospice	CHAP POC & Letter	6
Bristol Hospice - Pathways, L.L.C.	N/A	115 Park Place Blvd, Suite 100 Waxahachie, TX 75165	1568710358	15998	451743	CHAP accred.		Hospice	CHAP POC & Letter	7
Bristol Hospice - Rogue Valley, L.L.C.	N/A	848 NE 7th Street Grants Pass, OR 97526	1639469380	16-1080	381572	CHAP accred.	N/A	Hospice	CHAP POC & Letter	8
Bristol Hospice - Sacramento, L.L.C.	N/A	2140 Professional Drive, Ste 210 Roseville, CA 95661-3664	1235331828	550000805	551538	CHAP accred.	N/A	Hospice	CHAP POC & Letter	9
Bristol Hospice - Texas, L.L.C.	N/A	2002 Timberloch Place, Ste 150 The Woodlands, TX 77380-1198	1649563552	16069	671708	CHAP accred.	N/A	Hospice	CHAP POC & Letter	10
Bristol Hospice - Utah II, L.L.C.	N/A	1106 E. 6600 S., Murray, UT 84121	1619253606	2020-Hospice-78013	461595	CHAP accred.	10/25/2018	Hospice	State See Attached	11
Bristol Hospice-Utah, L.L.C.	N/A	1638 N. Washington Blvd., Ste 102 Ogden, UT 84404-3790	1164527792	2019-Hospice-104512	461566	CHAP accred.	N/A	Hospice	State See Attached	12
Companion Hospice and Palliative Care, LLC	Bristol Hospice - Simi Valley	3605 Alamo St., Ste 340, Simi Valley, CA., 93063	1215163985	550001301	551594	CHAP accred.	12/30/2020	Hospice	Not surveyed since purchase	
Bristol Hospice - Inland Empire, L.L.C.	N/A	6296 River Crest Drive, Ste L, Riverside, CA 92507 - 9738	1043683170	550003820	A01582	CHAP accred.	6/1/2020	Hospice	Not surveyed since purchase	
Bristol Hospice - Coachella Valley, L.L.C.	N/A	35400 Bob Hope Drive, Ste 213, Rancho Mirage, CA 92270-1774	1386025583	550003762	921731	CHAP accred.	6/1/2020	Hospice	Not surveyed since purchase	
Gerinet Palliative Care, LLC	Bristol Hospice - Tucson	6375 E. Tanque Verde Road, Suite 170, Tucson, AZ 85715-3883	1053625848	HSPC5172	31605	CHAP accred.	9/4/2020	Hospice	CHAP POC & Letter	13
Gerinet Physician Services, Inc.	Bristol Hospice - Greater LA	4010 Watson Plaza Drive, Suite 140 Lakewood, CA 90712-4037	1548217011	550000196	551502	CHAP accred.	9/4/2020	Hospice	CHAP POC & Letter	14
Gerinet Physician Services, Inc.	Bristol Hospice - Northern LA	700 North Central Avenue, Suite 550, Glendale, CA 91203-1244	1043449291	550000400	551546	CHAP accred.	9/4/2020	Hospice	Not surveyed since purchase	
High Desert Hospice LLC	Bristol Hospice - Klamath Falls	2210 Shallock Ave, Klamath Falls, OR 97601	1033191440	16-1009	381551	pending	11/1/2021	Hospice	Not surveyed since purchase	
Hospice Touch, Inc.	Bristol Hospice - Orange County	3070 Bristol Street, Suite 100, Cosa Mesa, CA 92626-7334	1497758593	80000769	51757	CHAP accred.	9/4/2020	Hospice	Not surveyed since purchase	
Hospice Touch LLC	Bristol Hospice - Las Vegas	1820 E Warm Spring Road Ste. 140, Las Vegas, NV 89119-4508	1750530077	6314-HPC-10	291526	CHAP accred.	9/4/2020	Hospice	Not surveyed since purchase	
Inspiring Hospice Partners of Georgia, LLC	Bristol Hospice - East Georgia	1252 Virgil Langford Rd., Watkinsville, GA. 30677-7245	1780105528	029-0427-H	111782	pending	11/1/2021	Hospice	Not surveyed since purchase	
Inspiring Hospice Partners of Oregon, LLC	Bristol Hospice - Hood River; Bristol Hospice - Gresham	407 Portway Ave, Ste. 201, Hood River, OR. 97031	1942387154	16-1070	381554	pending	12/30/2021	Hospice	Not surveyed since purchase	
Inspiring Hospice Partners of Oregon, LLC	Bristol Hospice - Snohomish County	12625 4th Ave. West, Ste. 203A and 203B, Everett, WA 98204-6427	1942387154	HIS.FS.60741443	351554	pending	12/30/2021	Hospice	Not surveyed since purchase	
Bristol Hospice - Inland Valley, L.L.C.	N/A	7365 Carnelian Street, Suite 240 Rancho Cucamonga, CA 91730-1156	1013318112	550003038	751690	CHAP accred.	9/30/2020	Hospice	Not yet surveyed by CHAP	
Optimal Hospice, Inc.	Bristol Hospice - Bakersfield; Bristol Hospice - Lake Isabella	1675 Chester Avenue, Ste 401 Bakersfield, CA 93301	1396726493	070000581	051725	CHAP accred.	7/13/2018	Hospice	CHAP POC & Letter	15
Optimal Hospice, Inc.	Bristol Hospice - Fresno; Bristol Hospice - Visalia	6780 North West Avenue, Ste 101 Fresno, CA 93711	1164590089	100000782	051769	CHAP accred.	7/13/2018	Hospice	CHAP POC & Letter	16
Optimal Hospice, Inc.	Bristol Hospice - Stockton; Bristol Hospice - Modesto	2800 W. March Lane, Ste 110 Stockton, CA 95219	1821166745	550000173	051793	CHAP accred.	7/13/2018	Hospice	CHAP POC & Letter	17
Optimal Hospice, Inc.	Bristol Hospice - Lancaster	44151 15th Street West, Ste 201 Lancaster, CA 93534	1689181323	550004054	A01526	CHAP accred.	7/13/2018	Hospice	CHAP POC	18

Sojourn Hospice & Palliative Care - Redding, LLC	Bristol Hospice - Redding	2150 Churn Creek Road, Ste 150, Redding, CA 96002	1972918753	550002893	751664	N/A	3/9/2020	Hospice	Not surveyed since purchase	
Sojourn Hospice & Palliative Care - East Bay, LLC	Bristol Hospice - East Bay	5820 Stoneridge Mall Rd., Ste 209, Pleasanton, CA 94588-3200	1508271388	550003382	921543	N/A	3/9/2020	Hospice	Not surveyed since purchase	
Sojourn Hospice & Palliative Care - San Diego, LLC	Bristol Hospice - San Diego	8765 Aero Drive, Ste 226 San Diego, CA 92123-1767	1659781045	550003077	751734	N/A	3/9/2020	Hospice	Not surveyed since purchase	
Suncrest Hospice LLC	Bristol Hospice- Colorado Springs	7660 Goddard Street, Ste 100 Colorado Springs, CO 80920-8231	1669767968	17F493	061576	N/A	8/17/2018	Hospice	State Survey/ Letter	19
Suncrest Hospice LLC	Bristol Hospice - Pueblo	5700 South Quebec Street, Ste 310 Greenwood Village, CO 80111-2008	1669767968	17D454	061576	N/A	8/17/2018	Hospice	State Survey/ Letter	19
Suncrest Hospice LLC	Bristol Hospice - Denver	1721 West US Highway 50, Ste 150 Pueblo, CO 81008-1691	1669767968	17R196	061576	N/A	8/17/2018	Hospice	State Survey/ Letter	19
Suncrest Hospice - NOCO, L.L.C.	Bristol Hospice - NOCO	3770 West Puritan Way, Unit E Frederick, CO 80516-9436	1629090725	17C957	061561	N/A	2/27/2020	Hospice	Not surveyed since purchase	
Regional Hospice Care Group of NW Louisiana, LLC	N/A	1634 Highway 531, Minden, LA 71055	1114200870	2203783956	191616		12/30/2021	Hospice	Not surveyed since purchase	
Regional Hospice Care Group of NW Louisiana, LLC	N/A	9301 Wallace Lake Rd., Shreveport, LA 71106	1114200870	2203783956-B	191616		12/30/2021	Hospice	Not surveyed since purchase	

1

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

CHAP

November 2, 2018

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending
	Location and/or Site Accredited: Bristol Hospice-Eugene, LLC 1077 Gateway Loop, Suite B Springfield, OR 97477	
	Site Visit Dates:	October 8, 2018 – October 10, 2018
	Type of Survey/Site Visit:	Initial
	Accreditation Determination:	Full Accreditation
	Medicare Certification:	Pending
	Deemed Status Recommendation:	Deemed Status Recommended
	Plan of Correction Accepted Date:	October 24, 2018
	Effective Date of Accreditation:	October 24, 2018
	Expiration Date of Accreditation:	October 24, 2021
	Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted October 8, 2018 – October 10, 2018, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.862.3413 | Fax: 202.862.3419
fpetrella@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO X - Seattle)
CMS Central Office
State Agency

Action Plan Summary

Site Visit 9/14/2021 - 9/16/2021

CCN 381568

Organization

Bristol Hospice, LLC

Summary of Citations

Hospice	1

Condition Level Deficiencies **0**

Service Provider

Bristol Hospice-Eugene, LLC

1077 Gateway Loop Suite B Springfield, OR 97477

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Action Plan Summary

HCDT.16.I

Citation

CMS Tag: 626

CMS CFR: 418.76(g)(2)

HCDT.16.I - A hospice aide provides services:

1. Ordered by the Interdisciplinary Group;
2. Included in the plan of care;
3. Permitted to be performed under state law and regulation;
4. Consistent with the hospice aide training.

It is required that a hospice aide provides services that are ordered by the Interdisciplinary Group, included in the plan of care, permitted to be performed under state law and regulation, and consistent with the hospice aide training.

This standard was not met as evidenced by a joint review of clinical records, agency policy, and interview. Agency policy 9-020 Hospice Aide Services (dated 5/2020) states, "Hospice aide assignments, plan of care and interventions will be documented and included in the patient's clinical record." 4 of 12 (33%) applicable records in which a hospice aide (HA) provided services, failed to provide documentation that was consistent with the Hospice Aide plan of care.

Record #76077: Review of the plan of care dated 8/7/21-11/14/21. The HA order dated 8/7/21 states, "HCA: Start on 08/09/2021: 2x/wk x 13 wks." A HA visit was documented on 8/18/21. The record failed to provide documentation of a second HA visit the week of 8/15/21-8/21/21. There were no HA visits documented the week of 8/30/21-9/4/21. The record failed to provide documentation that 2 HA visits occurred the week of 8/30/21-9/4/21 in accordance with the HA plan of care.

Record #35848: Review of the plan of care dated 7/26/21-9/23/21. The HA order dated 7/26/21 states, "HCA: 3x week x 6 wks (7/26/21-8/28/21) then 2x week x 4 weeks (8/29/21-9/23/21)." There were no HA visits documented the week of 7/26/21- 7/31/21 & 8/1/21-8/7/21. The record failed to provide documentation that 3 HA visits occurred the week of 7/26/21- 7/31/21 & 8/1/21-8/7/21 in accordance with the HA plan of care. There were no HA visits documented the week of 8/29/21-9/4/21. The record failed to provide documentation that 2 HA visits occurred the week of 8/29/21-9/4/21. A HA missed visit was documented on 9/7/21. The record failed to provide documentation of a second HA visit the week of 9/5/21-9/11/21 in accordance with the HA plan of care.

Record #12252: Review of the plan of care dated 8/10/21-11/7/21. The HA order dated 8/10/21 states, "HCA: 1x/wk x 1 wk (8/11/2021 to

8/14/2021), 3x/wk x 13 wks." HA visits were documented on 8/24/21 & 8/26/21. The record failed to provide documentation of a third HA visit the week of 8/22/21-8/28/21 in accordance with the HA plan of care. A HA visit was documented on 9/4/21. The record failed to provide documentation of a second and third HA visit the week of 8/29/21-9/4/21 in accordance with the HA plan of care.

Record #96095: Review of the plan of care dated 7/14/21-10/11/21. The HA order dated 7/14/21 states, "HCA: 2x/wk." There were no HA visits documented the week of 8/15/21- 8/21/21. The record failed to provide documentation that 2 HA visits occurred the week of 8/15/21- 8/21/21 in accordance with the HA plan of care. A HA visit was documented on 8/26/21. The record failed to provide documentation of a second HA visit the week of 8/22/21-8/28/21 in accordance with the HA plan of care.

Interview and record review with the Director of Clinical Services confirmed this finding.

Agency Response

What action will we take to correct the deficiency cited?

• All clinical supervisors received training regarding care plans and the COP and CHAP standards associated with them on September 23, 2021, including: o Medicare COP §418.76(g)(2)o CHAP Standard HCDT 16.Io Agency Policy 9-020• Education was provided on September 23, 2021, to all RN Case Managers and admission nurses aligned with the COPs and CHAP standards for elements of care planning, including:o Medicare COP §418.76(g)(2)o CHAP Standard HCDT 16.Io Agency Policy 9-020• Nurses were instructed on September 16, 2021, and September 23, 2021, to ensure that care plans and visit frequency orders that are created with the interdisciplinary team meet each patient's needs and that the hospice team, as the expert in their patients' end-of-life care, remains the manager of all patient care.• All disciplines were instructed on September 16, 2021, and September 23, 2021, to collaborate within the interdisciplinary team to create a care plan for each patient that is individualized to that patient's specific needs.• All disciplines were educated on September 23, 2021, to document any changes in patient condition and the ensuing timely modifications made to the plan of care• Quality Assurance Coordinator(s) will utilize the Plan of Care PiP and associated audit tool to monitor compliance.

Who is responsible to implement the corrective action?

The Executive Director (ED), Director of Patient Care Services (DPCS), or designee are responsible to implement the corrective actions listed above.

Action Plan Summary

When will the corrective action be implemented?

September 23, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Once 100% compliance is met for three consecutive months, continued monitoring will be ongoing monthly with the chart review sampling of 10% of charts. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

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Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

December 10, 2021

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	55-1501
	Location and/or Site Accredited: Bristol Hospice-California, LLC 374 East Yosemite Avenue, 200 Merced, CA 95340	
	Site Visit Dates:	November 30, 2021 - December 2, 2021
	Type of Survey/Site Visit:	Re-accreditation
	Accreditation Determination:	Full Accreditation
	Plan of Correction Accepted Date:	N/A
	CHAP Accreditation Dates:	January 20, 2022 - January 20, 2025
	Method of Follow-up:	N/A

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted November 30, 2021 - December 2, 2021, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

Should you wish to appeal, please email your Director of Accreditation, Frances Petrella, with the details of your appeal request within the next 10 days of notification receipt.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

ID: *NOV3021_IMF*
Ref: *RHFX698400*

Plan of Correction Summary

Site Visit 12/17/2018 - 12/21/2018

CCN 551501

Organization

Bristol Hospice, LLC

Service Provider

BRISTOL HOSPICE-CALIFORNIA, LLC

374 EAST YOSEMITE AVENUE 200 MERCED, CA 95340

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Summary of Citations

Core	1
Hospice	2

Condition Level Deficiencies **0**

Plan of Correction Summary

CII.7i

Citation

CII.7i - The organization demonstrates compliance with its TB Exposure Control Plan.

It is required that the organization demonstrates compliance with its TB Exposure Control Plan.

This standard was not met as evidenced by a review of personnel files and agency policy. Policy NO. C:2-041.1 titled Tuberculosis Exposure Control Plan reads in part, "...C. Where required by state and/or local regulations, a two (2)-step Mantoux TST or TB Blood test (will be given to all personnel upon hire, if no TST or blood test will be given to all personnel upon hire, if no TST or blood test has been performed within 12 months of hire date, and thereafter, according to risk assessment. If the new hire has documented prior history of negative result within 12 months of hire, the organization may consider this the first stage of testing and the additional TST represents the second stage of two-step testing." 3 of 10 (30%) files reviewed revealed the agency did not follow policy related to the requirement for pre-employment TB screening and annual TB screen.
Record #99398, RN Case Manager hired 7/31/2017: the file evidenced one TB skin test result, dated 8/26/2017.
Record #39306, Volunteer Coordinator, hired 3/6/2017: the file evidenced one TB skin test result, dated 2/27/2017.
Record #19075, MSW, hired 5/4/2017: the file evidenced one TB skin test result, dated 4/27/2017.
This finding was confirmed with both the Regional Director of Operations and Regional Director of Quality who revealed they were aware that the policy and procedure had not been consistently followed and were putting a performance improvement plan in place.

Agency Response

What action will we take to correct the deficiency cited?

To comply with the CDC guidelines all clinical healthcare workers will be tested for TB by a 2 step TST or TB blood draw. All newly hired employeesand employees that have been hired within the past three years that have not had either a 2 step TST or TB blood test will have a mandatoryTB blood test. The mandatory testing will be completed by 2/15/2019. Going forward, for all newly hired employees the TB blood test, the first step of two step process or CXR will be scheduled by the HR department along with all of the new hire mandatory requirements. The Business Office Manager will update the HR spreadsheet reflecting the

date of TB blood draw, first step or CXR. The Business Office Manager will be responsible for scheduling the second step within two weeks of the fist skin test. The HR spreadsheet will be updated when results are obtained. The direct care employees will not provide services until the results are obtained. To maintain standard interpretation of the test results the employee will have annual TB blood testing or skin test. will be scheduled by the HR department along with all of the new hire mandatory requirements. The Business Office Manager will update theHR spreadsheet reflecting the date of TB blood draw or CXR. The HR spreadsheet will be updated when results are obtained. The direct care employees will not provide services until the results are obtained. To maintain standard interpretation of the test results the employee will have annual TB blood testing.or skin test.

Who is responsible to implement the corrective action?

Executive Director

When will the corrective action be implemented?

January 09, 2019

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

The Business Office Manager will review and document on the HR spreadsheet all of the mandatory required forms received fromthe corporate HR department including the TB blood draw results, the first and second skin test and/or the CXR..This information will be updated and maintained on the HR spreadsheet. The Executive Director will audit 100% of all new hire HR charts for compliance that all mandatory forms and tests have been completed.The Executive Director will also monitor that the HR spreadsheet is kept updated and current.The HR spreadsheet reviewed by theExecutive Director will be presented to the QAPI committee monthly,when 100% compliance is attained the HR spreadsheet will be submitted to the QAPI committee quarterly for continued compliance.

Plan of Correction Summary

CII.7n

Citation

CMS Tag: 579

CMS CFR: 418.60(a)

CII.7n - The organization demonstrates compliance with its Infection Control policies and procedures, which must be in compliance with accepted professional standards and principles.

It is required that the organization demonstrates compliance with its Infection Control policies and procedures, which must be in compliance with accepted professional standards and principles.

This standard was not met as evidenced by observation during home visits and review of agency policies. Policy No. C:2-055.1 titled Bag Technique reads in part, "...2) ...Hand washing will always be completed before opening bag. 3) After hand washing, the supplies and/or equipment needed for the visit will be removed from the bag. 4) The bag will contain a designated clean and dirty area.... 6) Hands will be decontaminated prior to returning clean equipment to bag." Policy No. C:2-048.1 titled Hand Hygiene reads in part, "...Hand decontamination with an alcohol-based hand rub: 3) Hand decontamination using an alcohol-based hand rub should be performed: A) Before having direct contact with patients; B) Before donning sterile gloves when performing sterile procedures...; C) After contact with a patient's intact skin (when taking a pulse, blood pressure or lifting a patient)... F) After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient; G) After removing gloves. Hand Washing with Soap and Water: 3) Rinse with warm water and dry the hands with a disposable towel from the fingers toward the forearm." 2 of 3 (67%) visits revealed clinical staff failed to follow the agency's Infection Control policies and procedures regarding accepted standards in hand washing and bag technique.
Record #18474: The patient resided in a skilled nursing facility and was admitted 5/7/2018. The aide was observed not following the Hand Hygiene policy in that the aide dried their hands with a paper towel from the forearm down to the finger tips.
Record #60730: The patient was admitted 7/23/2018. The RN reached into the clean section of the bag without cleaning their hands, to remove the blood pressure cuff, thermometer, and pulse oximeter. It was noted that he RN typed assessment information using the tablet keyboard and then returned directly to the patient to assess blood pressure, went back to the tablet keyboard to type, then returned to the patient to assess temperature, went back to the tablet keyboard to type, then examined the oxygen concentrator, touching the concentrator and tubing, then returning to the patient and touching the patient's lower extremity and assessed lung sounds. The RN did not clean hands after touching

inanimate objects or before touching the patient.

Agency Response

What action will we take to correct the deficiency cited?

Reeducation to all clinical staff on infection control agency policies C: 2-055 and C: 2-048 will be completed 1/10/2019. Verbalization and demonstration of hand hygiene and bag technique by each employee with a supervisor completed by 1/31/2019 with goal of 100% conformance.Beginning 2/1/2019 supervisor/designee will complete a minimum of two visits per employee over the next two months to monitor for 100% demonstrated conformance with policies C: 2-055 and C: 2-048. Expectation of new hire orientation, new hires will demonstrate conformance of the policies C:2-055 and C:2-048 during a joint visit with supervisor.

Who is responsible to implement the corrective action?

Director of Patient Care Services

When will the corrective action be implemented?

January 10, 2019

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Observation of compliance will be measured using "QAPI Visit Audit Tool". Use of this audit tool will be ongoing as part of the orientation process and all supervisory visits conducted for each staff member. Data from the audit tool will be tracked, trended, analyzed and reported to the QAPI Committee with the goal of 100% compliance. When 100% compliance is achieved and sustained for one quarter the QAPI Committee will determined further actions as needed. The QAPI Committee will report QAPI outcomes to the Governing Body.

Plan of Correction Summary

HII.5d

Citation

CMS Tag: 531

CMS CFR: 418.54(c)(7)

HII.5d - The Hospice bereavement plan of care is developed based on an assessment of the patient/family needs at the time of admission and during the provision of hospice care and when the patient dies and includes:
HII.5d1 - Patient/family grief and/or loss issues.
HII.5d2 - Survivor needs.
HII.5d3 - Social, spiritual, and cultural issues.
HII.5d4 - Services to be provided.
HII.5d5 - Referrals to be made.
HII.5d6 - Grief risk factors.
HII.5d7 - Potential for pathological grief reactions.
HII.5d8 - Individual counseling, support groups, letters and cards.

It is required that the Hospice bereavement plan of care is developed based on an assessment of the patient/family needs at the time of admission and during the provision of hospice care and when the patient dies and includes: patient/family grief and/or loss issues; survivor needs; social, spiritual, and cultural issues; services to be provided; referrals to be made; grief risk factors; potential for pathological grief reactions; and individual counseling, support groups, letters and cards.

This standard was not met as evidenced by review of policy and procedure, clinical record review and interview with the Bereavement Coordinator (12/20/2018). Policy N. H:2-008.1 titled Bereavement Services reads in part, "...The program will provide bereavement services to the families/caregivers of hospice patients before and after the patient's death in accordance with the plan of care. Procedure 2) After the bereavement risk assessment is completed, a plan will be developed to address bereavement/grief issues and will be implemented as needed." 1 of 1 (100%) applicable record of an expired patient was missing a bereavement care plan for the bereaved caregiver to which they were providing bereavement services [Record #37056: The patient was admitted 8/27/2018 and expired 9/24/2018. the EMR record for the bereaved does not contain a bereavement care plan but does contain documentation to show contact made from the clergy and bereavement coordinator]. The Bereavement Coordinator revealed that the bereavement care plans were completed on paper before the implementation of the Electronic Medical Record (EMR) and the focus for EMR training was with the RN Case Managers. The Bereavement Coordinator stated that they do send the mailings, make the phone calls, one on one support, and groups but some bereaved records do not include bereavement care plans in the EMR; the Bereavement

Coordinator did not know how many were missing bereavement plans of care and stated she was aware, "they are working on it," but could not provide any further information or clarification on what was being done to address the missing bereavement care plans or who was missing a bereavement care plan. The Regional Director of Quality confirmed this finding and stated there is a company-wide performance improvement plan in place.

Agency Response

What action will we take to correct the deficiency cited?

A mandatory in-service will be held with the bereavement staff and all supervisory staff to assure compliance in developing and documenting aCare Plan that reflects the needs of the bereaved based on bereavement assessment.Bereavement Plan of Care should reflect family need, as wellas a clear delineation of services to be provided and frequency of service delivery. The bereavement plan of care should be based on anassessment of the individual bereaved needs and includes specific scope and frequency of interventions and goals.

Who is responsible to implement the corrective action?

Executive Director

When will the corrective action be implemented?

January 10, 2019

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

100% of all new bereavement care plans will be audited by the Director of Patient Care Services and/or Supervisors for accuracy andcompletion.When 100% compliance has been achieved for at minimum three months the bereavement care plans will be audited with the 5% ofall discharged charts monthly. All auditing results will be presented to the QAPI committee and the committee will direct any additionalinterventions or measures based upon outcomes.

3

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

January 30, 2020

Gary Bordelon-Godfrey, Administrator
Bristol Hospice Georgia, Llc
2849 Paces Ferry Road, Suite 380
Atlanta, GA 30339

Dear Bordelon-Godfrey,

Enclosed is a copy of the report pertaining to the validation Licensure Inspection completed at your facility on January 21- 23, 2020 by this office. The report indicates that no deficiencies were cited during the inspection of your facility.

We appreciate the courtesy extended to our representatives during the visit. If you have any questions, please contact us at (404) 657-5700 or by email at Canessa.johnson@dch.ga.gov.

Sincerely,

Home Health & Hospice Programs
Healthcare Facility Regulation Division
Department of Community Health

Enclosure

MY

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

January 30, 2020

Gary Bordelon-Godfrey, Administrator
Bristol Hospice Georgia, Llc
2849 Paces Ferry Road, Suite 380
Atlanta, GA 30339

Dear Bordelon-Godfrey,

Enclosed is a copy of the report of the Medicare/Medicaid Validation survey conducted at your facility on January 21-23, 2020 by this office. The report indicates that **no deficiencies** were cited during the inspection of your facility.

We appreciate the courtesy extended to our representatives during the visit. If you have any questions, please contact us at (404) 657-5700 or by email at Canessa.johnson@dch.ga.gov.

Sincerely

Home Health & Hospice Programs
Healthcare Facility Regulation Division
Department of Community Health

Enclosure

MY

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111711	A. BUILDING _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL HOSPICE GEORGIA, LLC	2849 PACES FERRY ROAD, SUITE 380 ATLANTA, GA 30339

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS At the time of the survey, Bristol Hospice Georgia LLC was in substantial compliance with 42 CFR Part 418, Requirements for Hospices, as a result of a validation survey conducted on January 21-23, 2020. No deficiencies were cited:	L 000		

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

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

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	033-0357-H	A. BUILDING: _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL HOSPICE GEORGIA, LLC	2849 PACES FERRY ROAD, SUITE 380 ATLANTA, GA 30339

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	Initial Comments. Bristol Hospice Georgia LLC., was in compliance with Criminal Background Checks for Hospices, as a result of a validation survey conducted on January 21-23, 2020. No deficiencies were cited.	B 000		

State of GA Inspection Report

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111711	A. BUILDING _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL HOSPICE GEORGIA, LLC	**2849 PACES FERRY ROAD, SUITE 380 ATLANTA, GA 30339**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Bristol Hospice Georgia, LLC was in compliance with 42 CFR Part 418.113, Emergency Preparedness for Hospices, as a result of a validation survey conducted on January 21-23, 2020. No deficiencies were cited.	E 000		

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

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

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	033-0357-H	A. BUILDING: _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL HOSPICE GEORGIA, LLC	2849 PACES FERRY ROAD, SUITE 380 ATLANTA, GA 30339

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	INITIAL COMMENTS. Bristol Hospice Georgia, LLC was in compliance with Chapter 111-8-37, Rules and Regulations for Hospices, as a result of a validation survey conducted on January 21-23, 2020. No deficiencies were cited.	Z 000		

State of GA Inspection Report

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

4

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

January 24, 2019

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	12-1508

Location and/or Site Accredited:
Bristol Hospice Hawaii LLC
55 Merchant St., Ste 2900
Honolulu, HI 96813

Site Visit Dates:	December 10, 2018 – December 14, 2018
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	January 14, 2019
CHAP Accreditation Dates:	February 15, 2019 – February 15, 2022
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted December 10, 2018 – December 14, 2018, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: DEC1018_RA
Ref: SIQV751952

Action Plan Summary

Site Visit 11/15/2021 - 11/19/2021

CCN 121508

Organization

Bristol Hospice, LLC

Summary of Citations

Hospice	3

Condition Level Deficiencies **0**

Service Provider

Bristol Hospice Hawaii LLC

55 Merchant St. Ste 2900 Honolulu, HI 96813

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Action Plan Summary

HCDT.15.I

Citation

CMS Tag: 625

CMS CFR: 418.76(g)(1)

HCDT.15.I - Hospice aides are assigned to a specific patient by a registered nurse who is a member of the Interdisciplinary Group.
1. Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide.

It is required that hospice aides are assigned to a specific patient by a Registered Nurse who is a member of the Interdisciplinary Group. Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide.

This standard was not met as evidenced by interviews and review of clinical records. 2 of 18 (11%) applicable clinical records of patients who received Hospice Aide services, there was no documented evidence that the RN prepared clear written patient care instructions for the Hospice Aide.

Record #35019 - The terminal diagnosis was senile degeneration of the brain, and the patient lived at home with her husband. During the dates of service reviewed, the Hospice Aide visit frequency was two times a week. The Hospice Aide care plan (under "clinical orders" and Hospice Aide "interventions") stated, in part, complete "bed bath" and "transfer to or from tub or shower" every visit, which was also populated onto the Hospice Aide visit notes. The Hospice Aide care plan did not provide clear instructions on the type of bath to be performed.

Record #77250 - The terminal diagnosis was a hypertensive heart with heart failure, and the patient lived at a facility. During dates of service reviewed, the Hospice Aide visit frequency was two times a week for personal care plus an additional two times a week for the "sweet dreams" program. The Hospice Aide care plan for personal care under "interventions" stated, in part, "complete seated shower" and "OK for bed bath, for now, patient in isolation," which was assigned in the "special instructions" section of the Hospice Aide care plan. The Hospice Aide care plan did not provide clear instructions on the type of bath to be performed and if the patient was in isolation.

During the dates of service reviewed, the Quality Assurance Coordinator and Director of Patient Care Services confirmed that the patient was not in isolation. During a phone interview, the RN stated, "This patient had shingles and was on isolation before I received this patient," "This patient was transferred to me around July or August," and "In October the patient was not on isolation and should only be receiving a shower."

Action Plan Summary

During a phone interview, the Hospice Aide stated, "I remember in October that the patient was no longer on isolation and that the patient was only getting a shower."

This standard was not met as evidenced by interviews and review of clinical records with the Quality Assurance Coordinator and Director Patient Care Services.

Agency Response

What action will we take to correct the deficiency cited?

All RNs, LPNs, and CNAs were assigned the following Relias (online education platform) modules on November 18, 2021:o RNs: Plan of Correction – RN Training November 2021 o Aide/LPN: Plan of Correction – Aide/LPN Training November 2021o Online education will be completed, as assigned, by November 29, 2021. Report of completion will be maintained as part of the Performance Improvement Project, which is detailed in the monitoring process section below."All RNs/LPNs/CNAs were instructed, with handouts included, on the following on November 22, 2021:• Medicare Condition of Participation §418.76(g)(1)• CHAP Standard HCDT 15.I• An educational offering: Plan of Care Fast Blast• HCA POC PiP education for RNsPowerPointt• HCA POC PiP educati HCAsPowerPointt• Report of completion will be maintained as part of the Performance Improvement Project, which is detailed in the monitoring process section below."

Who is responsible to implement the corrective action?

The Executive Director (ED), Director of Patient Care Services (DPCS), or designee are responsible to implement the corrective actions listed above.

When will the corrective action be implemented?

November 18, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Quality Assurance Coordinator(s) will use the HCA POC Compliance Tracking audit tool associated with the HCA POC Compliance Performance Improvement Project to audit 10% charts (up to 20 patients) that have received aide services and that are on service during the month that is being audited to ensure 100% compliance. 100% compliance in all audit areas will be met and maintained for at least three consecutive monthly audits. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects, as determined. The QAPI Committee will present

the findings to the Governing Body for their review.

Action Plan Summary

HCDT.16.I

Citation	HCDT.16.I - A hospice aide provides services:
CMS Tag: 626	1. Ordered by the Interdisciplinary Group;
CMS CFR: 418.76(g)(2)	2. Included in the plan of care;
	3. Permitted to be performed under state law and regulation;
	4. Consistent with the hospice aide training.

It is required that a hospice aide provides services ordered by the Interdisciplinary Group and included in the plan of care.

This standard was not met as evidenced by interviews and review of clinical records. 2 of 18 (11%) applicable clinical records of patients who received Hospice Aide services, there was no documented evidence that the Hospice Aide provided services included in the plan of care.

Record #35019 - The terminal diagnosis was senile degeneration of the brain, and the patient lived at home with her husband. During the dates of service reviewed, the Hospice Aide visit frequency was two times a week. The Hospice Aide care plan (under "clinical orders" and Hospice Aide "interventions") stated, in part, complete "bed bath" and "transfer to or from tub or shower" every visit, which was also populated onto the Hospice Aide visit notes. The Hospice Aide visit note dated 7/20/2021 documented, in part, "performed transfer to or from tub or shower" and "not applicable: bed bath." There was no documented communication with the RN as to why the bed bath was not applicable. Additionally, a Hospice Aide visit note dated 7/23/2021 included, in part, "performed bed bath" and "performed transfer to shower or tub." There was no documented communication with the RN as to why the bed bath and transfer to the shower or tub were performed.

Record #77250 - The terminal diagnosis was a hypertensive heart with heart failure, and the patient lived at a facility. During dates of service reviewed, the Hospice Aide visit frequency was two times a week for personal care plus an additional two times a week for the "sweet dreams" program. The Hospice Aide care plan for personal care under "interventions" stated, in part, "complete seated shower" and "OK for bed bath, for now, patient in isolation," which was assigned in the "special instructions" section of the Hospice Aide care plan. The Hospice Aide visit note dated 10/25/2021 documented, in part, the assigned task of "seated shower - OK for bed bath, for now, patient in isolation" was "completed and tolerated well." There was no clear documentation if the Hospice Aide performed the shower as well as the bed bath. Additionally, the Hospice Aide visit note dated 10/27/2021 documented,

in part, "shower completed and tolerated well" after the assigned task of "seated shower - OK for bed bath, for now, patient in isolation." There was no documented communication with the RN as to why the shower was completed and why the "bed bath for now patient in isolation" was not completed.

During the dates of service reviewed, the Quality Assurance Coordinator and Director of Patient Care Services confirmed that the patient was not in isolation. The RN stated during a phone interview, "This patient had shingles and was in isolation before I received this patient. This patient was transferred to me around July or August, and in October, the patient was not in isolation and should only be receiving a shower." During a phone interview, the Hospice Aide stated, "I remember in October that the patient was no longer on isolation and that the patient was only getting a shower."

Agency Response

What action will we take to correct the deficiency cited?

All RNs, LPNs, and CNAs were assigned the following Relias (online education platform) modules on November 18, 2021:o RNs: Plan of Correction – RN Training November 2021o Aide/LPN: Plan of Correction – Aide/LPN Training November 2021All RNs/LPNs/CNAs were instructed, with handouts included, on the following on November 22, 2021:• Medicare Condition of Participation §418.76(g)(2)• CHAP Standard HCDT 16.I• An educational offering: Plan of Care Fast Blast• HCA POC PiP education for RNs PowerPoint Online education will be completed, as assigned, by November 29, 2021. Report of completion will be maintained as part of the Performance Improvement Project, which is detailed in the monitoring process section below"

Who is responsible to implement the corrective action?

The Executive Director (ED), Director of Patient Care Services (DPCS), or designee are responsible to implement the corrective actions listed above.

When will the corrective action be implemented?

November 18, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Quality Assurance Coordinator(s) will use the HCA POC Compliance Tracking audit tool associated with the HCA POC Compliance Performance Improvement Project to audit 10% charts (up to 20 patients) that have received aide services and that are on service during the month that is being audited to ensure 100% compliance. 100%

compliance in all audit areas will be met and maintained for at least three consecutive monthly audits. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects, as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HSIM.3.I

Citation

CMS Tag: 678

CMS CFR: 418.104(a)(7)

HSIM.3.I - A patient clinical record containing past and current findings is maintained for each hospice patient.

The record contains correct clinical information that is available to the patient's attending physician and hospice staff.

The record may be maintained electronically or on paper. Each patient's record includes, at a minimum:

1. The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes including the care and services provided;
2. Signed copies of the notice of patient rights and the hospice election statement;
3. Responses to medications, symptom management, treatments, and services;
4. Outcome measure data elements per regulation;
5. Physician certification and recertification of terminal illness as required;
6. Any advance directives;
7. Copies of inpatient discharge summary, as applicable;
8. Physician orders.

It is required that a patient clinical record containing past and current findings is maintained for each hospice patient. The record contains correct clinical information that is available to the patient's attending physician and hospice staff. The record may be maintained electronically or on paper. Each patient's record includes, at a minimum, physician orders.

This standard was not met as evidenced by an interview and review of clinical records, 1 of 20 (0.5%) records, and there was no documented evidence that the clinical record included physician's orders for a medication the patient was receiving.

Record #28086 - The "IDT Meeting Note" dated 8/5/2021 included, in part, "Daughter administers PRN Benadryl for itching." There was no documented physician's order for Benadryl in the clinical record.

During an interview, the Quality Assurance Coordinator stated that a physician's order for the Benadryl was not located in the clinical record.

Action Plan Summary

Agency Response

What action will we take to correct the deficiency cited?

All RNs/LPNs/CNAs were instructed, with handouts included, on the following on November 22, 2021:• Medicare Condition of Participation §418.104(a)(7)• CHAP Standard HSIM 3.I• An educational offering: Plan of Care Fast Blast• An educational offering: PRN and Scheduled Opioid HIS Fast Blast• Online education will be completed, as assigned, by November 29, 2021. Report of completion will be maintained as part of the Performance Improvement Project, which is detailed in the monitoring process section below"

Who is responsible to implement the corrective action?

The Executive Director (ED), Director of Patient Care Services (DPCS), or designee are responsible to implement the corrective actions listed above.

When will the corrective action be implemented?

November 22, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Quality Assurance Coordinator(s) will use the Medication Reconciliation audit tool associated with the Medication Reconciliation Performance Improvement Project to audit 10% of charts that are admitted to service during the month that is being audited to ensure 100% compliance. 100% compliance in all audit areas will be met and maintained for at least three consecutive monthly audits. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects, as determined. The QAPI Committee will present the findings to the Governing Body for their review.

5

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

May 17, 2018

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
2016 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Bristol Hospice - Miami-Dade, LLC
5201 Blue Lagoon Drive, Suite 570
Miami, FL 33126-2075

Site Visit Dates:	April 3, 2018 – April 5, 2018
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
CHAP Accreditation Dates:	April 19, 2018 – February 15, 2019

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted April 3, 2018 – April 5, 2018, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: *APR0318_HGC*
Ref: *DAQJ226186*

Action Plan Summary

Site Visit 1/11/2021 - 1/13/2021

CCN 101558

Organization

Bristol Hospice, LLC

Summary of Citations

Hospice	1

Condition Level Deficiencies **0**

Service Provider

Bristol Hospice - Miami Dade, LLC

5201 Blue Lagoon Drive Ste 570 Miami, FL 33126-2075

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Action Plan Summary

HCPC.19.I

Citation

CMS Tag: 543

CMS CFR: 418.56(b)

HCPC.19.I - The hospice designates a registered nurse member of the IDG to:

1. Provide coordination of care;
2. Ensure continuous assessment of each patient's and family's needs;
3. Ensure the implementation of the interdisciplinary plan of care.

Hospice care and services provided to patients and families follow the individualized plan of care established by:

1. The hospice IDG in collaboration with the attending physician (if any);
2. The patient or patient representative;
3. The primary caregiver in accordance with the patient's needs.

It is required that the hospice designates a registered nurse member of the IDG to: ensure the implementation of the interdisciplinary plan of care. Hospice care and services provided to patients and families follow the individualized plan of care established by: the hospice IDG in collaboration with the attending physician (if any); the patient or patient representative; the primary caregiver in accordance with the patient's needs.

This standard was not met as evidenced by clinical record review, review of agency policy and interview with the agency Director of Clinical Services. The policy NURSING CARE, POLICY NO. H:2-004.1 addressed how professional nursing services will be provided. It states in part, in PROCEDURE 1: "The hospice nurse will participate in developing and implementing the plan of care." 1 of 13 (8%) records revealed no documentation to support compliance with the ordered nursing visit frequency [Record #47155: The physician order dated 12/29/2020 ordered the nursing visit frequency as 1-2 visits per week. A nursing visit was documented on 12/29/2020 and 12/30/2020. Two subsequent visits were documented during the same week on 12/31/2020 and 1/2/2021. No order was documented to allow for the two subsequent visits, resulting in 4 visits documented but only 2 ordered. There was no order to change the frequency of the nursing visits, thus the nurse did not implement the IDG plan of care]. In an interview with the agency Director on 1/12/2021, she stated that the documented nursing visits did not match the ordered visit frequency.

Action Plan Summary

Agency Response

What action will we take to correct the deficiency cited?

o 1/13/2021 - Initial survey education provided to direct-patient care teams by Inservice.o Education included related.? CHAP Standard HCPC.21.I? CMS CFR 418.56 (b) ? Cited agency policy H:2-004.1.o Education Points: ? Policy- NURSING CARE, POLICY NO. H:2-004 addressing how nursing services are provided regarding developing and implementing the plan of care.? RNCM, in concert with the IDT, is to provide coordination of care.? RNCM, in concert with the IDT, is to ensure continuous assessment of each patient and family's needs.? RNCM, in concert with the IDT, is to ensure implementation of the interdisciplinary plan of care.? Hospice care and services provided to patients and families follow the individualized plan of care established by:• The hospice IDT in collaboration with the attending physician if any • The patient or patient representative• The primary caregiver in accordance with the patient's needs.? The care plan reflects the picture of your patient/family. ? The care plan changes as your patient changes.? All things going on with the patient must be included in the plan of care.? Inclusion of the follow item in the individualize plan of care:• Visit Frequencies for all disciplines are established by the IDT, in conjunction with the patient and family, and RNCM. o QAPI Meeting held to update the QAPI Committee on Plan of Correction and actions to be taken.o All Interdisciplinary Team (IDT) members on the policies noted at the bottom of this section. Policies emailed to all IDT Members 1/28/2021o Clinical Leadership was educated on the below. Content also emailed to clinical leadership. o Hospice Medical Directors and other Providers educated on the content reflected at the beginning of this section. Content also emailed to the associate medical director and the nurse practitioner. o Date the above interventions will be accomplished.o 1/29/2021 – Initial Survey Education Power Point Presentation provided to all newly hired staff for the duration of this plan of correction.o 1/29/21 - Date by which all current, direct-patient care staff will receive this education.o 1/29/21 Survey Task Force established and meets weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement until stated goal is met.

Who is responsible to implement the corrective action?

Executive Director & Director of Patient Care Services or designee

When will the corrective action be implemented?

January 13, 2021

Action Plan Summary

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o The Quality Assurance Coordinator(s) will audit 10 new admissions and randomly selected records weekly for evidence of IDT:? Coordination of Care? Assessment of patient/family needs? Individualization of care per patient needs.o The audit findings will be maintained in the CHAP Plan of Correction binder and reviewed in the Hospice leadership team's Plan of Correction Meetingo The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary by the QAPI Committee.o Audits will continue until 100% compliance is achieved and sustained for 90 days, at which point regular monitoring will continue within the QAC chart audit requirement.

6

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

January 15, 2019

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	38-1559

Location and/or Site Accredited:
Bristol Hospice - Oregon LLC
10365 SE Sunnyside Road, Suite 340
Clackamas, OR 97015

Site Visit Dates:	November 6, 2018 – November 9, 2018
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	December 14, 2018
CHAP Accreditation Dates:	February 15, 2016 – February 15, 2019
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted November 6, 2018 – November 9, 2018, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: *NOV0618_UUG*
Ref: *SMOA748224*

Action Plan Summary

Site Visit 9/21/2021 - 9/23/2021

CCN 381559

Organization

Bristol Hospice, LLC

Summary of Citations

Hospice	5

Condition Level Deficiencies **0**

Service Provider

Bristol Hospice - Oregon LLC

10365 SE Sunnyside Road Suite 340 Clackamas, OR 97015

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Action Plan Summary

HCPC.15.I

Citation

CMS Tag: 530

CMS CFR: 418.54(c)(6)

HCPC.15.I - The documented comprehensive assessment includes a drug profile that contains the patient's current:

1. Prescription and over-the-counter (OTC) drugs;
2. Supplements;
3. Herbal remedies;
4. Other alternative treatments that could affect drug therapy.

The medication review process includes the identification of the following:

1. The effectiveness of drug therapy;
2. Drug side effects;
3. Actual or potential drug interactions;
4. Duplicate drug therapy;
5. Drug therapy associated with laboratory monitoring.

The assessment includes evidence that common side effects of medication in the hospice populations are anticipated, and, as appropriate, preventive measurements are implemented to manage the side effects.

The drug profile is updated per the hospice policy and procedure, but, at minimum, at the time of each comprehensive assessment and/or when new medication is added or changes are made to existing medication.

It is required that the documented comprehensive assessment includes a drug profile that contains the patient's current prescription and over-the-counter (OTC) drugs. The drug profile is updated per the hospice policy and procedure, but, at minimum, at the time of each comprehensive assessment and/or when new medication is added, or changes are made to existing medication.

This standard was not met as evidenced by a review of agency policy, clinical records, and an interview with the Administrator. Agency policy "Medications" (No. 2-004), (revised May 2020), read in part, "Patients receiving medications administered by the hospice will have a current, accurate medication profile in the clinical record. The medication profiles will be updated for each change to reflect current medications, and new and/or discontinued medications." In addition, "upon admission to hospice, the admitting Registered Nurse will initiate a medication profile to document the current medication regimen, including name, dose, strength, route, frequency, date and time of administration." 3 of 15 (20%) records reviewed revealed the agency had failed to update the

medication profile with completed and updated medications as ordered for an accurate patient medication history and make a current, complete medication profile.

Record #79148: Start of care (SOC) 07/6/2021, an 83-year-old diagnosed with CHF due to ischemic cardiomyopathy and Alzheimer's Disease. This client was documented as having a previous hospitalization from 12/28/2020 thru 1/5/2021 for increased weakness. The Initial Physician Certification of Terminal Illness was signed and dated 7/7/2021. Per documentation reviewed, "he is short of breath and does not always use his oxygen." In addition, the Skilled Nurse notes of 7/23/2021 documented "facility will monitor and apply supplemental 02 if needed, and as tolerated by the patient." The current medication sheet does not include Oxygen. The medication report was incomplete in that the Oxygen did not include the delivery device/modality, specific parameters, and the amount (usually expressed as a liter flow per minute, or a percentage of Oxygen to be delivered by cannula or mask depending on the delivery system to be utilized.)

Record #60131: Start of Care (SOC), an 84-year-old client, diagnosed with Waldenstrom Macroglobulinemia. During a visit at the patient's home, on the morning of 9/22/2021, the patient had medications on the counter reading on the medication bottle, Linzess 145mcg 1-2 caps daily. The medication sheet in the home did not include Linzess. In addition, the most current medication list provided by the agency did not contain this medication on the drug profile. During this home visit, the nurse assigned to attend to this client confirmed that the medication had not been listed on the medication sheet in the patient's home, to ensure that an accurate medication history was available to both the patient and their family, as well as being available to other medical professionals involved with this client's care.

Record #36006: Start of care (SOC) 2/9/2021, an 87-year-old client was diagnosed with Mesothelioma. The plan of care, dated 8/1/2021, listed "Oxygen 2LPM via NC PRN comfort." The current medication sheet did not list Oxygen. In addition, the current medication list contains Keflex 500mg 2 times a day x 7d for right toe infection ordered on 7/30/2021. There is no end/discontinuation date listed for the Keflex. Additionally, per review of the documentation relating to the NP face-to-face visit documented as having taken place on 9/17/2021, "The right first toe shows no s/s infection, and there is neither documentation nor indications that Keflex was restarted or discontinued.

Per the Administrator, the current electronic health record limits the agency's clinicians to add Oxygen as a medication. The only way to add it is by adding it as an unlisted/compounded medication. The Administrator stated that this is not consistently being done. The agency updated the

medication sheets in the EMR prior to exit, per this Administrator.

Agency Response

What action will we take to correct the deficiency cited?

All staff was instructed on September 21, 2021, to:• Ensure patient records have oxygen added to the medication list as ordered by a physician• Review and ensure any medication that is ordered for a specific amount of time is discontinued once completedAll staff was instructed on September 23, 2021, to:• Update the medication list based on what the patient is takingAll staff was instructed, with handouts included, on the following on October 1, 2021:• Medicare Condition of Participation §418.54(c)(6) • CHAP Standard HCPC 15. I• Oxygen Instruction• Addendum to SN Admission (Medications)• Fast Blast: Physician Orders – Oxygen and Suction

Who is responsible to implement the corrective action?

The Executive Director (ED), Director of Patient Care Services (DPCS), or designee are responsible to implement the corrective actions listed above.

When will the corrective action be implemented?

September 21, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Quality Assurance Coordinator(s) will use the Medication reconciliation audit tool associated with the Medication Reconciliation Performance Improvement Project to audit 5% of charts that are on service during the month that is being audited to ensure 100% compliance. 100% compliance in all audit areas will be met and maintained for at least three consecutive monthly audits. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HCPC.19.I

Citation

CMS Tag: 540

CMS CFR: 418.56(a)(1)

HCPC.19.I - The hospice designates a registered nurse member of the IDG to:

1. Provide coordination of care;
2. Ensure continuous assessment of each patient's and family's needs;
3. Ensure the implementation of the interdisciplinary plan of care.

Hospice care and services provided to patients and families follow the individualized plan of care established by:

1. The hospice IDG in collaboration with the attending physician (if any);
2. The patient or patient representative;
3. The primary caregiver in accordance with the patient's needs.

It is required that the hospice designates that the Registered Nurse, as a member of the IDG Team, to provide coordination of care, so as to ensure continuous assessments of each patient's and family's needs. This to be able to ensure the implementation of the interdisciplinary plan of care. Hospice care and services is provided to patients and families following an individualized plan of care as established by: The hospice IDG, in collaboration with the attending physician (if any), the patient or patient representative, [and] the primary caregiver in accordance with the patient's needs.

This standard was not met as evidenced by a review of agency policy, clinical records, along with an interview with the Administrator on 09/22/2021. Agency policy "Interdisciplinary Group Coordination of Care" (No. 1-035), revised May 2020, read in part, "The hospice will utilize a case management system to guide an interdisciplinary group to provide comprehensive, coordinate health care to patients and families/caregivers by the hospice." 1 of 15 (6%) records reviewed revealed that the agency had failed to provide coordination of care following assessment findings to the Medical Director, IDT/IDG members ongoing evaluation and assessment requirements to ensure the provision of hospice Also lacking were recommendations to the IDT/IDG for modifications to the plan of care based on patient's response to hospice services.

Record #79148: The Start of Care (SOC) 7/6/2021, diagnosis included CHF, secondary to ischemic cardiomyopathy, and Alzheimer's Dementia,

with a previous hospitalization from 12/28/2020 through 1/5/2021 for weakness and weight loss. On 9/10/2021, the Skilled Nurse documented "patient had been found lying on his back with his head on the back of a fallen chair. The patient has complained of some pain." However, the nurse also documented that the patient was at that time assessed for pain and had reported" no pain." This was followed by a narrative section indicating that the patient reported that they had mild pain r/t to the fall, with no injuries being evident. The Skilled Nurse had reported the fall to the daughter. Further investigation revealed that the Medical Director and the IDT/IDG had not been appraised of this event until the IDG of 9/22/2021. This was 11 days after the fall. There was no documented evidence that care coordination had taken place in this hospice care setting. In addition, the previous IDG/IDT dated 9/8/2021, under the narrative by the RN stated, "he continues to be a fall risk due to increased weakness, unsteadiness on his feet, with evidence of an ongoing lack of safety awareness. This patient is unable to observe safety and fall precautions due to cognitive impairment."

In an interview on 9/22/2021, with the Administrator, it was stated that the RN should have notified the Medical Director.

Agency Response

What action will we take to correct the deficiency cited?

All staff was instructed on September 21, 2021, and September 23, 2021, to:• Document communication and details of updates to family members and collaboration after falls or incidents in Casamba, not just on incident forms. The documentation in the record must be clear regarding communication and collaboration.• Continue to show collaboration and communication to all parties in the medical record. All staff has completed the following Relias module:• Understanding the IDG, the Plan of Care, Conditions of Participation All staff was instructed, with handouts included, on the following on October 1, 2021:• Medicare Condition of Participation §418.56(a)(1)• CHAP Standard HCPC 19. IAll RNs and LPNs have been assigned the following Relias module with a due date of October 18, 2021:• The Interdisciplinary Group, the Care Planning Process, and Coordination of Services in Hospice

Who is responsible to implement the corrective action?

The Executive Director (ED), Director of Patient Care Services (DPCS), or designee are responsible to implement the corrective actions listed above.

When will the corrective action be implemented?

October 01, 2021

Action Plan Summary

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Quality Assurance Coordinator(s) will use the Coordination of Care audit tool associated with the Coordination of Care Performance Improvement Project to audit 5% of charts that are on service during the month that is being audited to ensure 100% compliance. 100% compliance in all audit areas will be met and maintained for at least three consecutive monthly audits. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HCPC.21.I

Citation

CMS Tag: 549

CMS CFR: 418.56(c)(4)

HCPC.21.I - Each patient's individualized written plan of care:
1. Reflects patient and family goals;
2. Identifies planned interventions based on problems identified in the initial and updated comprehensive assessments;
3. Includes all services necessary for the palliation and management of the terminal illness, including the following:
a) Intervention to manage pain and symptoms;
b) A detailed statement of the scope and frequency of services necessary to meet specific patient and family needs;
c) Measureable outcomes anticipated from implementing and coordinating the plan of care;
d) Drugs and treatment necessary to meet the needs of the patient;
e) Medical supplies and appliances necessary to meet the needs of the patient;
4. Includes the Interdisciplinary Group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC;
a) The documentation in the patient's record is in accordance with the hospice's policies and procedure.

It is required that each patient's individualized written plan of care: Reflects patient and family goals, identifies planned interventions based on problems identified in the initial and updated comprehensive assessments, and includes all services necessary for the palliation and management of the terminal illness, including the following: drugs and treatment necessary to meet the needs of the patient.

This standard was not met as evidenced by a review of agency policy and procedures, clinical records, and an interview conducted with the Administrator. Agency policy, "Ongoing Comprehensive Assessment" (No. 1-015), revised May 2020, read in part, "The scope and intensity of ongoing hospice patient assessments will be determined by the patient's prognosis, diagnoses, condition, desire for care, response to previous care, and the care setting...based on the assessments, the plan of care – including problems, needs, goals, and outcomes – will be reviewed and updated by the interdisciplinary group members responsible for the case." The agency had failed to include integumentary or wound care needs being addressed as a problem in the individualized written plan of care in 1 of 15 (6%) records reviewed.

Record #12481 – The Start of Care (SOC) 9/10/2021, a 99-year-old client

whose diagnosis included: Senile degeneration of the brain. The SOC visit conducted by the RN on 9/10/2021, and the follow-up RN visit conducted on 9/11/2021, included documentation of four separate stage 1 pressure injuries. These lesions were noted as follows. Wound #1 (dorsal right great toe pressure injury stage 1), wound #2 (dorsal left foot pressure injury stage 1), wound #3 (anterior right knee pressure injury stage 1), and wound #4 (anterior left knee pressure injury stage 1). The hospice Plan of Care dated 9/10/2021, with certification period 9/10/2021 through 12/8/2021, signed by attending NP on 9/19/2021 did not include mention of integumentary or wound care being addressed as a problem. Any drugs or treatment that might have been required to meet the needs of the patient, relating to the integumentary interventions that might be ordered to address the assessed Stage 1 lesions were absent.

In an interview with the Administrator, it was stated, "care plan items regarding wound care were missed."

Agency Response

What action will we take to correct the deficiency cited?

All staff was instructed on September 21, 2021, to:• Include all wounds on the care plan from the start of care, including minor skin breakdownAll staff was instructed on September 23, 2021, to:• Create individualized care plans based on interventions appropriate from findings of the comprehensive assessments. • Ensure treatments are initiated according to the patient assessment.All staff has completed the following Relias module:• Understanding the IDG, the Plan of Care, Conditions of Participation All staff was instructed, with handouts included, on the following on October 1, 2021:• Medicare Condition of Participation §418.56(c)(4) • CHAP Standard HCPC 21. I• Fast Blast an education offering: Physician Orders – Plan of Care • Documenting a Wound in the Electronic Medical RecordAll RNs and LPNs have been assigned the following Relias (Online Education Platform) module with a due date of October 18, 2021:• The Interdisciplinary Group, the Care Planning Process, and Coordination of Services in Hospice

Who is responsible to implement the corrective action?

The Executive Director (ED), Director of Patient Care Services (DPCS), or designee are responsible to implement the corrective actions listed above.

When will the corrective action be implemented?

October 01, 2021

What is the monitoring process we will put into place to ensure

implementation and effectiveness of this corrective action plan?

Quality Assurance Coordinator(s) will use the Care Plan audit tool associated with the Plan of Care Performance Improvement Project to audit 5% charts (up to 20 patients) that are on service during the month that is being audited to ensure 100% compliance. 100% compliance in all audit areas will be met and maintained for at least three consecutive monthly audits. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HSIM.3.I

Citation

CMS Tag: 678

CMS CFR: 418.104(a)(7)

HSIM.3.I - A patient clinical record containing past and current findings is maintained for each hospice patient.

The record contains correct clinical information that is available to the patient's attending physician and hospice staff.

The record may be maintained electronically or on paper. Each patient's record includes, at a minimum:

1. The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes including the care and services provided;
2. Signed copies of the notice of patient rights and the hospice election statement;
3. Responses to medications, symptom management, treatments, and services;
4. Outcome measure data elements per regulation;
5. Physician certification and recertification of terminal illness as required;
6. Any advance directives;
7. Copies of inpatient discharge summary, as applicable;
8. Physician orders.

It is required that a patient clinical record containing past and current findings is maintained for each hospice patient. The record contains correct clinical information that is available to the patient's attending physician and hospice staff. The record may be maintained electronically or on paper. Each patient's record includes, at a minimum, Physician orders.

This standard was not met as evidenced by the review of agency policy, clinical records, and interview conducted with the Administrator. Agency policy, "Ongoing Comprehensive Assessment" (No. 1-015), revised May 2020, read in part, " hospice patient assessments will be determined by the patient's prognosis, diagnoses, condition, desire for care, response to previous care, and the care setting...based on the findings of the assessment, change/verbal orders will be generated and forwarded to the physician (or other authorized independent practitioners) as needed." This revealed that the agency failed to ensure wound care orders in 1 of 15 (6%) records reviewed.

Record #12481 – The Start of Care (SOC) 9/10/2021, a 99-year-old whose diagnosis included: Senile degeneration of the brain. The SOC visit

conducted by the RN on 9/10/2021 and the follow-up RN visit from 9/11/2021 included documentation of 4 separate stage 1 pressure injuries noted as wound #1 (dorsal right great toe pressure injury stage 1) , wound #2 (dorsal left foot pressure injury stage 1), wound #3 (anterior right knee pressure injury stage 1), and wound #4 (anterior left knee pressure injury stage 1). The hospice Plan of Care dated 9/10/2021 with certification period 9/10/2021 through 12/8/2021 and signed by attending NP on 9/19/2021 did not include any documented evidence of wound care orders directed at treating these reported lesions.

In an interview with the Administrator, it was stated, "wound care orders were missed."

Agency Response

What action will we take to correct the deficiency cited?

All staff was instructed on September 23, 2021, to:• Create the initial plan of care, update the plan of care, conduct an initial assessment, perform a comprehensive assessment. Complete clinical notes to include the care provided, appropriate symptom management, treatments, and services.• Ensure that all wounds have care plans and interventions initiated when the wound is assessed. All staff was instructed, with handouts included, on the following on October 1, 2021:• Medicare Condition of Participation §418.104(a)(7) • CHAP Standard HSIM 3.I• Fast Blast (Educational Offering): Physician Orders – Plan of Care • Documenting a Wound• Fast Blast(Educational Offering): Wound Care Consults with OptumAll RNs and LPNs have been assigned the following Relias module with a due date of October 18, 2021:•Optum Wound Care Modules (Focused Educational Offering) 2021

Who is responsible to implement the corrective action?

The Executive Director (ED), Director of Patient Care Services (DPCS), or designee are responsible to implement the corrective actions listed above.

When will the corrective action be implemented?

October 01, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Quality Assurance Coordinator(s) will use the Wound audit tool associated with the Wound Care Performance Improvement Project to audit 5% of charts that are on service during the month that is being audited to ensure 100% compliance. 100% compliance in all audit areas will be met and maintained for at least three consecutive monthly audits. Findings will be tracked, trended, and presented to the QAPI Committee.

Action Plan Summary

The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HSRM.16.I

Citation	HSRM.16.I - The hospice obtains a criminal background check on all hospice employees who have direct patient contact or access to patient records.
CMS Tag: 795	1. Hospice contracts require that all contracted employees who have direct patient contact or access to patient records obtain criminal background checks.
CMS CFR: 418.114(d)(1)	2. Criminal background checks are obtained in accordance with state requirements.
	a) In the absence of state requirements, criminal background checks are obtained within three (3) months of the date of employment for all states in which the individual has lived or worked during the past three (3) years.
	It is required that the hospice obtains a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts require that all contracted employees who have direct patient contact or access to patient records obtain criminal background checks.
	This standard was not met as evidenced by contract review and an interview with the Administrator on 9/23/2021. This revealed that the agency had failed to ensure that the Medical Supply Distributor and Durable Medical Equipment contracts contained the required verbiage that all contracted entities are to obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.

Agency Response	**What action will we take to correct the deficiency cited?**
	Immediate action included leadership team education on the following:• Medicare Condition of Participation §418.114(d)(1) • CHAP Standard HSIM 16.1On 10/6/2021, all contracts were reviewed to determine that all agency contracts are currently in compliance. Additionally, all newly initiated contracts will be audited to determine compliance with the standard before obtaining signatures.
	Who is responsible to implement the corrective action?
	The Executive Director or designee.
	When will the corrective action be implemented?

Action Plan Summary

October 06, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

The Executive Director will audit every new contract upon initiation before signatures before contract utilization. 100% compliance in all audit areas will be met and maintained for at least three consecutive monthly audits. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

7

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

CHAP

July 15, 2020

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	45-1743
	Location and/or Site Accredited: Bristol Hospice - Pathways, L.L.C. 115 Park Place Blvd., Suite 100 Waxahachie, TX 75165	
	Site Visit Dates:	June 23, 2020 - June 25, 2020
	Type of Survey/Site Visit:	Initial
	Accreditation Determination:	Full Accreditation
	Medicare Certification:	Pending
	Deemed Status Recommendation:	Deemed Status Recommended
	Plan of Correction Accepted Date:	July 6, 2020
	Effective Date of Accreditation:	July 6, 2020
	Expiration Date of Accreditation:	July 6, 2023
	Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted June 23, 2020 - June 25, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
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CC: CMS Regional Office (CMS RO VI - Dallas)
CMS Central Office
State Agency

Action Plan Summary

HCDT.15.I

Citation	HCDT.15.I - Hospice aides are assigned to a specific patient by a registered nurse who is a member of the Interdisciplinary Group. 1. Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide.
CMS Tag: 625	
CMS CFR: 418.76(g)(1)	

It is required that hospice aides are assigned to a specific patient by a registered nurse who is a member of the Interdisciplinary Group. Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide.

This standard was not met as evidenced by review of agency policy, clinical record review and interview with the Executive Director. Agency policy H:2-030 (revised October, 2015) titled "The Plan of Care" stated, in part, "A written individualized patient and family/caregiver plan of care will be established and maintained for each individual admitted to the hospice program." 1 of 10 (10%) applicable records with hospice aide services revealed a lack of clear and specific written instructions for the hospice aide assignments, thus leaving the aide to make decisions that are outside of the aide's scope of practice [Record #94819: This patient was admitted 2/10/2020 with a diagnosis of dementia. The hospice aide assignment initiated by the RN on 2/10/2020 assigned the hospice aide to give a "Bath of choice as requested." Per ongoing skilled nursing assessments and POC updates, the patient was unable to make their needs known due to being lethargic and oriented to self only]. Interview with the Executive Director on 6/25/2020 confirmed the findings and "education and in-services were already being scheduled" by end of the site visit. The findings were also confirmed with the Director of Patient Care Services, Executive Director, Quality Assurance Coordinator, Vice President of Quality, and Regional Director of Quality during final exit on 6/25/2020.

Agency Response

What action will we take to correct the deficiency cited?

Who is responsible to implement the corrective action?

When will the corrective action be implemented?

What is the monitoring process we will put into place to ensure

Action Plan Summary

HCDT.18.I

Citation

CMS Tag: 628

CMS CFR: 418.76(g)(4)

HCDT.18.I - Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities.

The hospice aide must also complete appropriate records of service, including the report of changes in the patient's needs.

Hospice aide documentation complies with hospice policies and procedures.

It is required that hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities. The hospice aide must also complete appropriate records of service, including the report of changes in the patient's needs. Hospice aide documentation complies with hospice policies and procedures.

This standard was not met as evidenced by review of agency policies, clinical record review and interview with the Executive Director and Hospice Aide. Agency policy H:2-005 (revised October, 2015) titled "Hospice Aide Services" stated, in part, "Hospice aide duties may include reporting changes in the patient's condition and needs." Agency policy H:2-035 (revised October, 2015) titled "Interdisciplinary Group Coordination of Care" stated, in part, "Hospice personnel will communicate changes in a timely manner via telephone, secure mail and/or text message, one-on-one meetings, interdisciplinary group meeting form, and home visits. Documentation of all communications will be included in the clinical record on a communication note, interdisciplinary group meeting form, and/or clinical note." 1 of 10 (10%) applicable records of patients receiving hospice aide services revealed no documented evidence that the hospice aide reported changes to the RN that may impact the plan of care [Record #99128: This patient was admitted on 11/30/2019. Hospice aide notes dated 5/22/2020, 6/8/2020, and 6/15/2020 documented that all care was provided but the record included documentation that the patient did not receive a change of bed linens or application of compression stockings as assigned in the hospice aide plan of care. Notifications sent by the hospice aide to the care team for each day revealed activities reported to the team that were completed, not what was incomplete. The record lacked documentation that the RN was notified of the interventions not

performed]. Interview with the hospice aide on 6/24/2020 revealed that when an intervention is not performed, the process is to notify the RN. Interview with the Executive Director on 6/25/2020 revealed that the hospice aide notifies the care team daily of activities via secure messaging and confirmed that notification did not include interventions not performed. The findings were also confirmed with the Director of Patient Care Services, Executive Director, Quality Assurance Coordinator, Vice President of Quality, and Regional Director of Quality during final exi

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Agency Response

What action will we take to correct the deficiency cited?

Who is responsible to implement the corrective action?

When will the corrective action be implemented?

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Action Plan Summary

HIPC.2.I

Citation

CMS Tag: 579

CMS CFR: 418.60(a)

HIPC.2.I - The hospice follows accepted standards of practice to prevent the transmission of infections and communicable disease, including the use of standard precautions, such as:

1. Hand hygiene;
2. Use of gloves, mask, eye protection, or face shield depending on anticipated exposure;
3. Safe handling of equipment in the patient's care environment if it is likely to have been contaminated with body fluids;
4. Safe handling of soiled items in the patient's care environment;
5. Other requirements of applicable state and federal law and regulation.

It is required that the hospice follows accepted standards of practice to prevent the transmission of infections and communicable disease, including the use of standard precautions, such as hand hygiene; use of gloves, mask, eye protection, or face shield depending on anticipated exposure; safe handling of equipment in the patient's care environment if it is likely to have been contaminated with body fluids; safe handling of soiled items in the patient's care environment; other requirements of applicable state and federal law and regulation.

This standard was not met as evidenced by review of agency policies, observation on home visits and interview with the Registered Nurse and Executive Director. Agency policy C:2-055 (revised October, 2015) titled "Bag Technique" states, in part, "When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment will be returned to the bag. Hands will be decontaminated prior to returning clean equipment to bag." Agency policy C:2-048 (revised October, 2015) titled "Hand Hygiene" states, in part, "Hand decontamination using an alcohol-based hand rub should be performed before having direct contact with patients, after contact with patient's intact skin (when taking a pulse, blood pressure or lifting a patient), after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient, and after removing gloves." 1 of 3 (33%) visits revealed clinical staff failed to follow infection control procedures in accordance with agency policies related to hand washing and bag technique [Record #99128: This patient was admitted 11/30/2019. During the observed home visit on 6/23/2020, the RN (personnel record #80927) was observed sanitizing hands prior to entering the home and after entering the home. The RN laid a barrier down and placed her bag

on the barrier. She then pulled her tablet out of the bag and placed it on the couch without a barrier. She sanitized her hands and removed the BP cuff, thermometer, and stethoscope from the bag and placed the equipment on the clean barrier. The RN picked up the tablet from the couch and began to enter information. The RN began providing patient care without donning gloves or re-sanitizing her hands. She checked the patient's temperature, and placed the thermometer onto the dirty barrier, entered information into tablet; obtained the patient's BP using cuff and stethoscope, then placed the cuff and stethoscope on the dirty barrier and entered information into tablet. She removed the stethoscope from the dirty barrier and continued to assess the patient. The RN placed her stethoscope on the dirty barrier and entered information into tablet using touchscreen and keyboard. She then reached into the bag, then pockets, and obtained gloves, donned gloves and reached into the bag and obtained sanitizing wipes. The RN did not sanitize her hands prior to reaching into bag, pockets or donning gloves. The RN cleaned the equipment and placed the cleaned equipment into the bag, cleaned the tablet keyboard, removed gloves and placed the tablet in her lap. The tablet was then placed on the dirty barrier and the RN touched the patient's ankles without sanitizing her hands prior to assessment. The RN sanitized her hands, grabbed the tablet from the dirty barrier and began entering information using keyboard and touchscreen. The tablet was then placed into the bag without either the tablet or hands being sanitized. The RN obtained a pen from the bag and signed the hospice binder located in the patient's home and placed the pen back into the bag without sanitizing the pen or her hands. Tablet retrieved from bag and handed to patients caregiver to e-sign on tablet. The tablet was retrieved from the caregiver and placed back into the bag without sanitizing the tablet or her hands. Medical waste was then handed to the family and the RN exited the residence without cleaning her hands]. Interview with the RN on 6/23/2020 revealed that tablet is cleaned before and after each use with "bleach wipes". Interview with the Executive Director on 6/23/2020 confirmed the findings and revealed that an in-service and one-on-one education will be conducted as soon as possible.

The findings were also confirmed with the Director of Patient Care Services, Executive Director, Quality Assurance Coordinator, Vice President of Quality, and Regional Director of Quality during final exit on 6/25/2020.

NOTE: The agency conducted an Infection Control In-service discussing bag technique and hand hygiene procedures, including return demonstration, with staff on 6/24/2020, the 2nd day of the site visit.

Agency Response **What action will we take to correct the deficiency cited?**

Action Plan Summary

Who is responsible to implement the corrective action?

When will the corrective action be implemented?

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Action Plan Summary

HSRM.14.I

Citation

HSRM.14.I - The hospice assesses the skills and competencies of all individuals providing care, including volunteers providing services and, as necessary, provides in-service training and education programs where required.
The hospice has written policies and procedures describing the method(s) of assessing competency and:
1. Maintains a written description of the in-service training provided during the previous 12 months.

It is required that the hospice assesses the skills and competencies of all individuals providing care, including volunteers providing services and, as necessary, provides in-service training and education programs where required. The hospice has written policies and procedures describing the method(s) of assessing competency.

This standard was not met as evidenced by review of agency policies, personnel record review, and interview with the Executive Director. Agency policy C:3-020 (revised October, 2015) titled "Orientation" stated, in part, "The orientation process, for all clinical personnel will consist of both didactic and field supervision. Observation visits will be made by an appropriate supervisor to assess the skills demonstrated...." and "During the orientation process, the supervisor will be responsible for evaluating the knowledge and skills of the clinical personnel being oriented." Agency policy C:3-024 (revised October, 2015) titled "Initial Clinical Competency Assessment" stated, in part, "When the Initial Competency Assessment Skills Checklist is completed, it will be reviewed by the preceptor and the supervisor." 1 of 10 (10%) applicable records of staff lacked documentation of initial competency assessments that were completed by a supervisor in accordance with agency policy [Record #17806 - Hospice Aide: This employee was hired 3/11/2019. The initial competency assessment was completed, signed and dated 3/20/2019 by the employee and preceptor (a hospice aide) but not by the RN supervisor]. Interview with the Executive Director on 6/23/2020 revealed that there were competency assessments signed by the RN but not until January, 2020 and May, 2020 and confirmed that the initial competency assessment should have been signed by the supervising RN. The findings were also confirmed with the Director of Patient Care Services, Executive Director, Quality Assurance Coordinator, Vice President of Quality, and Regional Director of Quality during final exit on 6/25/2020.

Action Plan Summary

Agency Response

What action will we take to correct the deficiency cited?

Who is responsible to implement the corrective action?

When will the corrective action be implemented?

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

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Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

May 14, 2020

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending
	Location and/or Site Accredited: Bristol Hospice-Rogue Valley 848 NE 7th Street Grants Pass, OR 97526	
	Site Visit Dates:	April 27, 2020 - April 29, 2020
	Type of Survey/Site Visit:	Initial
	Accreditation Determination:	Full Accreditation
	Medicare Certification:	Pending
	Deemed Status Recommendation:	Deemed Status Recommended
	Plan of Correction Accepted Date:	May 5, 2020
	Effective Date of Accreditation:	May 5, 2020
	Expiration Date of Accreditation:	May 5, 2023
	Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted April 27, 2020 - April 29, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO X - Seattle)
CMS Central Office
State Agency

Action Plan Summary

Site Visit 4/27/2020 - 4/29/2020

CCN pending

Organization

Bristol Hospice, LLC

Summary of Citations

Hospice	5

Condition Level Deficiencies **0**

Service Provider

Bristol Hospice-Rogue Valley

848 NE 7th Street Grants Pass, OR 97526

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Action Plan Summary

HCDT.39.I

Citation	HCDT.39.I - If a patient revokes the election of hospice care or is discharged from hospice per hospice regulation §418.26 (i.e., no longer terminally ill), the hospice forwards to the patient's attending physician: 1. A copy of the hospice discharge summary; 2. The patient's record, if requested.
CMS Tag: 683	
CMS CFR: 418.104(e)(2)	

It is required that if a patient revokes the election of hospice care or is discharged from hospice per hospice regulation §418.26 (i.e., no longer terminally ill), the hospice forwards to the patient's attending physician: a copy of the hospice discharge summary; [and] the patient's record, if requested.

This standard was not met as evidenced by a clinical record review assisted by the Director of Nursing/Administrator and further discussion with the Regional Director of Nursing/Alternate Administrator. The policy titled "Discharge from Hospice Program," revised 2003, (Policy No. H:2-085.1) read in relevant part, "... A copy of the discharge summary will be set to the attending physician." In 1 of 1 (100%) applicable records of patients who had revoked hospice services, there was no evidence that a discharge summary was sent to the attending physician [Record #32374- The start of care dated 2/7/2020, for this 101-year-old, included the diagnoses: malignant neoplasm of unspecific kidney, and disorders of kidney and ureter. The daughter had requested revocation 12/20/2020, stating that "Hospice was a death sentence." The daughter refused to allow a nurse to visit the patient's home to obtain the required revocation signatures. There was no evidence that the discharge summary produced for inspection was forwarded to the patient's attending physician, or that the attending physician had otherwise been notified]. In an interview with the Director of Nursing/Administrator, it was stated that the agency had not sent the discharge summary to the attending physician, but had documented that a telephone call had been made to the clinic informing the clinic of the revocation. During the exit conference with the Director of Nursing/Administrator, Regional Director of Nursing/Alternate Administrator and corporate via phone, on 4/29/2020, it was stated that they had already started their plan of correction.

Agency Response

What action will we take to correct the deficiency cited?

All clinical staff will be given a copy of the policy H2:86.1 "Discharge Summary". The current policy identifies what needs to be included in the

discharge summary, who needs to receive a copy of the summary and the time frame summary needs to be completed and distributed. The staff will be instructed on the policies and process for sending the summary and any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility. A copy of the discharge summary that was sent to the physician or receiving facility will be scanned into patient chart. The nurse will document in the discharge narrative note that a copy of the discharge summary including requested documents were sent to the primary care physician or receiving facility. The Executive Director will reinforce to the staff that they are to follow all the Hospice policies.

Who is responsible to implement the corrective action?

The Executive Director/Director of Clinical Services

When will the corrective action be implemented?

April 28, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Executive Director/Director of Clinical Services will audit 100% of all discharged patient charts for correct documentation of discharged patients according to the policy H2:086.1.. The audits will be tracked, trended and reported to the QAPI Committee. When the goal of 100% compliance is attained the QAPI committee will monitor for ongoing compliance and direct any interventions or performance improvement projects as determined necessary to achieve sustainment. All QAPI projects will be reported to the Governing Body.

Action Plan Summary

HCPC.15.I

Citation

CMS Tag: 530

CMS CFR: 418.54(c)(6)

HCPC.15.I - The documented comprehensive assessment includes a drug profile that contains the patient's current:

1. Prescription and over-the-counter (OTC) drugs;
2. Supplements;
3. Herbal remedies;
4. Other alternative treatments that could affect drug therapy.

The medication review process includes the identification of the following:

1. The effectiveness of drug therapy;
2. Drug side effects;
3. Actual or potential drug interactions;
4. Duplicate drug therapy;
5. Drug therapy associated with laboratory monitoring.

The assessment includes evidence that common side effects of medication in the hospice populations are anticipated, and, as appropriate, preventive measurements are implemented to manage the side effects.

The drug profile is updated per the hospice policy and procedure, but, at minimum, at the time of each comprehensive assessment and/or when new medication is added or changes are made to existing medication.

It is required that the medication review process includes the identification of the following: the effectiveness of drug therapy; drug side effects; actual or potential drug interactions; duplicate drug therapy; and drug therapy associated with laboratory monitoring. The assessment includes evidence that common side effects of medication in the hospice populations are anticipated, and as appropriate, preventive measurements are implemented to manage the side effects. The drug profile is updated per the hospice policy and procedure, but, at minimum, at the time of each comprehensive assessment and/or when new medication is added, or changes are made to existing medication.

This standard was not met as evidenced by review of organizational policy, and clinical record review assisted by the Director of Nursing/Administrator and further discussion with the Regional Director of Nursing/Alternate Administrator. The policy "Medication Profile", revised 2015, (Policy No. 2-055.1) read in relevant parts, "...Upon admission to hospice, the admitting nurse will initiate a medication profile to document the current medications" and "a drug regimen

interaction check will be performed at the time of the admission as a component of the comprehensive assessment, and whenever updates to the comprehensive assessments are performed. The review will identify drug/food interactions, potential adverse effects and drug interactions." In 1 of 7 (14%) records reviewed there was no documentation to support that the medication profile was reviewed and updated [Record #29058- For the initial certification period dated 3/23/2020 through 6/20/2020, the diagnoses included COPD, Hypoxia, Respiratory Failure, and Pneumonia. The agency had not updated the medication profile to reflect the Oxygen prescribed at 2 liters/min per nasal cannula, dated on 3/23/2020, the date of admission]. In an interview with the Director of Nurses/Administrator, it was stated that the EMR did not allow Oxygen to be listed on the medication profile. This was corrected prior to exit by the Regional Director of Nursing/Alternate Administrator. During the exit conference with the Director of Nursing/Administrator, Regional Director of Nursing/Alternate Administrator and corporate via phone, on 4/29/2020, it was stated that they had already started their plan of correction.

Agency Response

What action will we take to correct the deficiency cited?

The Executive Director/Director of Patient Care Services and the RNCM were instructed on the policy H2-055 medication profile to include all medications including oxygen, OTC and herbal remedies, and any changes to the current medications. Additionally, the documentation must include the patients response, side-effects, interactions and duplicate therapies. Education was also provided on where in the EMR system all medications are located and the documentation of timelines for medication reconciliation when new medications or changes to the current medications and during each comprehensive assessment.

Who is responsible to implement the corrective action?

Executive Director/Director of Patient Care Services

When will the corrective action be implemented?

April 28, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

The Executive Director will perform a focused audit of 100% of all medication profiles completed over the course of 90 days to ensure compliance. The results of the audit will be tracked and trended and presented to the QAPI committee with the goal of 100% compliance. The audit will continue until compliance is sustained for a minimum of 3 months. The QAPI Committee will monitor for ongoing compliance and direct any interventions or performance improvement projects as

determined necessary to achieve sustainment. The findings will be presented to the Governing Body.

Action Plan Summary

HCPC.21.I

Citation

CMS Tag: 545

CMS CFR: 418.56(c)

HCPC.21.I - Each patient's individualized written plan of care:
1. Reflects patient and family goals;
2. Identifies planned interventions based on problems identified in the initial and updated comprehensive assessments;
3. Includes all services necessary for the palliation and management of the terminal illness, including the following:
a) Intervention to manage pain and symptoms;
b) A detailed statement of the scope and frequency of services necessary to meet specific patient and family needs;
c) Measureable outcomes anticipated from implementing and coordinating the plan of care;
d) Drugs and treatment necessary to meet the needs of the patient;
e) Medical supplies and appliances necessary to meet the needs of the patient;
4. Includes the Interdisciplinary Group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC;
a) The documentation in the patient's record is in accordance with the hospice's policies and procedure.

It is required that each patient's individualized written plan of care: identifies planned interventions based on problems identified in the initial and updated comprehensive assessments; includes all services necessary for the palliation and management of the terminal illness, including the following: measurable outcomes anticipated from implementing and coordinating the plan of care.

This standard was not met as evidenced by a review of clinical records and review of organizational policy. The policy "Plan of Care" (H:2-030,1) reads in relevant part, "... The Plan of Care will be based on the Initial, Comprehensive and Ongoing Assessments performed by the members of the interdisciplinary group and will be reviewed on a regular basis but no less than every 15 days. This plan will focus on identified problems, goals and interventions." 3 of 7 (43%) records revealed that the patients' plans of care do not include planned interventions based on problems identified in the initial and updated comprehensive assessments. Record #16780: For the start of care beginning 4/3/2020, the diagnosis included Dementia, as well as wheelchair-bound. The RN documented "Discomfort with Buttock" on 4/4/2020. The RN visit note dated 4/15/2020 documented "wound care completed, wound appears to be doing better with no drainage at this time." On the Interdisciplinary

Team (IDT) meeting note dated 4/21/2020, the RN documented "Patient has breakdown on his buttock that seems to be the same." Under systems, the Integumentary field is blank. There is no evidence of an updated comprehensive assessment, implementation, coordination or measurable outcomes.
Record # 29058: For the start of care beginning 3/23/2020, the diagnoses included Hypoxia, Pneumonia with Respiratory Failure. The hospice aide documented, on 3/25/2020, "wound to coccyx, more on the right buttock. It's more of the size of a half dollar with an open area about the size of a quarter. RN notified of above concern." The IDT meeting note, dated 4/7/2020, did not evidence documentation of tissue breakdown to the buttock. The RN visit note dated 4/13/2020, documented "Red areas to right and left second toe". The RN visit note, dated 4/20/2020, documented "small opening on buttock without drainage." On the IDT meeting note, dated 4/21/2020, the RN documented "Daughter states that the buttock is doing great and patient states it does itch at times." There is no additional documented evidence of the open area on the buttock, with corresponding measurements or description of the reported lesion. The same lack of specific descriptors regarding the "red toes", documented 4/13/2020, applies. There is no evidence, in the IDT notes, of an updated comprehensive assessment, implementation, coordination, or measurable outcomes.
Record #51507: For the start of care episode dated 1/23/2020 through 4/21/2020, the diagnoses included COPD with Respiratory Failure, Heart Disease, Metabolic Encephalopathy. The RN visit note dated 4/6/2020, documented "Wounds are completed" [and] "Wound to buttock is doing better with no drainage at this time." On the IDT note dated 4/7/2020, the RN documented "patient has contact dermatitis and "has left hip open due to chaffing as well as new wound to left buttock, CalZinc provided." There is no evidence, in the IDT notes, of an updated comprehensive assessment, implementation, coordination, or measurable outcomes.
In an interview with the Director of Nursing/Administrator, Regional Director of Nursing/Alternate Administrator on 4/28/2020, it was stated that the agency has a wound care document in the EHR. This purported document was not provided to this site-visitor for review prior to exit for purposes of verification. During the exit conference on 4/29/2020, with the Director of Nursing/Administrator, Regional Director of Nursing/Alternate Administrator and corporate via phone, it was stated that they had already started their plan of correction.

Agency Response

What action will we take to correct the deficiency cited?

An educational in-service was held with all staff to demonstrate the importance of care plan development that provides appropriate care to meet the needs of the patient. The education included: The plan of care

development focusing on services necessary to meet to meet the patient and family goals, identifies planned interventions based on problems identified in the initial and updated comprehensive assessments including; interventions to manage wounds, pain and symptoms, drugs and treatment necessary to meet the needs of the patient, medical supplies and appliances necessary to meet the needs of the patient, measurable outcomes anticipated from implementing and coordinating the plan of care. The nursing staff will review the wound care protocol and documentation and visit summary in the EMR system. The documentation will reflects the IDT coordination on what interventions to perform and the outcome of those interventions. The care plan will be updated at a minimum of every 14 days during IDT or sooner based on the Documentation of the IDT collaboration of the measurable outcomes based on the plan of care and patient's goals, medications, supplies and equipment that meet the needs of the patient.

Who is responsible to implement the corrective action?

Executive Director/Director of Patient Care Services

When will the corrective action be implemented?

April 28, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

The Executive Director/Director of Patient Care Services will audit 100% of all new admissions and 10% of all current patients for 30 days to ensure that the plan of care per the comprehensive assessment and collaboration with IDT includes ; • The plan of care development focusing on the specific needs of the patient, the wound care protocol and documentation is being completed for all patients that have wounds and that the measurable outcomes based on the plan of care are being documented and discussed at each IDT. • Collaboration with the IDT in the development of the patient's plan of care and any ongoing changes will be documented. When 100% compliance is met the focus audit will become part of the monthly chart audit process for continued sustainment. If 100% compliance is not met within the thirty days the 100% focused audit will continue. Findings will be tracked, trended and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HSEP.3.D

Citation	HSEP.3.D - The hospice implements emergency preparedness (EP) policies and procedures, based on the emergency plan, the risk assessment, and the communication plan.
CMS Tag: 25	The policies and procedures address:
CMS CFR: 418.113(b)(5)	1. Development and inclusion of a plan for each hospice patient during a natural or man-made disaster as part of a patient/family comprehensive assessment; 2. The documented discussion of the plan provided to the patient/family, and maintained by the hospice; 3. Follow up with patients/families to determine needs in the event that care is interrupted during or due to an emergency; 4. Arrangements with facilities and other providers to receive patients to maintain the continuity of care to patients; 5. Informing local and state emergency officials about patients in need of evacuation from their residence at any time due to the emergency based on the patient's medical or psychiatric condition, or home environment; 6. The minimum information provided to facilitate patient evacuation and transportation including: a) If the patient is mobile or not; b) If the patient has life-dependent equipment, and if so, is it able to be transported (e.g. battery operated, size, condition, etc.); and, c) Any patient special needs including cognitive disorders, intellectual disabilities, or communication issues (e.g. deaf, non-English speaking, etc.). 7. A system of medical documentation that preserves patient information, protects the confidentiality of patient information, and secures and maintains the availability of records; 8. Informing local and state emergency officials of any on-duty employees that the hospice is unable to contact; 9. The role of hospice employees in providing care at alternate care sites during emergencies; and, 10. The use of volunteers, off-duty hospice employees and other emergency staffing strategies, including the process and role for the integration of State and Federally designated health care professionals to address surge patient care needs during an emergency. Policies and procedures are reviewed and updated at least every two (2) years. It is required that the hospice implements emergency preparedness (EP) policies and procedures, based on the emergency plan, the risk assessment, and the communication plan. The policies and procedures

address: arrangements with facilities and other providers to receive patients to maintain the continuity of care to patients.

This standard was not met as evidenced by a review of the agency's Emergency Preparedness manual, and an interview with the Director of Nurses/Administrator and the Regional Director of Nurses/Alternate Administrator. Review of the agency's policy on Emergency Preparedness revealed that the policy does not make provision with other providers to receive patients in the event of an emergency. In an interview with the Director of Nurses/Administrator, it was stated that the agency was aware of the requirement but has not completed the requirement. In an interview with the Regional Director/Alternate Administrator, it was stated that the policies are being updated this week. During the exit conference with the Director of Nursing/Administrator, Regional Director of Nursing/Alternate Administrator and corporate via phone, on 4/29/2020, it was stated that they had already started their plan of correction.

Agency Response

What action will we take to correct the deficiency cited?

The Executive Director will establish arrangements with facilities and other providers to receive patients to maintain the continuity of care to the hospice patients. To complete the EPP plan for the Executive Director will contact a local facility that has the capability to provide care for any of the hospice patients that should need an alternate care site during an emergency.

Who is responsible to implement the corrective action?

Executive Director

When will the corrective action be implemented?

April 28, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

A memorandum of understanding will be completed with a facility that can provide for an alternate care site and maintain continuity of care to the hospice patients within the next 30 days. The MOU will be made part of the emergency preparedness plan and reviewed by the governing body.

HSRM.9.I

Citation

CMS Tag: 615

CMS CFR: 418.76(c)(1)

HSRM.9.I - All hospice aide services must be provided by an individual who has successfully completed one (1) of the four (4) training and competency evaluations programs described below.
AND
The individual furnishes hospice aide services on behalf of a hospice only after successfully completing a competency evaluation program also described below.
AND
The hospice maintains documentation that each hospice aide has met the requirements.
Documentation of training includes:
1. A description of the training and competency evaluation program;
2. The qualifications of the instructor;
3. A statement that distinguishes skills taught in a laboratory using a real person (not a mannequin);
4. Indicators of which skills the aide was judged to be competent in;
5. How additional skills, if any, are taught and tested if the hospice's admission policies and case-mix of hospice patients requires aides to perform more complex procedures.

Option 1 for Hospice Aide Training and Competency Evaluation
Option 1: A qualified hospice aide has successfully completed:
6. A training program and competency evaluation that includes classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse who is under the supervision of a registered nurse:
a) Classroom and supervised practical training that total at least 75 hours. Applicable Regulation: L611:§418.76(b)(1).
b) A minimum of 16 hours of classroom training that precedes a minimum of 16 hours of supervised practical training as part of the 75 hours. Applicable Regulation: L612 §418.76(b)(2).
AND
7. A training program that addresses each of the following subject areas:
a) Communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff;
b) Observation, reporting, and documentation of patient status and the care or service provided;
c) Reading and recording temperature, pulse, and respiration;
d) Basic infection control procedures;
e) Basic elements of body function and changes in body

function that must be reported to an aide's supervisor;
f) Maintenance of a clean, healthy, and safe environment;
g) Recognizing emergencies and the knowledge of emergency procedures and their application;
h) The physical, emotional, and developmental needs of—and ways to work with—the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property;
i) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:
i. Bed bath;
ii. Sponge, tub, and shower bath;
iii. Hair shampoo (sink, tub, and bed);
iv. Nail and skin care;
v. Oral hygiene;
vi. Toileting and elimination;
j) Safe transfer techniques and ambulation;
k) Normal range of motion and positioning;
l) Adequate nutrition and fluid intake;
m) Any other task that the hospice may choose to have an aide perform not addressed
item 2.i (a-f) above, the basic checklist. Applicable Regulation: L613-§418.76(b)(3).
AND
8. The competency evaluation addresses each of the following subject areas from item 2, above; they are evaluated by observation of an aide's performance with a patient, including:
a) Communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff;
b) Reading and recording temperature, pulse, and respiration;
c) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:
i. Bed bath;
ii. Sponge, tub, and shower bath;
iii. Hair shampoo (sink, tub, and bed);
iv. Nail and skin care;
v. Oral hygiene;
vi. Toileting and elimination;
d) Safe transfer techniques and ambulation;
e) Normal range of motion and positioning.
9. The remaining subject areas in item 2 above may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient. Applicable Regulation: L615 §418.76(c)(1).
AND

10. The competency evaluation is performed by a registered nurse in consultation with other skilled professionals, as appropriate. Applicable Regulation: L617-418.76(c)(3).
AND
11. A hospice aide is not considered competent in any task for which he or she is evaluated as "unsatisfactory."
a) A hospice aide may not perform that task without direct supervision by a registered nurse until after he or she has received training in the task for which he or she was evaluated as "unsatisfactory" and has successfully completed a subsequent evaluation.
b) A hospice aide is not considered to have successfully completed a competency evaluation if the aide has an "unsatisfactory" rating in more than one (1) of the required areas. Applicable Regulation: L618 §418.76(c)(4).
AND
12. The hospice maintains documentation that demonstrates the requirements of competency evaluation are met (items 3-5 above). Applicable Regulation: L619 §418.76(c)(5).

Option 2 for Hospice Aide Training and Competency Evaluation
Option 2: A qualified hospice aide has successfully completed a competency evaluation program that:
13. Evaluates the aide's competency in the following subject areas by observation of the aide's performance with a patient:
a) Communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff;
b) Reading and recording temperature, pulse, and respiration;
c) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:
i. Bed bath;
ii. Sponge, tub, and shower bath;
iii. Hair shampoo (sink, tub, and bed);
iv. Nail and skin care;
v. Oral hygiene;
vi. Toileting and elimination;
d) Safe transfer techniques and ambulation;
e) Normal range of motion and positioning.
14. Evaluates the aide's competency in the following subject areas by written exam, oral examination, or after observation of a hospice aide with a patient:
a) Observation, reporting, and documentation of patient status and the care or service provided;
b) Basic infection control procedures;
c) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;

d) Maintenance of a clean, safe, and healthy environment;
e) Recognizing emergencies and the knowledge of emergency procedures and their application;
f) The physical, emotional, and developmental needs of—and ways to work with—the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property;
g) Adequate nutrition and fluid intake;
h) Any remaining task(s) that the hospice chooses to have an aide perform. Applicable Regulation: L615 §418.76(c)(1).
AND
15. The competency evaluation is performed by a registered nurse in consultation with other skilled professionals, as appropriate. Applicable Regulation: L617 §418.76(c)(3).
AND
16. A hospice aide is not considered competent in any task for which he or she is evaluated as "unsatisfactory."
a) A hospice aide may not perform that task without direct supervision by a registered nurse until after he/she has received training in the task for which he/she was evaluated as "unsatisfactory" and has successfully completed a subsequent evaluation.
b) A hospice aide is not considered to have successfully completed a competency evaluation if the aide has an "unsatisfactory" rating in more than one (1) of the required areas. Applicable Regulation: L618 §418.76(c)(4).
AND
17. The hospice maintains documentation that demonstrates the requirements of competency evaluation are met. Applicable Regulation: L619 §418.76(c)(5).

Option 3 for Hospice Aide Training and Competency Evaluation
Option 3. A qualified hospice aide:
18. Has completed a nurse aide training and competency evaluation program approved by the state as meeting the requirements of nurse aide training and competency evaluation per CMS CFR 483.151-154 (state approval of aide training and competency program per regulation);
19. Is currently listed in good standing on the state nurse aide registry.

Option 4 for Hospice Aide Training and Competency Evaluation
Option 4: A qualified hospice aide has completed a state licensure program.

It is required that a qualified hospice aide has successfully completed a competency evaluation program that evaluates the aide's competency in the following subject areas by observation of the aide's performance

with a patient: a) Communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff; b) Reading and recording temperature, pulse, and respiration; c) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist: i. Bed bath; ii. Sponge, tub, and shower bath; iii. Hair shampoo (sink, tub, and bed); iv. Nail and skin care; v. Oral hygiene; vi. Toileting and elimination; d) Safe transfer techniques and ambulation; e) Normal range of motion and positioning.

This standard was not met as evidenced by a review of organizational policy, review of personnel records, and an interview with the Director of Nurses (DON), and the Administrator. The policy "Hospice Aide Competency Evaluation" reads in relevant part, "...For Hospice aides, the competency evaluation and skills checkoff, administered by registered nurse, in consultation with other skilled professionals as appropriate, will be scheduled during the orientation period. The RN will sign, date, and include direct observation by the RN of all required skills, on an actual patient." 1 of 1 (100%) applicable records of hospice aides revealed the hospice failed to ensure that the required skills were observed by an RN, to ensure appropriate and safe techniques in performing personal hygiene and grooming tasks [Record #45100-DOH -11/15/2019: The form, "Skills Competency Checklist" did not evidence that the skills were assessed on a patient and observed by an RN. Under the sections titled, Bed Bath, Other Bath; Sponge, Tub, Shower and Shampoo: Sink, Tub and Bed, all had listed an "O" for observation. An RN signed off on the document, but there was no evidence of actual observation having been conducted on a patient]. In an interview with the Director of Nursing/Administrator, Regional Director of Nursing/Alternate Administrator on 4/28/2020, it was stated that they would look at the form to ensure compliance. During the exit conference with the Director of Nursing/Administrator, Regional Director of Nursing/Alternate Administrator and corporate via phone, on 4/29/2020, it was stated that

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Agency Response

What action will we take to correct the deficiency cited?

On hire and annually all Hospice aides will be observed by an Registered Nurse for competence of all the required skills on their checklist The Registered Nurse will document the actual patient the skill was performed on and the date that the skill was observed. Prior to a Hospice Aide being assigned patient the aide will be observed by Registered Nurse for competence.of these tasks. The completed skills checklist will be given to the Executive Director for review to ensure all elements requiring direct observation have been completed by the Registered Nurse prior to the Hospice Aide delivering care. The documentation that the requirements are met will be placed in the

Hospice aides personnel file.

Who is responsible to implement the corrective action?

Executive Director

When will the corrective action be implemented?

April 28, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Upon hire and annually the Executive Director will audit 100% of Hospice Aide HR files to ensure 100% compliance of completed skills checklist is achieved and sustained. To ensure sustainment of improvement a quarterly audit of Hospice Aide HR files will be completed. Findings will be tracked, trended and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions or performance improvement projects as determined. All QAPI projects will be reported to the Governing Body.

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Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

February 1, 2019

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	55-1538

Location and/or Site Accredited:
Bristol Hospice-Sacramento, LLC
2140 Professional Drive, Suite 210
Roseville, CA 95661

Site Visit Dates:	December 17, 2018 – December 21, 2018
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	January 10, 2019
CHAP Accreditation Dates:	February 15, 2019 – February 15, 2022
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted December 17, 2018 – December 21, 2018, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
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CHAP

February 1, 2019

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:

Customer ID:	2006002
Service:	Hospice [Deemed]
CCN/PTAN:	55-1538

Location and/or Site Accredited:
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2140 Professional Drive, Suite 210
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Site Visit Dates:	December 17, 2018 – December 21, 2018
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Medicare Certification:	Recertification
Deemed Status Recommendation:	Continued Deemed Status
Plan of Correction Accepted Date:	January 10, 2019
Effective Date of Accreditation:	January 20, 2019
Expiration Date of Accreditation:	January 20, 2022
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted December 17, 2018 – December 21, 2018, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended continued Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

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CC: CMS Regional Office (CMS RO IX - San Francisco)
CMS Central Office
State Agency

Plan of Correction Summary

Site Visit 12/17/2018 - 12/21/2018

CCN 551538

Organization

Bristol Hospice, LLC

Service Provider

Bristol Hospice-Sacramento, LLC

2140 Professional Drive Suite 210 Roseville, CA 95661

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Summary of Citations

Core	2
Hospice	3

Condition Level Deficiencies 0

Plan of Correction Summary

CII.7i

Citation	CII.7i - The organization demonstrates compliance with its TB Exposure Control Plan. It is required that the organization demonstrates compliance with its TB Exposure Control Plan. This standard was not met as evidenced by a review of personnel files and agency policy. Policy NO. C:2-041.1 titled Tuberculosis Exposure Control Plan reads in part, "...C. Where required by state and/or local regulations, a two (2)-step Mantoux TST or TB Blood test (will be given to all personnel upon hire, if no TST or blood test will be given to all personnel upon hire, if no TST or blood test has been performed within 12 months of hire date, and thereafter, according to risk assessment. If the new hire has documented prior history of negative result within 12 months of hire, the organization may consider this the first stage of testing and the additional TST represents the second stage of two-step testing." 2 of 9 (22%%) applicable files reviewed for newly hired staff revealed that the agency did not follow policy related to the requirement for a TB screen on hire. Record #49243-DOH 7/26/18: The file contained only a one-step PPD dated 8/18/17. No second step was obtained as per organizational policy. Record #51235-DOH 2/21/18. The health record contained a one-step PPD dated 6/29/16 and another one-step dated 2/12/18. The PPD reading 6/29/16 was greater than 12 months prior to hire. The record documented no second step PPD upon hire. This finding was verified with the Executive Director and Director of Patient Care Services.
Agency Response	**What action will we take to correct the deficiency cited?** To comply with the CDC guidelines all clinical healthcare workers will be tested for TB by a 2 step TST or TB blooddraw. All newly hired employees and employees that have been hired within the past three years that have not had either a 2 step TST or TB blood testwill have a mandatory TB blood test. The mandatory testing will be completed by 1/31/2019. Going forward, for all newly hired employeesthe TB blood test, the first step of two step process or CXR will be scheduled by the HR department along with all of the new hire mandatory requirements. The Business Office Manager will update the HR spreadsheet reflecting the date of TB blood draw, first step or CXR. The Business Office Manager will be

responsible for scheduling the second step within two weeks of the fist skin test. The HR spreadsheet will be updated when results areobtained. The direct care employees will not provide services until the results are obtained. To maintain standard interpretation of the testresults the employee will have annual TB blood testing or skin test.

Who is responsible to implement the corrective action?

Executive Director

When will the corrective action be implemented?

January 09, 2019

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

The Business Office Manager will review and document on the HR spreadsheet all of the mandatory required forms received from thecorporate HR department including the TB blood draw results, the first and second skin test and/or CXR. This information will be updated and maintained on the HR spreadsheet. The Executive Director will audit 100% of all new hire HR charts for compliance that all mandatory forms and tests have been completed.The Executive Director will also monitor that the HR spreadsheet is kept updated and current.The HR spreadsheet reviewed by the ExecutiveDirector will be presented to the QAPI committee monthly,when 100% compliance is attained the HR spreadsheet will be submitted to the QAPIcommittee quarterly for continued compliance.

Plan of Correction Summary

CIII.1i

Citation

CIII.1i - An annual written performance evaluation process is completed on all employees by the respective supervisor and includes:
CIII.1i1 - Supervisor assessment of employee performance in accordance with established criteria (Job Description)
CIII.1i2 - Achievement of previously established goals
CIII.1i4 - A signed, dated validation of the evaluation process by the employee and employer representative

It is required that an annual written performance evaluation process is completed on all employees by the respective supervisor and includes: supervisor assessment of employee performance in accordance with established criteria (Job Description), achievement of previously established goals, and a signed, and a dated validation of the evaluation process by the employee and employer representative.

This standard was not met as evidenced by a review of personnel records, QAPI program and organizational policy. Agency Policy titled "Performance Evaluations", # C:3-019.1 stated "Performance evaluations will be completed (and dated) on all personnel as follows: Annually, based on personnel's annual evaluation date". 1 of 10 (10%) records reviewed revealed the agency failed to document an annual written performance evaluation in accordance with organizational policy [Record #48202-DOH 11/5/15: the record was missing a written performance evaluation for 2017]. NOTE: A review of the quality assurance and performance improvement program revealed this issue was self-identified and a performance improvement plan was initiated 3/1/18.

Agency Response

What action will we take to correct the deficiency cited?

All supervisory personnel will be educated on the evaluation process. It will be mandatory for all management staff to review the policy C3-019 Performance Evaluations on 1/10/2019. A focused audit of 100% of all personnel files will be conducted by the Director of Patient Care Services and Supervisors to ensure compliance regarding evaluations are current, to be completed by 1/31/2019. Those employees who did not have a complete evaluation recorded at the time of the audit will be scheduled for visit with their supervisor no later then 1/31/2019. The annual evaluation will include an evaluation of the clinical competency and learning needs, which will be used to develop an individualized learning needs, which will be development and overall clinical improvement.

Who is responsible to implement the corrective action?

Plan of Correction Summary

Executive Director

When will the corrective action be implemented?

January 10, 2019

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

All employee's evaluation dates will be tracked electronically on a monthly basis by the Executive Director to ensure 90 day and annual evaluations are completed within the month they are due. Goal is 100% compliance. Once the goal for compliance is met, continued monitoring will be ongoing quarterly and the findings will be reported to the QAPI committee. The QAPI committee will direct any additional interventions or measures based upon outcomes.

Plan of Correction Summary

HII.2I

Citation *CMS Tag:* 626 *CMS CFR:* 418.76(g)(2)	HII.2I - Nursing services are provided in accordance with a plan of care. HII.2I5 - The Hospice Aide and/or Homemaker function in a supportive relationship to professional disciplines and may function as an extension of these professional services with written instructions, appropriate supervision and specialized hospice training. The Hospice Aide meets the qualifications specified in 418.76 (a) (1) (2). HII.2I5a - Hospice Aide responsibilities (ii) include tasks listed on the plan of care, (iii) permitted to be performed under State law by such Hospice Aide (iv) consistent with Hospice Aide training and sub elements 1-8. 418.76(g) (2) (ii) - (iv.) HII.2I5a1 - 1) Providing care consistent with written instructions . It is required that nursing services are provided in accordance with a plan of care. The Hospice Aide and/or Homemaker function in a supportive relationship to professional disciplines and may function as an extension of these professional services with written instructions, appropriate supervision and specialized hospice training. The Hospice Aide meets the qualifications specified in 418.76(a)(1)-(2). Hospice Aide responsibilities (ii) include tasks listed on the plan of care, (iii) permitted to be performed under State law by such Hospice Aide, (iv) consistent with Hospice Aide training and sub elements 1-8. Hospice Aides provide care consistent with written instructions. This standard was not met as evidenced by a review of clinical records. 1 of 11 (9%) records reviewed for patients receiving aide services revealed that the aide did not document specific care provided to the patient in accordance with the aide plan of care [Record # 35789: The aide plan of care assigned the aide to provide a bath "of patient's choice; either bed bath or shower". On visit notes dated 11/5, 11/8, 11/12, and 11/15/18 the aide documented that both types of bath were completed]. An interview with the Director of Clinical Services revealed that the agency is unaware of which type of bath was provided.

Agency Response	**What action will we take to correct the deficiency cited?** Re-training and education with RN/HHA team on how to complete the hospice aide plan of care, review of frequencies and descriptions ofassigned tasks, review of how to document these tasks accurately.Training to be completed in 2 sessions, initial review to be done with all RN/HHA staff by 1/20/2019 and second training session for reinforcement to be done by 1/31/2019. Review of care plan in the

Plan of Correction Summary

EMRwill be done to address some items that may be causing inconsistencies with documentation. Increase sampling of joint visits with HHA and RN.Minimally will have each HHA complete a joint visit 1 x month starting on 1/31/2019 for 3 months with an RN to monitor compliance withfollowing care plan duties as assigned with a goal of 100% compliance for at least 3 consecutive months. Complete chart review on 100% of allHHA care plans and documentation of visit notes until we are at 100% compliance with HHA following the plan of care and visit frequencies asassigned is met.

Who is responsible to implement the corrective action?

Director of Patient Care Services

When will the corrective action be implemented?

January 11, 2019

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Demonstrated conformance with joint visits and supervisory visits over the next 3 months with each hospice aide maintaining goalconformance, and then on an ongoing basis as part of their annual review to ensure ongoing compliance. Supervisor will complete focusedchart audits/review on sampling of 100% of applicable charts for at least 3 consecutive months. Goal is 100% compliance.Once the agencydemonstrates goal for compliance, continued monitoring in our ongoing quarterly chart review sampling of 10% and the findings are reported toQAPI committee. If compliance drops below 100%, then the QAPI committee will review and initiate a performance improvement plan torestore compliance including ongoing re-education and training, increase chart review sampling, and supervisory visits. Individual non-conformancewill be addressed and resolved with the Director Patient Care Services.

Plan of Correction Summary

HII.5d

Citation	HII.5d - The Hospice bereavement plan of care is developed based on an assessment of the patient/family needs at the time of admission and during the provision of hospice care and when the patient dies and includes: HII.5d1 - Patient/family grief and/or loss issues. HII.5d2 - Survivor needs. HII.5d3 - Social, spiritual, and cultural issues. HII.5d4 - Services to be provided. HII.5d5 - Referrals to be made. HII.5d6 - Grief risk factors. HII.5d7 - Potential for pathological grief reactions. HII.5d8 - Individual counseling, support groups, letters and cards.
CMS Tag: 531	
CMS CFR: 418.54(c)(7)	

It is required that the Hospice bereavement plan of care is developed based on an assessment of the patient/family needs at the time of admission and during the provision of hospice care and when the patient dies and includes: patient/family grief and/or loss issues; survivor needs; social, spiritual, and cultural issues; services to be provided; referrals to be made; grief risk factors; potential for pathological grief reactions; individual counseling, support groups, letters and cards.

This standard was not met as evidenced by a review of organizational policy and clinical records. Agency Policy titled "Bereavement Assessment" #H:2-053.1 stated "After the death occurs, the hospice social worker or Bereavement Coordinator will complete the bereavement follow-up assessment. The Bereavement Coordinator will develop a plan for intervention based on the findings of the bereavement follow-up assessment". 1 of 1 (100%) applicable death records reviewed revealed that a bereavement plan of care was not developed for the bereaved individual in compliance with organizational policy [Record #72058: The patient expired 5/2/18. A review of bereavement activities in the EMR revealed that mailings were completed, phone calls and a visit was made due to level of difficulty with the bereaved, yet no plan of care was written]. Through interview with the Director of Clinical Services and both bereavement coordinators, it was confirmed that the bereavement plan of care was not written. NOTE: This issue was self-identified and a performance improvement plan has been initiated.

Agency Response **What action will we take to correct the deficiency cited?**

Plan of Correction Summary

A mandatory in-service will be held with the bereavement staff and all supervisory staff to assure compliance in developing and documenting a Care Plan that reflects the needs of the bereaved based on bereavement assessment.Bereavement Plan of Care should reflect family need, as well as a clear delineation of services to be provided, frequency of service delivery and documentation of such. The bereavement plan of care should be based on an assessment of the individual bereaved needs and includes specific scope and frequency of interventions and goals.

Who is responsible to implement the corrective action?

Executive Director

When will the corrective action be implemented?

December 21, 2018

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

100% of all new bereavement care plans will be audited by the Director of Patient Care Services and/or Supervisors for accuracy and completion.When 100% compliance has been achieved for at minimum three months the bereavement care plans will be audited with the 5% of all discharged charts monthly. All auditing results will be presented to the QAPI committee and the committee will direct any additional interventions or measures based upon outcomes..

Plan of Correction Summary

HIII.1h

Citation *CMS Tag:* 663 *CMS CFR:* 418.100(g)(3)	HIII.1h - Clinical competency evaluations are performed at time of hire and annually to assess employee basic skill levels for all staff/employees providing patient/family care. It is required that clinical competency evaluations are performed at time of hire and annually to assess employee basic skill levels for all staff/employees providing patient/family care. This standard was not met as evidenced by a review of personnel files and a review of organizational policy. Agency Policy titled "Annual Core Competence" #H:6-006.1 stated "Hospice personnel will demonstrate proficiency in the performance criteria/skills during the orientation period, and at least annually thereafter as part of the annual performance evaluation process". 1 of 8 (13%) records reviewed for newly hired staff revealed a lack of documentation of a clinical skills competency evaluation upon hire [Record #48351-an LVN with DOH 5/29/17: The record lacked evidence of a clinical skills competency evaluation on hire]. Additionally, 1 of 5 (20%) records reviewed for staff employed longer than one year revealed a lack of documented clinical skills competency evaluation annually [Record #48202-a Volunteer Coordinator with DOH 11/5/15: The record lacked evidence of a clinical skills competency evaluation for 2017].
Agency Response	**What action will we take to correct the deficiency cited?** All supervisory personnel will be educated on the evaluation process. It will be mandatory for all management staff to review the policies H6-006, Annual Core Competency on 1/10/2019. A focused audit of 100% of all personnel files will be conducted by the Director of Patient Care Services and Supervisors to ensure compliance regarding competencies in the clinical setting are current, to be completed by 1/31/2019. Those employees who did not have a complete competency recorded at the time of the audit will be scheduled for visit with their supervisor no later then 1/31/2019. The annual competency will include an evaluation of the clinical competency and learning needs, which will be used to develop an individualized learning needs, which will be development and overall clinical improvement. **Who is responsible to implement the corrective action?** Executive Director, Director of Patient Care Services, Supervisors **When will the corrective action be implemented?**

Plan of Correction Summary

January 10, 2019

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

All employee's evaluation dates will be tracked electronically on a monthly basis by the Executive Director to ensure 90 day and annual competencies are completed within the month they are due. Goal is 100% compliance. Once the goal for compliance is met, continued monitoring will be ongoing quarterly and the findings will be reported to the QAPI committee. The QAPI committee will direct any additional interventions or measures based upon outcomes.

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CHAP

February 1, 2019

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	55-1538

Location and/or Site Accredited:
Bristol Hospice-Sacramento, LLC
2140 Professional Drive, Suite 210
Roseville, CA 95661

Site Visit Dates:	December 17, 2018 – December 21, 2018
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	January 10, 2019
CHAP Accreditation Dates:	February 15, 2019 – February 15, 2022
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted December 17, 2018 – December 21, 2018, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: *DEC1718_TEZ*
Ref: *SIQV751952*

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Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

December 8, 2020

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	67-1708

Location and/or Site Accredited:
Bristol Hospice-Texas, LLC
2002 Timberloch Place, Suite 150
The Woodlands, TX 77380

Site Visit Dates:	October 13, 2020 - October 15, 2020
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	November 10, 2020
CHAP Accreditation Dates:	January 21, 2020 - February 15, 2022
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted October 13, 2020 - October 15, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

ID: *OCT1320_DQP*
Ref: *SIQV751952*

Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

CHAP

December 8, 2020

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	67-1708

Location and/or Site Accredited:
Bristol Hospice-Texas, LLC
2002 Timberloch Place, Suite 150
The Woodlands, TX 77380

Site Visit Dates:	October 13, 2020 - October 15, 2020
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Medicare Certification:	Recertification
Deemed Status Recommendation:	Continued Deemed Status
Plan of Correction Accepted Date:	November 10, 2020
Effective Date of Accreditation:	February 6, 2021
Expiration Date of Accreditation:	February 6, 2024
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted October 13, 2020 - October 15, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended continued Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO VI - Dallas)
CMS Central Office
State Agency

Action Plan Summary

Site Visit 10/13/2020 - 10/15/2020

CCN 671708

Organization

Bristol Hospice, LLC

Summary of Citations

Hospice	11

Condition Level Deficiencies **0**

Service Provider

Bristol Hospice-Texas, LLC

2002 Timberloch Place Suite 150 The Woodlands, TX 77380

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Action Plan Summary

HCDT.18.I

Citation

CMS Tag: 628

CMS CFR: 418.76(g)(4)

HCDT.18.I - Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities.

The hospice aide must also complete appropriate records of service, including the report of changes in the patient's needs.

Hospice aide documentation complies with hospice policies and procedures.

It is required that hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities. The hospice aide must also complete appropriate records of service, including the report of changes in the patient's needs. Hospice aide documentation complies with hospice policies and procedures.

This standard was not met as evidenced by review of clinical records with the Director of Patient Care Services and the Regional Director of Quality and review of hospice policy. The policy No H:2-005.1 states in part, "Hospice aide duties may include:...D. Reporting changes in the patient's condition and needs." 1 of 12 (8%) applicable records with hospice aide services revealed the hospice aide failed to notify the registered nurse that the hospice aide tasks were not performed as assigned in the hospice aide care plan [Record #33173: This patient was admitted 9/26/2020 with a hospice diagnosis of malignant neoplasm of the pancreas. The hospice aide care plan dated 9/28/2020 assigned the aide to provide a shampoo at each visit. A hospice aide visit documented that a shampoo was not performed, but no documentation was present that the RN was notified]. This finding was confirmed with the Director of Patient Care Services during joint record review.

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams? Education included related• CHAP Standard HCDT.18.I• CMS CFR 418.76(g)(4)• Cited agency policy H:2-005.1o "Hospice aide duties may include. Reporting changes in the patient's condition and needs."• Education Pointso The

Action Plan Summary

Care Plan is a written document specific to the patient and the patient needs, based on the IDG assessmento Any item on the care plan must be followed as written, unless the patient status or needs changeoAides are to notify RN of ANY care plan (need) not followed and reason why. Documentation should reflect this communication and coordination of careo RNs are encouraged to use the Special Instructions option when writing CNA care plans to specify and individualize patient careo 10/21/2020 – Initial Survey Education Power Point Presentation will be provided to all newly hired staff for the duration of this plan of correctiono 10/28/2020 - Date by which all direct-patient care staff will receive this education.o 11/6/2020 - Focused education provided to RNs about individualizing aide care plans as well as aide scope of practiceo 11/6/2020 - Focused education provided to CNAs about following care plan written by RN, communication and documentation with patient's needs change or care plan is not followed for any reasono 10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

When will the corrective action be implemented?

October 21, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o The Quality Assurance Coordinator (QAC) will audit the most recent aide care plan in 10% of active charts monthly for:? Does RN utilize Special Instructions when writing aide care plan (Yes/No)? Do items on aide care plan coincide with the current clinical status of the patient? (Yes/No)o The QAC will audit the last 14 days' worth of aide visit notes in 10% of active charts monthly for:? Does aide document indication for any non-performed care plan items? (Yes/No/NA)? Does aide document notification of RN for any care plan item not followed? (Yes/No/NA)? Does chart evidence RN documentation of having received aide notification about changes in patient's needs and/or aide care plan items? (Yes/No/NA)o The audit findings will be maintained in the Plan of Correction – Documentary Evidence binder and reviewed biweekly in the leadership team's Plan of Correction Meeting.o The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review.

Action Plan Summary

Action Plan Summary

HCDT.33.I

Citation

CMS Tag: 692

CMS CFR: 418.106(d)

HCDT.33.I - The Interdisciplinary Group determines the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in their home.

The plan of care identifies the IDG's finding regarding safe self-administration and/or family administration of drugs and biologicals.
1. If the patient and/or family cannot administer drugs or biologicals, it is noted in the plan of care, as well as how it is addressed by the IDG.

It is required that the Interdisciplinary Group determines the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in their home. The plan of care identifies the IDG's finding regarding safe self-administration and/or family administration of drugs and biologicals. If the patient and/or family cannot administer drugs or biologicals, it is noted in the plan of care, as well as how it is addressed by the IDG.

This standard was not met as evidenced by review of clinical records with the assistance of the Director of Patient Care Services and the Regional Director of Quality, and review of the hospice policy. The policy No. H:-2-058.1 states in part, "C. Assess the patient's ability to self-administer medications correctly and document the patient's response and understanding to teaching." 2 of 13 (15%) records reviewed failed to evidence documentation that the patient/family was assessed for the ability to safely manage medications.
Record #89279 : This patient was admitted 8/22/2020 with hospice diagnoses of pulmonary fibrosis and a longstanding history of malignant neoplasm of the colon. The patient lived alone in an apartment and was cared for by paid caregivers. There was no documentation present that the patient or caregivers were assessed for their ability to safely administer medications. The Director of Patient Care Services stated that there was no evidence that an assessment of abilities had been completed. She stated that the RN initial comprehensive assessment should include a question within the assessment tool which would prompt the RN to perform this assessment. She stated she would contact the EMR company and make this request.
Record #39562: This patient was admitted 9/10/2020 with a hospice diagnosis of senile dementia of the brain. The RN initial assessment dated 9/10/2020 and review of the medication education provided to the patient and family evidenced no documentation that an assessment of abilities was completed to ensure that the patient/family were able to

safely administer medications.

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams? Education included related• CHAP Standard HCDT.33.I• CMS CFR 418.106(d)• Cited agency policy H:2-058.1o "C. Assess the patient's ability to self-administer medications correctly and document the patient's response and understanding to teaching."• Education Pointso The IDG must initially, and in an ongoing fashion, assess the ability and safety of patient/family/caregiver administering meds in the home.o If the IDG assesses the patient/family/caregiver to be unable to safely manage medications, the actions of the IDG should be in the record and care plan.o 10/21/2020 – Initial Survey Education Power Point Presentation will be provided to all newly hired staff for the duration of this plan of correctiono 10/28/2020 - Date by which all direct-patient care staff will receive this education.o 10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

When will the corrective action be implemented?

October 21, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o The Quality Assurance Coordinator (QAC) will audit 10% of active patient records for:? Does the record reflect identification of who will be administering medications to the patient? (Yes/No)? Does the record evidence documentation that the patient/family/caregiver was assessed for the ability to safely manage medications? (Yes/No)? If the patient/family/caregiver is determined to not be able to safely administer medications, is the plan for addressing this documented? (Yes/No/NA)o The audit findings will be maintained in Hospice Plan of Correction – Documentary Evidence binder and reviewed biweekly in the Hospice leadership team's Plan of Correction Meeting.o The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review.

Action Plan Summary

HCDT.39.I

Citation	HCDT.39.I - If a patient revokes the election of hospice care or is discharged from hospice per hospice regulation §418.26 (i.e., no longer terminally ill), the hospice forwards to the patient's attending physician: 1. A copy of the hospice discharge summary; 2. The patient's record, if requested.
CMS Tag: 683	
CMS CFR: 418.104(e)(2)	

It is required that if a patient revokes the election of hospice care or is discharged from hospice per hospice regulation §418.26 (i.e., no longer terminally ill), the hospice forwards to the patient's attending physician: a copy of the hospice discharge summary; the patient's record, if requested.

This standard was not met as evidenced by review of clinical records with the assistance of the Director of Patient Care Services and Regional Director of Quality, and review of the hospice policy. The policy No. H:2-086.1 states in relevant parts, "All patients discharged from a service will have a discharge summary completed and filed in the clinical record." and "3. A copy of the discharge summary will be provided to the patient's attending physician." 1 of 1 (100%) applicable records of patients who were discharged from the hospice failed to evidence documentation that a discharge summary was sent to the attending physician [Record #24927: This patient was admitted 4/30/2020 with a hospice diagnosis of frontal-temporal dementia. The patient was admitted to a non-contracted assisted living facility on 7/14/2020, so was transferred to another hospice agency. There was no evidence in the record that the discharge summary was sent to the attending physician]. On interview with the Director of Patient Care Services, she stated, "I feel like all of that (elements of the discharge summary process) was sitting there for the 15th". and "We missed the documentation."

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams? Education included related• CHAP Standard HCDT.39.I• CMS CFR 418.104(e)(2)• Cited agency policy H:2-086.1o "All patients discharged from a service will have a discharge summary completed and filed in the clinical record. A copy of the discharge summary will be provided to the patient's attending [receiving] physician."• Education Pointso Receiving attending physician should be coordinated by IDG prior discharge/transfero Discharge Summary should be completed by the IDGo

Action Plan Summary

BOM/BOS to print/fax discharge summary and ensure deliver of the discharge summary to identified physician and/or facility? Documentation of this communication to be maintained in the patient's record.o 10/21/2020 – Initial Survey Education Power Point Presentation will be provided to all newly hired staff for the duration of this plan of correctiono 10/28/2020 - Date by which all direct-patient care staff will receive this education.o 10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

When will the corrective action be implemented?

October 21, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o The Quality Assurance Coordinator (QAC) will audit 100% of live discharges for? Does the record include a completed Discharge Summary? (Yes/No)? Does the record evidence documentation that a discharge summary was sent to the attending physician? (Yes/No)? Is the fax confirmation uploaded into EMR (Yes/No/NA)o The audit findings will be maintained in the Plan of Correction – Documentary Evidence binder and reviewed biweekly in the leadership team's Plan of Correction Meeting.o The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review

Action Plan Summary

HCPC.12.I

Citation

CMS Tag: 524

CMS CFR: 418.54(c)

HCPC.12.I - The patient's pain is assessed as part of a comprehensive assessment.

1. Assessment of pain in children and adolescents is conducted with consideration of age and neurocognitive development.

The documented assessment of the patient's pain includes:

1. History of pain and its treatment, both pharmacological and non-pharmacological;
2. Use of a standardized pain assessment tool appropriate to the patient's developmental and cognitive status;
3. Characteristics of the pain, including:

a) Location, frequency, and intensity;

b) How pain impacts the patient's ability to engage in usual activities and function (e.g., appetite, sleeping);

4. The patient's/family's goals for pain management and their satisfaction with the current level of pain control.

It is required that the patient's pain is assessed as part of a comprehensive assessment. Assessment of pain in children and adolescents is conducted with consideration of age and neurocognitive development.
The documented assessment of the patient's pain includes: the patient's/family's goals for pain management and their satisfaction with the current level of pain control.

This standard was not met as evidenced by review of clinical records, with the assistance of the Director of Patient Care Services and the Regional Director of Quality, observation/interview on home visits and review of the hospice policy. The policy No. H:2-50.1 states in relevant parts, "All patients will receive pain assessments. When pain is identified, a more comprehensive pain assessment will be completed when warranted by the patient's condition." and "I. The patient's pain goal, including pain intensity and goals related to function, activities, and quality of life." 2 of 13 (15%) records failed to address all aspects of the pain assessment, specifically, the patient's/family's goal(s) for pain relief. Record #89279: This patient was admitted 8/22/2020 with a hospice diagnosis of pulmonary fibrosis. during an observed home visit on 10/14/2020, the patient stated she was having some pain in her abdomen. The Director of Patient Care Services, following the visit, stated, "We couldn't find anything that documents the pain goal." The RN initial comprehensive assessment dated 8/22/2020, documented that

the patient rated her pain at 4, but there was no documentation of what the patient's goal was for pain control. The DPCS stated, "This nurse is no longer with us due to shoddy documentation."
Record #12220: This patient was admitted 1/12/2019 with a hospice diagnosis of Alzheimer's Disease. In the initial comprehensive assessment, the RN documented that a pain measurement scale was "Not Needed", and "Pt has no complaints of pain as evidenced by facial expression." The Director of Patient Care Services stated, "She should have used a PAINAD." The record included no documented evidence of the patient's pain goal.

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams? Education included related• CHAP Standard HCPC.12.I• CMS CFR 418.54(c)• Cited agency policy H:2-050.1o "All patients will receive pain assessments. When pain is identified, a more comprehensive pain assessment will be completed when warranted by the patient's condition."o "I. The patient's pain goal, including pain intensity and goals related to function, activities, and quality of life"• Education Pointso Utilizing a standardized pain scale for a demented patiento Consistently document the goal identified by the patient/family regarding their pain and other symptoms to be management plan? For example: Pain level of 2/10 is goal? For example: Anxiety level on the ESAS of 3/10 is goalo EACH pain assessment should be a comprehensive assessment including:? Interventions? Efficacy of interventions? Document the patient/family's goal for pain and symptom managemento Pain assessments utilize standardized scaleso When a patient has active pain or measures in place controlling pain, a comprehensive pain assessment is documented with each nursing visit, including efficacy of interventions as it relates to the patient/family's identified goalo 10/21/2020 – Initial Survey Education Power Point Presentation will be provided to all newly hired staff for the duration of this plan of correctiono 10/28/2020 - Date by which all current, direct-patient care staff will receive this education.o 10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

When will the corrective action be implemented?

October 21, 2020

Action Plan Summary

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o The Quality Assurance Coordinator (QAC) will audit 10% of patient charts for patients who have pain as an active problem, monthly for:? Is a pain scale used in the assessment of the patient's pain level? (Yes/No)? Does the last RN visit note include a comprehensive pain assessment (Yes/No)? Does the pain assessment cite the patient/family's goal(s) for pain relief? (Yes/No)o The audit findings will be maintained in the Plan of Correction – Documentary Evidence binder and reviewed biweekly in the leadership team's Plan of Correction Meeting.o The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review

Action Plan Summary

HCPC.15.I

Citation

CMS Tag: 530

CMS CFR: 418.54(c)(6)

HCPC.15.I - The documented comprehensive assessment includes a drug profile that contains the patient's current:

1. Prescription and over-the-counter (OTC) drugs;
2. Supplements;
3. Herbal remedies;
4. Other alternative treatments that could affect drug therapy.

The medication review process includes the identification of the following:

1. The effectiveness of drug therapy;
2. Drug side effects;
3. Actual or potential drug interactions;
4. Duplicate drug therapy;
5. Drug therapy associated with laboratory monitoring.

The assessment includes evidence that common side effects of medication in the hospice populations are anticipated, and, as appropriate, preventive measurements are implemented to manage the side effects.

The drug profile is updated per the hospice policy and procedure, but, at minimum, at the time of each comprehensive assessment and/or when new medication is added or changes are made to existing medication.

It is required that the documented comprehensive assessment includes a drug profile that contains the patient's current: prescription and over-the -counter (OTC) drugs; supplements; herbal remedies; other alternative treatments that could affect drug therapy. The medication review process includes the identification of the following: the effectiveness of drug therapy; drug side effects; actual or potential drug interactions; duplicate drug therapy; drug therapy associated with laboratory monitoring. The assessment includes evidence that common side effects of medication in the hospice populations are anticipated, and, as appropriate, preventive measurements are implemented to manage the side effects. The drug profile is updated per the hospice policy and procedure, but, at minimum, at the time of each comprehensive assessment and/or when new medication is added or changes are made to existing medication.

This standard was not met as evidenced by review of clinical records with the Director of Patient Care Services and Regional Director of Quality, and review of the hospice policy. The policy No. H:2-055.1 states in part,

"Patients receiving medications administered by the organization will have a current accurate medication profile. The medication profiles will be updated for each change to reflect current medications, and new and/or discontinued medications." 2 of 13 (15%) records failed to evidence documentation that the drug profiles were updated in accordance with hospice policy.
Record #47311: This patient was admitted on 1/29/2020 with a hospice diagnosis of Parkinson's Disease. The RN documented that the patient was on oxygen PRN; oxygen was not included on the drug profile.
Record #12220: This patient was admitted 1/12/2019 with a hospice diagnosis of Alzheimer's disease. The RN initial comprehensive assessment dated 1/12/2019 documented that the patient was on oxygen at 2L per nasal cannula; oxygen was not listed on the drug profile.
These findings were confirmed by the Director of Patient Care Services.

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams? Education included related• CHAP Standard HCPC.15.I• CMS CFR 418.54(c)(6)• Cited agency policy H:2-055.1o "Patients receiving medications administered by the organization will have a current accurate medication profile. The medication profiles will be updated for each change to reflect current medications, and new and/or discontinued medications."• Education Pointso ALL meds and treatments should be on the med list (and care plan)o This includes Oxygeno Oxygen orders match documented utilization, and vice-versao Oxygen can be found under Compound Medications in EMRo 10/21/2020 – Initial Survey Education Power Point Presentation provided to all newly hired staff for the duration of this plan of correctiono 10/28/2020 - Date by which all current, direct-patient care staff will receive this education.o 10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

When will the corrective action be implemented?

October 21, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o The Quality Assurance Coordinator (QAC) will audit 10% of

patient charts for patients using oxygen monthly for:? Is the medication profile inclusive of all noted medications? (Yes/No)? Is Oxygen on the Medication Profile? (Yes/No/NA)? Does the ordered liter flow coincide with what is documented in visit notes? (Yes/No/NA)• Review last 14 days of visit notes from time of auditoThe audit findings will be maintained in the Plan of Correction – Documentary Evidence binder and reviewed biweekly in the leadership team's Plan of Correction Meeting.o The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review

Action Plan Summary

HCPC.21.I

Citation

CMS Tag: 545

CMS CFR: 418.56(c)

HCPC.21.I - Each patient's individualized written plan of care:
1. Reflects patient and family goals;
2. Identifies planned interventions based on problems identified in the initial and updated comprehensive assessments;
3. Includes all services necessary for the palliation and management of the terminal illness, including the following:
a) Intervention to manage pain and symptoms;
b) A detailed statement of the scope and frequency of services necessary to meet specific patient and family needs;
c) Measureable outcomes anticipated from implementing and coordinating the plan of care;
d) Drugs and treatment necessary to meet the needs of the patient;
e) Medical supplies and appliances necessary to meet the needs of the patient;
4. Includes the Interdisciplinary Group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC;
a) The documentation in the patient's record is in accordance with the hospice's policies and procedure.

It is required that each patient's individualized written plan of care: reflects patient and family goals; identifies planned interventions based on problems identified in the initial and updated comprehensive assessments; includes all services necessary for the palliation and management of the terminal illness, including the following: intervention to manage pain and symptoms;
a detailed statement of the scope and frequency of services necessary to meet specific patient and family needs; measurable outcomes anticipated from implementing and coordinating the plan of care; drugs and treatment necessary to meet the needs of the patient; medical supplies and appliances necessary to meet the needs of the patient. (The plan of care) includes the Interdisciplinary Group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC. The documentation in the patient's record is in accordance with the hospice's policies and procedure.

This standard was not met as evidenced by review of clinical records with the assistance of the Director of Patient Care Services and the Regional Director of Quality, and review of the hospice policy. The policy No. H:2-03.1 states in part, "The plan of care will identify the needs and services to meet those needs, including the management of pain and discomfort

and symptom relief." 3 of 13 (23%) records reviewed failed to evidence that the plans of care identified the needs and services required to meet the patient's/family's needs based on the problems identified in the initial and updated comprehensive assessments.
Record #52817: This patient was admitted 10/10/2018 with a hospice diagnosis of dysphagia following a cerebral infarction. The medical history of the patient upon admission documented that the patient had a tracheostomy. Care for the tracheostomy was not included in the plan of care.
Record #56650: This patient was admitted 10/1/2020 with a hospice diagnosis of Alzheimer's Disease. The RN assessment dated 10/12/2020 documented a stage 4 open area in the posterior lumbar area measuring 1.8cm (length), 0.6cm (width), and 1.3cm (depth). The plan of care did not include interventions for the wound as confirmed with the Regional Director of Quality, who stated "that is not indicated" in the plan of care. The SN visit on 10/15/2020 documented the following: "PRN comfort visit made. Pt is on bed, eyes closed, resp non-labored. Pt awakens briefly than falls back to sleep. Medication given pre-ADLs. Wound care is effective. Pt with no facial grimacing. Last meal was 6 days ago, since than sips of H2O via syringe. Family agree to hold medications...cont with comfort meds; PRN morphine and Ativan." The plan of care reflected no update to this change in condition.
Record #33173: This patient was admitted 9/27/2020 with a hospice diagnosis of malignant neoplasm of the pancreas. The RN initial comprehensive assessment dated 9/27/2020 documented the patient was noted to have "dysphagia". The plan of care did not identify planned interventions based upon this problem.
These findings were confirmed with the Director of Patient Care Services and the Regional Director of Quality.

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams? Education included related• CHAP Standard HCPC.21.I• CMS CFR 418.56(c)• Cited agency policy H:2-030.1o "The plan of care will identify the needs and services to meet those needs, including the management of pain and discomfort and symptom relief"• Education Pointso The care plan should paint the picture of your patient/familyo The care plan changes as patient changeso All things going on with the patient must be included in the plan of care. Don't forget items such as:? Tracheostomies? Pegs? Foleys? Wound Care? Oxygen and other compound medicationso 10/21/2020 – Initial Survey Education Power Point Presentation will be provided to all newly hired staff for the duration of this plan of correctiono 10/28/2020 - Date by which all current, direct-

patient care staff will receive this education.o 10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

When will the corrective action be implemented?

October 21, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o The Quality Assurance Coordinator (QAC) will audit 10% of active patient charts monthly for:? Based on a 14-day look-back, does the plan of care identify the needs and services required to meet the patient's/family's needs, based on the problems identified in the assessments? (Yes/No)• Audit tip: compare current documentation with that of the admission visit.• Audit tip: This deficiency was cited due to the following not being on the plan of care:o A tracheostomyo A woundo A change of conditiono Dysphagia interventionso The audit findings will be maintained in the Plan of Correction – Documentary Evidence binder and reviewed biweekly in the leadership team's Plan of Correction Meeting.o The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review

Action Plan Summary

HSRF.6.I

Citation

CMS Tag: 774

CMS CFR: 418.112(d)(1)

HSRF.6.I - Hospice care of the patient/resident is stated in a written plan of care established and maintained in consultation with SNF/NF or ICF/IDF representatives.
1. The hospice plan of care identifies the care and services that are needed and specifies which provider is responsible for performing the functions that are agreed upon and included in the plan of care.
2. The plan of care reflects the participation of the hospice, the SNF/NF or ICF/IDF, and the patient and family to the extent possible.
3. All hospice care is provided in the facility in accordance with the hospice plan of care.
4. Any changes to the hospice plan of care are discussed with the patient or representative and SNF/NF or ICF/IDF representatives, and are approved by the hospice before implementation.

It is required that hospice care of the patient/resident is stated in a written plan of care established and maintained in consultation with SNF/NF or ICF/IDF representatives. The hospice plan of care identifies the care and services that are needed and specifies which provider is responsible for performing the functions that are agreed upon and included in the plan of care. The plan of care reflects the participation of the hospice, the SNF/NF or ICF/IDF, and the patient and family to the extent possible. All hospice care is provided in the facility in accordance with the hospice plan of care. Any changes to the hospice plan of care are discussed with the patient or representative and SNF/NF or ICF/IDF representatives, and are approved by the hospice before implementation.

This standard was not met as evidenced by review of clinical records, observation on home visits and review of the hospice policy. The policy No. 1-030 states in relevant part, "F. A delineation of the hospice's responsibilities, which include, but are not limited to the following: 1. Providing medical direction and management 2. Providing nursing, counseling (including spiritual, dietary, and bereavement) social work 3. Providing medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness 4. Provision of other hospice services that are necessary for care related to the terminal status and related conditions 5. Providing ongoing assessment, monitoring, care planning, coordination and provision of care by the IDG. 6. Assessment, coordination and provision of needed general inpatient or continuous care. 7. Consultation about the patient's/resident's care with the facility staff. 8. Provide hospice aide services, if these services are determined to be necessary by the IDG

to supplement the nurse aide services provided by the facility. 9. Financial management (supplies, medications, biologicals, etc.) related t o the terminal illness and related conditions. 9. Determination of the appropriate level of care." 1 of 1 (100%) applicable records of a patient who resided in a SNF failed to delineate, in the plan of care, functions for which each provider was responsible [Record #12220: This patient was admitted 1/12/2019 with a hospice diagnosis of Alzheimer's Disease. An observed home visit was conducted on 10/14/2020. The facility clinical record was reviewed on-site and also the hospice EMR with the assistance of the Director of Patient Care Services. The hospice plan of care did not delineate which provider was responsible for performing the functions agreed upon and included in the plan of care].

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams? Education included related• CHAP Standard HSRF.6.1• CMS CFR 418.112(d)(1)• Cited agency policy H:1-030o "F. A delineation of the hospice's responsibilities, which include, but are not limited to the followingo Providing medical direction and managemento Providing nursing, counseling (including spiritual, dietary, and bereavement) social worko Providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illnesso Provision of other hospice services that are necessary for care related to the terminal status and related conditionso Providing ongoing assessment, monitoring, care planning, coordination, and provision of care by the IDGo Assessment, coordination, and provision of needed general inpatient or continuous careo Consultation about the patient's/representative's care with the facility staffo Provide hospice aide services, if these services are determined to be necessary by the IDG to supplement the nurse aide services provided by the facilityo Financial management (supplies, medications, biologicals, etc.) related to the terminal illness and related conditions o Determination of the appropriate level of care• Education Pointso EMR such as? "Facility to do_____ task _____ times per week on days _____"o RNs should consistently utilize "special instructions" in Aide care planso Care plans for patients in nursing facilities should delineate functions for which each provider is responsibleo 10/21/2020 – Initial Survey Education Power Point Presentation will be provided to all newly hired staff for the duration of this plan of correctiono 10/28/2020 - Date by which all current, direct-patient care staff will receive this education.o 11/6/2020 – Updated Admission Workflow including care plan items related to facility/hospice duties education provided to nursing team.o

10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

When will the corrective action be implemented?

October 21, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o The Quality Assurance Coordinator (QAC) will audit 5 active patient charts for patients who reside in NFs monthly for:? Does the POC delineate which provider is responsible for functions agreed upon and in the plan of care? (Yes/No)? Does the aid care plan delineate which provider is responsible for functions agreed upon and in the plan of care? (Yes/No/NA)o The audit findings will be maintained in the Plan of Correction – Documentary Evidence binder and reviewed biweekly in the leadership team's Plan of Correction Meeting.o The Audit Tool results will be tracked, trended shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review

Action Plan Summary

HSRF.9.I

Citation

CMS Tag: 781

CMS CFR: 418.112(e)(3)

HSRF.9.I - The designated IDG member provides the SNF/NF or ICF/IDF with the following information for each patient/resident:

1. The most recent hospice plan of care;
2. Hospice election form and any advance directives;
3. Physician certification and recertification of the terminal illness;
4. Names and contact information for hospice staff involved in the patient's care;
5. Instructions on how to access the hospice's 24-hour on-call system;
6. Hospice medication information;
7. Hospice physician and attending physician (if any) orders.

It is required that the designated IDG member provides the SNF/NF or ICF/IDF with the following information for each patient/resident: the most recent hospice plan of care; hospice election form and any advance directives; physician certification and recertification of the terminal illness; names and contact information for hospice staff involved in the patient's care; instructions on how to access the hospice's 24-hour on-call system; hospice medication information; hospice physician and attending physician (if any) orders.

This standard was not met as evidenced by review of clinical records with the assistance of the Director of Patient Care Services and the Regional Director of Quality, observation/interview during home visits, and review of the hospice policy. The policy No. 1-30 states in part, "Hospice will assume responsibility for professional management of the SNF/NF, ICF/ID or CLHF resident's hospice services provided, in accordance with the hospice plan of care and the hospice CoPs." 1 of 1 (100%) applicable records of patients who resided in a SNF did not evidence the presence of the required documents in the facility's clinical record [Record #12220: This patient was admitted 1/12/2019 with a hospice diagnosis of Alzheimer's Disease. A review of the hospice binder was performed during an observed home visit conducted on 10/14/2020. The following information was not found in the hospice binder: the most recent hospice plan of care; hospice election form and any advance directives; physician certification and recertification of the terminal illness; and hospice medication information. Two facility nurses were interviewed to ensure there was no other place that the information could be housed; there was no evidence that the required information was present at the facility]. On interview with the Director of Patient Care Services, she stated that there was a process in place to make sure the hospice

provides the SNF with what they need but could not explain why the required information was not present. She stated "We know what tags there are" and indicated that the leadership team was working hard to correct the issues.

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams? Education included related• CHAP Standard HSRF.9.1• CMS CFR 418.112(e)(3)o In addition to meeting..., a hospice that provides hospice care to residents of a... [facility]...must abide by the following additional standards.o Standard: Coordination of services. The hospice must? Designate a member of each interdisciplinary group that is responsible for a patient who is a resident of a...[facility]. The designated interdisciplinary group member is responsible for ? Provide the [facility] with the following information• The most recent hospice plan of care specific to each patient• Hospice election form and any advance directives specific to each patient• Physician certification and recertification of the terminal illness specific to each patient• Names and contact information for hospice personnel involved in hospice care of each patient• Instructions on how to access the hospice's 24-hour on-call system• Hospice medication information specific to each patient• Hospice physician and attending physician (if any) orders specific to each patient• Cited agency policy H:1-030o "Hospice will assume responsibility for professional management of the SNF/NF, ICF/ID or CLHF resident's hospice services provided, in accordance with the hospice plan of care and the hospice CoPs."• Education Pointso RNCM primarily responsible for thiso ALL team members can support this and review the content of the facility binder/charto 10/21/2020 – Initial Survey Education Power Point Presentation will be provided to all newly hired staff for the duration of this plan of correctiono 10/28/2020 - Date by which all current, direct-patient care staff will receive this education.o 10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

When will the corrective action be implemented?

October 21, 2020

What is the monitoring process we will put into place to ensure

implementation and effectiveness of this corrective action plan?

o The Quality Assurance Coordinator (QAC) will audit 5 nursing facility patient charts monthly for:? Does the facility chart include the following hospice documentation?• The most recent hospice plan of care specific to each patient (Yes/No)• Hospice election form and any advance directives specific to each patient? (Yes/No)• Physician certification and recertification of the terminal illness specific to each patient? (Yes/No)• Names and contact information for hospice personnel involved in hospice care of each patient? (Yes/No)• Instructions on how to access the hospice's 24-hour on-call system? (Yes/No)• Hospice medication information specific to each patient? (Yes/No)• Hospice physician and attending physician (if any) orders specific to each patient? (Yes/No/NA)o The audit findings will be maintained in the Plan of Correction – Documentary Evidence binder and reviewed biweekly in the team's Plan of Correction Meeting.o The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review

Action Plan Summary

HSRM.14.I

Citation

CMS Tag: 663

CMS CFR: 418.100(g)(3)

HSRM.14.I - The hospice assesses the skills and competencies of all individuals providing care, including volunteers providing services and, as necessary, provides in-service training and education programs where required.
The hospice has written policies and procedures describing the method (s) of assessing competency and:
1. Maintains a written description of the in-service training provided during the previous 12 months.

It is required that the hospice assesses the skills and competencies of all individuals providing care, including volunteers providing services and, as necessary, provides in-service training and education programs where required. The hospice has written policies and procedures describing the method(s) of assessing competency and: maintains a written description of the in-service training provided during the previous 12 months.

This standard was not met as evidenced by review of personnel records with the assistance of the Director of Patient Care Services and review of the hospice policy. The policy No. C:3-023.1 states in part, "6. After completion of orientation, competency will be monitored periodically thereafter and may be a part of the annual performance evaluation process." 3 of 6 (50%) applicable records of staff requiring competency evaluation failed to evidence documentation of competency testing on hire and/or annually.
Record #55574: This chaplain was hired on 4/30/2019. There was no documentation of competency testing found in the record. On interview with the Director of Patient Care Services, she stated, "There is an eval, but I don't see the competency attached." and "I don't see any competencies."
Record #78985: This bereavement counselor was hired 5/16/2016. There was no documentation of competency testing for 2019 found in the record. On interview with the Director of Patient Care Services, she stated, "None of the competencies are loaded in here" (referring to the electronic record).
Record #31092: This RN was hired 2/2/2017. There was no evidence of a competency evaluation completed for 2019. The Director of Patient Care Services called Human Resources to find out where to find competency evaluation, and was informed, "So far I see (20)17 and (20)18, but I don't see (20)19."

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams? Education included related• CHAP Standard HSRM.14.I• CMS CFR 418.100(g)(3)• Cited agency policy C:3-023.1o "After completion of orientation, competency will be monitored periodically thereafter and may be a part of the annual performance evaluation process" • Education Pointso Competency should be monitored annually for each employee. o Paylocity process supports identification of due competency reviewso 10/21/2020 – Initial Survey Education Power Point Presentation will be provided to all newly hired staff for the duration of this plan of correctiono 10/28/2020 - Date by which all current, direct-patient care staff will receive this education.o 10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

When will the corrective action be implemented?

October 21, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o Monthly, the Executive Director will validate:? Are we 100% in compliance with annual competency and skills evaluations that have come due? (Yes/No)o The audit findings will be maintained in the Plan of Correction – Documentary Evidence binder and reviewed biweekly in the leadership team's Plan of Correction Meeting.o The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review

Action Plan Summary

HSRM.15.I

Citation	HSRM.15.I - The hospice provides an initial orientation for each employee that addresses the employee's specific job duties, including infection control and organization procedures and policies and procedures on advance directives. Orientation on the hospice philosophy is also provided to all employees and contracted staff who have patient and family contact. Orientation includes the following, as appropriate to the employee's specific job duties: 1. The needs and concerns of patients and families coping with a terminal illness; 2. Education regarding the hospice's policies and procedures on advance directives.
CMS Tag: 661	
CMS CFR: 418.100(g)(1)	

It is required that the hospice provides an initial orientation for each employee that addresses the employee's specific job duties, including infection control and organization procedures and policies and procedures on advance directives. Orientation on the hospice philosophy is also provided to all employees and contracted staff who have patient and family contact. Orientation includes the following, as appropriate to the employee's specific job duties:
1. The needs and concerns of patients and families coping with a terminal illness;
2. Education regarding the hospice's policies and procedures on advance directives.

This standard was not met as evidenced by review of personnel records with the assistance of the Director of Patient Care Services and review of the hospice policy.
The hospice policy No. C:3-020.1 states in part, "All personnel and volunteers will be required to attend an orientation program upon employment and at time of reassignment." 3 of 10 (30%) records failed to evidence documentation of initial orientation on hire.
Record #55574: This chaplain was hired 4/30/2019; no documented evidence could be found in the record that initial orientation was provided.
Record #78778: This hospice aide was hired 10/25/2018; there was no documented evidence of initial orientation in the record.
Record #34307: This LVN was hired 12/23/2019; there was no evidence of initial orientation documented in the record.
These findings were confirmed with the Director of Patient Care Services.

Action Plan Summary

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams Education included related• CHAP Standard HSRM.15.I• CMS CFR 418.100(g)(1)• Cited agency policy C:3-020.1o "All personnel and volunteers will be required to attend an orientation program upon employment and at time of reassignment"• Education Pointso 10/21/2020 – Initial Survey Education Power Point Presentation will be provided to all newly hired staff for the duration of this plan of correctiono 10/28/2020 - Date by which all current, direct-patient care staff will receive this education.o 10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

When will the corrective action be implemented?

October 21, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o Monthly, the Executive Director will validate: Are we 100% in compliance with new hire orientation for all newly-hired staff? (Yes/No)o The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review

Action Plan Summary

HSRM.27.D

Citation

CMS Tag: 632

CMS CFR: 418.76(h)(2)

HSRM.27.D - A registered nurse makes an annual on-site visit to the location where a patient is receiving care in order to observe and assess each hospice aide while he or she is performing care per the hospice's policies and procedures.

It is required that a registered nurse makes an annual on-site visit to the location where a patient is receiving care in order to observe and assess each hospice aide while he or she is performing care per the hospice's policies and procedures.

This standard was not met as evidenced by review of personnel records with the assistance of the Director of Patient Care Services and review of the hospice policy. The policy No. H:3-001.1 states in part, "The overall performance of the aide will be evaluated at least annually for competency by the Case Manager making an on-site visit." 1 of 2 (50%) applicable records of hospice aides failed to evidence documentation of the hospice aide joint, annual on-site skills evaluation [Record #78778: This hospice aide was hired 10/25/2018. There was no documented evidence of an annual on-site skills evaluation for 2019 in the record]. This finding was confirmed by the Director of Patient Care Services.

Agency Response

What action will we take to correct the deficiency cited?

o 10/21/2020 - Initial survey education provided to direct-patient care teams? Education included related• CHAP Standard HSRM.27.D• CMS CFR 418.76(h)(2)• Cited agency policy C:3-000.1o "The overall performance of the aide will be evaluated at least annually for competency by the Case Manager making an on-site visit"• Education Pointso An RN must be involved in the annual evaluation process of aides and must make an on-site visit for evaluation of aide competence at least annually. o 10/21/2020 – Initial Survey Education Power Point Presentation will be provided to all newly hired staff for the duration of this plan of correctiono10/28/2020 - Date by which all current, direct-patient care staff will receive this education.o 10/15/2020 Survey Task Force established and will meet weekly to identify and conduct PDSA cycles for practice change focused on immediate and sustained improvement

Who is responsible to implement the corrective action?

o The Executive Director, or designee, is responsible for the implementation of this corrective action

Action Plan Summary

When will the corrective action be implemented?

October 21, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

o Monthly, the Executive Director will validate:? Are we 100% in compliance with on-site annual competency evaluation by an RN for each hospice aide evaluation that has come due? (Yes/No)o The audit findings will be maintained in the Plan of Correction – Documentary Evidence binder and reviewed biweekly in the leadership team's Plan of Correction Meeting.o The Audit Tool results will also be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.o Audits will continue until 100% compliance is achieved and sustained for 90 days.o Audit results will be presented to the Governing Body for review

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	461595	A. BUILDING _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL HOSPICE-UTAH II, LLC	1106 EAST 6600 SOUTH, SUITE 100 MURRAY, UT 84121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 651	Continued From page 1 1, 2, 3, 5, 9 and 10 was reviewed. The provider listed on the PoCs was a nonexistent unlicensed hospice agency. Patient 1 - certification period 10/5/2020 through 1/2/21; Patient 2 - certification period 2/11/21 through 5/10/21; Patient 3 - certification period 3/12/21 through 5/10/21; Patient 5 - certification periods 1/1/21 through 3/1/21 and 3/2/21 through 4/30/21; Patient 9 - certification periods 32/21 through 3/15/21 and 3/16/21 through 5/14/21; and Patient 10 - certification period 2/25/21 through 5/25/21. 2. The SN (Skilled Nursing) for Admission Visit Summary form for patients 1, 2, 3, 4, 5 and 6 was reviewed. The provider listed on the SN for Admission Visit Summary forms was a nonexistent unlicensed hospice agency. Patient 1, dated 10/5/2020; Patient 2, dated 2/11/21; Patient 3, dated 3/16/2020; Patient 4, dated 2/10/21; Patient 5, dated 1/1/21; and Patient 6, dated 8/31/2020. 3. The Recertification Assessment form for patients 1 and 9 was reviewed. The provider listed on the Recertification Assessment form was a nonexistent unlicensed hospice agency. Patient 1, dated 4/2/21; and Patient 9, dated 3/1/21	L 651		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	461595	A. BUILDING _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL HOSPICE-UTAH II, LLC	1106 EAST 6600 SOUTH, SUITE 100 MURRAY, UT 84121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 651	Continued From page 2 4. The Integrated Assessment form for patients 9, 10 and 11 was reviewed. The provider listed on the Integrated Assessment form was a nonexistent unlicensed hospice agency. Patient 9, dated 3/2/21 Patient 10, dated 3/25/21; and Patient 11, dated 1/13/21. 5. The SOC (start of care) SN Clinical note form, dated 2/25/21 for patient 10 was reviewed. The provider listed on the SOC SN Clinical Note form was a nonexistent unlicensed hospice agency. 6. There was a PRN (as needed) SN Clinical Note, dated 1/13/21; a SN Clinical Note, dated 1/14/21 and 1/15/21; a MD (medical doctor) Note, dated 1/13/21; a MSW (Medical Social Worker) Clinical Note, dated 1/13/21 and 1/15/21; and a HCA (Healthcare Aide) Clinical note, dated 1/13/21 and 1/15/21 that had a nonexistent unlicensed hospice agency listed as the provider. An email correspondence was sent to the administrator on 4/20/21 at 10:23 AM related to the nonexistent unlicensed provider on the hospice agency forms. On 4/20/21 at 11:14 AM, the administrator responded with, "Bristol Hospice acquired (the name of the nonexistent unlicensed hospice agency) towards the end of 2018. The name on the NPI (unknown) was changed. I'd (sic) working to get the legal name change and dba (doing business as) information from corporate to answer your question."	L 651		

State of Utah
Spencer J. Cox
Governor
Deidre M. Henderson
Lieutenant Governor

Utah Department of Health
Richard Saunders
Executive Director

Division of Family Health and Preparedness
Dr. Marc Babitz
Division Director

Bureau of Licensing and Certification
Joel Hoffman
Bureau Director

July 20, 2021

Ms. Valerie Ackley, Administrator
Bristol Hospice-Utah II, LLC
valerie.ackley@bristolhospice.com
1106 East 6600 South, Suite 100
Murray, UT 84121

Dear Ms. Ackley:

On July 15, 2021, a health follow-up was completed by the Utah Department of Health, Division of Family Health and Preparedness, Bureau of Licensing and Certification to determine if your facility corrected deficiencies cited on April 21, 2021. Upon completion of the follow-up it was determined your facility achieved substantial compliance on May 18, 2021.

If you have questions, please contact Michelle at (801) 273-2994, toll free at 1-800-662-4157, or via email at mwilson2@utah.gov.

Sincerely,

Kelly J. Criddle

Kelly Criddle, Manager
Hospital and Ambulatory Care Section

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	461595	A. BUILDING _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL HOSPICE-UTAH II, LLC	1106 EAST 6600 SOUTH, SUITE 100 MURRAY, UT 84121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS A health follow-up was completed on July 15, 2021 for all deficiencies previously cited on April 21, 2021. All cited deficiencies have been corrected as of May 18, 2021 and no new noncompliance was found.	L 000		

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

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

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	461595	A. BUILDING _____ B. WING _____	04/21/2021

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BRISTOL HOSPICE-UTAH II, LLC	1106 EAST 6600 SOUTH, SUITE 100 MURRAY, UT 84121

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E 000	Initial Comments Based on a recertification survey conducted 4/19/21 through 4/21/21, it was determined that Bristol Hospice was in compliance with the Conditions of Participation for Emergency Preparedness for Hospices: 42 CFR (Code of Federal Regulations) 418.113. No deficiencies were cited in this area.	E 000		
L 651	GOVERNING BODY AND ADMINISTRATOR CFR(s): 418.100(b) A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body. This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the hospice agency did not ensure the governing body assumed full legal authority and responsibility for the agency's overall management and operation. Specifically, the agency was commingling with another nonexistent unlicensed hospice entity. (Patient identifiers: 1, 2, 3, 4, 5, 6, 9, 10 and 11) Findings include: 1. The Hospice Plan of Care (PoCs) for patients	L 651		

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L 651	Continued From page 1 1, 2, 3, 5, 9 and 10 was reviewed. The provider listed on the PoCs was a nonexistent unlicensed hospice agency. Patient 1 - certification period 10/5/2020 through 1/2/21; Patient 2 - certification period 2/11/21 through 5/10/21; Patient 3 - certification period 3/12/21 through 5/10/21; Patient 5 - certification periods 1/1/21 through 3/1/21 and 3/2/21 through 4/30/21; Patient 9 - certification periods 32/21 through 3/15/21 and 3/16/21 through 5/14/21; and Patient 10 - certification period 2/25/21 through 5/25/21. 2. The SN (Skilled Nursing) for Admission Visit Summary form for patients 1, 2, 3, 4, 5 and 6 was reviewed. The provider listed on the SN for Admission Visit Summary forms was a nonexistent unlicensed hospice agency. Patient 1, dated 10/5/2020; Patient 2, dated 2/11/21; Patient 3, dated 3/16/2020; Patient 4, dated 2/10/21; Patient 5, dated 1/1/21; and Patient 6, dated 8/31/2020. 3. The Recertification Assessment form for patients 1 and 9 was reviewed. The provider listed on the Recertification Assessment form was a nonexistent unlicensed hospice agency. Patient 1, dated 4/2/21; and Patient 9, dated 3/1/21	L 651		

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L 651	Continued From page 2 4. The Integrated Assessment form for patients 9, 10 and 11 was reviewed. The provider listed on the Integrated Assessment form was a nonexistent unlicensed hospice agency. Patient 9, dated 3/2/21 Patient 10, dated 3/25/21; and Patient 11, dated 1/13/21. 5. The SOC (start of care) SN Clinical note form, dated 2/25/21 for patient 10 was reviewed. The provider listed on the SOC SN Clinical Note form was a nonexistent unlicensed hospice agency. 6. There was a PRN (as needed) SN Clinical Note, dated 1/13/21; a SN Clinical Note, dated 1/14/21 and 1/15/21; a MD (medical doctor) Note, dated 1/13/21; a MSW (Medical Social Worker) Clinical Note, dated 1/13/21 and 1/15/21; and a HCA (Healthcare Aide) Clinical note, dated 1/13/21 and 1/15/21 that had a nonexistent unlicensed hospice agency listed as the provider. An email correspondence was sent to the administrator on 4/20/21 at 10:23 AM related to the nonexistent unlicensed provider on the hospice agency forms. On 4/20/21 at 11:14 AM, the administrator responded with, "Bristol Hospice acquired (the name of the nonexistent unlicensed hospice agency) towards the end of 2018. The name on the NPI (unknown) was changed. I'd (sic) working to get the legal name change and dba (doing business as) information from corporate to answer your question."	L 651		

Bristol Hospice

Provider's Plan of Correction – In response to the Statement of Deficiencies 4/21/2021

ID Prefix Tag	Summary Statement of Deficiencies	Provider's Plan of Correction	Completion Date
L651	Governing Body and Administrator CFR(s): §418.100(b)	**Immediate Actions to Address Deficiencies implemented to improve processes and sustain improvement** **Education** • An email and internal Secure Text message was sent to all relevant parties (Electronic Medical Record users) to educate users to the solitary use of the specific Electronic Medical Record (EMR) site. • Reiterated for this location's Electronic Medical Record (EMR) users the information initially shared company-wide on 2/7/2021 regarding the use of a specific Electronic Medical Record (EMR) site. **Responsible Party: Executive Director or Designee** **Immediate Actions** • Identified relevant users to be only those who have access and use the Electronic Medical Record (EMR) platform in the Casamba EMR System. • An email and internal Secure Text message was sent to all relevant parties (Electronic Medical Record users) • Reiterated for this location's Electronic Medical Record (EMR) users the information initially shared company-wide on 2/7/2021 regarding the use of a specific Electronic Medical Record (EMR) site. **Responsible Party: Executive Director or Designee** **Ongoing Actions** • Subsequently hired employees who will use the Electronic Medical Record (EMR) platform will be educated to the solitary use of the specific Electronic Medical Record (EMR) site.	5/17/2021 5/17/2021 5/17/2021 5/17/2021 5/18/2021 and Ongoing

			• Auditing per below to ensure compliance, until compliance goal met. **Responsible Party: Executive Director or Designee**	5/18/2021 and Ongoing
			Audit Activity to Ensure Future Compliance • The Quality Assurance Coordinator, or Designee, will audit 10 charts weekly for: - At least one document scanned into the chart to ensure the proper and existing hospice's name reflected on the document. Reviewed documents will be printed and maintained in the Bristol Hospice Plan of Correction Binder.	5/18/2021 and Ongoing
			• The audit results will be tracked, trended, and presented to the location QAPI Committee per the Quality Assurance Performance Improvement Program. Additional actions and in-services will be initiated as determined by said committee. **Audits will continue until 100% compliance is achieved and sustained for 90 days.**	5/18/2021 and Ongoing
			• The QAPI will present the audit findings to the Governing Body for review and approval. **Responsible Party: Executive Director or Designee**	5/18/2021 and Ongoing

Valerie Ackley
Executive Director – Bristol Hospice Salt Lake City

5-18-2021
May 18, 2021

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	461566	A. BUILDING _____ B. WING _____	12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL HOSPICE - UTAH, LLC	1638 NORTH WASHINGTON BLVD, SUITE 102 OGDEN, UT 84404

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E 000	Initial Comments Based on a recertification survey, it was determined that Bristol Hospice was in compliance with the Conditions of Participation for Emergency Preparedness; 42 CFR (Code of Federal Regulations) 418.113. No deficiencies were cited related to Emergency Preparedness.	E 000		
L 671	CLINICAL RECORDS CFR(s): 418.104 A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. This STANDARD is not met as evidenced by: Based on interview and medical record review, it was determined the hospice did not ensure the clinical record contained current and correct clinical information for 1 of 13 medical records reviewed. Findings include: Patient 1 was admitted to the hospice on 9/9/2021 with a diagnosis of Amyotrophic Lateral Sclerosis (ALS). Patient 1 medical record review was completed on 12/29/2021 and revealed the following: On 9/9/2021, it was documented on the admission assessment completed by the skilled nurse (SN) that patient 1's wound status was active; the date identified was documented as	L 671		

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

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

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L 671	Continued From page 1 09/09/2021. It was documented that the wound location was at the posterior right buttock and was a stage II pressure ulcer. Wound type was documented as a, "Pressure Injury." On 9/10/2021, the following was documented by a different skilled nurse, "Skin is CDI (clean, dry, and intact), pt (patient) reports he has never had a pressure sore." On the interdisciplinary team (IDT) note dated 9/14/2021, the following was documented by the SN who completed patient 1's admission, "Pt. has PU (pressure ulcer) on coccyx stg (stage) II and calmoseptine used Q (every) change to protect area." The IDT note was electronically signed by the admission nurse, the physician, and the nurse that visited patient 1 on 9/10/2021 who documented that patient 1 had never had a pressure sore. On the IDT note dated 9/28/2021, the following was documented by the SN who completed the visit note on 9/10/2021, "No pressure sores present." The plan of care and updated plans of care had a diagnosis of pressure ulcer of right buttock, stage 2 with a date of 9/9/2021. At the time of survey on 12/29/2021, the diagnosis had not been removed or updated to correct the error in the PU diagnosis. On 12/28/2021 at 4:55 PM, via email, the administrator was asked to provide additional information and help clarify the conflicting documentation identified in patient 1's medical record regarding the wound.	L 671		

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L 671	Continued From page 2 On 12/29/2021 at 10:35 AM the administrator responded, "In summary, there was actually no wound, and the Admit RN (registered nurse) documented those details in error. There was no lotion used for (patient's name). Our Admit RN is adding an addendum to document the error. The IDT note includes the incorrect documentation from the admit RN. It also includes the RNCM (case manager) report/finding that there was no wound. When the RNCM attended the day two visit, she documents that there was no wound. On 9/28/21 The RNCM notes that the skin condition is clean, dry and intact..." On 12/29/2021 at 10:48 AM the administrator was asked to confirm that the SN admission assessment of the wound, and the diagnosis of stage II pressure ulcer, were documented or assessed in error. On 12/29/2021 at 11:18 AM, the administrator responded, "Yes, documented in error. In speaking with the RNCM, she recalls how upset the family was that the RNCM was asking to see pt's buttock to see a wound that they said didn't exist. Pt did lean over for RNCM to observe wound and there wasn't one. So she documented no wound. Admit RN can't recall where she got that information. We have reviewed every chart that the Admit RN admitted that week, and can't find a patient that that matches."	L 671		
L 678	CONTENT CFR(s): 418.104(a)(7) [Each patient's record must include the following:] (7) Physician orders.	L 678		

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L 678	Continued From page 3 This STANDARD is not met as evidenced by: Based on interview and medical record review, it was determined the clinical records did not contain physicians orders for wound care that was provided for 2 of 3 patients with documented wounds. Findings include: Patient 12 was admitted to the hospice on 7/7/2021 with a diagnosis of Heart Failure. Patient 12's medical record review was completed on 12/28/2021 and revealed the following: Skilled nurse (SN) visits notes from 10/10/2021 through 12/11/2021 were reviewed. The SN completed eighteen visits to patient 12 during that time. Sixteen of the eighteen visit notes mention some form of wound care being provided to patient 12 for various wounds. There was no documented evidence that a physician had ordered any of the wound care. The hospice administrator (ADM) was asked about physician wound care orders. The ADM responded on 12/27/2021 at 4:39 PM via email stating, "...it looks like the RNCM (registered nurse case manager) for (patient 12) did not know how to use the system to generate an order for would care. She only has it mentioned in the narrative notes." Note: The RNCM for patient 12 had been employed with the hospice for approximately 8 months. Patient 10 was admitted to the hospice on	L 678		

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L 678	Continued From page 4 11/17/2021 with a diagnosis of hypertensive heart disease with heart failure. Patient 10 medical record review was completed on 12/29/2021 and revealed the following: On 11/17/2021, it was documented on the admission assessment completed by the SN that patient 10 had "Scattered venous stasis wounds on his BLE (bilateral lower extremities). He has a stage 2 pressure sore on his buttocks due to increased bowel incontinence and increased time sitting." SN visits notes from 11/17/2021 through 12/24/2021 were reviewed. The SN completed fourteen visits to patient 10 during that time. Six of the fourteen visit notes mention some form of wound care being provided to patient 12 for various wounds. There was no documented evidence that a physician had ordered any of the wound care. On 12/29/2021 at 10:00 AM, the ADM was interviewed. She was asked about the lack of wound care orders and documentation. She stated they have identified that their wound care charting is not "intuitive" and the nurses were not documenting appropriately in the wound care section. She stated, "we need to do more education with our nurses."	L 678		

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Community Health Accreditation Partner

2300 Clarendon Blvd, Suite 405, Arlington, VA 22201

Phone: 202.862.3413 / Fax: 202.862.3419

February 9, 2021

Mrs. Jeannie Bacco
Executive Director
GeriNet Palliative Care, LLC dba Remita Health
6375 E. Tanque Verde Rd, Suite 170
Tucson, AZ 85715

RE:	Customer ID:	2015175
	Service:	Hospice [Deemed]
	CCN/PTAN:	03-1605

Location and/or Site Accredited:
GeriNet Palliative Care, LLC dba Remita Health
6375 E. Tanque Verde Rd, Suite 170
Tucson, AZ 85715

Site Visit Dates:	January 26, 2021 - January 28, 2021
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	February 5, 2021
CHAP Accreditation Dates:	June 12, 2021 - June 12, 2024
Method of Follow-up:	Acceptable POC

Dear Mrs. Bacco,

I am pleased to inform you that based on the findings of the site visit conducted January 26, 2021 - January 28, 2021, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

ID: JAN2621_JMM
Ref: BICU14.1963

Action Plan Summary

Site Visit 1/26/2021 - 1/28/2021

CCN 031605

Organization

GeriNet Palliative Care, LLC

Summary of Citations

Hospice	1

Condition Level Deficiencies **0**

Service Provider

GeriNet Palliative Care, LLC

6375 E. Tanque Verde Rd suite 170 Tucson, AZ 85715

Contact

Jeannie Bacco

jean.bacco@remitahealth.com

Action Plan Summary

HCPC.4.I

Citation

CMS Tag: 667

CMS CFR: 418.102(b)

HCPC.4.I - The hospice medical director or physician designee reviews the clinical information for each patient being evaluated for admission and provides written certification that it is anticipated that the patient's life expectancy is six months or less if the illness runs its normal course. The physician considers the following when making this determination:

1. The primary terminal condition;
2. Related diagnosis(es), if any;
3. Current subjective and objective medical findings;
4. Current medication and treatment orders;
5. Information about the medical management of any of the patient's conditions unrelated to the terminal illness.

It is required that the hospice medical director or physician designee reviews the clinical information for each patient being evaluated for admission and provides written certification that it is anticipated that the patient's life expectancy is six months or less if the illness runs its normal course.

This standard was not met as evidenced by review of clinical records with the Quality Manager and Director of Patient Care Services. The organization's policy "Certification of Terminal Illness", No. H:2-025.1, states, in part, "If written certification cannot be obtained within two (2) calendar days following the start of care, verbal certification must be obtained and documented in the clinical record within two (2) days following initiation of care and written certification must be obtained before the hospice submits a claim for payment." CFR 418.22(a)(3)(i) states, "If the hospice cannot obtain the written certification within 2 calendar days after a period begins, it must obtain an oral certification within 2 calendar days." 1 of 13 (8%) records revealed no evidence that an initial certification of terminal illness (either written or verbal) was obtained from the attending physician within 2 calendar days after the hospice start of care, as required in hospice policy and in accordance with CFR 418.22 [Record #23194 - Start of care 12/17/20: The "Election of Hospice Benefit Informed Consent" form, signed by the patient/representative on 12/17/20, included that the patient designated a community physician, not the hospice physician, as the attending physician. The "Certification" form included that the RN received a verbal certification order on 12/17/20 from only the hospice Medical Director and the "Certification" form included the name of the Medical Director in the "attending physician" section. Additionally, there was no documented evidence that the attending physician signed an initial certification. There was no documented verbal or written certification

from the patient's designated attending physician]. During interview, the Quality Manager stated that the Medical Director's name was incorrectly entered in to the electronic medical record system instead of the patient's designated attending physician and she confirmed that the patient did want the community physician as the attending physician and that the hospice was now in the process of obtaining the initial certification from the patient's attending physician.

Agency Response

What action will we take to correct the deficiency cited?

1. The CTI was printed out and sent to the community physician designated on consents and compliance was demonstrated prior to surveyor's exit.2. Individual counseling and education with RN who did the admission regarding the differentiation of the Attending Physician and the Medical Director in the admission process was completed on February 4, 2021 by Executive Director and QAPI Manager.3. Mandatory Group education with all RN's (including RN's who complete admissions) referencing C.O.P.'s and standard. HCPC-4-1 "The hospice medical director or physician designee reviews the clinical information for each patient evaluated for admission and provides written certification that it is anticipated that the patient's life expectancy is six months or less if the illness runs its normal course. The physician considers the following when making this determination:a. The primary terminal conditionb. Related diagnosis(es) if anyc. Current subjective and objective medical findingsd. Current medication and treatment orderse. Information about the medical management of any of the patient's conditions unrelated to the terminal illness. Training to include:a. The importance of ensuring that the documentation reflects the patient's choice regarding the designated attending physician.b. The program leadership, business office staff, medical directors and registered nurses will receive training on the elements of the certification of terminal illness.

Who is responsible to implement the corrective action?

Executive Director

When will the corrective action be implemented?

February 01, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Effective February 1, 2021 and for 90 days forward, every admission will be analyzed for the correct physicians listed as attending physician in the EMR and as designated by patient/legal representative on the Election of Hospice Benefit form. This will take place within 24 hours of admission or next business day by the Director of Patient Care Services/Designee. If any discrepancies are noted, corrections will be made at that time with

the admitting nurse. Goal is 100% accuracy.Once 100% compliance is met for three consecutive months, continued monitoring will be ongoing monthly with the chart review sampling 10% of charts of open charts. Findings will be tracked, trended and presented to the QAPI Committee. The QAPI Committee will direct any interventions of performance improvement projects as determined. The QAPI Committee will present findings to the Governing Body for their review.

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Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

December 21, 2021

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:

Customer ID:	2006002
Service:	Hospice [Deemed]
CCN/PTAN:	55-1502

Location and/or Site Accredited:
Gerinet Physician Services, Inc dba Bristol Hospice - Greater Los Angeles
4010 Watson Plaza Drive, Suite 140
Lakewood, CA 90712

Site Visit Dates:	December 6, 2021 - December 8, 2021
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	N/A
CHAP Accreditation Dates:	February 2, 2022 - February 2, 2025
Method of Follow-up:	N/A

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted December 6, 2021 - December 8, 2021, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

Should you wish to appeal, please email your Director of Accreditation, Frances Petrella, with the details of your appeal request within the next 10 days of notification receipt.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

ID: *DEC0621_XGK*
Ref: *RHFX698400*

Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

CHAP

December 21, 2021

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	55-1502

Location and/or Site Accredited:
Gerinet Physician Services, Inc dba Bristol Hospice - Greater Los Angeles
4010 Watson Plaza Drive, Suite 140
Lakewood, CA 90712

Site Visit Dates:	December 6, 2021 - December 8, 2021
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Medicare Certification:	Recertification
Deemed Status Recommendation:	Continued Deemed Status
Plan of Correction Accepted Date:	N/A
Effective Date of Accreditation:	February 2, 2022
Expiration Date of Accreditation:	February 2, 2025
Method of Follow-up:	N/A

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted December 6, 2021 - December 8, 2021, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended continued Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

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CC: CMS Regional Office (CMS RO IX - San Francisco)
CMS Central Office
State Agency

15

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

July 2, 2020

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:	Customer ID:	2006002
	Service:	Hospice [Deemed]
	CCN/PTAN:	05-1725

Location and/or Site Accredited:
Optimal Hospice, Inc dba Optimal Hospice Care
1675 Chester Avenue, Suite 401
Bakersfield, CA 93301

Optimal Hospice, Inc
6504 Lake Isabella Blvd., Suite E
Lake Isabella, CA 93240

Site Visit Dates:	June 8, 2020 - June 11, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	June 29, 2020
CHAP Accreditation Dates:	January 21, 2020 - February 15, 2022
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted June 8, 2020 - June 11, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

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ID: *JUN0820_QBD*
Ref: *QUHR682063*

Community Health Accreditation Partner
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CHAP

July 2, 2020

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:

Customer ID:	2006002
Service:	Hospice [Deemed]
CCN/PTAN:	05-1725

Location and/or Site Accredited:

Optimal Hospice, Inc dba Optimal Hospice Care
1675 Chester Avenue, Suite 401
Bakersfield, CA 93301

Optimal Hospice, Inc
6504 Lake Isabella Blvd., Suite E
Lake Isabella, CA 93240

Site Visit Dates:	June 8, 2020 - June 11, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	June 29, 2020
Effective Date of Accreditation:	June 29, 2020
Expiration Date of Accreditation:	June 29, 2023
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted June 8, 2020 - June 11, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

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Teresa.Harbour@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO IX - San Francisco)
CMS Central Office
State Agency

Action Plan Summary

Site Visit 6/8/2020 - 6/11/2020

CCN 051725

Organization

Bristol Hospice, LLC

Summary of Citations

Hospice	3

Condition Level Deficiencies **0**

Service Provider

Opitmal Hospice, Inc

1675 Chester Avenue Suite 401 Bakersfield, CA 93301

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Action Plan Summary

HCDT.18.I

Citation

CMS Tag: 628

CMS CFR: 418.76(g)(4)

HCDT.18.I - Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities.

The hospice aide must also complete appropriate records of service, including the report of changes in the patient's needs.

Hospice aide documentation complies with hospice policies and procedures.

It is required that hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities. The hospice aide must also complete appropriate records of service, including the report of changes in the patient's needs. Hospice aide documentation complies with hospice policies and procedures.

This standard was not met as evidenced by review of agency policies, clinical record review and interview with Director of Patient Care Services and Hospice Aide. Agency policy H:2-005 titled, "Hospice Aide Services" stated, in relevant parts, "Hospice aide duties include reporting changes in the patient condition and needs." and "Hospice aides will document care provided in accordance with the hospice aide assignment." Agency policy H:2-035 titled "Interdisciplinary Group Coordination of Care" stated, in part, "[Hospice] personnel will communicate changes in a timely manner via telephone, secure mail and/or text message, one-on-one meetings, interdisciplinary group meeting form, and home visits. Documentation of all communications will be included in the clinical record on a communication note, interdisciplinary group meeting form, and/or clinical note." 2 of 11 (18%) applicable records of patients receiving hospice aide services revealed no documented evidence that the hospice aide reported changes that may impact the plan of care.
Record #45882: This patient was admitted on 5/29/2020. The hospice aide note dated 6/1/2020 revealed the hospice aide did not perform dressing or shower as assigned in the hospice aide assignment. The record lacked documentation as to why the tasks were not performed. The record lacked evidence that the RN was notified that care was not provided.
Record #93308: This patient was admitted on 2/18/2019 and discharged

9/13/2019. The hospice aide note dated 8/15/2019 revealed the hospice aide did not change the linens as assigned in the hospice aide assignment and documented "patient refused." The record lacked documentation that the RN was notified of the refusal of care. Interview with the hospice aide on 6/9/2020 revealed that agency process is to notify the RN when the patient declines care.
Interview with the Director of Patient Care Services on 6/9/2020 revealed that the process is for the hospice aide to send a message to the RN case manager and confirmed that "there is no proof that theses messages were sent" within the record. The findings were confirmed with the Director of Patient Care Services, Vice President of Quality, and

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Agency Response

What action will we take to correct the deficiency cited?

On July 2, 2020 an educational training will be conducted with all Hospice Aides regarding: 1. The Hospice Aide's function in a relationship with the professional disciplines to include their function as an extension of the professional services. 2. Following the written individualized care plan for each patient. 3. Providing care consistent with written instructions to include providing frequency of visits in accordance with the plan of care. 4. Reporting changes in the patient's condition and needs that affect the plan of care to a registered nurse. 5. Process for notifying the registered nurse and or the nursing supervisor if the Hospice Aide is unable to perform services in accordance with the plan of care of visit frequencies. During this training the Aides will be given a copy of the policies, H2-005, "Hospice Aide Services" and H2-035, "Interdisciplinary Group Coordination of Care". This training will be included in the orientation process for all new Hospice Aides.

Who is responsible to implement the corrective action?

Executive Director and/or designee

When will the corrective action be implemented?

July 02, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

A 100% focused audit of the Hospice Aide notes and documentation of communication between the Hospice Aide and Registered Nurse will be conducted for thirty days for compliance and accuracy for: 1. The Hospice Aide's function in a relationship with the professional disciplines to include their function as an extension of the professional services.2. Following the written individualized care plan for each patient. 3. Providing care consistent with written instructions to include providing frequency of visits in accordance with the plan of care. 4. Reporting changes in the patient's condition and needs that affect the plan of care

to a registered nurse. 5. Process for notifying the registered nurse and or the nursing supervisor if the Hospice Aide is unable to perform services in accordance with the plan of care of visit frequencies. If 100% compliance is not met with the thirty days the 100% focused audit will continue. Findings will be tracked, trended and presented to the QAPI committee. The QAPI Committee will monitor for ongoing compliance and direct an interventions of performance improvement projects as determined. The QAPI committee will present the findings to the Governing Body for their review.

Action Plan Summary

HCPC.19.I

Citation

CMS Tag: 543

CMS CFR: 418.56(b)

HCPC.19.I - The hospice designates a registered nurse member of the IDG to:
1. Provide coordination of care;
2. Ensure continuous assessment of each patient's and family's needs;
3. Ensure the implementation of the interdisciplinary plan of care.

Hospice care and services provided to patients and families follow the individualized plan of care established by:
1. The hospice IDG in collaboration with the attending physician (if any);
2. The patient or patient representative;
3. The primary caregiver in accordance with the patient's needs.

It is required that the hospice designates a registered nurse member of the IDG to provide coordination of care, ensure continuous assessment of each patient's and family's needs, and ensure the implementation of the interdisciplinary plan of care. Hospice care and services provided to patients and families follow the individualized plan of care established by the hospice IDG in collaboration with the attending physician, the patient or patient representative, and the primary caregiver in accordance with the patient's needs.

This standard was not met as evidenced by review of agency policy, clinical record review, and interview with Director of Patient Care Services. Agency policy H:2-030 titled "The Plan of Care" states, in part, "[The plan of care] must state, in detail, the scope and frequency of services needed to meet the patient's and family/caregiver's needs." 2 of 16 (12%) records revealed the hospice social worker did not follow the visit frequency established in the plans of care.
Record #20500: This patient was admitted on 4/22/2020. The hospice social worker visit frequency initiated on 4/23/2020 was "2x/mo x 2 mos." In the month of April, the hospice social worker documented only one visit on 4/23/2020 resulting in 1 missed visit.
Record #43366: This patient was admitted on 12/31/2019. The hospice social worker visit frequency initiated on 12/16/2019 was "1x/day x 1 day." The social worker failed to document a visit or a reason why the visit was missed.
Interview with the Director of Patient Care Services on 6/10/2020 revealed that agency audits a missed visit report and this visit was

missed. Interview with the QAPI Manager and Director of Patient Care Services on 6/11/2020 revealed that there is an existing PIP on visit frequency compliance.
The findings were confirmed with the Director of Patient Care Services, Vice President of Quality, and Regional Director of Quality during final exit on 6/11/2020.

Agency Response

What action will we take to correct the deficiency cited?

A mandatory in-service was held on 6/26/2020 with the Social Workers regarding the plan of care development focusing on the scope and frequencies of services necessary to meet specific needs of the patient. The in-service focused on the reeducation of the Social Workers on how to write the visit frequency orders based on the needs of the patient and/or family and that the visit frequency is written correctly based on medicare week or time remaining in the month. The in-service included the review of the Policy H2-030 "Plan of Care", that focuses on updating the plan of care based on any changes in patient condition, notifying physician of these changes and that the visit frequencies are met in accordance with the plan of care.

Who is responsible to implement the corrective action?

Executive Director or designee

When will the corrective action be implemented?

June 26, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

A 100% focused audit for Social Worker visit frequencies will be conducted for thirty days for compliance and accuracy. If 100% compliance is met the focused audit will become part of the monthly chart audit process for continued sustainment. If 100% compliance is not met within the thirty days the 100% focused audit will continue. When the 100% compliance is attained the focused audit will become part of the mandatory 10% monthly chart audits. The QAPI will monitor for compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HCPC.9.I

Citation

CMS Tag: 523

CMS CFR: 418.54(b)

HCPC.9.I - The hospice Interdisciplinary Group, in consultation with the individual's attending physician (if any), completes an initial comprehensive assessment no later than five (5) calendar days after the election of hospice care, in accordance with CMS §418.24–the elements of the hospice care election statement.

It is required that the hospice Interdisciplinary Group, in consultation with the individual's attending physician (if any), completes an initial comprehensive assessment no later than five (5) calendar days after the election of hospice care, in accordance with CMS §418.24–the elements of the hospice care election statement.

This standard was not met as evidenced by review of agency policy, clinical record review and interview with Director of Patient Care Services. Agency policy H:2-046 titled "Comprehensive Assessment" stated "A comprehensive patient assessment will be performed by the interdisciplinary group no later than 5 calendar days after the election of hospice care in consultation with attending physician." 1 of 16 (6%) records reviewed for patients admitted to service did not contain documented evidence that the hospice IDG completed an initial comprehensive assessment no later than five calendar days after the election of hospice care [Record #93308: This patient was admitted on 2/18/2019. The spiritual counselor documented an initial assessment on 2/25/2019 (7 days after admission). There was no documentation of the reason why the initial spiritual assessment was completed late]. Interview with the Director of Patient Care Services on 6/11/2020 confirmed the findings and stated the agency has a performance improvement project (PIP) in progress for visit frequencies and missed visits. The findings were confirmed with the Director of Patient Care Services, Vice President of Quality, and Regional Director of Quality during final exit on 6/11/2020.

Agency Response

What action will we take to correct the deficiency cited?

A mandatory in-service and review of the policy, "Comprehensive Assessment" will be held with all clinical staff, to include spiritual care. The staff will be re-educated on COP 418.54(b) that states "it is required that the hospice Interdisciplinary Group, in consultation with the individual's attending physician, completes an initial comprehensive assessment no later than five calendar days after the election of hospice care". The re-education will include the expectations of the

comprehensive assessment being completed; nursing will complete the psychosocial and spiritual assessment upon admission, Social Work and Spiritual Care will complete their appropriate assessment within the five days but if either or both are declined by the patient and/or family or if a request is made for the visit be scheduled after the five days documentation will be completed stating the decline or reason for late assessment. The mandatory in-service and education will be held on 6/24/2020.

Who is responsible to implement the corrective action?

Executive Director or designee

When will the corrective action be implemented?

June 24, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

100% focused audit of all new admission charts will be conducted by the Director of Patient Care Services and/or Quality Coordinator for accuracy and completion of the comprehensive assessment by all disciplines. The audit will also include evidence that if the Social Worker and/or Spiritual Care services were declined that there is documentation stating declination of services. Once 100% compliance is met for three consecutive months, the audits will be part of the random monthly audits. If 100% compliance is not met the focused audit will continue. Findings will be tracked, trended and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the governing Body for their review.

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Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

July 8, 2020

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:

Customer ID:	2006002
Service:	Hospice [Deemed]
CCN/PTAN:	05-1769

Location and/or Site Accredited:
Optimal Hospice, Inc dba Optimal Hospice Care
6780 No West Avenue, Suite 101
Fresno, CA 93711

Optimal Hospice, Inc
2439 W. Whitendale Ave., Suite B
Visalia, CA 93277

Site Visit Dates:	June 15, 2020 - June 19, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	July 1, 2020
CHAP Accreditation Dates:	January 21, 2020 - February 15, 2022
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted June 15, 2020 - June 19, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
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ID: *JUN1520_YIX*
Ref: *QUHR682063*

Community Health Accreditation Partner
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CHAP

July 8, 2020

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:

Customer ID:	2006002
Service:	Hospice [Deemed]
CCN/PTAN:	05-1769

Location and/or Site Accredited:
Optimal Hospice, Inc dba Optimal Hospice Care
6780 No West Avenue, Suite 101
Fresno, CA 93711

Optimal Hospice, Inc
2439 W. Whitendale Ave., Suite B
Visalia, CA 93277

Site Visit Dates:	June 15, 2020 - June 19, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	July 1, 2020
Effective Date of Accreditation:	July 1, 2020
Expiration Date of Accreditation:	July 1, 2023
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted June 15, 2020 - June 19, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.467.1701| Fax: 202.862.3419
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CC: CMS Regional Office (CMS RO IX - San Francisco)
CMS Central Office
State Agency

Action Plan Summary

Site Visit 6/15/2020 - 6/19/2020

CCN 051769

Organization

Bristol Hospice, LLC

Summary of Citations

Hospice	6

Condition Level Deficiencies **0**

Service Provider

Optimal Hospice, Inc

6780 No West Avenue Suite 101 Fresno, CA 93711

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Action Plan Summary

HCDT.15.I

Citation

CMS Tag: 625

CMS CFR: 418.76(g)(1)

HCDT.15.I - Hospice aides are assigned to a specific patient by a registered nurse who is a member of the Interdisciplinary Group.
1. Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide.

It is required that hospice aides are assigned to a specific patient by a registered nurse who is a member of the Interdisciplinary Group. Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide.

This standard was not met as evidenced by review of agency policy, joint clinical record review with the Director of Patient Care Services (DPCS) and interview with DPCS and Quality Assurance Coordinator. Agency policy H:2-030 (revised October, 2015) titled "The Plan of Care" states, in part, "A written individualized patient and family/caregiver plan of care will be established and maintained for each individual admitted to the hospice program." 2 of 10 (20%) applicable records with hospice aide services revealed a lack of clear and specific written instructions for the hospice aide assignments.
Record #78116: This patient was admitted 2/18/2020. The hospice aide assignment initiated by the RN 2/18/2020 assigned the hospice aide to "apply barrier cream to perineum PRN"; "Brush and comb daily and PRN"; "Clean fingers & toes PRN." The assignment lacked clear and specific direction for the hospice aide to follow leaving decisions to the aide that are outside of the aide's scope of practice.
Record #36699: This patient was admitted 5/1/2019. The hospice aide assignment initiated by the RN on 4/29/2020 and updated on 6/10/2020 assigned the hospice aide to "brush and comb hair daily prn"; "brush teeth (dentures) daily and prn"; "clean fingers and toes prn"; "linen change daily and prn." The assignment lacked clear and specific direction for the hospice aide to follow leaving decisions to the aide that are outside of the aide's scope of practice.
Interview with the Quality Assurance Coordinator and DPCS on 6/17/2020 confirmed the findings and revealed that the agency has held in-services on the topic of clear and specific instructions for the hospice aide by the RN.
The findings were confirmed with the Director of Patient Care Services, Executive Director, Quality Assurance Coordinator, Vice President of Quality, and Regional Director of Quality during final exit on 6/19/2020.

Agency Response

What action will we take to correct the deficiency cited?

Action Plan Summary

A mandatory educational in-service was held on 6/26/20 for all Registered Nurses and Hospice Aides to review the Policy H2-030 "The Plan of Care". The care plan is a written individualized patient/family/caregiver plan of care that is established and maintained for each individual patient admitted to hospice focusing on the needs of the patient. The in-service included the expectation of the Registered Nurse to write specific assignments within the scope of practice for the Hospice Aide with definitive tasks assigned, such as; brush and comb hair, brush teeth, clean fingers and toes and the process of communication between the Hospice Aide and the Registered Nurse Case Manager as the patient's needs change. The Registered Nurses were instructed that when creating the patient's care plan the aides assignments will be clear with specific direction for the hospice aide to follow leaving out decisions for the aide to make that are outside of the aide's scope of practice.

Who is responsible to implement the corrective action?

The Executive Director/Director of Patient Care Services and/or the Clinical Supervisor

When will the corrective action be implemented?

June 26, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

A 100% focused audit of the Hospice Aide Plan of Care focusing on the clear and detailed specific tasks will be conducted for thirty days for compliance and accuracy. If 100% compliance is met the focused audit will become part of the monthly chart audit to monitor sustainment of the goal. If 100% compliance is not met with the thirty days the 100% focused audit will continue. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review

Action Plan Summary

HCDT.18.I

Citation

CMS Tag: 628

CMS CFR: 418.76(g)(4)

HCDT.18.I - Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities.

The hospice aide must also complete appropriate records of service, including the report of changes in the patient's needs.

Hospice aide documentation complies with hospice policies and procedures.

It is required that hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities. The hospice aide must also complete appropriate records of service, including the report of changes in the patient's needs. Hospice aide documentation complies with hospice policies and procedures.

This standard was not met as evidenced by review of agency policies, joint clinical record review with the Director of Patient Care Services (DPCS) and interview with DPCS and Quality Assurance Coordinator. Agency policy H:2-005 (revised October, 2015) titled "Hospice Aide Services" states, in part, "Hospice aide duties may include reporting changes in the patient's condition and needs." Agency policy H:2-035 (revised October, 2015) titled "Interdisciplinary Group Coordination of Care" states, in part, "[Hospice] personnel will communicate changes in a timely manner via telephone, secure mail and/or text message, one-on-one meetings, interdisciplinary group meeting form, and home visits. Documentation of all communications will be included in the clinical record on a communication note, interdisciplinary group meeting form, and/or clinical note." 2 of 10 (20%) applicable records of patients receiving hospice aide services revealed no documented evidence that the hospice aide reported changes to the RN that may impact the plans of care.
Record #32395: This patient was admitted 2/28/2020. The record lacked evidence of documentation that the RN was notified that care was not provided. The hospice aide note dated 4/28/2020 revealed the hospice aide did not perform a shampoo or bed making as assigned in the hospice aide plan of care. The record lacked documentation as to why the tasks were not performed.
Record #15153: This patient admitted 1/13/2020. The record lacked

evidence of documentation that the RN was notified that care was not provided. Hospice aide notes dated 4/8/2020, 5/22/2020, 5/27/2020, 6/1/2020, 6/10/2020, and 6/12/2020 revealed the hospice aide did not perform teeth brushing as assigned in the hospice aide plan of care. The record lacked documentation as to why the interventions were not performed.
Interview with the DPCS on 6/17/2020 revealed that the intervention should have been stopped because it does not apply to the patient any longer and confirmed the "communication piece is not there." Interview with the Quality Assurance Coordinator on 6/17/2020 revealed that the agency is unsure if "not applicable" option is patient refused or not performed. Interview with the Regional Director of Quality on 6/17/2020 revealed that "not applicable" should not be used and the EMR will not allow the "not applicable" to be removed. The process is to select "patient refused" and document why the intervention was not performed.
The findings were confirmed with the Director of Patient Care Services, Executive Director, Quality Assurance Coordinator, Vice President of Quality, and Regional Director of Quality during final exit on 6/19/2020.

Agency Response

What action will we take to correct the deficiency cited?

An educational training was held on 6/26/20 with the Hospice Aides focusing on Hospice Aide duties. It is required that Hospice Aides must report changes in the patient's medical, nursing, rehabilitative, and /or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities. All of the Hospice Aides were given a copy of the policy H2005, "Hospice Aide Services" that states the hospice aide will report changes in the patient's conditions and needs. The aide must complete appropriate records of service including the report of changes in the patient condition and needs. The policy H2035, "Interdisciplinary Group Coordination of Care", was also presented and reviewed with the hospice aides. This policy focuses on the coordination of care and the requirement that all hospice personnel will communicate changes in a timely manner via telephone, secure mail and/or secure text message, one-on-one meetings, interdisciplinary group meeting form, and home visits. Documentation of all communications will be included in the clinical record on a communication note, interdisciplinary group meeting form, and/or clinical note.

Who is responsible to implement the corrective action?

The Executive Director/Director of Patient Care Services and/or the Clinical Supervisor

When will the corrective action be implemented?

Action Plan Summary

June 26, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

A 100% focused audit of the Hospice Aide notes related to documentation of communication between the Hospice Aide and Registered Nurse will be conducted for thirty days for compliance and accuracy of reporting changes in the patient's condition and needs that affect the plan of care to the Registered Nurse or nursing Supervisor. If 100% compliance is met the focused audit will become part of the monthly chart audit to monitor sustainment of the goal. If 100% compliance is not met with the thirty days the 100% focused audit will continue. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HCPC.19.I

Citation

CMS Tag: 543

CMS CFR: 418.56(b)

HCPC.19.I - The hospice designates a registered nurse member of the IDG to:

1. Provide coordination of care;
2. Ensure continuous assessment of each patient's and family's needs;
3. Ensure the implementation of the interdisciplinary plan of care.

Hospice care and services provided to patients and families follow the individualized plan of care established by:

1. The hospice IDG in collaboration with the attending physician (if any);
2. The patient or patient representative;
3. The primary caregiver in accordance with the patient's needs.

It is required that the hospice designates a registered nurse member of the IDG to provide coordination of care, ensure continuous assessment of each patient's and family's needs, ensure the implementation of the interdisciplinary plan of care. Hospice care and services provided to patients and families follow the individualized plan of care established by the hospice IDG in collaboration with the attending physician (if any), the patient or patient representative, the primary caregiver in accordance with the patient's needs.

This standard was not met as evidenced by review of agency policies, joint clinical record review with the Director of Patient Care Services (DPCS) and interview with DPCS and Quality Assurance Coordinator. Agency policy H:2-001 (revised February, 2019) titled "Scope of Services" states, in part, "Routine home visits, including scope and frequency, will be provided according to the plan of care." Agency policy H:2-030 (revised October, 2015) titled "The Plan of Care" states, in part, "[The plan of care] must state, in detail, the scope and frequency of services needed to meet the patient's and family/caregiver needs." 4 of 20 (20%) records reviewed revealed professional disciplines did not follow the visit frequencies established in the plans of care.
Record #10838: This patient was admitted 4/27/2020. The hospice spiritual counselor visit frequency initiated on 4/30/2020 was "2x/mo x 2 mos." The record lacked evidence of a visit or telephone call/telehealth visit being conducted until 5/13/2020, resulting in 2 missed visits for April.
Record #87313: This patient was admitted 10/4/2019. The hospice

spiritual counselor visit frequency initiated on 5/31/2020 was "1x/mo x 3mos." The record lacked evidence of a visit or telephone call/telehealth visit being conducted until 6/3/2020, resulting in 1 missed visit for May.
Record #50817: This patient was admitted on 5/4/2020. The skilled nursing visit frequency initiated 5/4/2020 was "2x/wk x 13wks." The skilled nurse documented routine visits on 5/4/2020, 5/5/2020, and 5/6/2020, resulting in 1 extra visit for the week beginning 5/4/2020.
Interview with DPCS on 6/18/2020 revealed that agency's process is to do 3 visits on the first week to assess pain at admission, 48hrs and 72hrs. However, no visit order reflects that practice for this patient.
Record #78116: This patient was admitted on 2/18/2020. The hospice social worker visit frequency initiated on 2/20/2020 was "1x/mo x 3mos." The record lacks evidence of a visit or telephone call/telehealth visit being conducted in February, resulting in 1 missed visit for February.
Interview with QAPI Coordinator on 6/15/2020 revealed that the agency has an ongoing Performance Improvement Process with respect to visit frequencies. The findings were confirmed with the Director of Patient Care Services, Executive Director, Quality Assurance Coordinator, Vice President of Quality, and Regional Director of Quality during final exit on 6/19/2020.

Agency Response

What action will we take to correct the deficiency cited?

A mandatory in-service was held on 6/26/2020 with the RNs, LVNs, SWs, Clergy and Aides regarding the plan of care development focusing on the scope and frequencies of services necessary to meet specific needs of the patient. The clinical staff will be reeducated on how to write the visit frequencies based on the needs of the patient and within the Medicare week. A review of the Policy H2-030 "Plan of Care" outlines the process for patient care plan development the includes; 1.the plan of care will identify the patient's needs and services to meet those needs, 2. the management of pain and discomfort, 3. symptom relief, 4. in detail, the scope and frequency of services to meet the patient's and family/caregiver's needs. The individualized patient care plan is developed by the IDT and the patient's attending physician. The care provided to the patient will be in accordance with the plan of care including the specific frequency of visits.

Who is responsible to implement the corrective action?

The Executive Director/Director of Patient Care Services and/or the Clinical Supervisor

When will the corrective action be implemented?

June 26, 2020

What is the monitoring process we will put into place to ensure

implementation and effectiveness of this corrective action plan?

A 100% focused chart audit will be conducted on all new admissions for the development of visit frequencies are in compliance and accurate to meet the needs of the patient. A missed visit report will be run daily and reviewed by the Director of Patient Care Services or Clinical Managers to monitor that the visits are being completed according to the plan of care and/or there is documentation stating why visit was not completed. The audit will be conducted for thirty days. If compliance is met the audit will become part of the monthly chart audit process. If 100% compliance is not met the audit will continue until the goal is attained. The QAPI committee will monitor for compliance and direct any interventions of performance improvement projects as determined. The QAPI committee will present the findings to the Governing Body for their review.

Action Plan Summary

HCPC.21.I

Citation

CMS Tag: 545

CMS CFR: 418.56(c)

HCPC.21.I - Each patient's individualized written plan of care:
1. Reflects patient and family goals;
2. Identifies planned interventions based on problems identified in the initial and updated comprehensive assessments;
3. Includes all services necessary for the palliation and management of the terminal illness, including the following:
a) Intervention to manage pain and symptoms;
b) A detailed statement of the scope and frequency of services necessary to meet specific patient and family needs;
c) Measureable outcomes anticipated from implementing and coordinating the plan of care;
d) Drugs and treatment necessary to meet the needs of the patient;
e) Medical supplies and appliances necessary to meet the needs of the patient;
4. Includes the Interdisciplinary Group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC;
a) The documentation in the patient's record is in accordance with the hospice's policies and procedure.

It is required that each patient's individualized written plan of care reflects patient and family goals, identifies planned interventions based on problems identified in the initial and updated comprehensive assessments, and includes all services necessary for the palliation and management of the terminal illness.

This standard was not met as evidenced by review of agency policies and joint clinical record review with the Director of Patient Care Services (DPCS). Agency policy (revised October, 2015) H:2-030 titled "The Plan of Care" states, in part, "A written individualized patient and family/caregiver plan of care will be established and maintained for each individual admitted to the hospice program." Agency policy H:2-035 (revised October, 2015) titled "Interdisciplinary Group Coordination of Care" states, in part, "The type and scope of services provided by the interdisciplinary group will be based upon comprehensive and ongoing assessments regarding the needs of the patient and family/caregiver and the comprehensive plan of care that defines patient and family/caregiver problems, goals and interventions." 3 of 20 (15%) records lacked evidence that the Plans of Care (POC) included all hospice care and services needed to meet the needs of the patients and families as identified in the comprehensive and ongoing assessments.

Record #50817: This patient was admitted 5/4/2020. The initial and ongoing assessments identified that the patient was dependent for all activities of daily living and had poor oral intake. The POC included pain and "mental status changes" only. The POC lacked identification of problems, interventions and goals related to the nutritional status and safety/fall risk.
Record #13480: This patient was admitted 5/27/2020. The initial and ongoing assessments identified that the patient had incontinence of the bowel and had an ostomy. The POC did not address any problems, interventions, or goals related to the gastrointestinal problems.
Record #68200: This patient was admitted 5/19/2020. The initial and ongoing assessments identified the patient was on continuous oxygen due to a terminal diagnosis of COPD. The POC did not address any problems, interventions, or goals related to respiratory issues.
The findings were confirmed with the Director of Patient Care Services, Executive Director, Quality Assurance Coordinator, Vice President of Quality, and Regional Director of Quality during final exit on 6/19/2020.

Agency Response

What action will we take to correct the deficiency cited?

An educational in-service was held on 6/26/2020 with all staff to review and reeducate on the importance of care plan development that provides appropriate care to the individual patient. The education will include: • the plan of care development focusing on patient and family goals of care and all interventions for symptom management • Measurable outcomes based on the plan of care and patient's goals • Medications, supplies and equipment that meet the needs of the patient • Collaboration with the IDT in the development of the patient's plan of care.

Who is responsible to implement the corrective action?

The Executive Director/Director of Patient Care Services and/or the Clinical Supervisor

When will the corrective action be implemented?

June 26, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

100% focused audit on all new admissions and 10% of all current patients will be conducted for 30 days to ensure that the plan of care per the comprehensive assessment and in collaboration with IDT includes; • The plan of care development focusing on delivery of the scope and frequency of services necessary to meet specific needs of the patient. • Patient and family goals of care and all interventions for symptom management • Measurable outcomes based on the plan of care and

patient's goals • Medications, supplies and equipment that meet the needs of the patient • Collaboration with the IDT in the development of the patient's plan of care. When 100% compliance is met the focus audit will become part of the monthly chart audit process for continued sustainment. If 100% compliance is not met within the 30 days the 100% focused audit will continue. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HCPC.6.I

Citation

CMS Tag: 676

CMS CFR: 418.104(a)(5)

HCPC.6.I - The hospice medical director or physician-designee provides written and signed recertification of the terminal illness to meet the hospice care benefit requirement.

1. Recertification for the hospice care benefit is informed by the medical director or physician designee's review of the patient's clinical information.

2. Recertification is completed no later than two (2) calendar days after the first day of each benefit period, and no more than fifteen (15) days before the next benefit period begins.

It is required that the hospice medical director or physician-designee provides written and signed recertification of the terminal illness to meet the hospice care benefit requirement. Recertification for the hospice care benefit is informed by the medical director or physician designee's review of the patient's clinical information. Recertification is completed no later than two (2) calendar days after the first day of each benefit period, and no more than fifteen (15) days before the next benefit period begins.

This standard was not met as evidenced by review of agency policy, joint clinical record review with the Director of Patient Care Services (DPCS) and interview with DPCS and Quality Assurance Coordinator. Agency policy H:2-025 (revised May, 2020) titled "Certification of Terminal Illness" stated, in part, "[A subsequent recertification requires] a verbal or written certification statement must be obtained from the hospice Medical Director or the Attending Physician no more than fifteen (15) calendar days prior to two (2) calendar days after the first day of each period." 1 of 15 (7%) applicable records revealed a verbal order or signed order for the recertification of terminal illness was not obtained within the designated time frame of 15 calendar days before the start of the new recertification period and/or 2 calendar days after the first day of the new recertification period [Record #66444: This patient was admitted 4/9/2020. The recertification period beginning on 5/31/2020 lacked documentation that a signature or verbal order was obtained within the required time period(s). The verbal order received by the RN was obtained on 4/28/2020 (33 days before the start of the new recertification period) and a signature was obtained from the Medical Director on 6/4/2020 (4 days after the start of the new recertification period)]. Interview with the DPCS on 6/18/2020 revealed that "this was a typo due to the RN completing her recertification documentation and visit on 5/28/2020."
The findings were confirmed with the Director of Patient Care Services,

Action Plan Summary

Executive Director, Quality Assurance Coordinator, Vice President of Quality, and Regional Director of Quality during final exit on 6/19/2020.

Agency Response

What action will we take to correct the deficiency cited?

A mandatory in-service and review of Policy H2-025 "Certificate of Terminal Illness" was reviewed with all Registered Nurses on 6/26/2020. The policy identifies the certification procedure stating the certification may be completed no more than fifteen calendar days prior to the effective date of the hospice election statement or start of new benefit period. The in-service will provide the step by step process on completing a recertification visit within the EMR system and how to enter the recertification verbal date correctly.

Who is responsible to implement the corrective action?

The Executive Director/Director of Patient Care Services and/or the Clinical Supervisor

When will the corrective action be implemented?

June 26, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

100% focused audit will be conducted for 30 days of all certification verbal order dates will be conducted for accuracy and assurance that all verbal order dates are within the 15- day time period. All new admissions and recertifications will be audited daily for accuracy of verbal order dates. If 100% compliance is not met within the 30 days, the 100% focused audit will continue. When 100% compliance is attained, the focused audit will continue in the 10% mandatory monthly chart audits. Findings will be tracked, trended, and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HSRF.6.I

Citation

CMS Tag: 774

CMS CFR: 418.112(d)(1)

HSRF.6.I - Hospice care of the patient/resident is stated in a written plan of care established and maintained in consultation with SNF/NF or ICF/IDF representatives.
1. The hospice plan of care identifies the care and services that are needed and specifies which provider is responsible for performing the functions that are agreed upon and included in the plan of care.
2. The plan of care reflects the participation of the hospice, the SNF/NF or ICF/IDF, and the patient and family to the extent possible.
3. All hospice care is provided in the facility in accordance with the hospice plan of care.
4. Any changes to the hospice plan of care are discussed with the patient or representative and SNF/NF or ICF/IDF representatives, and are approved by the hospice before implementation.

It is required that hospice care of the patient/resident is stated in a written plan of care established and maintained in consultation with SNF/NF or ICF/IDF representatives. The hospice plan of care identifies the care and services that are needed and specifies which provider is responsible for performing the functions that are agreed upon and included in the plan of care. The plan of care reflects the participation of the hospice, the SNF/NF or ICF/IDF, and the patient and family to the extent possible.

This standard was not met as evidenced by review of agency policy, joint clinical record review with the Director of Patient Care Services (DPCS) and interview with DPCS and Quality Assurance Coordinator. Agency policy H:2-043 (revised November, 2018) titled "Provision of Care to Residents of SNF/NF or ICF/MR" states, in part, "A delineation of hospice's responsibilities, which include, but are not limited to the following: providing medical direction and management; providing nursing, counseling (including spiritual, dietary and bereavement), social work; providing medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with terminal illness; provision of other hospice services that are necessary for care related to the terminal status and related conditions." 2 of 2 (100%) applicable records of patients residing in a SNF revealed a lack of evidence of specific delineation of services provided between the SNF and the agency in the patient's clinical record at the agency.
Record #50817: This patient was admitted 5/4/2020. The clinical record lacked evidence of a delineation of care or documentation of when the SNF would perform duties and when the hospice staff would perform duties.

Record #76176: This patient was admitted 1/4/2020. The clinical record lacked evidence of a delineation of care or documentation of when the SNF would perform duties and when the hospice staff would perform duties.
Interview with the Director of Patient Care Services on 6/18/2020 revealed that the delineation of services is included in the contract with the SNF but the agency does not leave a copy in each record or specify on the plans of care that are left at the SNF. The findings were confirmed with the Director of Patient Care Services, Executive Director, Quality Assurance Coordinator, Vice President of Quality, and Regional Director of Quality during final exit on 6/19/2020.

Agency Response

What action will we take to correct the deficiency cited?

A mandatory in-service and review of Policy H2-043, "Provision of Care to Residents of SNF/NF or ICF/MR" was conducted with all staff on 6/26/2020, the focus of the in-service was on developing an individualized care plan related to the terminal diagnosis, comorbidities, meeting the needs of each patient and with a clear delineation of responsibilities for the Facility staff and the Hospice staff to provide care and services for patients. A mandatory in-service will be conducted with all direct patient care staff on the frequency of services, the responsibility of each Hospice IDT member and the responsibility of the facility staff to ensure the care provided is in accordance with the Hospic

Who is responsible to implement the corrective action?

The Executive Director/Director of Patient Care Services and/or the Clinical Supervisor

When will the corrective action be implemented?

June 26, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

100% of patient care plans that reside in a facility will be audited for delineation of care responsibilities, frequency of visits, individualization based on relatedness to the terminal and co-morbid diagnosis and the patient/family goals. Care plans will clearly delineate the care responsibilities for hospice staff and the care responsibility of the facility staff for all patients residing in a SNF/NF or ICF/MR. The audit results will be tracked, trended, analyzed and reported to the QAPI Committee with the goal of 100% compliance. When 100% compliance is achieved and sustained for three consecutive months the audit will continue through the 10% mandatory monthly chart audits. Findings will be presented to the QAPI committee. The QAPI committee will monitor for ongoing compliance and direct any interventions of performance improvement

projects as determined. The QAPI committee will present the findings to the Governing Body.

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Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

April 23, 2020

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:

Customer ID:	2006002
Service:	Hospice [Deemed]
CCN/PTAN:	05-1793

Location and/or Site Accredited:

Optimal Hospice, Inc dba Optimal Hospice Care
2800 W March Lane, Suite 110
Stockton, CA 95219

Optimal Hospice, Inc dba Optimal Hospice Care
1101 Sylvan Ave., Suite B-10
Modesto, CA 95350

Site Visit Dates:	March 16, 2020 - March 20, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	April 6, 2020
CHAP Accreditation Dates:	January 21, 2020 - February 15, 2022
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted March 16, 2020 - March 20, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
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ID: *MAR1620_VOK*
Ref: *QUHR682063*

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CHAP

April 23, 2020

Mrs. Jeanette Dove
Chief Quality Officer
Bristol Hospice, LLC
206 North 2100 West, Suite 202
Salt Lake City, UT 84116

RE:

Customer ID:	2006002
Service:	Hospice [Deemed]
CCN/PTAN:	05-1793

Location and/or Site Accredited:
Optimal Hospice, Inc dba Optimal Hospice Care
2800 W March Lane, Suite 110
Stockton, CA 95219

Optimal Hospice, Inc dba Optimal Hospice Care
1101 Sylvan Ave., Suite B-10
Modesto, CA 95350

Site Visit Dates:	March 16, 2020 - March 20, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	April 6, 2020
Effective Date of Accreditation:	April 6, 2020
Expiration Date of Accreditation:	April 6, 2023
Method of Follow-up:	Acceptable POC

Dear Mrs. Dove,

I am pleased to inform you that based on the findings of the site visit conducted March 16, 2020 - March 20, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
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CC: CMS Regional Office (CMS RO IX - San Francisco)
CMS Central Office
State Agency

Action Plan Summary

Site Visit 3/16/2020 - 3/20/2020

CCN 051793

Organization

Bristol Hospice, LLC

Summary of Citations

Hospice	5

Condition Level Deficiencies **0**

Service Provider

Optimal Hospice, Inc

2800 W March Lane Suite 110 Stockton, CA 95219

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Action Plan Summary

HCDT.15.I

Citation	HCDT.15.I - Hospice aides are assigned to a specific patient by a registered nurse who is a member of the Interdisciplinary Group. 1. Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide.
CMS Tag: 625	
CMS CFR: 418.76(g)(1)	

It is required that hospice aides are assigned to a specific patient by a registered nurse who is a member of the Interdisciplinary Group. Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide.

This standard was not met as evidenced by review of clinical records. 1 of 10 (70%) applicable records with hospice aide services revealed a hospice aide plan of care was not developed by the RN prior to the aide initiating care [Record #27782: The patient was admitted on 12/03/2019. No documented aide plan of care was created prior to aide services being initiated on 12/04/2019].

Agency Response

What action will we take to correct the deficiency cited?

Through our on-line educational website, "Relias" all clinical staff will be assigned to review Policy H2-030, "The Plan of Care". A mandatoryeducational in-service will be held for all Registered Nurses and HospiceAides to review the Hospice Aide Care Plan. A written individualizedpatient/family/caregiver plan of care will be established and maintainedfor each individual admitted to hospice to include communication anddocumentation of such care plan. The in -service was held on 3/27/20and it included the expectation of the Registered Nurse to write specificassignments within the scope of practice for the Hospice Aide withdefinitive tasks assigned, and the process of communication betweenthe Hospice Aide and the Registered Nurse Case Manager as the patientneeds change. A 100% focused audit of the Hospice Aide Plan of Care,Aide notes, visit frequencies and documentation of communicationbetween the Hospice Aide and Registered Nurse will be conducted forthirty days for compliance and accuracy. This education process will beincluded in all new hire orientation for the Registered Nurses and Aides.

Who is responsible to implement the corrective action?

The Executive Director/Director of Patient Care Services and/or the Clinical Supervisor

Action Plan Summary

When will the corrective action be implemented?

March 27, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

A 100% focused audit of the Hospice Aide Plan of Care, Aide notes, visitfrequencies and documentation of communication between the HospiceAide and Registered Nurse will be conducted for thirty days forcompliance and accuracy. If 100% compliance is met the focused auditwill become part of the monthly chart audit to monitor sustainment ofthe goal. If 100% compliance is not met with the thirty days the 100%focused audit will continue. Findings will be tracked, trended andpresented to the QAPI Committee. The QAPI Committee will monitor forongoing compliance and direct any interventions of performanceimprovement projects as determined. The QAPI Committee will presentthe findings to the Governing Body for their review.

Action Plan Summary

HCDT.38.I

Citation	HCDT.38.I - If the care of a hospice patient is transferred to a Medicare/Medicaid/MediCal-certified facility, the hospice forwards to the receiving facility a copy of:
CMS Tag: 682	1. The hospice discharge summary described in HCDT 41.I; and
CMS CFR: 418.104(e)(1)	2. The patient's record, if requested.

It is required that if the care of a hospice patient is transferred to a Medicare/Medicaid/MediCal-certified facility, the hospice forwards to the receiving facility a copy of:

1. The hospice discharge summary described in HCDT 41.I; and
2. The patient's record, if requested.

This standard was not met as evidenced by a joint review of clinical records and review of company policy. The policy # H:2-085.1, dated October 2015, titled "Discharge From The Hospice Program" reads in part, "Documentation will be filed in the clinical record. Information will be documented on a discharge/transfer form, which is to be completed within 72 hours." 1 of 1 100%) applicable records of patients discharged from the hospice and transferred to another hospice revealed no evidence that a discharge summary was sent to the receiving hospice [Record #13632: The patient was admitted on 12/30/2019 and transferred to another hospice on 01/15/2020. There is no documented evidence that a discharge summary was sent to the receiving hospice]. This finding was reviewed and confirmed with the Regional Vice President of Quality.

Agency Response

What action will we take to correct the deficiency cited?

Through our online education website, Relias, all Registered nurses will be assigned to review Policy H2085: Discharge from Hospice Program. Online education to be completed by 4/13/2020. Initiated reeducation to all RNs on 3/27/2020 regarding expectations for live discharges. Education includes the policies and process for sending the summary and any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility. Daily review provided to all clinical staff, specifically the RN Case Managers. Bi-weekly reeducation provided at IDT meetings. All RNs will receive reeducation by 4/3/2020.

Who is responsible to implement the corrective action?

Action Plan Summary

Executive Director, Director of Patient Care Services and/or Clinical Supervisor

When will the corrective action be implemented?

March 27, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

100% focused audit on all live discharges will be conducted for 90 days to ensure the discharge summary was sent to the physician and/or receiving facility. If 100% compliance is met the focused audit will become part of the monthly chart audit process for continued sustainment. If 100% compliance is not met with the 90 days, the 100% focused audit will continue until compliance is met for 3 consecutive months. Findings will be tracked, trended and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HCPC.13.I

Citation

CMS Tag: 531

CMS CFR: 418.54(c)(7)

HCPC.13.I - The comprehensive assessment includes an initial bereavement assessment of the needs of the patient's family and other individuals, focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death.

Information gathered from the initial bereavement assessment is incorporated into the plan of care and considered in the bereavement plan of care.

It is required that the comprehensive assessment includes an initial bereavement assessment of the needs of the patient's family and other individuals, focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment is incorporated into the plan of care and considered in the bereavement plan of care.

This standard was not met as evidenced by review of agency policy and review of clinical records. Agency policy # H:2-046.1, titled "Comprehensive Assessment", dated October 2015, states in part, "A comprehensive patient assessment will be performed by the interdisciplinary group no later than 5 calendar days after election of hospice care in consultation with attending physician." 5 of 13 (38%) records reviewed revealed no documentation of an initial bereavement risk assessment.
Record #61016: the patient was admitted 04/25/2019; there is no evidence of an initial bereavement risk assessment documented as of the date of review, 03/19/2020.
Record #61332: the patient was admitted 09/27/2019; there is no evidence of an initial bereavement risk assessment documented as of the date of review, 03/19/2020.
Record #16647: the patient was admitted 06/01/2019; there is no evidence of an initial bereavement risk assessment documented as of the date of review, 03/19/2020.
Record #97622: the patient was admitted 01/09/2020; there is no evidence of an initial bereavement risk assessment documented as of the date of review, 03/19/2020.
Record #34068: the patient was admitted 08/16/2019; there is no evidence of an initial bereavement risk assessment documented as of the date of review, 03/19/2020.
These findings were reviewed and confirmed with the Regional Vice President of Quality.

Action Plan Summary

Agency Response

What action will we take to correct the deficiency cited?

A mandatory in-service with all staff to re-educate on the compliance of completing a bereavement assessment including bereavement risk upon admission to hospice. All clinical staff will be mandated to review through our on line educational website "Relias" Policy # H2-008 " Bereavement Services" and H2046 Comprehensive Assessement.. An initial bereavement assessment and bereavement risk is completed on admission by the nurse and within five days of admission by the social worker and clergy. The reeducation will be done with the Social Workers and Chaplains regarding the correct documentation that needs to be completed if their services are declined by the patient and/or family/caregiver. In the case of no Social Worker the assessments still will have been completed by the nurse. This reeducation will be completed by 4/13/2020.

Who is responsible to implement the corrective action?

Executive Director, Director of Patient Care Services and/or Clinical Supervisor

When will the corrective action be implemented?

March 27, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

100% of all new admission charts will be audited by the Executive Director/Director of Professional Services and the Clinical Supervisor for accuracy and completion of the Bereavement Assessment and Bereavement risk. The audit includes the completion of both bereavement assessment and bereavement risk has been completed by the nurse, social worker and chaplain. The audit will also include evidence that if the Social Worker or Chaplain services were declined that there is documentation stating that. Once 100% compliance is met for three consecutive months, continued monitoring will be ongoing monthly with the chart review sampling of 10% of charts. Findings will be tracked, trended and presented to the QAPI Committee. The QAPI Committee will monitor for ongoingcompliance and direct any interventions of performance improvement projects as determined. The QAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HCPC.9.I

Citation

CMS Tag: 523

CMS CFR: 418.54(b)

HCPC.9.I - The hospice Interdisciplinary Group, in consultation with the individual's attending physician (if any), completes an initial comprehensive assessment no later than five (5) calendar days after the election of hospice care, in accordance with CMS §418.24–the elements of the hospice care election statement.

It is required that the hospice Interdisciplinary Group, in consultation with the individual's attending physician (if any), completes an initial comprehensive assessment no later than five (5) calendar days after the election of hospice care, in accordance with CMS §418.24–the elements of the hospice care election statement.

This standard was not met as evidenced by a joint review of clinical records. 1 of 13 (8%) records revealed that the chaplain did not conduct a comprehensive initial assessment of the patient within 5 days of the patient electing hospice care [Record #10758: The patient was admitted to hospice services on 12/06/2019. The chaplain visited the patient for the first time on 12/13/2019 which was 7 days after admission. There was no documented evidence that the chaplain attempted to contact the patient or completed an assessment visit prior to the first visit]. This finding was reviewed and confirmed by the Regional Director of Quality. NOTE: The requirement for completion of the initial comprehensive assessment within 21 days, rather than 5 days is included under the CMS COVID-19 hospice blanket waiver, however, the effective date of the waiver is 3/1/2020.

Agency Response

What action will we take to correct the deficiency cited?

A mandatory in-service with all staff to re-educate on the compliance ofcompleting a spiritual assessment upon admission to hospice. All clinicalstaff will be mandated to review through our online educational website"Relias", Policy # H2-052 "Spiritual Assessment" and Policy H2-007"Spiritual Care Counseling Services". The policies identify therequirement that an initial spiritual assessment is completed by thenurse on admission and the social worker and clergy in their initialassessment. The reeducation will be done with the Social Workers andChaplains regarding the correct documentation that needs to becompleted if their services are declined by the patient and/orfamily/caregiver. This education will be completed by 4/6/2020.

Who is responsible to implement the corrective action?

Action Plan Summary

The Executive Director/Director of Patient Care Services and/or the Clinical Supervisor

When will the corrective action be implemented?

March 27, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

100% of all new admission charts will be audited by the ExecutiveDirector/Director of Professional Services and the Clinical Supervisor foraccuracy and completion of the Spiritual Assessment by the Chaplain within five days of the patient's admission. The audit includesthe verification that if the Chaplain services were declined there is documentation stating that. Once 100% compliance is met for three consecutive months, continued monitoring will be ongoing monthly with the mandatory chart review sampling of 10%. Findings will be tracked, trended and presented to the QAPI Committee. The QAPI Committee will monitor for ongoing compliance and direct anyinterventions of performance improvement projects as determined. TheQAPI Committee will present the findings to the Governing Body for their review.

Action Plan Summary

HIPC.4.I

Citation

CMS Tag: 579

CMS CFR: 418.60(a)

HIPC.4.I - Bags used to carry medical equipment (e.g., BP cuff) or supplies into or out of the care environment are transported and used in a manner consistent with organizational policy to prevent the spread of infections and communicable diseases.

It is required that bags used to carry medical equipment (e.g., BP cuff) or supplies into or out of the care environment are transported and used in a manner consistent with organizational policy to prevent the spread of infections and communicable diseases.

This standard was not met as evidenced by observation during home visits and review of Agency policy. The organization's policy # C:2-055.1 titled "Bag Technique" states in relevant parts, "The bag will be placed on a clean surface (i.e., a surface that can be easily disinfected) in the car and in the home. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment and supplies will be returned to the bag." 2 of 3 (66%) visits revealed the clinical staff did not follow the organization's policy to prevent the spread of infections and communicable diseases.
Record #27782: (The patient was admitted 12/03/2019). During the observed home visit, it was noted that the social worker did not clean the area or place a barrier before putting her laptop on a chair in the patient's home.
Record #15532: (The patient was admitted 02/08/2019). During the observed home visit, it was noted that the nurse returned her blood pressure cuff into her bag without cleaning the cuff.
These findings were reviewed and confirmed with the Regional Vice President of Quality.

Agency Response

What action will we take to correct the deficiency cited?

Reeducation to all clinical staff on infection control agency policies C2055: Bag Technique will be completed 4/13/2020. Verbalization and demonstration of bag technique by each employee with a supervisor completed by 4/17/2020 via video conferencing with a goal of 100% conformance. Once there is clearance from the state/government regarding social distancing in relation to COVID-19, supervisor/designee will complete a minimum of two visits per employee over the next three months to monitor for 100% demonstrated conformance with policies C2055. Expectation of new hires to demonstrate conformance of the

policies C2055 during a joint visit with supervisor prior to end of orientation period.

Who is responsible to implement the corrective action?

Executive Director, Director of Patient Care Services and/or Clinical Supervisor

When will the corrective action be implemented?

March 27, 2020

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Observation of compliance will be measured using video conferencing or onsite visit.with all clinical staff. This audit will be part of the orientation process and all supervisory visits conducted for each staff member. Data from the audit will be tracked, trended, analyzed and reported to the QAPI Committee with the goal of 100% compliance. When 100% compliance is achieved and sustained for one quarter the QAPI Committee will determined further actions as needed. The QAPI Committee will report QAPI outcomes to the Governing Body.

18

Action Plan Summary

Site Visit 4/20/2021 - 4/22/2021

CCN A01526

Organization

Bristol Hospice, LLC

Summary of Citations

Hospice	3

Condition Level Deficiencies **0**

Service Provider

Optimal Hospice, Inc

44151 15th St W Suite 201 Lancaster, CA 93534

Contact

Jeanette Dove

jeanette.dove@bristolhospice.com

Action Plan Summary

HCDT.22.I

Citation

CMS Tag: 596

CMS CFR: 418.64(d)(1)

HCDT.22.I - Counseling services include an organized program for providing bereavement services delivered by or under the supervision of a qualified professional with experience or education in grief or loss counseling.

Bereavement services are available to the family and other individuals up to one (1) year following the death of the patient. Bereavement counseling extends to residents of a SNF/NF (skilled nursing facility/nursing facility) or ICF/IDF (intermediate care facility/intellectual disability facility) when appropriate and identified in the bereavement plan of care.

The bereavement services reflect the needs of the bereaved per a bereavement plan of care that includes:

1. The types of bereavement services to be offered;
2. The frequency of service delivery.

It is required that counseling services include an organized program for providing bereavement services delivered by or under the supervision of a qualified professional with experience or education in grief or loss counseling. The bereavement services reflect the needs of the bereaved per a bereavement plan of care that includes the types of bereavement services to be offered and the frequency of service delivery.

This standard was not met as evidenced by a review of clinical records with the Regional VP of Quality and Executive Director/Director of Patient Care Services and policy. Policy "Bereavement Assessment," Policy No. 1-021, revised May 2020, included, in part, "After the death occurs, the hospice social worker or bereavement coordinator will complete the bereavement follow up assessment" and "The bereavement coordinator will develop a plan for intervention based on the findings of the bereavement follow up assessment." 1 of 3 (33%) applicable records of patients receiving bereavement services, there was no documented evidence that a bereavement plan was completed to include interventions based on the findings of the bereavement follow-up assessment, as required in hospice policy.

Record #79707 - Patient expired on 12/8/2020. A review of the clinical record revealed that the bereavement follow-up assessment completed was on 12/17/2020. After-death bereavement contacts were documented as completed on 12/17/2020 by phone, and bereavement mailings were sent on 12/21/2020 and 3/8/2021. However, there was no

documented post-death bereavement plan of care that identified the types of bereavement services provided and the frequency of bereavement services.

During an interview, the Regional VP of Quality stated a performance improvement project (PIP) already in place for the bereavement plan of care.

Agency Response

What action will we take to correct the deficiency cited?

A mandatory in-service will be held with the bereavement staff and all supervisory staff to assure compliance in developing and documenting a Care Plan that reflects the needs of the bereaved based on bereavement assessment. Bereavement Plan of Care should reflect family need, as well as a clear delineation of services to be provided and frequency of service delivery. The bereavement plan of care should be based on an assessment of the individual bereaved needs and includes specific scope and frequency of interventions and goals.

Who is responsible to implement the corrective action?

The Executive Director/Director of Patient Care Services and/or the Clinical Supervisor

When will the corrective action be implemented?

April 26, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

100% of all new bereavement care plans will be audited by the Director of Patient Care Services and/or Supervisors for accuracy and completion. When 100% compliance has been achieved for at minimum three months the bereavement care plans will be audited with the 5% of all discharged charts monthly. All auditing results will be presented to the QAPI committee and Governing Body and the committee will direct any additional interventions or measures based upon outcomes.

Action Plan Summary

HCDT.40.I

Citation

CMS Tag: 684

CMS CFR: 418.104(e)(3)

HCDT.40.I - The hospice discharge summary provided to a facility receiving a hospice patient for care—or to the patient's community attending physician upon hospice discharge—includes at least the following:

1. A summary of the patient's hospice stay, including treatments, symptoms, and pain management;
2. The patient's current plan of care;
3. The patient's latest physician orders;
4. Any other documentation that will assist in the post-discharge continuity of care or that is requested by the receiving facility or the attending physician.

It is required that the hospice discharge summary provided to a facility receiving a hospice patient for care—or to the patient's community attending physician upon hospice discharge—includes at least the following: a summary of the patient's hospice stay, including treatments, symptoms, and pain management, the patient's current plan of care, the patient's latest physician orders and any other documentation that will assist in the post-discharge continuity of care or that is requested by the receiving facility or the attending physician.

This standard was not met as evidenced by a review of clinical records with the Regional VP of Quality and Executive Director/Director of Patient Care Services. 1 of 2 (50%) applicable records of patients who revoked and/or transferred to another hospice, there was no documented evidence that a discharge summary was sent to the receiving hospice at the time of transfer.

Record #30599 - The patient transferred to another hospice on 11/1/2020. There was no documented evidence that the discharge summary, which included a summary of the patient's hospice stay, the plan of care, and the physician's orders, was sent to the receiving hospice at the time of transfer.

During an interview, the Director of Patient Care Services/Executive Director stated that he completed the discharge summary and was not sent to the receiving hospice.

Agency Response

What action will we take to correct the deficiency cited?

All clinical staff will be given a copy of the policy H2:86.1 "Discharge

Summary". The current policy identifies what needs to be included in the discharge summary, who needs to receive a copy of the summary and the time frame summary needs to be completed and distributed. The staff will be instructed on the policies and process for sending thesummary and any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility. A copy of the discharge summary that was sent to the physician or receiving facility will be scanned into patient chart. The nurse will document in the discharge narrative note that a copy of the discharge summary including requested documents were sent to the primary care physician or receiving facility. The Executive Director will reinforce to the staff that they are to follow all the Hospice policies.

Who is responsible to implement the corrective action?

The Executive Director/Director of Patient Care Services and/or the Clinical Supervisor

When will the corrective action be implemented?

April 26, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Executive Director/Director of Clinical Services will audit 100% of all discharged patient charts for correct documentation of discharged patients according to the policy H2:086.1.. The audits will be tracked, trended and reported to the QAPI Committee. When the goal of 100% compliance is attained the QAPI committee will monitor for ongoing compliance and direct any interventions or performance improvement projects as determined necessary to achieve sustainment. All QAPI projects will be reported to the Governing Body.

Action Plan Summary

HIPC.9.I

Citation

HIPC.9.I - Hospice staff at risk for occupational exposure to TB, are screened and tested as defined in state or local law and regulation or per the organization's assessment of TB exposure risk based on the population and/or the community served.

In the absence of state or local law and regulation or organization identified risk, screening and testing of occurs per the current Centers for Disease Control and Prevention (CDC) guidelines.

There is appropriate follow-up when TB risk is identified.

It is required that hospice staff at risk for occupational exposure to TB are screened and tested as defined in state or local law and regulation or per the organization's assessment of TB exposure risk based on the population and/or the community served.

This standard was not met as evidenced by a review of policies and procedures and personnel records with the Clinical Liaison/former Office Business Specialist. Policy "Tuberculosis Exposure Control Plan," Policy No. C:2-041.1, revised November 2018, included, in part, "All personnel will be tested for TB according to risk assessment identification for which personnel has potential exposure to TB," "OSHA has determined that home health care is not provided in one of the workplaces where CDC has identified workers as having a higher incidence of TB infection than the general population," "Where required by state and/or local regulation, a two (2)-step TST will be given to all personnel upon hire if no TST had been performed within 12 months of hire date, and thereafter according to the risk assessment, if the new hire has a documented prior history of a negative result within 12 months of hire, the hospice may consider this the first stage of testing and the additional TST represents the second stage of the two-step testing" and "low-risk personnel will be tested annually." 2 of 11 (18%) records, there was no documented evidence of the initial and/or annual TB testing, as required in agency policy.

Record #12541 - The Medical Director's contracted hire was 3/30/2017. A review of the personnel record revealed a missing annual TB test for 2019 and 2020, as required by the hospice policy. During an interview, the Regional VP Quality and the Clinical Liaison/former Business Office Specialist stated that the hospice medical director gets her TB tests done at the hospital where she works and that the medical director did not have a copy of the 2019 TB test and that TB test for 2020 was not done

since the hospital where she works did not do TB testing in 2020 due to COVID.

Record #81504 - Patient Care Volunteer start date was 3/18/2019. A review of the personnel record revealed one TST was initially completed on 3/16/2019, and the 2nd-step TST was missing, as required by policy. There was no documented TB test within the 12 months prior to the start of the volunteer or a completed blood test. The Clinical Liaison/former Business Office Specialist checked with the HR department and confirmed no documented 2nd-step TST completed.

During an interview, the Clinical Liaison/former Business Office Specialist and Regional VP of Quality stated the hospice's policy on TB was to include a blood test, either a T-Spot or QuantiFeron, or a two-step TST at the time of hire or if personnel presented a copy of a TST within the past 12 months, then only one TST is performed at the time of hire, and that a TST is required to be completed annually.

Agency Response

What action will we take to correct the deficiency cited?

All new personnel who will be in contact with patients and rehires who have not been employed by the hospice for over six (6) months, must have TB test or show evidence that there is no active Tuberculosis in the past 12 months (by providing a copy of a negative TB test taken within the past 12 months) prior to providing care. Each year, personnel with patient contact must have a TB test or Tuberculosis screen. Documentation of these tests will be maintained in the personnel health file.

Who is responsible to implement the corrective action?

The Executive Director/Director of Patient Care Services and Business Office Managers

When will the corrective action be implemented?

April 22, 2021

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

The Business Office Manager will review and document on the HR spreadsheet all of the mandatory required forms received from the corporate HR department including the TB test results. This information will be updated and maintained on the HR spreadsheet. The Executive Director will audit 100% of all new hire HR charts for compliance that all mandatory forms and tests have been completed. The Executive Director will also monitor that the HR spreadsheet is kept updated and current. The HR spreadsheet reviewed by the Executive Director will be presented

to the QAPI committee monthly, when 100% compliance is attained the HR spreadsheet will be submitted to the QAPI committee quarterly for continued compliance. All QAPI committee reports will be presented to the Governing Body.

19

Colorado Health Facilities Message Center
SUNCREST HOSPICE DENVER
HOSPICE - MEDICARE
Tuesday, October 16, 2018 4:45 PM

"Warning do not use the browser's back button. Use the links below on the left or the buttons below on this screen to avoid losing your work."

Message Center
My Account Setup
Documentation
Electronic Letter of Intent
Electronic Plan of Correction
Facility Contact Information
Flu Vaccination Reporting
Occurrence Reporting
Technical Support
Sign Out

Message Center

You have 340 messages!

Subject	Date Sent	Date Read
POC submission successful	10/16/2018	
POC submission successful	10/16/2018	
POC submission successful	10/16/2018	
POC submission successful	10/16/2018	
REMINDER ABOUT ANNUAL HEALTH CARE WORKER FLU VACCINE DATA	10/10/2018	
Proposed Rule to Revise Emergency Preparedness Requirements	10/10/2018	
09/26/2018 health complaint revisit survey results	10/10/2018	
09/26/2018 health recertification/complaint revisit survey results	10/10/2018	
09/26/2018 health complaint survey results	10/10/2018	
09/26/2018 health complaint survey results	10/10/2018	10/10/2018
Chapter 2 Rule Revision Stakeholder Meetings	09/28/2018	10/01/2018
2018-2019 CDPHE Assessment and Planning	09/27/2018	
TB Update and Skin Testing Practicum for Health Care Providers	09/12/2018	
Department of Human Services Informational Bulletin	09/12/2018	
Chapter 2 Rule Revision Stakeholder Meetings	08/31/2018	09/09/2018
Colorado (HAI) Advisory Committee seeking input on reporting deadline for (SSIs)	08/31/2018	
VERY SMALL QUANTITY GENERATOR HEALTHCARE FACILITY HAZARDOUS WASTE SELF-CERTIFICATION CHECKLIST	08/29/2018	
07/25/2018 health recertification/complaint survey POC has been accepted	08/29/2018	08/29/2018
07/25/2018 health complaint survey POC has been accepted	08/29/2018	08/29/2018
POC resubmission successful	08/28/2018	08/28/2018
POC resubmission successful	08/28/2018	08/28/2018
07/25/2018 health complaint survey POC not accepted	08/24/2018	
07/25/2018 health recertification/complaint	08/24/2018	08/24/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(x3) DATE SURVEY COMPLETED
	061576	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNCREST HOSPICE DENVER	5700 S QUEBEC ST STE 310 GREENWOOD VILLAGE 80111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS An abbreviated survey prompted by complaint investigations #CO24288 and #CO24053 was completed on 12/12/19. Deficient practice was cited.			
L 512	418.52(c)(1) RIGHTS OF THE PATIENT The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness; Based on interview and record review, the agency failed to ensure patients received effective pain management and symptom control for 2 of 6 patient records reviewed (Patients #4 and #6). Findings include: 1. The clinical record for Patient #4 was reviewed on 12/10/19. The patient was admitted for hospice care and services on 7/10/19 with a terminal diagnosis of urothelial cancer. Plan of Care for the certification period dated 7/10/19 to 10/7/19 included orders for Skilled Nurse (SN) visits weekly and as needed for observation and symptom management; Social Worker (SW)twice monthly for psychosocial support; Chaplain visits monthly for spiritual support and Certified Nurse Aide (CNA) visits three times weekly for activities of daily living (ADLs) and personal care. a) The hospice failed to provide adequate pain control and symptom management for Patient #4 who resided in his home. Review of a SN Clinical Note dated 7/22/19	L 512	A. Education: Responsible Party: Administrator All Interdisciplinary Group (IDG) members will be educated on the following: Obtain order form PCP or Hospice MD (if PCP is not available). Make sure to give doctor full picture of what you are assessing so they can make the best decision possible for patient. o You should always go through PCP for medication orders. o If you cannot reach PCP in timely fashion, please leave a message that you are going to get orders from Hospice MD and collaborate with them after order is received so they now what Hospice MD ordered. o If you are reaching out to Hospice D and cannot reach them timely please... i. Call to see if you can reach them directly ii. If you are unable to reach them via doc halo and calling, please notify leadership so they can reach out and help expedite process. Any time there is a med change, or a refill needed please let family and facility know when they can expect delivery (STAT, Next day, later this afternoon, etc.), Immediately enter order into iprescribe (for C2) or call order into pharmacy. Do not wait until end of day to do this, this delays med delivery unnecessarily. For orders entered into iprescribe	

- Alert MD once order is entered so they can sign order timely, ask them to let you know once it has been signed.
- Once signed by MD, call pharmacy to confirm they have received order and request an ETA for delivery
- Update family and facility with ETA of med delivery

For orders called into pharmacy

- Request an ETA for delivery
- Update family and facility with ETA of med delivery

STAT deliveries

- Must be marked stat on the order
- Once pharmacy receives stat order deliver, is withing 2-4 hours

In the event delivery is not possible timely (pain is to severe or weather is not allowing fast delivery) we can utilize local pharmacies IF the family is willing to pick up the medications. WE DO NOT TRANSPORT MEDICATIONS.

- Please notify leadership this is happening so they can guide you.
- Coordinate with family on which pharmacy is accessible to them
- Coordinate with doctor so they know where to send prescription

If you are expecting any sort of medication delay, please let leadership know so we can help.

Any time you make a change in pain medication or symptom management medications, a visit within 24 hours to assess for efficacy should be done.

All IDG members will be educated on the following regulatory requirements related to Volunteer Services.

§418.52(c)(1) Condition of Participation: Patient's Rights

The patient ahs the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.

- (C.) Standard: Rights of the patient. The patient has a right to the following:
  - (1) receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.

2. Immediate Action to Address Deficiencies:

Responsible Party: Administrator

- Education provided to nursing and

social services teams was conducted, consistent with education referened above, by 12/20/19
- Education content, including above-referneced policies and regulatiory guidance was emailed to all nursing and social service teams on 12/23/19
- From survey exit Clinical Supervisors began spot-checking for documentation of monitoring for medication/intervention efficacy during regular review of intermin orders in EMR.

3. Ongoing Actions to Ensure Compliance:

Responsible Party: Administrator

- Same education to be represented at staff meetings during March, June, September, and December 2020
- Clinical Supervisors will continue reviewing for documentation of intervention efficacy for a minimum of 90 days post-exit and will discontinue with QAPI review.
- QAC, or designee, to perform focused audits for compliance consistent with section 3 of this plan

4. Audit Activity to Ensure Future Compliance:

Responsible Party: Administrator

The QAC, or designee, will audit 30 charts monthly for which interim orders are entered related to changes in symptom management interventions. The focused audit will review for timely documented evidence of the efficacy of the intervention, including timely delivery of newly-ordered medications if applicable.

The IDG Audit Tool results will be shared in the Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary.

Audits will continue until 95% compliance is achieved and sustained for 90 days.

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

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	061576	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNCREST HOSPICE DENVER	5700 S QUEBEC ST STE 310 GREENWOOD VILLAGE 80111

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L 512	Continued From page 1	L 512		

completed by the patient's case manager (registered nurse, RN #7) revealed RN #7 had conducted a visit to Patient #4 beginning at 12:45 p.m. and ending at 2:00 p.m. During the visit, RN #7 documented Patient #4 had experienced increased pain that was not relieved by oxycodone or MS Contin (extended release morphine sulfate). Further review showed RN #7 discussed symptom management with the patient's family and contacted the physician and received an order for Roxanol (a highly concentrated solution of morphine sulfate for oral administration) for treatment of severe pain.

Review of a Patient Note dated 7/22/19 completed by RN #7 at 5:29 p.m., showed the RN received an order for Roxanol from the hospice medical director at approximately 4:00 p.m. Further review showed RN #7 made multiple attempts to expedite the delivery of Roxanol. RN #7 documented the pharmacy had not received the electronically signed physician's order in the web portal until after 6:00 p.m. According to the RN's documentation, the pharmacy confirmed delivery would be within two hours or sooner. However, further review showed the Roxanol had not been delivered to the patient's home until 9:15 p.m.; greater than five hours after the RN received the order for Roxanol.

Review of a subsequent Patient Note dated 7/22/19 by RN #8, at 9:15 p.m., showed the patient's daughter called the hospice after hours team at 8:41 p.m. stating the patient was in pain and the Roxanol had not yet arrived. The daughter requested the estimated arrival time of the Roxanol. RN #8 documented at 9:13 p.m. the on call pharmacist informed the RN the delivery department had not heard from the

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L 512	Continued From page 2	L 512		

driver, and would call with an update as they received information. According to the above documentation, the Roxanol had not been received by the patient until 9:15 p.m.

During interview on 12/11/19 at 12:33 p.m., RN #7 stated prior to the Roxanol order, Patient #4 had oxycodone and MS Contin in the home and in a very short time, a matter of hours, the patient was unable to swallow tablets. RN #7 stated she had educated the family and caregivers to crush the medications and give to the patient sublingual (under the tongue). RN #7 stated on 7/22/19 she assessed Patient #4 to have increased pain with decreased effectiveness of oxycodone and MS Contin. RN #7 stated following the visit, she contacted the physician to obtain an order for Roxanol.

During continued interview, RN #7 explained following the receipt of an order for pain medications, the order was entered electronically for the physician to sign, and after the physician signed the order then the pharmacy obtained the order from the portal and filled the prescription. According to the Regional Director of Quality (RN #1) who had joined the interview, she stated RN #7 entered the Roxanol order electronically at 4:00 p.m. RN #7 stated she entered the Roxanol order electronically into the portal for the physician to sign as soon as she received the verbal order and made the physician aware the order was available for signature. RN #7 stated she called the pharmacy and the pharmacy had not received the Roxanol order until 6:00 p.m. RN #7 and the Regional Director of Quality stated the timeline for STAT (immediate) medications was two to four hours from the pharmacy's receipt of the order. RN #7 stated she felt the timeline for the receipt of the Roxanol for Patient

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L 512	Continued From page 3 #4 was prolonged and stated she would have preferred it get there earlier but it was within the criteria of the four hour timeline from the pharmacy's receipt of the order. During interview on 12/11/19 at 1:18 p.m., the Director of Patient Care Services (DPCS, RN #2) stated she had spoken with Patient #4's daughter about the concerns with the delay in the receipt of the Roxanol ordered on 7/22/19. The DPCS stated the hospice had completed its own own investigation of the complaint received from the patient's daughter which included a chart review of the timeliness of the delivery. The DPCS stated the investigation revealed there was a delay in the receipt of the Roxanol for Patient #4. The DPCS stated the hospice had provided education to the staff and implemented procedures to improve the timeliness of medication delivery. 2. The clinical record for Patient #6 was reviewed on 12/11/19. The patient was admitted for hospice care and services on 4/16/19 with a terminal diagnosis of urothelial cancer. Plan of Care for the certification period dated 4/16/19 to 7/14/19 included orders for SN visits once to twice weekly and as needed for observation and symptom management; SW once to twice monthly for psychosocial support; Chaplain visits once to twice monthly for spiritual support and CNA visits once daily for ADLs and personal care. a) The hospice failed to provide adequate pain control and symptom management for Patient #6 who resided in her home. Review of a SN Clinical Note dated 4/19/19 completed by RN #10 revealed RN #10 had conducted a visit to Patient #6 beginning at	L 512		

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L 512	Continued From page 4 11:00 a.m. and ending at 11:38 a.m. During the visit, RN #10 documented Patient #6 had increased pain levels and a new order for liquid morphine had been obtained. Further review showed RN #10 discussed pain control and medication effectiveness with the patient's son. RN #10 instructed the patient's son to to give a dose of oxycodone for pain control until the Roxanol arrived. Review of the Hospice Interim Orders revealed on 4/19/19 the physician had ordered morphine sulfate liquid concentrate (Roxanol) 10 mg (milligrams) orally every hour as needed for breakthrough pain for Patient #6. Review of the physician orders showed orders to discontinue oxycodone capsules. Review of a Patient Note dated 4/19/19 completed by RN #11 at 5:35 p.m., showed the patient's son had called the hospice after hours team at 5:04 p.m. requesting the estimated time of arrival for the morphine. Further review showed RN #11 called the pharmacy who reported an arrival time of approximately 90 minutes. RN #11 documented she informed the patient's son of the estimated time of arrival for the morphine. Review of a subsequent Patient Note dated 4/19/19 by RN #12, at 7:03 p.m., showed the patient's son again called the hospice after hours team at 6:03 p.m. stating the patient was in pain and the Roxanol had not yet arrived. The son requested the estimated arrival time of the morphine, stating the patient was was in a "tremendous amount of pain." RN #12 informed Patient #6's son, the pharmacy stated the morphine was estimated to arrive at 7:00 p.m. RN #12 documented the son refused a nurse visit to assess the patient when offered.	L 512		

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L 512	Continued From page 5 During interview on 12/12/19 at 9:00 a.m., the Regional Director of Quality stated the morphine was delivered to Patient #6 on 4/19/19 at 7:24 p.m. Review of the nursing clinical note dated 4/19/19 showed documentation RN #10 coordinated with the physician and obtained an order for liquid morphine during her visit on 4/19/19, beginning at 11:00 a.m. and ending at 11:38 a.m. However, according to the interview with the Regional Director of Quality, the morphine had not been delivered until 7:24 p.m.; approximately seven and one half hours following the receipt of the medication order by RN #10.	L 512		
L 556	418.56(e)(3) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (3) Ensure that the care and services provided are based on all assessments of the patient and family needs. Based on interview and record review, the agency failed to ensure care and services were provided according to assessment of patient needs for 1 of 4 patients who resided in an assisted living resident (ALR). (Patient #1). Findings include: Agency Policy According to policy titled, "Hospice Nursing Care." (2003) - Provide an ongoing evaluation of the patient and family/caregiver response to care.	L 556	A. Education: Responsible Party: Administrator All Interdisciplinary Group (IDG) members will be educated on the following: • Falls can lead to much more severe complications; falls should be assessed by RN in timely manner. • Please educate facilities and families that all falls need to be reported to Suncrest as they occur so we can come out to do an assessment and manage patients' symptoms. • If injury is assessed, please make sure to collaborate with physician and family on suspected findings and all treatment options. Please document all conversations, physician suggestion for care, education provided to family about options and families decision about those options. • Educate family and facility if chosen course of action dose appear to be working or effective to call hospice immediately so we can address pain and comfort. • If fall or change in condition happens	

on a Friday, please add visit or check in request (based on your assessment) to the Weekend FYI's, so patient is assessed over the weekend. This includes assessment of efficacy of med changes that happened on Friday.

- Not all deaths are cut and dry as we may think. If a fall or any sort of injury occurs close to death, please make sure to notify leadership as this may be a reportable event and we have a specific window of time to report these events.

i.calling, please notify leadership so they can reach out and help expedite process.

All Interdisciplinary Group (IDG) members will be educated on the following Suncrest Home Health and Hospice Policy and Procedure documents:

Hospice Nursing Care – Policy No. H:2-004.01

Specifically:

K. Provide an ongoing evaluation of the patient and family/caregiver response to care.

Care/Service Coordination – Policy No. C:2-008.1

Specifically:

It will be the responsibility of the Case Manager to facilitate communication about changes in the patient's status among assigned personnel.

Written evidence of care coordination may be found in the plan of care/service, case conference summary forms, clinical notes in the patient's clinical record or interdisciplinary group meeting notes.

All IDG members will be educated on the following regulatory requirements related to Volunteer Services.

§418.56(e)(3) Condition of Participation: Interdisciplinary group, care planning and coordination of services

The hospice must designate, and interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patients attending physician, must prepare a written pal of care

for each patient. The plan of care must specify the hospice care and services necessary to meet the patients and family-specific needs identifies int eh comprehensive assessment as such needs relate to terminal illness and related conditions.

4. (E.) Standard: Coordination of services. The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to—

o (3) Ensure that the care and services provided are base on all assessment of the patient and family needs.

B. Immediate Action to Address Deficiencies:

Responsible Party: Administrator

o Education provided to nursing and social services teams was conducted, consistent with education referened above, by 12/20/19
o Education content, including above-referneced policies and regulatiory guidance was emailed to all nursing and social service teams on 12/23/19

C. Ongoing Actions to Ensure Compliance:

Responsible Party: Administrator
o Same education to be represented at staff meetings during March, June, September, and December 2020
o QAC, or designee, to perform audits for compliance consistent with section 3 of this plan

D. Audit Activity to Ensure Future Compliance:

Responsible Party: Administrator

The QAC, or designee, will attend IDG meetings during which he/she will learn about patients with change in status. The QAC, or designee, will audit 30 records per month regarding change in patients' status. These focused audits will determine the percentage of presence of
o Documentation of scope and frequency of services needed to meet patient and family needs
o Written evidence of the coordination of care to meet patient and family needs

The IDG Audit Tool results will be shared in the

			Quarterly QAPI meetings and additional Performance Improvement Projects will be added, as necessary. Audits will continue until 95% compliance is achieved and sustained for 90 days.	

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L 556	Continued From page 6 - Assessing patient and family/caregiver response to care. According to policy titled, "Care/Service Coordination," (2003) - It will be the responsibility of the primary clinician to facilitate communication about changes in the patient's status among all assigned disciplines. - Written evidence of care coordination may be found in the plan of care/service, case conference summary forms, and clinical notes in the patient's clinical record or interdisciplinary group meeting notes. 1. The clinical record for Patient #1 was reviewed on 12/10/19. The Patient was admitted for hospice care services on 7/9/18, with a terminal diagnosis of Alzheimer's disease. Plan of Care orders for certification period 3/6/19 to 5/4/19 included Skilled Nurse (SN) visits once a week to provide nursing assessment and symptom management, Certified Nursing Assistant (CNA) visits four times a week to provide personal care assistance with activities of daily living (ADL); and Medical Social Worker (MSW) visits once a month for psychosocial counseling and support. The patient resided at an (ALR). a) Interview and clinical record review revealed the hospice staff failed to ensure that care and services were provided according to assessment of the patient's need. Specifically, the agency failed to properly assess and provide ongoing assessment of the patient after a fall with a change in condition.	L 556		

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L 556	Continued From page 7 According to the hospice plan of care for the certification period dated 3/6/19 to 5/4/19, Patient #1's SN visits were to monitor the effectiveness of drug therapy. Review of the SN Clinical Note dated 4/14/19 at 10 p.m. completed by RN #5 showed Patient #1 sustained a fall with injury. RN #5 stated Patient #1 had an unwitnessed fall with injury to the right side of the body including the forehead. While Patient #1 was able to move the lower extremities with the fall assessment, RN #5 noted Patient #1 had a mild limp to the right side. This assessment revealed no pain, grimacing or moaning. RN #5 also noted no abnormalities to right side. Review of SN Clinical Note dated 4/15/19 at 4:00 p.m. completed by RN #6 revealed Patient #1 was now experiencing pain. Documentation revealed Patient #1 had a large lump to the right eye and grimaced with movement. RN #6 noted, "discoloration throughout body, more prominent on the side of right gluteal Maximus." RN #6 called the physician and received orders for Morphine Sulfate (narcotic pain medication), 5 milligrams four times a day. Review the next SN Clinical Note on 4/18/19 completed by RN #6 revealed that Patient #1 showed no signs of pain and was visiting with a friend during the assessment. While Patient #1 was experiencing pain relief with this assessment, there was no documentation to show that RN #6 re-assessed Patient #1 until three days after the initiation of the narcotic pain medication. Review of SN Clinical Note dated 4/19/19 revealed RN #6 was dispatched to the ALR where Patient #1 resided. RN #6 documented	L 556		

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the ALR contacted nurse to report uncontrolled pain with Patient #1. RN #6 noted, "Right side of hip protruding, hard to touch, red in discoloration, unable to extend right leg, moaning and grimacing; this is new finding from my previous assessment." RN #6 called the physician to report an increase in pain and received orders to double the narcotic pain medication from 5 milligrams four times a day to 10 milligrams four times a day. The documentation also revealed the family of Patient #1 was called to report an increase with pain and subsequent increase in pain medication. Documentation also revealed Patient #1 was now in a high back wheelchair and vital signs (blood pressure, pulse, and respirations) deviated from her baseline numbers.

Three days later, the next clinical visit note dated 4/22/19 documented by RN #6 at 1:00 p.m. revealed a change in condition which included an increase in pain and the narcotic pain medication increased on 4/19/19 was no longer effective.

A review of a SN clinical note dated 4/23/19 documented by RN #6 revealed on the previous day (4/22/19), the family of the Patient #1 requested an x-ray which showed a right femoral neck fracture (right hip fracture).

There was no documented evidence of any follow up assessments for Patient #1 for three days following the initiation of the narcotic pain medication on 4/15/19 and the doubling of narcotic pain medication on 4/19/19. With both examples, a SN re-assessment visit did not occur until three days later. The agency failed to re-assess Patient #1 for the appropriateness

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L 556	Continued From page 9 and efficacy of the narcotic pain medication with the increase of pain and change of condition. Patient #1 expired 4/25/19. During interview on 12/11/19 at approximately 4:30 p.m., the Vice President of Operations and RN Quality Assurance Coordinator stated that a follow up assessment of the patient is expected of their RNs within 24 hours of a change in condition and/or a change in narcotic pain medication. During interview on 12/12/19 at approximately 9:47 a.m., the Director of Quality Control and the Director of Patient Care Services was asked about Patient #1's clinical notes on 4/15/19 and 4/19/19. Both stated that a follow up assessment would be expected of the RN case manager (RNCM) within 24 hours following the initiation and/or increase of narcotic pain medication and the change in condition with Patient #1 on 4/15/ 19 and 4/19/19. b) Clinical Record review failed to show documentation of communication to the physician regarding Patient #1's right protrusion. 2. Record review of SN note dated 4/19/19 documented by RN #6 revealed lack of documentation as to the assessment of Patient #1's right hip protrusion report to the physician. The documentation on 4/19/19 revealed a report to physician of increase in pain. MD Clinical note dated 4/22/19 documented by the Medical Director revealed documentation as to the assessment of Patient #1's right hip assessment. MD #9 documents, "right leg turned outward, right hip guarding, physical examination consistent with right hip fracture." An x-ray on 4/22/19 revealed a right hip fracture.	L 556		

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

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L 556	Continued From page 10 This x-ray occurred three days after RN #6's assessment on 4/19/19 documenting a "right hip protrusion."	L 556		

Exhibit 3

ADMISSION CRITERIA AND PROCESS
Policy No. H:2-024.1

PURPOSE

To establish standards and a process by which a patient can be evaluated and accepted for admission.

POLICY

Bristol Hospice - Pierce, L.L.C. will admit any patient with a life-limiting illness that meets the admission criteria.

Patients will be accepted for care without discrimination on the basis of race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

Patients will be accepted for care based on need for hospice services. Consideration will be given to the adequacy and suitability of hospice personnel, resources to provide the required services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence.

The patient's life-limiting illness and prognosis of six (6) months or less will be determined by utilizing standard clinical prognosis criteria developed by the fiscal intermediary's Local Coverage Determinations (LCDs).

Bristol Hospice - Pierce, L.L.C. reserves the right not to accept any patient who does not meet the admission criteria.

A patient will be referred to other resources if Bristol Hospice - Pierce, L.L.C. cannot meet his/her needs.

Once a patient is admitted to service, the organization will be responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations.

The hospice registered nurse will contact at least one (1) other member of the interdisciplinary group for input into the plan of care, prior to the delivery of care. The two (2) remaining core services must be contacted and provide input into the plan of care within two (2) days of start of care; this may be in person or by phone.

If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than 5 calendar days after the election of hospice care. A plan of care will be developed by the attending hospice physician, the Medical Director or physician designee, and the hospice team. It will then be submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care. (See "Comprehensive Assessment" Policy No. H:2-046.)

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Exhibit 4

CHARITY CARE
Policy No. 5-017

PURPOSE

To identify the criteria to be applied when accepting patients for charity care.

POLICY

Patients without third-party payer coverage and who are unable to pay for medically necessary care will be accepted for charity care admission, per established criteria.

The hospice will establish objective criteria and financial screening procedures for determining eligibility for charity care.

The hospice will consistently apply the charity care policy.

PROCEDURE

1. When it is identified that the patient has no source for payment of services and requires medically necessary care/service, the patient must provide personal financial information upon which the determination of charity care will be made.
2. A social worker, as available, will meet with the patient to determine potential eligibility for financial assistance from other community resources.
3. The Executive Director/Administrator will review all applicable patient information, including financial declarations, physician (or other authorized licensed independent practitioner) orders, initial assessment information, and social work notes to determine acceptance for charity care.
4. All documentation utilized in the determination for acceptance for charity care will be maintained in the patient's billing record.
5. When financial declarations reveal the patient is able to make partial payment for services, the Executive Director/Administrator will determine the sliding-fee schedule to be implemented.
6. The revised sliding-fee schedule will be presented to the patient for agreement and signature.
7. After acceptance for charity care, the patient's ability to pay will be reassessed every 60–90 days.
8. When the hospice is unable to admit the patient or to continue charity care, every effort will be made to refer the patient for appropriate care/service with an alternate provider.

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9. The referral source will be advised of acceptance, non-acceptance, continuation, or discharge from charity care.

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Exhibit 5

GOALS of CARE

The Bristol AIM Goals of Care program is designed to provide the critical first step in identifying a patient's wishes and developing a plan that honors those wishes. Goals of Care discussion seek to improve quality of life for both the patient and family while working with the patient's care to define and achieve goals.

Bristol AiM
ADVANCED ILLNESS MANAGEMENT PROGRAM

What is a Goals of Care Consult?

- The AIM team evaluates the patient's understanding of their disease prognosis and trajectory.
- The AIM team fills in educational gaps that may exist.
- Based on disease-related knowledge, the AIM team assists the patient to establish short- and long-term goals.
- Through on-going management, the AIM team assists the patient to reach goals and update the plan of care as the patient's condition changes.

Who should have a Goals of Care referral? A patient who:



- Has had 2 or more recent hospitalizations or ER visits
- Has chronic or serious illnesses
- Has treatment goals which are not aligned with their caregiver's wishes
- You answer "no" to the Surprise Question. (Would you be surprised if the patient wasn't with us this time next year?)

How can the AIM team assist healthcare providers? The AIM team:

- Devotes time needed for lengthy, and often multiple, patient and family discussions.
- Provides extensive, specialized training in having difficult conversations.
- Ensures the patient and/or family comprehends the patient's prognosis and normal disease trajectory.

How can the AIM team assist patients and families?

- Family and patient meetings
- Advanced care planning
- Advanced directive completion/revision
- Symptom management and on-going support for serious illnesses



What are the outcomes of Goals of Care consults:

- Increased advanced care planning documentation completion.
- Increased and earlier referrals to hospice.
- Longer length of stay of hospice transitioned patients.
- Increased patient satisfaction.



Where can Goals of Care consults take place?

- Referral based services- Bristol AIM services are referred on a case-needed basis wherever the patient lives.
- Hospital based services- Goals of Care services provided in an acute care setting.
- On-site clinic-based services- AIM services provided at physician practices, CCRCs, ALFs, etc. to meet customer and patient needs.

www.bristolaim.com

Exhibit 6

Bristol Hospice
embracing a reverence for life

12/8/2021

Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Via electronic mail

Re: Bristol Hospice Letter of Intent for Hospice Services in the State of Washington

To Whom it may Concern:

Bristol Hospice, L.L.C. ("Bristol") is pleased to provide you this Letter of Intent ("LOI") to provide Hospice Services in Pierce County in the State of Washington. In accordance with WAC 246-310-080 and 246-310-290, the following information is provided:

1. DESCRIPTION OF SERVICES PROPOSED

Bristol Hospice requests Certificate of Need approval to operate a Medicare Certified and Medicaid Eligible Hospice Agency.

2. ESTIMATED COST

The estimated cost is $30,000.00

3. SERVICE AREA

The Service area will be Pierce County, Washington.

Please do not hesitate to contact us should any aspect of this proposal require clarification.

Thank you very much.

Sincerely,

Hyrum Kirton
Chief Executive Officer
Bristol Hospice, L.L.C.

Exhibit 7

Projected Patients	Projected Patients	Average Population (2016-2018)	2021 Projected Population	2022 Projected Population	2023 Projected Population	2024 Projected Population	2025 Projected Population	
Ages 0-64	534	756,339	769,918	774,696	779,475	784,253.00	789,032.00	
Ages 65+	3,115	130,688	142,422	148,729	155,037	161,344.00	167,652.00	
			Potental Volume	Potental Volume	Potental Volume	Potental Volume	Potental Volume	
Ages 0-64			543.6	547.0	550.3	553.7	557.1	
Ages 65+			3,394.7	3,545.0	3,695.4	3,845.7	3,996.1	
Total Admissions			3,938.3	4,092.0	4,245.7	4,399.4	4,553.1	
					2.6% of total admissions	3.6% of total admissions	4.5% of total admissions	
Bristol Admissions					110	158	205	
Bristol Patient Days					6,833	9,815	12,735	ALOS 62.12 per state average from need study
Bristol ADC					19	27	35	

Projected Patients/Avg Population 0-64	0.000706033
Projected Patients/Avg Population65+	0.023835394

Exhibit 8

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

WAC246-310-290(8)(a) Step 1:

Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics data:

WAC 246-310-290(8)(a)(i) The percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients sixty five and over by the average number of past three years statewide total deaths age sixty-five and over.

WAC246-310-290(8)(a)(ii) The percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients under sixty-five by the average number of past three years statewide total of deaths under sixty-five.

Hospice admissions ages 0-64	
Year	Admissions
2018	4,114
2019	3,699
2020	3,679
	average: 3,831

Deaths ages 0-64	
Year	Deaths
2018	14,055
2019	14,047
2020	16,663
	average: 14,922

Use Rates	
0-64	25.67%
65+	60.15%

Hospice admissions ages 65+	
Year	Admissions
2018	26,207
2019	26,017
2020	27,956
	average: 26,727

Deaths ages 65+	
Year	Deaths
2018	42,773
2019	44,159
2020	46,367
	average: 44,433

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

Washington State Department of Health

WAC246-310-290(8)(b) Step 2:
Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.

0-64				
County	2018	2019	2020	2018-2020 Average Deaths
Adams	28	35	20	**28**
Asotin	52	54	56	**54**
Benton	331	346	555	**411**
Chelan	130	137	224	**164**
Clallam	191	186	195	**191**
Clark	874	887	1,043	**935**
Columbia	6	7	7	**7**
Cowlitz	300	294	314	**303**
Douglas	51	63	42	**52**
Ferry	28	20	19	**22**
Franklin	145	123	100	**123**
Garfield	5	5	5	**5**
Grant	195	197	186	**193**
Grays Harbor	227	251	209	**229**
Island	135	167	110	**137**
Jefferson	64	72	68	**68**
King	3,264	3,275	4,456	**3,665**
Kitsap	515	557	454	**509**
Kittitas	68	90	78	**79**
Klickitat	58	46	42	**49**
Lewis	227	210	205	**214**
Lincoln	25	25	15	**22**
Mason	158	167	143	**156**
Okanogan	103	119	88	**103**
Pacific	64	66	55	**62**
Pend Oreille	43	31	41	**38**
Pierce	1,964	1,911	2,364	**2,080**
San Juan	19	20	18	**19**
Skagit	231	229	269	**243**
Skamania	27	19	26	**24**
Snohomish	1,533	1,533	1,587	**1,551**
Spokane	1,177	1,143	1,634	**1,318**
Stevens	113	112	86	**104**
Thurston	554	525	628	**569**
Wahkiakum	13	11	10	**11**
Walla Walla	110	118	150	**126**
Whatcom	360	394	457	**404**
Whitman	66	47	51	**55**
Yakima	601	555	653	**603**

65+				
County	2018	2019	2020	2018-2020 Average Deaths
Adams	72	93	59	**75**
Asotin	214	222	186	**207**
Benton	1,125	1,154	1,522	**1,267**
Chelan	573	626	785	**661**
Clallam	871	955	777	**868**
Clark	2,767	2,987	3,205	**2,986**
Columbia	43	52	43	**46**
Cowlitz	840	951	968	**920**
Douglas	255	270	160	**228**
Ferry	55	64	58	**59**
Franklin	278	313	263	**285**
Garfield	30	21	11	**21**
Grant	524	508	455	**496**
Grays Harbor	647	659	558	**621**
Island	675	642	505	**607**
Jefferson	336	338	273	**316**
King	9,917	10,213	11,186	**10,439**
Kitsap	1,713	1,811	1,714	**1,746**
Kittitas	239	266	241	**249**
Klickitat	158	160	113	**144**
Lewis	730	722	653	**702**
Lincoln	94	89	75	**86**
Mason	526	548	408	**494**
Okanogan	332	358	277	**322**
Pacific	279	265	177	**240**
Pend Oreille	130	125	101	**119**
Pierce	4,926	5,002	5,608	**5,179**
San Juan	114	127	94	**112**
Skagit	1,001	1,018	1,068	**1,029**
Skamania	56	87	47	**63**
Snohomish	4,055	4,081	4,278	**4,138**
Spokane	3,556	3,545	4,322	**3,808**
Stevens	373	345	248	**322**
Thurston	1,823	1,908	2,007	**1,913**
Wahkiakum	33	53	18	**35**
Walla Walla	445	450	522	**472**
Whatcom	1,252	1,461	1,481	**1,398**
Whitman	199	219	226	**215**
Yakima	1,517	1,451	1,675	**1,548**

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

WAC246-310-290(8)(c) Step 3.
Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort.

0-64		
County	2018-2020 Average Deaths	Projected Patients: 25.67% of Deaths
Adams	28	7
Asotin	54	14
Benton	411	105
Chelan	164	42
Clallam	191	49
Clark	935	240
Columbia	7	2
Cowlitz	303	78
Douglas	52	13
Ferry	22	6
Franklin	123	31
Garfield	5	1
Grant	193	49
Grays Harbor	229	59
Island	137	35
Jefferson	68	17
King	3,665	941
Kitsap	509	131
Kittitas	79	20
Klickitat	49	12
Lewis	214	55
Lincoln	22	6
Mason	156	40
Okanogan	103	27
Pacific	62	16
Pend Oreille	38	10
Pierce	2,080	534
San Juan	19	5
Skagit	243	62
Skamania	24	6
Snohomish	1,551	398
Spokane	1,318	338
Stevens	104	27
Thurston	569	146
Wahkiakum	11	3
Walla Walla	126	32
Whatcom	404	104
Whitman	55	14
Yakima	603	155

65+		
County	2018-2020 Average Deaths	Projected Patients: 60.15% of Deaths
Adams	75	45
Asotin	207	125
Benton	1,267	762
Chelan	661	398
Clallam	868	522
Clark	2,986	1,796
Columbia	46	28
Cowlitz	920	553
Douglas	228	137
Ferry	59	35
Franklin	285	171
Garfield	21	12
Grant	496	298
Grays Harbor	621	374
Island	607	365
Jefferson	316	190
King	10,439	6,279
Kitsap	1,746	1,050
Kittitas	249	150
Klickitat	144	86
Lewis	702	422
Lincoln	86	52
Mason	494	297
Okanogan	322	194
Pacific	240	145
Pend Oreille	119	71
Pierce	5,179	3,115
San Juan	112	67
Skagit	1,029	619
Skamania	63	38
Snohomish	4,138	2,489
Spokane	3,808	2,290
Stevens	322	194
Thurston	1,913	1,150
Wahkiakum	35	21
Walla Walla	472	284
Whatcom	1,398	841
Whitman	215	129
Yakima	1,548	931

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

Washington State Department of Health

WAC246-310-290(8)(d) Step 4:
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate

	0-64							
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
Adams	7	18,160	18,456	18,622	18,787	7	7	7
Asotin	14	16,715	16,596	16,540	16,485	14	14	14
Benton	105	167,984	171,026	172,638	174,249	107	108	109
Chelan	42	62,227	62,512	62,562	62,611	42	42	42
Clallam	49	52,494	52,233	52,027	51,821	49	49	48
Clark	240	411,278	421,901	426,529	431,158	246	249	252
Columbia	2	2,822	2,745	2,710	2,675	2	2	2
Cowlitz	78	85,817	85,843	85,769	85,695	78	78	78
Douglas	13	35,130	35,803	36,080	36,356	14	14	14
Ferry	6	5,628	5,541	5,506	5,470	6	6	6
Franklin	31	88,012	92,443	94,784	97,124	33	34	35
Garfield	1	1,581	1,541	1,522	1,502	1	1	1
Grant	49	86,033	88,240	89,322	90,403	51	51	52
Grays Harbor	59	57,387	56,679	56,401	56,122	58	58	57
Island	35	63,114	63,280	63,296	63,312	35	35	35
Jefferson	17	20,705	20,636	20,550	20,463	17	17	17
King	941	1,885,115	1,918,470	1,930,192	1,941,913	958	963	969
Kitsap	131	218,538	220,614	221,192	221,771	132	132	133
Kittitas	20	38,453	39,286	39,556	39,827	21	21	21
Klickitat	12	15,702	15,439	15,304	15,168	12	12	12
Lewis	55	62,700	63,164	63,327	63,491	55	55	56
Lincoln	6	7,864	7,751	7,698	7,644	5	5	5
Mason	40	50,632	51,397	51,672	51,946	41	41	41
Okanogan	27	32,364	32,087	31,991	31,896	26	26	26
Pacific	16	14,545	14,322	14,242	14,161	16	16	15
Pend Oreille	10	9,859	9,769	9,727	9,684	10	10	10
Pierce	534	756,339	769,918	774,696	779,475	543	547	550
San Juan	5	10,863	10,730	10,707	10,684	5	5	5
Skagit	62	100,807	101,887	102,236	102,586	63	63	63
Skamania	6	9,248	9,223	9,205	9,186	6	6	6
Snohomish	398	705,787	721,527	726,273	731,019	407	410	412
Spokane	338	423,256	426,740	428,033	429,326	341	342	343
Stevens	27	34,109	33,917	33,841	33,766	26	26	26
Thurston	146	238,190	243,867	246,235	248,602	150	151	152
Wahkiakum	3	2,498	2,405	2,368	2,332	3	3	3
Walla Walla	32	50,763	51,028	51,075	51,121	33	33	33
Whatcom	104	185,418	189,267	190,722	192,178	106	107	107
Whitman	14	43,222	43,315	43,322	43,330	14	14	14
Yakima	155	222,774	225,822	227,147	228,473	157	158	159

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

Washington State Department of Health

WAC246-310-290(8)(d) Step 4:
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate to determine the potential volume of hospice use by the projected population by age cohort using Office of Financial Management (OFM) data.

	65+							
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
Adams	45	2,227	2,383	2,424	2,466	48	49	50
Asotin	125	5,812	6,175	6,344	6,514	132	136	140
Benton	762	30,986	33,373	34,597	35,820	821	851	881
Chelan	398	15,876	17,052	17,695	18,339	427	443	460
Clallam	522	21,800	22,901	23,535	24,168	548	563	579
Clark	1,796	78,605	85,686	89,247	92,807	1,958	2,039	2,121
Columbia	28	1,236	1,287	1,304	1,322	29	29	30
Cowlitz	553	22,148	23,719	24,470	25,220	592	611	630
Douglas	137	7,976	8,666	8,974	9,283	149	155	160
Ferry	35	2,168	2,289	2,337	2,386	37	38	39
Franklin	171	9,188	10,083	10,557	11,030	188	197	206
Garfield	12	645	669	680	692	13	13	13
Grant	298	14,861	16,071	16,665	17,258	322	334	346
Grays Harbor	374	16,123	17,133	17,612	18,092	397	408	419
Island	365	20,239	21,412	22,047	22,682	386	398	409
Jefferson	190	11,588	12,323	12,722	13,121	202	208	215
King	6,279	310,572	337,771	350,881	363,992	6,829	7,094	7,359
Kitsap	1,050	53,833	58,185	60,492	62,800	1,135	1,180	1,225
Kittitas	150	7,647	8,266	8,589	8,911	162	168	174
Klickitat	86	5,829	6,268	6,448	6,627	93	96	98
Lewis	422	16,808	17,697	18,175	18,652	444	456	468
Lincoln	52	2,891	3,039	3,119	3,200	54	56	57
Mason	297	15,905	17,167	17,836	18,504	321	333	346
Okanogan	194	10,475	11,210	11,519	11,827	207	213	219
Pacific	145	6,747	7,035	7,159	7,284	151	153	156
Pend Oreille	71	3,925	4,239	4,371	4,504	77	80	82
Pierce	3,115	130,688	142,422	148,729	155,037	3,395	3,545	3,695
San Juan	67	5,768	6,174	6,357	6,541	72	74	76
Skagit	619	27,881	30,314	31,460	32,607	673	698	724
Skamania	38	2,670	2,923	3,048	3,172	42	43	45
Snohomish	2,489	119,333	131,978	138,737	145,495	2,753	2,894	3,035
Spokane	2,290	87,852	94,670	97,979	101,288	2,468	2,554	2,641
Stevens	194	11,360	12,214	12,591	12,969	208	215	221
Thurston	1,150	50,757	54,900	56,967	59,035	1,244	1,291	1,338
Wahkiakum	21	1,503	1,580	1,595	1,611	22	22	22
Walla Walla	284	11,006	11,350	11,632	11,915	293	300	308
Whatcom	841	40,902	44,217	45,794	47,372	909	941	974
Whitman	129	5,526	6,008	6,201	6,395	140	145	149
Yakima	931	37,530	39,475	40,559	41,643	979	1,006	1,033

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

Washington State Department of Health

WAC246-310-290(8)(e) Step 5:
Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity.

County	2021 potential volume	2022 potential volume	2023 potential volume	Current Supply of Hospice Providers	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*
Adams	55	56	57	**51.33**	4	5	6
Asotin	146	150	153	**105.00**	41	45	48
Benton	928	959	990	**1,016.67**	(88)	(57)	(26)
Chelan	469	486	502	**428.67**	41	57	73
Clallam	597	612	627	**392.80**	204	219	234
Clark	2,204	2,288	2,372	**2,584.47**	(380)	(296)	(212)
Columbia	30	31	31	**35.00**	(5)	(4)	(4)
Cowlitz	670	689	708	**788.00**	(118)	(99)	(80)
Douglas	163	168	174	**160.67**	2	8	13
Ferry	43	44	45	**32.00**	11	12	13
Franklin	221	231	240	**201.67**	19	29	39
Garfield	14	14	15	**6.00**	8	8	9
Grant	373	386	398	**292.33**	81	93	106
Grays Harbor	455	466	477	**295.57**	160	170	181
Island	422	433	445	**399.67**	22	34	45
Jefferson	219	226	232	**198.00**	21	28	34
King	7,786	8,057	8,328	**7,830.73**	(44)	226	497
Kitsap	1,267	1,312	1,358	**1,223.57**	43	89	134
Kittitas	182	189	195	**168.00**	14	21	27
Klickitat	105	108	110	**217.80**	(113)	(110)	(107)
Lewis	500	512	524	**445.33**	54	67	79
Lincoln	60	61	63	**29.00**	31	32	34
Mason	361	374	387	**304.57**	57	70	82
Okanogan	234	239	245	**188.33**	45	51	57
Pacific	166	169	171	**93.00**	73	76	78
Pend Oreille	87	89	92	**65.33**	22	24	26
Pierce	3,938	4,092	4,246	**3,596.23**	342	496	649
San Juan	77	79	81	**87.00**	(10)	(8)	(6)
Skagit	736	762	787	**729.00**	7	33	58
Skamania	48	50	51	**32.00**	16	18	19
Snohomish	3,160	3,303	3,447	**3,508.33**	(349)	(205)	(61)
Spokane	2,809	2,897	2,984	**2,720.50**	89	176	263
Stevens	235	241	247	**148.67**	86	92	99
Thurston	1,394	1,442	1,491	**1,565.30**	(171)	(123)	(75)
Wahkiakum	25	25	25	**9.33**	15	16	16
Walla Walla	326	333	340	**272.33**	53	60	68
Whatcom	1,015	1,048	1,081	**1,094.57**	(80)	(46)	(13)
Whitman	154	159	163	**158.17**	(4)	1	5
Yakima	1,136	1,164	1,192	**1,261.00**	(125)	(97)	(69)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

Washington State Department of Health

WAC246-310-290(8)(f) Step 6:
Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*	Statewide ALOS	2021 Unmet Need Patient Days*	2022 Unmet Need Patient Days*	2023 Unmet Need Patient Days*
Adams	4	5	6	62.12	244	300	356
Asotin	41	45	48	62.12	2,563	2,786	3,009
Benton	(88)	(57)	(26)	62.12	(5,497)	(3,565)	(1,633)
Chelan	41	57	73	62.12	2,535	3,539	4,542
Clallam	204	219	234	62.12	12,682	13,613	14,543
Clark	(380)	(296)	(212)	62.12	(23,619)	(18,396)	(13,174)
Columbia	(5)	(4)	(4)	62.12	(281)	(258)	(235)
Cowlitz	(118)	(99)	(80)	62.12	(7,320)	(6,160)	(5,000)
Douglas	2	8	13	62.12	134	470	807
Ferry	11	12	13	62.12	691	737	784
Franklin	19	29	39	62.12	1,201	1,801	2,401
Garfield	8	8	9	62.12	506	518	531
Grant	81	93	106	62.12	5,021	5,799	6,578
Grays Harbor	160	170	181	62.12	9,916	10,589	11,261
Island	22	34	45	62.12	1,377	2,090	2,802
Jefferson	21	28	34	62.12	1,324	1,726	2,127
King	(44)	226	497	62.12	(2,759)	14,070	30,899
Kitsap	43	89	134	62.12	2,696	5,513	8,331
Kittitas	14	21	27	62.12	889	1,290	1,691
Klickitat	(113)	(110)	(107)	62.12	(6,994)	(6,835)	(6,676)
Lewis	54	67	79	62.12	3,378	4,132	4,886
Lincoln	31	32	34	62.12	1,917	2,004	2,091
Mason	57	70	82	62.12	3,529	4,319	5,108
Okanogan	45	51	57	62.12	2,823	3,173	3,523
Pacific	73	76	78	62.12	4,554	4,714	4,875
Pend Oreille	22	24	26	62.12	1,337	1,483	1,630
Pierce	342	496	649	62.12	21,240	30,788	40,337
San Juan	(10)	(8)	(6)	62.12	(639)	(507)	(375)
Skagit	7	33	58	62.12	435	2,029	3,623
Skamania	16	18	19	62.12	984	1,094	1,204
Snohomish	(349)	(205)	(61)	62.12	(21,649)	(12,726)	(3,802)
Spokane	89	176	263	62.12	5,511	10,934	16,357
Stevens	86	92	99	62.12	5,345	5,741	6,136
Thurston	(171)	(123)	(75)	62.12	(10,646)	(7,645)	(4,643)
Wahkiakum	15	16	16	62.12	956	967	977
Walla Walla	53	60	68	62.12	3,304	3,758	4,213
Whatcom	(80)	(46)	(13)	62.12	(4,953)	(2,888)	(823)
Whitman	(4)	1	5	62.12	(231)	50	330
Yakima	(125)	(97)	(69)	62.12	(7,760)	(6,032)	(4,305)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

Sources: CPS MDCR Hospice 3 Report
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
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WAC246-310-290(8)(g) Step 7:
Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.

				Step 7 (Patient Days / 365) = Unmet ADC		
County	2021 Unmet Need Patient Days*	2022 Unmet Need Patient Days*	2023 Unmet Need Patient Days*	2021 Unmet Need ADC*	2022 Unmet Need ADC*	2023 Unmet Need ADC*
Adams	244	300	356	1	1	1
Asotin	2,563	2,786	3,009	7	8	8
Benton	(5,497)	(3,565)	(1,633)	(15)	(10)	(4)
Chelan	2,535	3,539	4,542	7	10	12
Clallam	12,682	13,613	14,543	35	37	40
Clark	(23,619)	(18,396)	(13,174)	(65)	(50)	(36)
Columbia	(281)	(258)	(235)	(1)	(1)	(1)
Cowlitz	(7,320)	(6,160)	(5,000)	(20)	(17)	(14)
Douglas	134	470	807	0	1	2
Ferry	691	737	784	2	2	2
Franklin	1,201	1,801	2,401	3	5	7
Garfield	506	518	531	1	1	1
Grant	5,021	5,799	6,578	14	16	18
Grays Harbor	9,916	10,589	11,261	27	29	31
Island	1,377	2,090	2,802	4	6	8
Jefferson	1,324	1,726	2,127	4	5	6
King	(2,759)	14,070	30,899	(8)	39	85
Kitsap	2,696	5,513	8,331	7	15	23
Kittitas	889	1,290	1,691	2	4	5
Klickitat	(6,994)	(6,835)	(6,676)	(19)	(19)	(18)
Lewis	3,378	4,132	4,886	9	11	13
Lincoln	1,917	2,004	2,091	5	5	6
Mason	3,529	4,319	5,108	10	12	14
Okanogan	2,823	3,173	3,523	8	9	10
Pacific	4,554	4,714	4,875	12	13	13
Pend Oreille	1,337	1,483	1,630	4	4	4
Pierce	21,240	30,788	40,337	58	84	111
San Juan	(639)	(507)	(375)	(2)	(1)	(1)
Skagit	435	2,029	3,623	1	6	10
Skamania	984	1,094	1,204	3	3	3
Snohomish	(21,649)	(12,726)	(3,802)	(59)	(35)	(10)
Spokane	5,511	10,934	16,357	15	30	45
Stevens	5,345	5,741	6,136	15	16	17
Thurston	(10,646)	(7,645)	(4,643)	(29)	(21)	(13)
Wahkiakum	956	967	977	3	3	3
Walla Walla	3,304	3,758	4,213	9	10	12
Whatcom	(4,953)	(2,888)	(823)	(14)	(8)	(2)
Whitman	(231)	50	330	(1)	0	1
Yakima	(7,760)	(6,032)	(4,305)	(21)	(17)	(12)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

WAC246-310-290(8)(h) Step 8:
Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five.

Application Year

Step 7 (Patient Days / 365) = Unmet ADC				Step 8 - Numeric Need	
County	2021 Unmet Need ADC*	2022 Unmet Need ADC*	2023 Unmet Need ADC*	Numeric Need?	Number of New Agencies Needed?**
Adams	1	1	1	FALSE	FALSE
Asotin	7	8	8	FALSE	FALSE
Benton	(15)	(10)	(4)	FALSE	FALSE
Chelan	7	10	12	FALSE	FALSE
Clallam	35	37	40	***TRUE***	***1***
Clark	(65)	(50)	(36)	FALSE	FALSE
Columbia	(1)	(1)	(1)	FALSE	FALSE
Cowlitz	(20)	(17)	(14)	FALSE	FALSE
Douglas	0	1	2	FALSE	FALSE
Ferry	2	2	2	FALSE	FALSE
Franklin	3	5	7	FALSE	FALSE
Garfield	1	1	1	FALSE	FALSE
Grant	14	16	18	FALSE	FALSE
Grays Harbor	27	29	31	FALSE	FALSE
Island	4	6	8	FALSE	FALSE
Jefferson	4	5	6	FALSE	FALSE
King	(8)	39	85	***TRUE***	***2***
Kitsap	7	15	23	FALSE	FALSE
Kittitas	2	4	5	FALSE	FALSE
Klickitat	(19)	(19)	(18)	FALSE	FALSE
Lewis	9	11	13	FALSE	FALSE
Lincoln	5	5	6	FALSE	FALSE
Mason	10	12	14	FALSE	FALSE
Okanogan	8	9	10	FALSE	FALSE
Pacific	12	13	13	FALSE	FALSE
Pend Oreille	4	4	4	FALSE	FALSE
Pierce	58	84	111	***TRUE***	***3***
San Juan	(2)	(1)	(1)	FALSE	FALSE
Skagit	1	6	10	FALSE	FALSE
Skamania	3	3	3	FALSE	FALSE
Snohomish	(59)	(35)	(10)	FALSE	FALSE
Spokane	15	30	45	***TRUE***	***1***
Stevens	15	16	17	FALSE	FALSE
Thurston	(29)	(21)	(13)	FALSE	FALSE
Wahkiakum	3	3	3	FALSE	FALSE
Walla Walla	9	10	12	FALSE	FALSE
Whatcom	(14)	(8)	(2)	FALSE	FALSE
Whitman	(1)	0	1	FALSE	FALSE
Yakima	(21)	(17)	(12)	FALSE	FALSE

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

**The numeric need methodology projects need for whole hospice agencies only - not partial hospice agencies. Therefore, the results are rounded down to the nearest whole number.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Admissions - Summarized

0-64 Total Admissions by County

Sum of 0-64	Column Labels		
Row Labels	2018	2019	2020
Adams	6	8	4
Asotin	6	9	24
Benton	118	103	132
Chelan	34	28	32
Clallam	16	23	24
Clark	336	287	297
Columbia	1	3	3
Cowlitz	107	121	94
Douglas	10	19	17
Ferry	6	5	3
Franklin	30	26	34
Garfield	1	1	3
Grant	41	45	40
Grays Harbor	35	41	27
Island	38	43	54
Jefferson	21	26	17
King	1009	765	889
Kitsap	180	173	96
Kittitas	15	16	12
Klickitat	10	12	12
Lewis	56	50	47
Lincoln	7	3	5
Mason	14	34	43
Okanogan	21	27	31
Pacific	13	15	12
Pend Oreille	8	4	17
Pierce	543	556	425
San Juan	6	6	8
Skagit	48	77	70
Skamania	2	1	3
Snohomish	422	342	361
Spokane	400	329	362
Stevens	30	20	21
Thurston	114	115	129
Wahkiakum	2	0	3
Walla Walla	24	41	41
Whatcom	117	138	80
Whitman	19	12	12
Yakima	248	175	195

65+ Total Admissions by County

Sum of 65+	Column Labels		
Row Labels	2018	2019	2020
Adams	34	54	48
Asotin	121	71	84
Benton	887	837	973
Chelan	386	385	421
Clallam	187	234	283
Clark	2124	2060	2238
Columbia	23	25	50
Cowlitz	600	735	707
Douglas	136	130	170
Ferry	29	25	28
Franklin	155	166	194
Garfield	2	4	7
Grant	261	236	254
Grays Harbor	180	212	186
Island	348	341	375
Jefferson	155	181	194
King	6359	6315	7131
Kitsap	1021	1074	921
Kittitas	135	169	157
Klickitat	81	90	87
Lewis	420	362	401
Lincoln	29	22	21
Mason	161	193	263
Okanogan	148	171	167
Pacific	72	98	69
Pend Oreille	53	65	49
Pierce	3175	3170	2714
San Juan	79	73	89
Skagit	680	705	607
Skamania	20	33	37
Snohomish	2636	2214	2636
Spokane	2247.5	2175	2648
Stevens	121	126	128
Thurston	936	947	1070
Wahkiakum	5	7	11
Walla Walla	227	242	242
Whatcom	770	995	978
Whitman	226.5	77	128
Yakima	977	998	1190

Total Admissions by County - Not Adjusted for New

County	2018	2019	2020	Average
Adams	40	62	52	**51.33**
Asotin	127	80	108	**105.00**
Benton	1005	940	1105	**1016.67**
Chelan	420	413	453	**428.67**
Clallam	203	257	307	**255.67**
Clark	2460	2347	2535	**2447.33**
Columbia	24	28	53	**35.00**
Cowlitz	707	856	801	**788.00**
Douglas	146	149	187	**160.67**
Ferry	35	30	31	**32.00**
Franklin	185	192	228	**201.67**
Garfield	3	5	10	**6.00**
Grant	302	281	294	**292.33**
Grays Harb	215	253	213	**227.00**
Island	386	384	429	**399.67**
Jefferson	176	207	211	**198.00**
King	7368	7080	8020	**7489.33**
Kitsap	1201	1247	1017	**1155.00**
Kittitas	150	185	169	**168.00**
Klickitat	91	102	99	**97.33**
Lewis	476	412	448	**445.33**
Lincoln	36	25	26	**29.00**
Mason	175	227	306	**236.00**
Okanogan	169	198	198	**188.33**
Pacific	85	113	81	**93.00**
Pend Oreill	61	69	66	**65.33**
Pierce	3718	3726	3139	**3527.67**
San Juan	85	79	97	**87.00**
Skagit	728	782	677	**729.00**
Skamania	22	34	40	**32.00**
Snohomish	3058	2556	2997	**2870.33**
Spokane	2647.5	2504	3010	**2720.50**
Stevens	151	146	149	**148.67**
Thurston	1050	1062	1199	**1103.67**
Wahkiakur	7	7	14	**9.33**
Walla Wall	251	283	283	**272.33**
Whatcom	887	1133	1058	**1026.00**
Whitman	245.5	89	140	**158.17**
Yakima	1225	1173	1385	**1261.00**

Total Admissions by County - Adjusted for New

Adjusted Cells Highlighted in YELLOW

County	2018	2019	2020	Average
Adams	40	62	52	**51.33**
Asotin	127	80	108	**105.00**
Benton	1005	940	1105	**1016.67**
Chelan	420	413	453	**428.67**
Clallam	203	462.7	512.7	**392.80**
Clark	2460	2552.7	2740.7	**2584.47**
Columbia	24	28	53	**35.00**
Cowlitz	707	856	801	**788.00**
Douglas	146	149	187	**160.67**
Ferry	35	30	31	**32.00**
Franklin	185	192	228	**201.67**
Garfield	3	5	10	**6.00**
Grant	302	281	294	**292.33**
Grays Harb	215	253	418.7	**295.57**
Island	386	384	429	**399.67**
Jefferson	176	207	211	**198.00**
King	7368	7400.4	8723.8	**7830.73**
Kitsap	1201	1247	1222.7	**1223.57**
Kittitas	150	185	169	**168.00**
Klickitat	272.7	281.7	99	**217.80**
Lewis	476	412	448	**445.33**
Lincoln	36	25	26	**29.00**
Mason	175	227	511.7	**304.57**
Okanogan	169	198	198	**188.33**
Pacific	85	113	81	**93.00**
Pend Oreill	61	69	66	**65.33**
Pierce	3718	3726	3344.7	**3596.23**
San Juan	85	79	97	**87.00**
Skagit	728	782	677	**729.00**
Skamania	22	34	40	**32.00**
Snohomish	3058	3378.8	4088.2	**3508.33**
Spokane	2647.5	2504	3010	**2720.50**
Stevens	151	146	149	**148.67**
Thurston	1255.7	1449.4	1990.8	**1565.30**
Wahkiakur	7	7	14	**9.33**
Walla Wall	251	283	283	**272.33**
Whatcom	887	1133	1263.7	**1094.57**
Whitman	245.5	89	140	**158.17**
Yakima	1225	1173	1385	**1261.00**

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/62.12 ALOS = 205.7 default admissions
205.7 Default

For affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Admissions - Summarized

Recent approvals showing default volumes:

Olympic Medical Center - Clallam County. Approved in September 2019. Default volumes for 2019-2020
Providence Hospice - Clark County. Approved in 2019. Default volumes in 2019-2020
The Pennant Group - Grays Harbor County. Approved August 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Wesley Homes Hospice - King County. Approved in 2015, operational since 2017. 2018 volumes exceed "default" - no adjustment for 2018. Adjustments in 2019.
Envision Hospice - King County. Approved in 2019. Default volumes for 2019-2020
Continuum Care of King - King County. CN issued March 2020. Default volumes for 2020
EmpRes Healthcare Group - King County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Seasons Hospice - King County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Envision Hospice - Kitsap County. Approved in 2020. Default volumes for 2020
Heart of Hospice - Klickitat County. Approved in August 2017. Operational since August 2017. Default volumes in 2018-2019.
The Pennant Group - Mason County. Approved September 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Providence Health & Services - Pierce County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Continuum Care of Snohomish - Snohomish County. Approved in July 2019. Default volumes in 2019-2020
Heart of Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Envision Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Glacier Peak Healthcare - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
EmpRes Healthcare Group - Snohomish County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Seasons Hospice - Snohomish County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Envision Hospice - Thurston County. Approved in September 2018. Default volumes in 2018-2020.
Symbol Healthcare - Thurston County. Approved in November 2019. Default volumes for 2019-2020
Bristol Hospice - Thurston County. Approved March 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
MultiCare Health - Thurston County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
EmpRes Healthcare Group - Whatcom County. Approved in 2020. Default volumes for 2020

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Survey Responses

Note: Kindred Hospice in Whitman and Spokane Counties did not respond to the department's survey for 2018 data. As a result, the average of 2016 and 2017 data was used as a proxy for 2018.

Agency Name	License Number	County	Year	0-64	65+
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Grant	2018	40	254
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Lincoln	2018	6	28
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Adams	2018	6	34
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Jefferson	2018	1	11
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Mason	2018	4	44
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Clallam	2018	16	186
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Thurston	2018	24	273
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Lewis	2018	35	280
Astria Home Health and Hospice (Yakima Regional Home Health and Hospice)	IHS.FS.60097245	Yakima	2018	41	8
Central Washington Hospital Home Care Services	IHS.FS.00000250	Douglas	2018	10	133
Central Washington Hospital Home Care Services	IHS.FS.00000250	Chelan	2018	34	386
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Wahkiakum	2018	2	5
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Clark	2018	54	383
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Cowlitz	2018	87	524
Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2018	1	2
Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2018	6	121
Evergreen Health Home Care Services	IHS.FS.00000278	Island	2018	1	9
Evergreen Health Home Care Services	IHS.FS.00000278	Snohomish	2018	79	690
Evergreen Health Home Care Services	IHS.FS.00000278	King	2018	348	1989
Franciscan Hospice	IHS.FS.00000287	Kitsap	2018	141	693
Franciscan Hospice	IHS.FS.00000287	King	2018	102	921
Franciscan Hospice	IHS.FS.00000287	Pierce	2018	331	2110
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Douglas	2018	0	3
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Grant	2018	1	7
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Okanogan	2018	21	148
Gentiva Hospice (Odyssey Hospice)	IHS.FS.60330209	King	2018	37	180
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2018	13	71
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2018	35	180
Heart of Hospice	IHS.FS.00000185	Skamania	2018	none repo	10
Heart of Hospice	IHS.FS.00000185	Klickitat	2018	1	23
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Benton	2018	6	137
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Yakima	2018	24	219
Home Health Care of Whidbey General Hospital (Whidbey General)	IHS.FS.00000323	Island	2018	20	235
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Skamania	2018	1	1
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Cowlitz	2018	20	76
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Clark	2018	243	1305
Horizon Hospice	IHS.FS.00000332	Spokane	2018	31	389
Hospice of Kitsap County	IHS.FS.00000335	Kitsap	2018	0	0
Hospice of Spokane	IHS.FS.00000337	Lincoln	2018	1	1
Hospice of Spokane	IHS.FS.00000337	Ferry	2018	6	29
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2018	8	53
Hospice of Spokane	IHS.FS.00000337	Stevens	2018	30	121
Hospice of Spokane	IHS.FS.00000337	Spokane	2018	346	1593
Hospice of Spokane	IHS.FS.00000337	Whitman	2018	none repo	none repor
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Island	2018	6	60
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Snohomish	2018	2	67
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	San Juan	2018	6	79
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Skagit	2018	48	680
IRREGULAR-COMMUNITY HOME HEALTH & HOSPICE	IHS.FS.00000262	Pacific	2018	0	1
IRREGULAR-MULTICARE	IHS.FS.60639376	Clallam	2018	0	1
Jefferson Healthcare Home Health and Hospice (Hospice of Jefferson County)	IHS.FS.00000349	Jefferson	2018	20	144
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2018	39	436
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Cowlitz	2018	none repo	none repor
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Skamania	2018	none repo	none repor
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Snohomish	2018	14	94
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Kitsap	2018	14	96
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Pierce	2018	35	198
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	King	2018	25	416
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Whitman	2018	19	226.5
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Spokane	2018	23	265.5
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2018	15	135
Klickitat Valley Home Health & Hospice (Klickitat Valley Health)	IHS.FS.00000361	Klickitat	2018	5	40
Kline Galland Community Based Services	IHS.FS.60103742	King	2018	29	368
Memorial Home Care Services	IHS.FS.00000376	Yakima	2018	183	750
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639376	King	2018	32	158

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
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Agency Name	License Number	County	Year	0-64	65+
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639377	Kitsap	2018	25	232
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639378	Pierce	2018	177	867
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Skamania	2018	1	9
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Klickitat	2018	4	18
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2018	11	44
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2018	316	1772
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	King	2018	none repo	none repor
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2018	11	13
Providence Hospice of Seattle	IHS.FS.00000336	King	2018	407	1959
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Mason	2018	10	117
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Lewis	2018	21	140
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Thurston	2018	90	663
Tri-Cities Chaplaincy	IHS.FS.00000456	Franklin	2018	30	155
Tri-Cities Chaplaincy	IHS.FS.00000456	Benton	2018	112	750
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2018	1	23
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2018	24	227
Wesley Homes	IHS.FS.60276500	King	2018	29	368
Whatcom Hospice (Peacehealth)	IHS.FS.00000471	Whatcom	2018	117	770
Alpha Home Health	IHS.FS.61032013	Snohomish	2019	0	0
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2019	9	71
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2019	1	4
Central Washington Homecare Services	IHS.FS.00000250	Chelan	2019	28	385
Central Washington Homecare Services	IHS.FS.00000250	Douglas	2019	19	125
Chaplaincy Health Care 2018	IHS.FS.00000456	Benton	2019	96	700
Chaplaincy Health Care 2018	IHS.FS.00000456	Franklin	2019	26	164
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2019	98	636
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2019	0	7
Community Home Health/Hospice	IHS.FS.00000262	Clark	2019	60	453
Continuum Care of King LLC	IHS.FS.61058934	King	2019	0	0
Continuum Care of Snohomish LLC	IHS.FS.61010090	Snohomish	2019	0	0
Envision Hospice of Washington	IHS.FS.60952486	Thurston	2019	2	22
EvergreenHealth	IHS.FS.00000278	King	2019	225	2025
EvergreenHealth	IHS.FS.00000278	Snohomish	2019	53	471
EvergreenHealth	IHS.FS.00000278	Island	2019	1	11
Franciscan Hospice	IHS.FS.00000287	King	2019	92	921
Franciscan Hospice	IHS.FS.00000287	Kitsap	2019	118	757
Franciscan Hospice	IHS.FS.00000287	Pierce	2019	364	2236
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2019	27	171
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2019	0	5
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2019	4	8
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2019	41	212
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2019	15	98
Heartlinks	IHS.FS.00000369	Benton	2019	7	137
Heartlinks	IHS.FS.00000369	Yakima	2019	21	180
Heartlinks	IHS.FS.00000369	Franklin	2019	0	2
Horizon Hospice	IHS.FS.00000332	Spokane	2019	30	393
Hospice of Jefferson County, Jefferson Healthcare	IHI.FS.00000349	Jefferson	2019	26	172
Hospice of Spokane	IHS.FS.00000337	Spokane	2019	289	1692
Hospice of Spokane	IHS.FS.00000337	Stevens	2019	20	126
Hospice of Spokane	IHS.FS.00000337	Ferry	2019	5	25
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2019	4	65
Hospice of the Northwest	IHS.FS.00000437	Island	2019	14	56
Hospice of the Northwest	IHS.FS.00000437	San Juan	2019	6	73
Hospice of the Northwest	IHS.FS.00000437	Skagit	2019	77	705
Hospice of the Northwest	IHS.FS.00000437	Snohomish	2019	5	58
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Skamania	2019	0	17
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Klickitat	2019	2	24
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Clark	2019	0	3
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Snohomish	2019	0	0
Kaiser Continuing Care Services Hospice	IHS.FS.00000353	Clark	2019	43	387
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	King	2019	37	489
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Kitsap	2019	18	123
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Pierce	2019	25	176
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Snohomish	2019	7	62
Kindred Hospice	IHS.FS.60308060	Spokane	2019	10	90
Kindred Hospice	IHS.FS.60308060	Whitman	2019	12	77
Kindred Hospice	IHS.FS.60330209	King	2019	6	217
Kittitas Valley Healthcare Home Health and Hospice	IHS.FS.00000320	Kittitas	2019	16	169

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
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Agency Name	License Number	County	Year	0-64	65+
Klickitat Valley Hospice	IHS.FS.00000361	Klickitat	2019	1	44
Kline Galland Community Based Services	IHS.FS.60103742	King	2019	35	345
Memorial Home Care Services	IHS.FS.00000376	Yakima	2019	148	730
MultiCare Hospice	IHS.FS.60639376	King	2019	27	149
MultiCare Hospice	IHS.FS.60639376	Pierce	2019	167	758
MultiCare Hospice	IHS.FS.60639376	Kitsap	2019	37	194
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2019	23	234
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2019	0	9
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2019	17	244
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2019	6	45
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2019	22	240
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2019	0	0
PeaceHealth Hospice	IHS.FS.60331226	Clark	2019	184	1217
PeaceHealth Hospice	IHS.FS.60331226	Cowlitz	2019	23	99
PeaceHealth Hospice	IHS.FS.60331226	Skamania	2019	0	1
PeaceHealth Whatcom	IHS.FS.00000471	Whatcom	2019	138	995
Providence Hospice	IHS.FS.60201476	Klickitat	2019	9	22
Providence Hospice	IHS.FS.60201476	Skamania	2019	1	15
Providence Hospice	IHS.FS.60201476	Clark	2019	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2019	272	1613
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2019	1	29
Providence Hospice of Seattle	IHS.FS.00000336	King	2019	338	2083
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2019	5	10
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2019	91	685
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2019	28	148
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2019	33	118
Puget Sound Hopsice	IHS.FS.61032138	Thurston	2019	0	0
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2019	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2019	3	25
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2019	8	54
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2019	41	228
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2019	3	22
Wesley Homes	IHS.FS.60276500	King	2019	5	86
WhidbeyHealth Home Health, Hospice	IHS.FS.00000323	Island	2019	27	245
Yakima HMA Home Health, LLC	IHS.FS.60097245	Yakima	2019	6	88
Alpha Hospice	IHS.FS.61032013	Snohomish	2020	1	30
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2020	24	84
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2020	3	7
Astria Hospice	IHS.FS.60097245	Yakima	2020	0	56
Central Washington Home Care Service	IHS.FS.00000250	Chelan	2020	32	421
Central Washington Home Care Service	IHS.FS.00000250	Douglas	2020	13	159
Chaplaincy Health Care	IHS.FS.00000456	Benton	2020	118	821
Chaplaincy Health Care	IHS.FS.00000456	Franklin	2020	30	192
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2020	78	616
Community Home Health/Hospice	IHS.FS.00000262	Pacific	2020	1	3
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2020	3	11
Community Home Health/Hospice	IHS.FS.60547198	Clark	2020	61	430
Continuum Care of King LLC	IHS.FS.61058934	King	2020	0	0
Continuum Care of Snohomish	IHS.FS.61010090	King	2020	2	40
Continuum Care of Snohomish	IHS.FS.61010090	Snohomish	2020	12	131
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Whatcom	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	King	2020	1	76
Envision Hospice of Washington LLC	IHS.FS.60952486	Kitsap	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Pierce	2020	1	20
Envision Hospice of Washington LLC	IHS.FS.60952486	Thurston	2020	1	24
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2020	0	0
EvergreenHealth	IHS.FS.00000278	King	2020	316	2451
EvergreenHealth	IHS.FS.00000278	Snohomish	2020	70	672
EvergreenHealth	IHS.FS.00000278	Island	2020	0	6
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2020	4	11
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2020	0	3
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2020	30	167
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2020	27	186
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2020	11	66
HEART OF HOSPICE	IHS.FS.60741443	Clark	2020	0	3
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2020	2	21
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2020	2	18
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2020	0	0

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
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Department of Health
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Agency Name	License Number	County	Year	0-64	65+
Heartlinks	IHS.FS.00000369	Benton	2020	14	152
Heartlinks	IHS.FS.00000369	Yakima	2020	20	181
Heartlinks	IHS.FS.00000369	Franklin	2020	4	2
Horizon Hospice & Palliative Care	IHS.FS.00000332	Spokane	2020	28	456
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2020	17	178
Hospice of Spokane	IHS.FS.00000337	Spokane	2020	302	1895
Hospice of Spokane	IHS.FS.00000337	Stevens	2020	21	128
Hospice of Spokane	IHS.FS.00000337	Ferry	2020	3	28
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2020	17	49
Hospice of Spokane	IHS.FS.00000337	Lincoln	2020	0	0
Hospice of Spokane	IHS.FS.00000337	Whitman	2020	0	1
Hospice of Spokane	IHS.FS.00000337	Okanogan	2020	1	0
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2020	42	433
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2020	49	446
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2020	13	114
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2020	30	181
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2020	3	84
Kindred Hospice	IHS.FS.60308060	Spokane	2020	32	297
Kindred Hospice	IHS.FS.60308060	Whitman	2020	12	127
Kindred Hospice	IHS.FS.60330209	King	2020	9	200
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2020	12	157
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2020	4	38
Kline Galland Hospice	IHS.FS.60103742	King	2020	83	896
Memorial Home Care Services	IHS.FS.00000376	Yakima	2020	175	953
Multicare Home Health, Hospice	IHS.FS.60639376	Pierce	2020	161	866
Multicare Home Health, Hospice	IHS.FS.60639376	King	2020	36	137
Multicare Home Health, Hospice	IHS.FS.60639376	Kitsap	2020	12	126
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2020	24	283
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2020	0	16
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2020	15	226
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2020	8	70
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2020	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2020	22	268
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2020	0	0
PeaceHealth Hospice Southwest	IHS.FS.60331226	Clark	2020	194	1372
PeaceHealth Hospice Southwest	IHS.FS.60331226	Cowlitz	2020	16	91
PeaceHealth Hospice Southwest	IHS.FS.60331226	Skamania	2020	0	3
Providence Hospice	IHS.FS.60201476	Klickitat	2020	6	28
Providence Hospice	IHS.FS.60201476	Skamania	2020	1	16
Providence Hospice	IHS.FS.60201476	Clark	2020	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2020	267	1645
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2020	5	36
Providence Hospice of Seattle	IHS.FS.00000336	King	2020	338	2059
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2020	0	0
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2020	106	772
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2020	35	193
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2020	32	175
Puget Sound Hospice	IHS.FS.61032138	Thurston	2020	0	6
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2020	20	81
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2020	8	89
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2020	70	607
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2020	8	74
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	King	2020	52	716
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Pierce	2020	232	1630
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Kitsap	2020	71	681
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2020	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2020	3	50
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2020	4	48
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2020	40	251
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2020	5	21
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2020	3	110
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2020	1	16

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
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Department of Health
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Preliminary Death Data Updated October 12, 2021

	0-64			65+		
County	2018	2019	2020	2018	2019	2020
ADAMS	28	35	20	72	93	59
ASOTIN	52	54	56	214	222	186
BENTON	331	346	555	1,125	1154	1522
CHELAN	130	137	224	573	626	785
CLALLAM	191	186	195	871	955	777
CLARK	874	887	1043	2,767	2987	3205
COLUMBIA	6	7	7	43	52	43
COWLITZ	300	294	314	840	951	968
DOUGLAS	51	63	42	255	270	160
FERRY	28	20	19	55	64	58
FRANKLIN	145	123	100	278	313	263
GARFIELD	5	5	5	30	21	11
GRANT	195	197	186	524	508	455
GRAYS HARBOR	227	251	209	647	659	558
ISLAND	135	167	110	675	642	505
JEFFERSON	64	72	68	336	338	273
KING	3,264	3,275	4456	9,917	10213	11186
KITSAP	515	557	454	1,713	1811	1714
KITTITAS	68	90	78	239	266	241
KLICKITAT	58	46	42	158	160	113
LEWIS	227	210	205	730	722	653
LINCOLN	25	25	15	94	89	75
MASON	158	167	143	526	548	408
OKANOGAN	103	119	88	332	358	277
PACIFIC	64	66	55	279	265	177
PEND OREILLE	43	31	41	130	125	101
PIERCE	1,964	1,911	2364	4,926	5002	5608
SAN JUAN	19	20	18	114	127	94
SKAGIT	231	229	269	1,001	1018	1068
SKAMANIA	27	19	26	56	87	47
SNOHOMISH	1,533	1,533	1587	4,055	4081	4278
SPOKANE	1,177	1,143	1634	3,556	3545	4322
STEVENS	113	112	86	373	345	248
THURSTON	554	525	628	1,823	1908	2007
WAHKIAKUM	13	11	10	33	53	18
WALLA WALLA	110	118	150	445	450	522
WHATCOM	360	394	457	1,252	1461	1481
WHITMAN	66	47	51	199	219	226
YAKIMA	601	555	653	1,517	1451	1675

Sources:
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
0-64 Population Projection

Washington State Department of Health

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2018-2020 Average Population
Adams	17,637	17,768	17,899	18,029	18,160	18,291	18,456	18,622	18,787	18,953	19,118	18,160
Asotin	16,969	16,906	16,842	16,779	16,715	16,652	16,596	16,540	16,485	16,429	16,373	16,715
Benton	162,262	163,693	165,123	166,554	167,984	169,415	171,026	172,638	174,249	175,861	177,472	167,984
Chelan	61,284	61,520	61,755	61,991	62,227	62,463	62,512	62,562	62,611	62,661	62,710	62,227
Clallam	52,716	52,661	52,605	52,550	52,494	52,439	52,233	52,027	51,821	51,615	51,409	52,494
Clark	387,296	393,291	399,287	405,282	411,278	417,273	421,901	426,529	431,158	435,786	440,414	411,278
Columbia	2,988	2,947	2,905	2,863	2,822	2,780	2,745	2,710	2,675	2,640	2,605	2,822
Cowlitz	85,417	85,517	85,617	85,717	85,817	85,917	85,843	85,769	85,695	85,621	85,547	85,817
Douglas	33,540	33,938	34,335	34,732	35,130	35,527	35,803	36,080	36,356	36,633	36,909	35,130
Ferry	5,834	5,782	5,731	5,680	5,628	5,577	5,541	5,506	5,470	5,435	5,399	5,628
Franklin	79,651	81,742	83,832	85,922	88,012	90,102	92,443	94,784	97,124	99,465	101,806	88,012
Garfield	1,665	1,644	1,623	1,602	1,581	1,560	1,541	1,522	1,502	1,483	1,464	1,581
Grant	81,535	82,660	83,784	84,909	86,033	87,158	88,240	89,322	90,403	91,485	92,567	86,033
Grays Harb	59,105	58,675	58,246	57,817	57,387	56,958	56,679	56,401	56,122	55,844	55,565	57,387
Island	62,514	62,664	62,814	62,964	63,114	63,264	63,280	63,296	63,312	63,328	63,344	63,114
Jefferson	20,636	20,653	20,670	20,688	20,705	20,722	20,636	20,550	20,463	20,377	20,291	20,705
King	1,798,581	1,820,215	1,841,848	1,863,482	1,885,115	1,906,749	1,918,470	1,930,192	1,941,913	1,953,635	1,965,356	1,885,115
Kitsap	212,548	214,045	215,543	217,040	218,538	220,035	220,614	221,192	221,771	222,349	222,928	218,538
Kittitas	36,206	36,768	37,330	37,892	38,453	39,015	39,286	39,556	39,827	40,097	40,368	38,453
Klickitat	16,208	16,082	15,955	15,828	15,702	15,575	15,439	15,304	15,168	15,033	14,897	15,702
Lewis	61,494	61,796	62,097	62,398	62,700	63,001	63,164	63,327	63,491	63,654	63,817	62,700
Lincoln	8,101	8,042	7,982	7,923	7,864	7,805	7,751	7,698	7,644	7,591	7,537	7,864
Mason	48,672	49,162	49,652	50,142	50,632	51,122	51,397	51,672	51,946	52,221	52,496	50,632
Okanogan	33,087	32,906	32,726	32,545	32,364	32,183	32,087	31,991	31,896	31,800	31,704	32,364
Pacific	15,115	14,972	14,830	14,688	14,545	14,403	14,322	14,242	14,161	14,081	14,000	14,545
Pend Oreil	10,045	9,998	9,952	9,905	9,859	9,812	9,769	9,727	9,684	9,642	9,599	9,859
Pierce	721,137	729,937	738,738	747,538	756,339	765,139	769,918	774,696	779,475	784,253	789,032	756,339
San Juan	11,305	11,194	11,084	10,974	10,863	10,753	10,730	10,707	10,684	10,661	10,638	10,863
Skagit	97,885	98,616	99,346	100,076	100,807	101,537	101,887	102,236	102,586	102,935	103,285	100,807
Skamania	9,272	9,266	9,260	9,254	9,248	9,242	9,223	9,205	9,186	9,168	9,149	9,248
Snohomish	661,812	672,806	683,800	694,793	705,787	716,781	721,527	726,273	731,019	735,765	740,511	705,787
Spokane	414,493	416,684	418,875	421,066	423,256	425,447	426,740	428,033	429,326	430,619	431,912	423,256
Stevens	34,576	34,459	34,343	34,226	34,109	33,992	33,917	33,841	33,766	33,690	33,615	34,109
Thurston	224,951	228,261	231,571	234,880	238,190	241,500	243,867	246,235	248,602	250,970	253,337	238,190
Wahkiakun	2,726	2,669	2,612	2,555	2,498	2,441	2,405	2,368	2,332	2,295	2,259	2,498
Walla Wall	49,893	50,111	50,328	50,546	50,763	50,981	51,028	51,075	51,121	51,168	51,215	50,763
Whatcom	175,840	178,234	180,629	183,023	185,418	187,812	189,267	190,722	192,178	193,633	195,088	185,418
Whitman	42,880	42,965	43,051	43,137	43,222	43,308	43,315	43,322	43,330	43,337	43,344	43,222
Yakima	215,882	217,605	219,328	221,051	222,774	224,497	225,822	227,147	228,473	229,798	231,123	222,774

Sources:
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

Department of Health
2020-2021 Hospice Numeric Need Methodology
65+ Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2018-2020 Average Population
Adams	1,773	1,887	2,000	2,114	2,227	2,341	2,383	2,424	2,466	2,507	2,549	2,227
Asotin	5,041	5,233	5,426	5,619	5,812	6,005	6,175	6,344	6,514	6,683	6,853	5,812
Benton	26,328	27,492	28,657	29,821	30,986	32,150	33,373	34,597	35,820	37,044	38,267	30,986
Chelan	13,746	14,279	14,811	15,343	15,876	16,408	17,052	17,695	18,339	18,982	19,626	15,876
Clallam	19,934	20,401	20,867	21,334	21,800	22,267	22,901	23,535	24,168	24,802	25,436	21,800
Clark	64,524	68,044	71,564	75,085	78,605	82,125	85,686	89,247	92,807	96,368	99,929	78,605
Columbia	1,102	1,135	1,169	1,202	1,236	1,269	1,287	1,304	1,322	1,339	1,357	1,236
Cowlitz	18,863	19,684	20,505	21,326	22,148	22,969	23,719	24,470	25,220	25,971	26,721	22,148
Douglas	6,450	6,831	7,213	7,595	7,976	8,358	8,666	8,974	9,283	9,591	9,899	7,976
Ferry	1,876	1,949	2,022	2,095	2,168	2,241	2,289	2,337	2,386	2,434	2,482	2,168
Franklin	7,499	7,921	8,343	8,765	9,188	9,610	10,083	10,557	11,030	11,504	11,977	9,188
Garfield	595	607	620	633	645	658	669	680	692	703	714	645
Grant	12,395	13,011	13,628	14,244	14,861	15,477	16,071	16,665	17,258	17,852	18,446	14,861
Grays Harb	14,005	14,535	15,064	15,594	16,123	16,653	17,133	17,612	18,092	18,571	19,051	16,123
Island	18,086	18,625	19,163	19,701	20,239	20,777	21,412	22,047	22,682	23,317	23,952	20,239
Jefferson	10,244	10,580	10,916	11,252	11,588	11,924	12,323	12,722	13,121	13,520	13,919	11,588
King	254,219	268,307	282,395	296,484	310,572	324,660	337,771	350,881	363,992	377,102	390,213	310,572
Kitsap	45,652	47,697	49,743	51,788	53,833	55,878	58,185	60,492	62,800	65,107	67,414	53,833
Kittitas	6,464	6,760	7,055	7,351	7,647	7,943	8,266	8,589	8,911	9,234	9,557	7,647
Klickitat	4,792	5,051	5,310	5,570	5,829	6,088	6,268	6,448	6,627	6,807	6,987	5,829
Lewis	15,166	15,576	15,987	16,398	16,808	17,219	17,697	18,175	18,652	19,130	19,608	16,808
Lincoln	2,619	2,687	2,755	2,823	2,891	2,959	3,039	3,119	3,200	3,280	3,360	2,891
Mason	13,528	14,123	14,717	15,311	15,905	16,499	17,167	17,836	18,504	19,173	19,841	15,905
Okanogan	8,773	9,198	9,624	10,050	10,475	10,901	11,210	11,519	11,827	12,136	12,445	10,475
Pacific	6,095	6,258	6,421	6,584	6,747	6,910	7,035	7,159	7,284	7,408	7,533	6,747
Pend Oreil	3,195	3,378	3,560	3,742	3,925	4,107	4,239	4,371	4,504	4,636	4,768	3,925
Pierce	108,983	114,409	119,836	125,262	130,688	136,114	142,422	148,729	155,037	161,344	167,652	130,688
San Juan	4,876	5,099	5,322	5,545	5,768	5,991	6,174	6,357	6,541	6,724	6,907	5,768
Skagit	22,735	24,021	25,308	26,595	27,881	29,168	30,314	31,460	32,607	33,753	34,899	27,881
Skamania	2,158	2,286	2,414	2,542	2,670	2,798	2,923	3,048	3,172	3,297	3,422	2,670
Snohomish	95,788	101,674	107,560	113,447	119,333	125,219	131,978	138,737	145,495	152,254	159,013	119,333
Spokane	73,817	77,325	80,834	84,343	87,852	91,361	94,670	97,979	101,288	104,597	107,906	87,852
Stevens	9,454	9,930	10,407	10,884	11,360	11,837	12,214	12,591	12,969	13,346	13,723	11,360
Thurston	42,459	44,534	46,608	48,683	50,757	52,832	54,900	56,967	59,035	61,102	63,170	50,757
Wahkiakur	1,254	1,316	1,379	1,441	1,503	1,565	1,580	1,595	1,611	1,626	1,641	1,503
Walla Wall	10,757	10,819	10,881	10,944	11,006	11,068	11,350	11,632	11,915	12,197	12,479	11,006
Whatcom	33,950	35,688	37,426	39,164	40,902	42,640	44,217	45,794	47,372	48,949	50,526	40,902
Whitman	4,370	4,659	4,948	5,237	5,526	5,815	6,008	6,201	6,395	6,588	6,781	5,526
Yakima	34,088	34,949	35,809	36,670	37,530	38,391	39,475	40,559	41,643	42,727	43,811	37,530

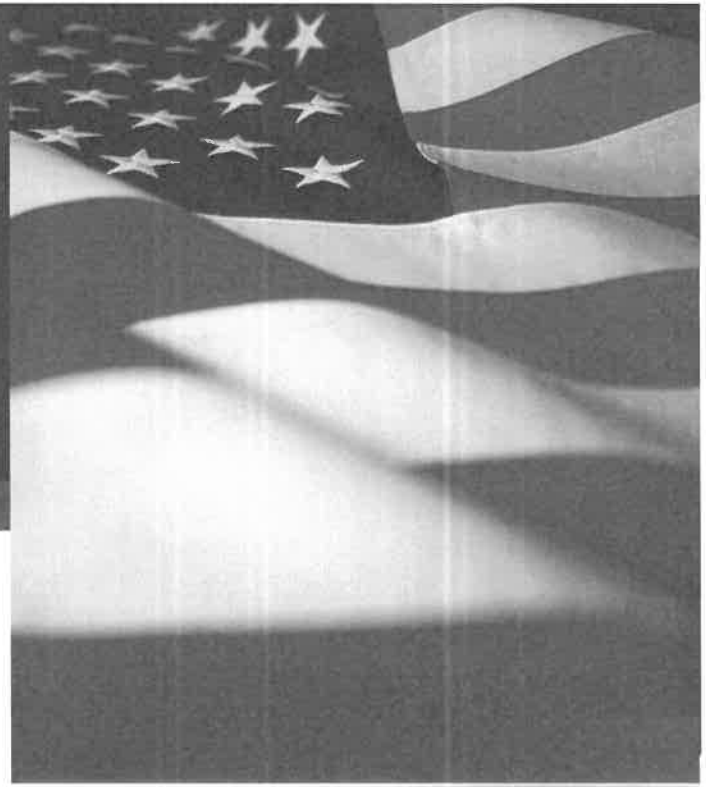
Sources:
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

Exhibit 9

"You have all shown such love and will forever be part of our best memories in this time of transition."
~ Family member



We Honor Veterans, a program of NHPCO and VA, is designed to empower hospice professionals to meet the unique needs of dying Veterans. The program teaches respectful inquiry, compassionate listening and grateful acknowledgement – to comfort patients with a history of military service and possibly physical or psychological trauma.



Bristol Hospice Services

The employees at Bristol Hospice embrace a reverence for life.

CHAP accreditation publicly certifies that an organization has voluntarily met the highest standards of excellence for home and community-based health care.

Bristol Hospice
embracing a reverence for life

*Bristol Hospice provides services directly or through arrangements with other qualified providers and does not refuse service to or employment to or in any other way discriminate against any person on the basis of race or color, age, religion, sex, pregnancy, sexual orientation, mental or physical handicap, childbirth and ancestry or national origin. Bristol Hospice will not discontinue or diminish care provided to a Medicare beneficiary because of the beneficiary's inability to pay for the care.

We Provide:

- Pain and Symptom Management
- Counseling and Supportive Services
- Spiritual Counseling
- Therapy Services
- Personal Care/Home Health Aide Services
- Volunteer Services
- Supplies, Medication and Durable Medical
- Equipment Related to the Life-Limiting Illness
- Continuous Care
- Inpatient Services
- Respite Care Services

Bristol Hospice
embracing a reverence for life

WE HONOR VETERANS:
A MISSION TO SERVE



Did you know?

- Nearly 40% of enrolled Veterans live in areas that are considered rural, where community hospices and VA palliative care programs are not readily available
- On any given night, more than 107,000 Veterans are without shelter and lack basic healthcare
- Veterans aged 18 to 25 are more likely than older Veterans to have higher rates of substance abuse disorder
- The United States National Comorbidity Survey Replication (NCS-R), conducted between February 2001 and April 2003 found that the estimated lifetime prevalence of PTSD among Vietnam Veterans was 30.9% for men and 26.9% for women



Regardless of the situation, it is a priority of the We Honor Veterans program to ensure that all Veterans receive compassionate, quality care at the end of life.

Needs by war or trauma



Veterans often take great pride in their service, seeing it as a period of time when they did something meaningful to make a difference in the world.

However, not all Veterans see their service as a positive one or do not see their sacrifice has having made any difference, and this has resulting complications.

Understanding how Veterans view their service, whether it is positive or negative, has implications for how they view their disease, especially if it is related to their service.

Veterans & Their Needs

Hospice professionals across the country focus on a single purpose: to provide comfort and support at the end of life.

That's why America's hospice professionals are on a mission to learn how to serve Veterans through the challenges they may be facing from illness, isolation or traumatic life experience.

America's Veterans have done everything asked of them in their mission to serve our country. Now it is time that we step up, acquire the necessary skills and fulfill our mission to serve these men and women with the dignity they deserve.



Our Memorial Book

A number of years ago, a couple of veterans had the idea of creating a memorial volume written specifically for the families of veterans. This book would be presented as a gift and keepsake from Bristol Hospice Visalia for the family when their veteran passes away. The book was written to celebrate military service, recognize the family, define the grieving process and provide resources for assistance. It would explain to the recipients not so much what all of us did as members of the Armed Forces, but more importantly, why we did it. That volume is now a reality. It is entitled One Who Served, A Memorial Tribute To Your Veteran.

Contents

Part 1 To Pay Tribute: Remembering One Who Served
A personal record and memorial of your loved one

Part 2 To Remember: Honoring All Who Served
An appreciation of our national heritage of military service

Part 3 To Grieve: Mourning One Who Served
A reflection on the human reality of grief that accompanies the loss of a loved one

Part 4 To Carry On: Continuing To Live
A seasonal meditation on the process of healing

Special Section To Reach Out: Being of Assistance
A compilation of helpful resources for families

Bright Moments - Points of Light Kit:

- ***Music Device and Headphones*** - Loaded with patient specific music favorites.
- ***Weighted Blanket*** - Clinical studies have shown that this produces comfort when managing agitated or unsettled behavior. Simulates the feeling of a hug.
- ***Chart A Life*** - To capture special moments and preserve patient memories.
- ***Hand Held Distraction Device***
- ***Memory-enhancing Aromatherapies***
- ***Therapeutic Companion Bear***
- ***Specialized Utensils***
- ***Specialized Care Products***



Offering effective innovation in the care of those affected by dementia & alzheimers.

Bright Moments is a program of care specifically designed for hospice patients with end-state dementia [ESD].

It is based on the belief that more can be done for and with dementia patients to generate positive outcomes.

Knowing that family members and caregivers often struggle with the challenges of late-state dementia, Bristol Hospice created Bright Moments, an innovative approach designed to support patients, family, staff and physicians.

Bright Moments
Giving Light to Life

www.bristolhospice.com

Bright Moments
Giving Light to Life

Offering an intensified program of care for Late-Stage Dementia Patients...

...in the home

... in assisted living

...in the long term care facility

Bristol Hospice
embracing a reverence for life

We believe that more can be done to give Light to Life for those struggling with dementia.

Our Bright Moments program is an innovative & non-pharmacological approach to person centered dementia care with specialized interventions that calm, comfort and support while providing the patient with a pathway to moments of light.



The patient needs

- Regular human contact
- More personalized care
- Assistance in eating
- Proactive skin care
- A calming environment
- Pain/Comfort assessment
- Spiritual/Emotional support



The family and loved ones need

- An understanding of the disease process
- Coaching on what to do and how to do it
- User friendly reference material
- Support



The caregivers/ professionals need

- Affiliation with experts who specialize in late-stage dementia
- Sensitivity to their emotional needs
- Staff Support

Our Bright Moments team joins with other caregivers to plan and implement a comfortable and calming experience for patients, families and caregivers.

We are committed to providing all patients with a clinically proven and innovative, end-stage dementia care.

Testimonials

"My mom would often get aggravated in the evening. After participating in the program and getting her hands soaked she was able to relax and even fell asleep."

– Loving Daughter

"I noticed my mom hadn't had much of an appetite but after getting her nails cut and having lotion applied, she was interested in eating her meal"

– Loving Daughter

"The aromatherapy was so soothing for my mother, it really helped her relax and get a good nights rest"

– Loving Son

"It gives residents something to look forward to. The one-on-one interaction is so helpful. It has also been great with residents that have sundowning – allows them to calm down, relax."

– Facility Staff Member

To learn more about Sweet Dreams Services

OUR MISSION

Bristol Hospice is graciously committed to our mission that all patients and families entrusted to our care will be treated with the highest level of compassion, respect and quality of care.

Bristol Hospice
embracing a reverence for life

*Bristol Hospice provides services directly or through arrangements with other qualified providers and does not refuse service to or employment to or in any other way discriminate against any person on the basis of race or color, age, religion, sex, pregnancy, sexual orientation, mental or physical handicap, childbirth and ancestry or national origin. Bristol Hospice will not discontinue or diminish care provided to a Medicare beneficiary because of the beneficiary's inability to pay for the care.

sweet dreams
Bristol Hospice

Sweet Dreams is based upon the belief that compassionate presence, the provision of a care plan devoted to end of day sleep rituals and comfort can result in an enhanced patient satisfaction. The Sweet Dreams Service is an included part of the Hospice benefit and is provided in the hours leading up to bed time.



www.bristolhospice.com

PLACE OF THE BRIDGE®

Components of Sweet Dreams

- Learning from the patient and family the history of bedtime rituals
- Assessing the patients likes, dislikes, and wishes regarding an evening routine
- Creation and delivery of a personalized care plan that meets the needs of the patient in the chosen home setting



Sweet Dreams Philosophy

Through creation of a nurturing and soothing environment our Bristol Hospice team can deliver an individualized night time routine that facilitates sleep and comfort at the end of the day.

Services Provided under Sweet Dreams Care

- Hand and Foot gentle touch techniques
- PM Care (face wash, foot soak, nail care, mouth care, etc.)
- Aromatherapy/Essential Oils
- Sound and/or music therapy
- Taste therapy
- Gentle spa approach, (Low lights, spa music, fountains, soft words, slow approach)



Exhibit 10

"Construye puentes en lugar de muros y tendrás un amigo."

~ RH Delaney



Declaración de misión:

Bristol Hospice-Miami-Dade, LLC, está generosamente comprometido con nuestra misión de que todos los pacientes y familias a nuestro cuidado serán tratados con el nivel más elevado de compasión, respeto y calidad de cuidado.

Visión:

Bristol Hospice-Miami-Dade, LLC, está generosamente comprometido en convertirse en el proveedor de elección para hospicios y cuidados paliativos.



Proporcionamos:

- Servicios de enfermería
- Gestión de síntomas y dolores
- Servicios de apoyo y orientación
- Orientación espiritual
- Servicios de terapia
- Servicios de asistencia médica en el hogar/cuidado personal
- Servicios de voluntarios
- Suministros, medicación, equipos médicos
- Cuidado continuo
- Servicios para pacientes hospitalizados
- Servicios de cuidado de relevo
- Apoyo en el duelo



Bristol Hospice
embracing a reverence for life
MIAMI-DADE

¿Cómo me comunico con Bristol Hospice?

Bristol Hospice - Miami-Dade, LLC
5201 Blue Lagoon Dr., Ste. 570
Miami-Dade, FL 33126

TEL: (786) 382-0433
FAX: (786) 254-2556

CHAP

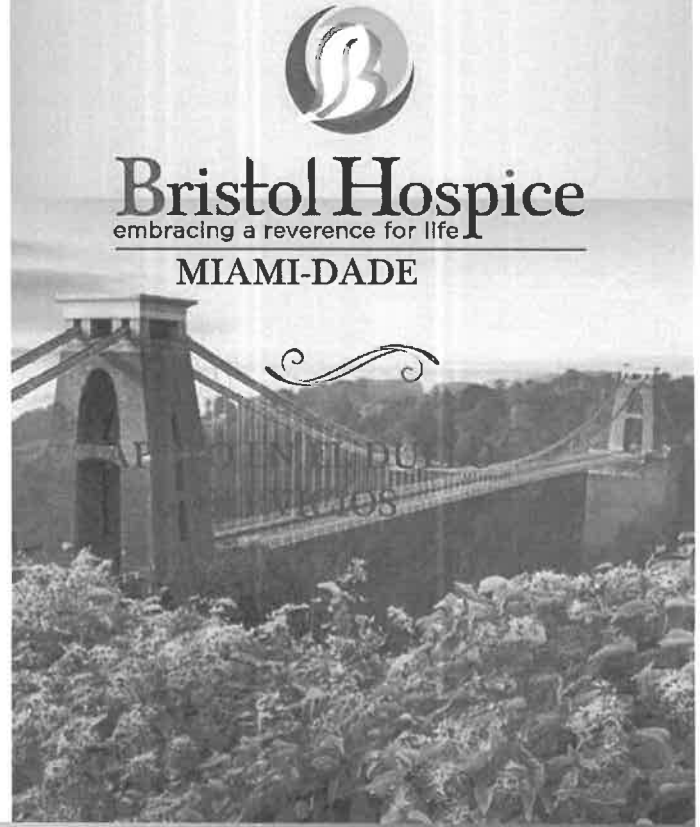
We Honor Veterans

*Bristol Hospice - Miami-Dade, LLC proporciona servicios directamente o a través de acuerdos con otros proveedores calificados y no niega servicio ni empleo o, de ninguna otra forma, discrimina contra ninguna persona sobre la base de raza o color, edad, religión, sexo, embarazo, orientación sexual, discapacidad mental o física, nacimiento o ancestros u origen nacional.

Bristol Hospice - Miami-Dade, LLC garantizará que el cuidado en un hospicio se proporcione sin importar la capacidad que el paciente o la unidad familiar tengan para pagar y sin importar raza, credo, color, religión, sexo, origen nacional o discapacidad.

bristolhospice-miami.com

Bristol Hospice
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MIAMI-DADE



EL LUGAR DEL PUENTE

Duelo

Cuando experimentamos la muerte de un ser querido, esta experiencia es muy dolorosa. Algunas veces, nos parece como si estos sentimientos nunca nos abandonarán. Las emociones pueden ir desde la tristeza hasta la depresión, llanto, sentimientos de vacío e incluso rabia. Aunque estos sentimientos son normales cuando atravesamos por una pérdida, nunca son agradables. Hay muchas formas de trabajar con estas emociones, algunas son útiles y otras dañinas.

Causas

Situaciones que pueden hacer que experimentemos un duelo:

- La muerte de un ser querido o una mascota
- La pérdida de una relación a través de un divorcio o una separación
- Deterioro de la salud o el diagnóstico de una enfermedad terminal
- Cambio de empleo
- Envejecer y cambios en la estructura familiar
- Problemas financieros

Respuestas al duelo

- Rabia
- Tristeza/llanto
- Dormir más o incapacidad para dormir
- Agitación y ansiedad
- Cambios en la alimentación: comer demasiado o no comer lo suficiente
- Automedicación: aumento en el consumo de alcohol o fármacos
- Apartarse de actividades normales
- Dificultades para concentrarse: aumento del olvido, la confusión y las alucinaciones



Esperanza

Cuando una persona está abrumada por el duelo, tiene mucho más dificultad para hacerle frente. El inicio de la curación empieza por identificar que el duelo es real. Necesita apoyo para atravesar este período de dolor emocional. Uno de los primeros pasos para sanar es descubrir que hay esperanza. La esperanza es lo que una persona experimenta cuando llega a creer en un resultado positivo para sus circunstancias.

Curación

La curación es una palabra que se usa con frecuencia para describir la reparación física del cuerpo cuando ha sido lastimado. El objetivo de ese tipo de curación es devolver el cuerpo a su estado antes de la lesión. Al considerar la curación de las emociones, es importante entender que estamos lastimados y necesitamos curarnos. Al igual que el cuerpo, la mente tiene capacidad de resistencia y poder; se curará. Proporcionar el cuidado y el apoyo correctos puede ser de ayuda para una curación mejor y más rápida. Requiere trabajo, al igual que para curar el cuerpo, pero con amor, ayuda y apoyo el proceso puede llevarnos hacia un lugar saludable.

Inicio del viaje



El pensamiento de un nuevo viaje puede ser abrumador. Recuerde que muchos han recorrido este camino antes que usted. Aunque el camino puede ser desconocido, las pendientes inclinadas, usted no estará solo. Hacer este viaje con un amigo, grupo y un líder de apoyo hará que el viaje sea más fácil. Los grupos de apoyo y los grupos de duelo de Bristol están diseñados para dirigir y ayudar a atravesar la experiencia del duelo, y encontrar paz y tranquilidad para seguir adelante en una forma saludable. Encontrar las herramientas y el apoyo correctos para este viaje es crucial. Venga y participe en su viaje y permítanos ser su guía en el descubrimiento de su salud y curación espiritual y emocional.





El "Grupo de Apoyo **Desarrollar un Puente de Esperanza"** ofrece una oportunidad para que las personas compartan sus sentimientos y reciban apoyo de otros que están experimentando un duelo similar.

Servicios de Hospicio Bristol

El Hospicio cuenta con voluntarios para ayudar con el trabajo administrativo también.

Estas funciones incluyen:

- Entrada de datos
- Envíos y fotocopias
- Extensión y educación comunitaria
- Contestadores telefónicos
- Asistencia en la coordinación de servicios de apoyo

Bristol Hospice
EMBRACING A REVERENCE FOR LIFE®

¿Cómo me pongo en contacto con Bristol Hospice?

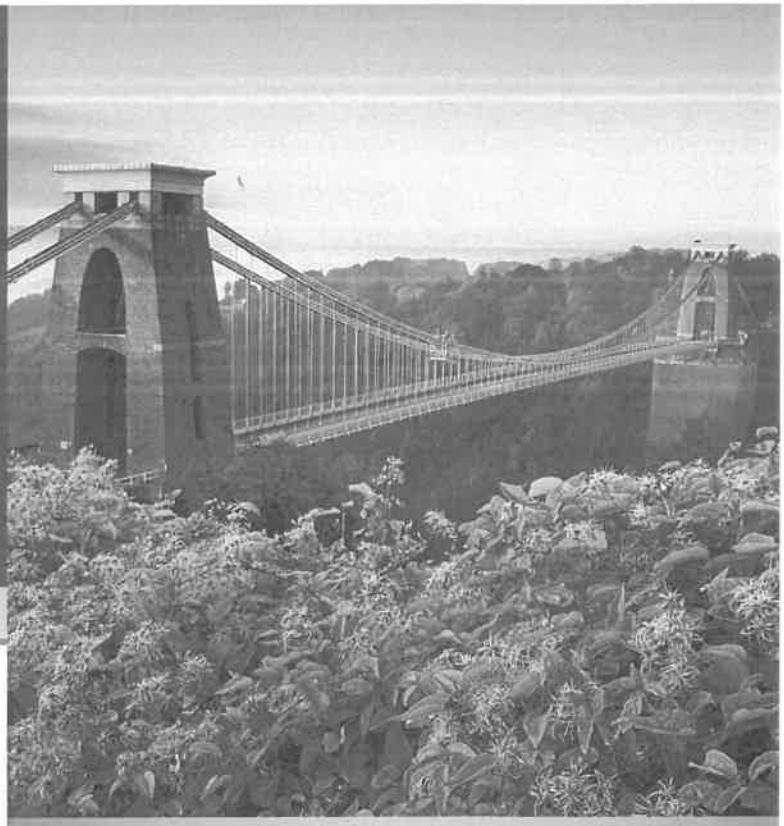
Bristol Hospice - Miami Dade, LLC
5201 Blue Lagoon Dr., Ste 570
Miami, FL 33126

TEL: (786) 382-0433
FAX: (786) 254-2556

WE HONOR VETERANS

*Bristol Hospice - Miami-Dade, LLC proporciona servicios directamente o a través de arreglos con otros proveedores calificados y no rechaza el servicio o empleo para, o de ninguna otra manera discrimina contra cualquier persona sobre la base de raza o color, edad, religión, sexo, orientación sexual, discapacidad mental o física, parto y ascendencia u origen nacional. Bristol Hospice- Miami-Dade, LLC no descontinuará o disminuirá la atención prestada al beneficiario de Medicare debido a la incapacidad del beneficiario para pagar por el cuidado.

www.bristolhospice.com



Bristol Hospice
EMBRACING A REVERENCE FOR LIFE®

MIAMI-DADE, LLC
SERVICIOS VOLUNTARIOS

UN OÍDO QUE ESCUCHA, UNA MANO PARA SOSTENER



Responsabilidades del Voluntario

Cada hospicio cuenta con el apoyo voluntario para proporcionar cuidado excelente al final de la vida a cada paciente y su familia. Al ser un voluntario de hospicio, puede obtener una gran satisfacción personal de saber que ha hecho un impacto en la vida de otra persona.

Como voluntario de hospicio se le darán opciones sobre cuántas y qué tipos de cosas desea hacer.

Algunos ejemplos de las tareas típicas de los voluntarios son:

- Proporcionar compañerismo a un paciente y su familia.
- Ser una presencia reconfortante y comprensiva.
- Proporcionar tiempo de descanso para los cuidadores del paciente.
- Hacer diligencias o hacer tareas domésticas ligeras para el paciente y la familia

Los voluntarios mejoran la comodidad y la calidad de vida de nuestros pacientes y familias.



"Usted importa por ser usted, e importa hasta el último momento de su vida."

~ Dame Cicely Saunders, fundadora del movimiento moderno de hospicio.

Voluntarios



Los voluntarios son una parte integral del cuidado paliativo. Ya sea brindando compañía a una persona en los últimos meses y semanas de vida, ofreciendo apoyo a los miembros de la familia y cuidadores, o ayudando con el alcance comunitario, las contribuciones de los voluntarios son esenciales para el importante trabajo proporcionado por nuestro equipo de hospicio.

¿Cómo puedo convertirme en un voluntario?



Comuníquese con el Coordinador de Voluntarios para hablar sobre Oportunidades de Voluntariado. Bristol Hospice proporciona el entrenamiento y la supervisión

. Pedimos que los miembros sobrevivientes de la familia que deseen unirse al personal voluntario esperen un mínimo de (1) año después de la muerte de su ser querido.

Acuerdo de Arbitraje

Introducción: este es el Acuerdo de Arbitraje de nuestro programa que respetuosamente le pedimos que firme. Nos permite aceptar que cualquier disputa que surja de los servicios que recibe de nuestro programa se resolverá mediante un arbitraje vinculante en lugar de un tribunal de justicia.

El arbitraje vinculante tiene beneficios tanto para nuestro programa como para usted, el paciente. Muchos tribunales supremos y la Corte Suprema de los Estados Unidos favorecen el arbitraje como un método alternativo para la resolución de disputas. Esto se debe a que el arbitraje es más rápido y menos costoso que los juicios con jurado y los procedimientos judiciales para resolver disputas entre los proveedores médicos y los pacientes. Ambas partes se libran de las tensiones de pasar por un juicio y la publicidad que puede acompañar a los procedimientos del juicio. Además, debido a que no hay apelaciones de un laudo arbitral, cuando un paciente prevalece, el paciente recibe un pago inmediato por su reclamo.

Nuestro objetivo, por supuesto, es brindarle una atención de calidad para satisfacer plenamente sus necesidades. Sabemos que la mayoría de las quejas comienzan por falta de comunicación. Por lo tanto, si tiene alguna pregunta sobre este Acuerdo de arbitraje, o sobre su atención en general, contáctenos.

El Acuerdo:

Se entiende que cualquier disputa sobre mi atención brindada por _____ (inserte el nombre del programa) se determinará mediante el envío al arbitraje según lo dispuesto por la ley estatal y federal, y no por una demanda o proceso judicial. Ambas partes de este Acuerdo entienden que están renunciando a un derecho de juicio ante un tribunal de justicia y, en cambio, aceptan el uso de un arbitraje vinculante.

Todos los reclamos serán arbitrados ante un árbitro del panel de arbitraje de la Asociación Americana de Abogados de Salud [AHLA, por sus siglas en inglés]. Ambas partes seleccionarán y se podrán de acuerdo sobre un árbitro si es posible. Si las partes no pueden llegar a un acuerdo, las partes acuerdan permitir que el panel de arbitraje de AHLA designe un árbitro.

Las reglas de arbitraje seguirán las reglas de procedimiento estatales para el arbitraje en el estado en el que se firma este Acuerdo, excepto en la medida en que las partes y el árbitro designado acuerden mutuamente estar sujetos a diferentes reglas de procedimiento de arbitraje. Todas las partes acuerdan estar obligadas por la decisión del árbitro.

Las partes acuerdan además que todos los reclamos basados en el mismo incidente, transacción o circunstancias relacionadas serán arbitrados en un solo procedimiento. También se entiende que cualquier disputa que no esté relacionada con la atención de hospicio, incluso si una disputa está sujeta a arbitraje, si este Acuerdo es desmesurado, así como cualquier disputa procesal, se determinará mediante el sometimiento a un arbitraje vinculante.

Es la intención de las partes que este Acuerdo obligue a todas las partes y posibles partes relacionadas con todos los reclamos, incluidos los reclamos derivados o relacionados con el tratamiento o los servicios prestados por el programa de hospicio [también referido como "cuidado de hospicio"] y que este Acuerdo cubra a los herederos del paciente, hijos o cónyuges pasados, presentes o futuros del paciente. Dichos reclamos pueden incluir la pérdida de consorcio o muerte injusta.

Si alguna disposición de este Acuerdo de Arbitraje se considera inválida o inaplicable, las disposiciones restantes permanecerán en pleno vigor y no se verán afectadas por la invalidez de cualquier otra disposición. Entiendo que tengo derecho a recibir una copia de este Acuerdo de Arbitraje.

AVISO: AL FIRMAR ESTE ACUERDO USTED ACEPTA QUE CUALQUIER PROBLEMA DE CUIDADO DE HOSPICIO SEA DECIDIDA POR EL ARBITRAJE NEUTRO, Y ESTÁ RENUNCIANDO A SU DERECHO A UN TRIBUNAL PROCEDENTE, INCLUYENDO UN JUICIO CON JURADO.

Paciente [o Firma del representante del paciente]	Fecha	[Relación con el paciente]
Representante del programa de hospicio	Fecha	Título o Cargo

INSTRUCCIONES PARA DICTAR UNA ORDEN DE OOH DNR

PROPÓSITO: la orden de no resucitar fuera del hospital (también conocida como OOH DNR) al reverso acata el Código de Salud y Seguridad (o HSC), Capítulo 166, para su uso por las personas calificadas o sus representantes autorizados para ordenar a los profesionales de salud que renuncien a sus intentos de resucitar y permitan que la persona tenga una muerte natural en paz y con dignidad. Dicha orden NO afecta la provisión de ningún otro tipo de atención de emergencia, incluida la atención para la comodidad de la persona.
APLICABILIDAD: la orden de OOH DNR se aplica a los profesionales de salud en entornos fuera del hospital, incluidos los consultorios médicos, las clínicas de hospital y los departamentos de emergencias.
IMPLEMENTACIÓN: la persona adulta competente, de al menos 18 años de edad, o el representante autorizado o un pariente calificado de dicha persona puede ejecutar o dictar la orden de OOH DNR. El médico tratante de la persona documentará la existencia de la orden en el expediente médico permanente de la persona. La orden de OOH DNR puede ejecutarse de la siguiente forma:
Sección A -si la persona adulta es competente y tiene al menos 18 años de edad, esta firmará y fechará la orden en la Sección A.
Sección B -si la persona adulta es incapaz o de alguna otra forma mental o físicamente incapaz de comunicarse y tiene ya sea un tutor legal, un agente con carta poder médica o un apoderado con instrucciones a médicos, el tutor, el agente o el apoderado puede ejecutar la orden de OOH DNR firmando y fechándola en la Sección B.
Sección C -si la persona adulta es incapaz o de alguna otra forma mental o físicamente incapaz de comunicarse y no tiene un tutor, un agente o un apoderado, entonces un pariente calificado puede ejecutar la orden de OOH DNR firmando y fechándola en la Sección C.
Sección D -si la persona es incapaz y su médico tratante ha visto pruebas de las debidas instrucciones previamente dadas a los médicos de la persona u observó que la persona dictó de forma competente una orden de OOH DNR no escrita, el médico puede ejecutar la orden a nombre de la persona firmando y fechándola en la Sección D.
Sección E -si la persona es un **menor** (que tiene menos de 18 años de edad), **a quien un médico ha diagnosticado sufre una enfermedad terminal o irreversible**, entonces los padres, el tutor legal o el custodio administrador del menor pueden ejecutar la orden de OOH DNR firmando y fechándola en la Sección E.
Sección F -si la persona adulta es incapaz o de alguna otra forma mental o físicamente incapaz de comunicarse y no tiene un tutor, un agente, un apoderado o un pariente calificado disponible que actúe en su representación, entonces el médico tratante puede ejecutar la orden de OOH DNR firmando y fechándola en la Sección F con la coincidencia de un segundo médico (que la firme en la Sección F) que no participe en el tratamiento de la persona o no sea representante del comité de ética o médico del complejo de salud en el que la persona es un paciente.
Además, deben firmar y fechar la orden de OOH DNR dos testigos adultos competentes, quienes han atestiguado ya sea que la persona adulta competente pone su firma en la Sección A o el declarante autorizado pone su firma en ya sea la Sección B, C o E y, de ser aplicable, han atestiguado que la persona adulta competente hizo la orden de OOH DNR mediante comunicación no escrita al médico tratante, quien debe firmar en la Sección D y también la sección de la declaración del médico. Optativamente, la persona adulta competente o el declarante autorizado puede firmar la orden de OOH DNR en presencia de un notario público. Sin embargo, un notario no puede dar fe de haber atestiguado que se dictó una orden de OOH DNR no escrita, la cual deben observar y sobre la cual sólo pueden dar fe dos testigos calificados.
No se requiere la firma del testigo o el notario cuando dos médicos ejecutan la Sección F de la orden de OOH DNR. El original o una copia de la orden de OOH DNR completa y debidamente rellenada o que la persona porte un dispositivo de OOH DNR es prueba suficiente de la existencia de la orden de OOH DNR original y los profesionales de salud de respuesta cumplirán una o la otra.

REVOCACIÓN: la persona, el representante autorizado de la persona o el médico que ejecutó la orden de OOH DNR puede revocarla en CUALQUIER momento. La revocación puede ser mediante comunicación verbal con los profesionales de salud de respuesta, la destrucción de la orden de OOH DNR o la remoción de todos los dispositivos de identificación de OOH DNR de la persona.
REVOCACIÓN AUTOMÁTICA: la orden de OOH DNR se revoca automáticamente si se sabe que la persona está embarazada o en caso de circunstancias no naturales o sospechosas.

DEFINICIONES

Médico tratante: el médico, seleccionado por o asignado a la persona, con la responsabilidad primaria del tratamiento y la atención de la persona que tiene licencia de la Junta Médica de Texas, o tiene las credenciales debidas y lleva el grado de oficial de los servicios uniformados de los Estados Unidos y está en servicio activo en este estado. [HSC, §166.002(12)].
Profesional de salud: significa los médicos, las enfermeras, los asociados médicos y el personal de servicios médicos de emergencia, y, a menos que el contexto exija lo contrario, incluye al personal del departamento de emergencias del hospital. [HSC, §166.081(5)]
Pariente calificado: la persona que cumple los requisitos del HSC, §166.088. Este establece que un pariente adulto puede ejecutar la orden de OOH DNR en nombre de la persona adulta que no ha ejecutado ni dictado una orden de OOH DNR y es incapaz o de alguna otra forma mental o físicamente incapaz de comunicarse y no tiene tutor legal, agente con carta poder médica o apoderado con instrucciones a médicos, y el pariente está disponible según una de las siguientes categorías por orden de prioridad: 1) el cónyuge de la persona; 2) los hijos adultos de la persona que estén razonablemente disponibles; 3) los padres de la persona o 4) el pariente más cercano de la persona. Dicho pariente calificado puede ejecutar la orden de OOH DNR en nombre de tal persona descrita.
Testigos calificados: ambos testigos deben ser adultos competentes, quienes han atestiguado que la persona adulta competente puso su firma en la Sección A, o que el representante autorizado de la persona puso su firma ya sea en la Sección B, C o E de la orden de OOH DNR, o, de ser aplicable, han atestiguado que la persona adulta competente hizo una orden de OOH DNR mediante comunicación no escrita al médico tratante, quien firmó en la Sección D. Optativamente, la persona adulta competente, el tutor, el agente, el apoderado o el pariente calificado puede firmar la orden de OOH DNR en presencia de un notario en vez de dos testigos calificados. No se requiere la firma del testigo o el notario cuando dos médicos ejecutan la orden firmando la Sección F. Uno de los testigos debe cumplir los requisitos del HSC, §166.003(2), el cual exige que al menos uno de los testigos: (1) no sea designado por la persona para tomar decisiones sobre el tratamiento; (2) no sea pariente de la persona por consanguinidad o afinidad; (3) no tenga derecho a ninguna parte del patrimonio de la persona después de muerta la persona ya sea por testamento o por ley; (4) no tenga derecho al momento de dictarse la orden de OOH DNR a ninguna parte del patrimonio de la persona después de muerta la persona (5) o no sea el médico tratante; (6) no sea empleado del médico tratante o (7) empleado del complejo de salud en el que la persona es un paciente si el empleado le provee atención directa al paciente o si es ejecutivo, director, socio o empleado de la oficina de facturación del complejo de salud o alguna organización matriz del complejo de salud.
Informe de problemas con este formulario al Departamento Estatal de Servicios de Salud de Texas (o DSHS) o pida formularios de la orden de OOH DNR o dispositivos de identificación al teléfono (512) 834-6700.

La firma electrónica o digital del declarante, el testigo, el notario o el médico debe cumplir los criterios resumidos en el HSC, §166.011

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Elección del beneficio de hospicio /Consentimiento informado

Bristol Hospice®
EMBRACING A REVERENCE FOR LIFE®

NOMBRE COMPLETO DEL PACIENTE	FECHA DE NACIMIENTO	R.M.

Consentimiento para tratar

Yo doy mi consentimiento y elijo recibir atención de hospicio, tratamiento y los servicios del personal de Bristol Hospice. Entiendo y acepto que los servicios de hospicio tienen naturaleza paliativa y no curativa. El enfoque de mi plan de atención de Bristol Hospice será proporcionarme con tratamiento y servicios para el manejo de síntomas y para facilitar comodidad y apoyo para mi enfermedad terminal. El equipo de hospicio trabajará de cerca conmigo y con mi médico primario para diseñar e implementar el plan de atención de hospicio. Entiendo que Bristol Hospice será económicamente responsable solo por aquellos servicios que están incluidos en su plan de atención. Entiendo que seré responsable por las facturas o cargos en los que incurro por tratamientos o servicios con un médico o instalaciones que no están bajo contrato con Bristol Hospice y/o no hayan sido previamente aprobados por Bristol Hospice.

Entiendo que tengo el derecho de elegir a mi médico primario. Elijo a:

NOMBRE COMPLETO DEL MÉDICO

Elección de Medicare

Yo, _____ he sido informado que Bristol Hospice ofrece atención de hospicio bajo el programa de beneficio de hospicio de Medicare a pacientes con una enfermedad terminal.
Entiendo que lo siguiente es una explicación del beneficio de hospicio de Medicare:

1. *Bristol Hospice recibirá pago por mi atención, relacionada con mi enfermedad terminal.*
   a. Entiendo cual es el propósito de la atención de hospicio y que el tratamiento tiene naturaleza paliativa en vez de curativa.
   b. Medicare continuará realizando pagos a mi médico primario independiente por los servicios si mi médico no es un empleado del hospicio o no está recibiendo pagos de parte de Bristol Hospice.
   c. Renuncio a mis derechos a los beneficios de Medicare relacionados con mi enfermedad terminal mientras que estoy inscrito en el programa de hospicio de Medicare.
   d. Yo soy responsable por el costo de la atención por mi enfermedad terminal si busco atención más allá de lo que el equipo interdisciplinario del hospicio considere médicamente necesario y de lo que está documentado en mi plan de atención.
2. Puedo cambiar el hospicio por otro hospicio, si así lo deseo. Para cambiar programas, confirmaré que puedo ser admitido a otro hospicio y luego informaré a Bristol Hospice de mis deseos, para que se puedan realizar los arreglos para el traslado. Especificaré la fecha para discontinuar la atención que recibo de Bristol Hospice, el nombre del hospicio que me estará proporcionando atención y la fecha en la que iniciará dicha atención. Al cambiar a otro programa de hospicio no perderé días de beneficio. Puedo cambiar de hospicio solo una vez durante cada periodo de beneficio.
3. El programa de hospicio de Medicare consiste de dos periodos de 90 días y periodos de 60 días ilimitados, de no haber revocaciones o altas. Usaré los periodos de beneficio en el orden arriba mencionado.
4. Podré discontinuar la atención de hospicio en cualquier momento al completar la declaración de revocación. Si revoco durante un periodo de beneficio, perderé los días restantes en dicho periodo de beneficio. (Ejemplo: Revoco la atención de hospicio el décimo día del primer periodo de 90 días, renuncio a los 80 días restantes de cobertura.) Sin embargo, puedo reelegir la atención en cualquier momento cuando sea elegible.
5. La atención de hospicio podrá involucrar atención de enfermería especializada, voluntarios, atención emocional y espiritual, terapia física y otras, trabajadores sociales, atención para pacientes internados y atención de relevo.
6. Toda la atención es dirigida por un médico mediante mi médico primario independiente y el Director Médico o Bristol Hospice.

Al aceptar y entender lo anterior, yo autorizo los servicios de hospicio de Medicare de parte de Bristol Hospice.

Fecha de elección para el inicio de la atención de hospicio: _____

Nombre	**No. de R.M.**	Iniciales del paciente o representante	

Elección del beneficio de hospicio /Consentimiento informado

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Proveedor de atención principal

❑ He identificado a _____ como mi proveedor de atención principal. La persona indicada será responsable y disponible para ser contactada y proporcionar asistencia con mis cuidados cuando yo ya no pueda asumir esta responsabilidad de forma segura. Entiendo que Bristol Hospice no puede asumir el rol del proveedor de atención principal.

❑ No elijo a un proveedor de atención principal en este momento. Entiendo que los servicios de hospicio no tienen la intención de reemplazar al proveedor de atención principal. Cuando sea necesario, acepto trabajar con Bristol Hospice para desarrollar un plan seguro para cumplir con mis necesidades de atención. Si no puedo desarrollar un plan y Bristol Hospice determina que mi situación no es segura, acepto que podré recibir el alta de los servicios de hospicio.

Consentimiento para fotografías

Doy permiso a Bristol Hospice para tomar fotografías para el propósito de la atención médica y tratamiento, de ser necesario. Entiendo que las fotografías tomadas serán parte de mi registro médico, liberación de las cuales se realizará de acuerdo a la Notificación de Prácticas de Privacidad aplicable y los reglamentos y leyes que regulan los registros médicos.

Autorización

Autorizo la libración de toda la información médica solicitada por Bristol Hospice.
Dicha información podrá incluir, sin limitación, a los siguientes:

- Historial y exámenes físicos
- Notas de avance
- Resumen de alta
- Registro de tratamiento
- Consultas
- Registros del departamento de emergencias
- Cualquier registro diagnóstico, incluyendo, pero sin limitarse a:
  - Reportes de laboratorio - Reportes de radiología - Reportes de patología - Reportes operativos

Toda la información es obtenida para facilitar la atención y servicios por parte de Bristol Hospice mientras que el paciente está bajo cuidados de Bristol Hospice. Mi autorización permanece vigente para el tiempo durante el cual estoy recibiendo los servicios de Bristol Hospice.

Seguro médico/Asignación de beneficios/Responsabilidad de pago

Como paciente de Seguro Comercial, elijo recibir atención bajo los beneficios estipulados en mi plan de seguro.

MARQUE LA FUENTE DE PAGO ADECUADA:
❑ MEDICARE ❑ Medicaid ❑ BCBS ❑ UNITED HEALTHCARE ❑ VA ❑ Otra:_____
❑ Managed Care:_____

Certifico que toda la información proporcionada a la organización por mi persona es correcta para solicitar y aplicar el pago bajo el Título XVIII (Medicare), Título XIX (Medicaid), de la Ley de Seguro Socialy/o cualquier otra tercera parte.
Entiendo y acepto pagar deducibles, copagos, responsabilidades económicas en cualquier cantidad pagaderas después del pago de Beneficios en mi nombre por cualquier pagador tercero..

Seré responsable por el _____% de cargos de los servicios de hospicio.

Mediante la presente autorizo a cualquier aseguradora u otra organización de la cual tengo derecho a recibir pago por los servicios de hospicio a realizar el pago de dichos servicios directamente a Bristol Hospice. Acepto liberar la información médica a mi compañía de seguro médico.

NOMBRE DE PACIENTE COMO APARECE
EN LAS TARJETAS DE SEGURO:

SEGURO PRINCIPAL/NO. SEGURO SECUNDARIO/NO.

Nombre	No. de R.M.	Iniciales del paciente o representante	

Elección del beneficio de hospicio /Consentimiento informado

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Mi firma en este formulario certifica que he recibido una explicación completa de los servicios ofrecidos por Bristol Hospice. He recibido, revisado y obtenido respuestas a mis preguntas con satisfacción sobre los siguientes (favor de colocar iniciales):

_____ Recibo del Manual de paciente
_____ Beneficio de hospicio de Medicare
_____ Educación de control de infecciones
_____ Política de desecho de medicamentos
_____ Notificación de derechos y responsabilidades
_____ Lista de instalaciones contratadas para servicios especiales
_____ Educación de seguridad básica
_____ Notificación de las prácticas de privacidad / HIPAA
_____ Proceso de resolución de quejas o inquietudes
_____ Plan de urgencia en caso de desastres Reglamentos
_____ Instrucciones anticipadas sobre la atención médica

He ejecutado un Poder durable para la atención médica. ❑ Sí ❑ No
De no tener un Poder durable para la atención médica, ¿le gustaría recibir información al respecto? ❑ Sí ❑ No

Estos documentos están guardados en (describe el sitio) _____, copias de los cuales podrán estar incluidas en mis registros de hospicio.

Mi Poder durable para la atención médica es:_____ Teléfono:_____

Al aceptar y entender lo anterior, elijo iniciar mi beneficio de hospicio de Medicare, Medicaid u otro el día de _____ _____ (Fecha efectiva).

PACIENTE (ESCRIBIR)	FECHA
FIRMA DEL PACIENTE/REPRESENTANTE DEL PACIENTE	FECHA
RELACIÓN SI EL PACIENTE NO PUEDE FIRMAR	RAZÓN POR QUÉ EL PACIENTE NO PUEDE FIRMAR
REPRESENTANTE DE BRISTOL HOSPICE	FECHA

Nombre	**No. de R.M.**	Iniciales del paciente o representante	

Preguntas y respuestas: Cuando una persona deja de comer o beber

Cuando la enfermedad de una persona la está llevando hacia el final de la vida, esta puede perder interés en comer o beber, o dejar de comer o beber por completo. Este cambio puede ser muy difícil para los seres queridos.

1) **¿Sufrirá mi ser querido de hambre y deshidratación?** Por lo general, no. La necesidad de comida y agua es muy diferente para alguien que está muriendo que para una persona saludable. Llegan a un punto en que su cuerpo ya no puede procesar los nutrientes y ya no siente hambre o sed. Con frecuencia, se sienten mucho mejor sin comida y sin agua.

2) **¿Estamos abandonando su bienestar al no forzar que coman y beban?** No. Hay otras formas de ayudar a que se sientan más cómodos. Un buen cuidado bucal y un entorno agradable y amoroso pueden hacer mucho más por su sentido de bienestar.

3) **Si se niegan a comer y beber un día, ¿debería dejar de ofrecerlos?** Si todavía pueden tragar, se les debe seguir ofreciendo agua y comida, pero sin obligarlos.

4) **¿Cuánto tarda una persona en morir sin alimentarse?** Depende de la persona, pero sin agua es posible que una persona solo dure unos pocos días, tal vez una semana. Con agua, pero sin comida, pueden durar más, tal vez unas pocas semanas.

5) **¿Deberíamos colocarle un tubo de alimentación?** Por lo general, no para una persona que está llegando al final de su vida. El tubo de alimentación no proporcionará la misma satisfacción que la comida. También aumenta los riesgos, tales como dolor estomacal, distensión abdominal, dificultades para respirar, infección y sacarse el tubo accidentalmente.

Para ayuda e información adicional, por favor pregunte a su enfermera encargada del caso. Usted también puede solicitar la visita de un dietista registrado.

Bristol Hospice
embracing a reverence for life
CALIFORNIA

We Honor Veterans

CHAP

¿Cómo podemos ayudar?

209-384-1415

bristolhospice-california.com

Bristol Hospice Miami-Dade
November 5 ·

Bereavement support services are available at Bristol Hospice Miami-Dade. The grief support group at the present time is once a month. For individual grief counseling our Bereavement/Volunteer Coordinator, Mr. Arlex Cardona, is available in the office. Please reach out to us at (786) 382-0433 or at bristolhospice-miami.com



Exhibit 11

CHARITY CARE
Policy No. 5-017

PURPOSE

To identify the criteria to be applied when accepting patients for charity care.

POLICY

Patients without third-party payer coverage and who are unable to pay for medically necessary care will be accepted for charity care admission, per established criteria.

The hospice will establish objective criteria and financial screening procedures for determining eligibility for charity care.

The hospice will consistently apply the charity care policy.

PROCEDURE

1. When it is identified that the patient has no source for payment of services and requires medically necessary care/service, the patient must provide personal financial information upon which the determination of charity care will be made.

2. A social worker, as available, will meet with the patient to determine potential eligibility for financial assistance from other community resources.

3. The Executive Director/Administrator will review all applicable patient information, including financial declarations, physician (or other authorized licensed independent practitioner) orders, initial assessment information, and social work notes to determine acceptance for charity care.

4. All documentation utilized in the determination for acceptance for charity care will be maintained in the patient's billing record.

5. When financial declarations reveal the patient is able to make partial payment for services, the Executive Director/Administrator will determine the sliding-fee schedule to be implemented.

6. The revised sliding-fee schedule will be presented to the patient for agreement and signature.

7. After acceptance for charity care, the patient's ability to pay will be reassessed every 60–90 days.

8. When the hospice is unable to admit the patient or to continue charity care, every effort will be made to refer the patient for appropriate care/service with an alternate provider.

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9. The referral source will be advised of acceptance, non-acceptance, continuation, or discharge from charity care.

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ADVANCE DIRECTIVES
Policy No. 9-007

PURPOSE

To support the implementation of the Patient Self-Determination Act within the framework of state and federal law and hospice policies.

POLICY

The hospice recognizes that all adult persons have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. It is the policy of the hospice to encourage individuals and their family/caregivers to participate in decisions regarding care, treatment, and services. Valid Advance Directives, such as living wills, Durable Powers of Attorney, and DNR (Do Not Resuscitate) or DNI (Do Not Intubate) orders will be followed to the extent permitted and required by law. In the absence of Advance Directives, the hospice will provide appropriate care according to the plan of care/service or as authorized by the attending physician. The hospice will not determine the provision of care/service or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive.

Definitions

1. *Adult:* A person 18 years or older, or a person legally capable of consenting to his/her own medical treatment.
2. *Advance Directives:* A document in which a person states choice for medical treatment.
3. *Attending Physician:* The physician who is primarily responsible for the medical care of a patient while receiving home care services.
4. *DNR (Do Not Resuscitate):* A medical order to refrain from cardiopulmonary resuscitation if the patient's heart stops beating.
5. *DNI (Do Not Intubate):* A medical order to refrain from inserting life-sustaining breathing and/or feeding tubes, if the need arises.
6. *Patient Self Determination Act:* A federal statute enacted as part of the 1990 Omnibus Budget Reconciliation Act (OBRA) (PL 101-508) which requires, among other things, that health care facilities provide information regarding the right to formulate Advance Directives concerning health care decisions.
7. *Patient Representative:* A person appointed to make decisions for someone else. He/she may be formally appointed (as in a durable power of attorney for health care) or, in the absence of a formal appointment, may be recognized by virtue of a relationship with the patient (such as the patient's next of kin or close family/caregiver).

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8. *Terminal Condition*: An incurable condition caused by an injury, disease, or illness, which regardless of the application of life-sustaining procedures, would within reasonable medical judgment produce death, and where the application of life-sustaining procedures only postpones the moment of death of the patient.

9. *POLST/MOLST*: Physician (Medical) Orders for Life-Sustaining Treatment is a physician order that helps give seriously ill patients more control over their end-of-life care. It does not replace an Advance Directive. There are a number of states which have established a POLST/MOLST program. Visit www.polst.org.

PROCEDURE

1. Upon admission, the clinician will provide information regarding a patient's right to make decisions concerning health care, which include the right to accept or refuse medical or surgical treatment, even if that treatment is life-sustaining, the right to execute Advance Directives, and applicable hospice policies. Written information designed for this purpose will be provided to the adult patient. The clinician will document in the clinical/service record that the information was provided and document all discussions concerning Advance Directives.

2. If the patient lacks a decision-making capacity, the admitting clinician will provide information and direct inquiry about Advance Directives to the patient's representative. The clinician will document that the patient representative received information and his/her name and responses will be noted in the clinical record.

3. If conditions are such that it is not practical to provide information to the patient or his/her representative at the time of admission, such information will be provided as soon as feasible after admission.

4. During the admission/evaluation visit, the admitting clinician will ask the patient or his/her representative whether or not he/she has completed an Advance Directive, Durable Power of Attorney (DPOA), living will, or DNR/DNI order. If an Advance Directive has been completed, the clinician will ask for a copy of the Advance Directive so it will be placed in the clinical/service record. If a copy is not immediately available, the patient will be informed that it is his/her responsibility to provide a copy of the Advance Directive to the hospice as soon as possible.

   A. Verify that the photocopy is an exact copy of the original and mark the top of the copy ("Copy From Original"). Document in the clinical/service record the date of the request and to whom the request was given.

   B. On the last page of the document, indicate "Provided By" and record the name of the person who is presenting the document to you. Document in the clinical/service record the date of the request and to whom the request was given.

   C. Indicate "Received By" and sign and date the document. Document in the clinical/service record the date of the request and to whom the request was given.

5. If a copy of the patient's Advance Directive is not available to the hospice, the clinician will discuss the contents of the Advance Directive with the patient and/or patient representative

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and document the contents of the Advance Directive in the clinical/service record and communicate the contents to other home care providers.

6. When applicable, the admitting clinician will document on the clinical/service record and notify the attending physician verbally if the patient has executed an Advance Directive.

7. The patient will be encouraged to participate in all aspects of decision-making regarding home care and treatment. Statements by a competent patient of his/her desire to accept or refuse treatment will be documented in the patient's clinical record.

8. All clinicians/technicians providing care/service for the patient will:

   A. Review the Advance Directive and report any discrepancies between the Directive and current treatment/service plan to the attending physician, Program Director, and the patient

   B. Utilize available educational materials to answer the patient's questions about Advance Directives, durable power of attorney, or living wills

   C. Encourage the patient to discuss questions and concerns with appropriate individuals such as the physician, family/caregiver, and his/her selected advocate

   D. Assist the patient who wants to develop an Advance Directive by obtaining a form and providing access to the outside individuals as necessary to execute the directive

9. An Advance Directive will be implemented as follows:

   A. The Durable Power of Attorney for an Advance Directive is effective *only* when the patient is unable to participate in his/her own medical treatment decisions.

   B. The attending physician and another physician or a licensed psychologist must document in the patient's clinical record that the patient is unable to participate in medical treatment decisions.

   C. The patient's designated advocate can then make medical treatment choices based on the Advance Directive. The patient advocate may make a decision to withhold or withdraw treatment that allows the patient to die. This is done *only* if the patient expressed, in a clear and convincing manner, that the advocate is authorized to make such a decision and acknowledges that such a decision would or could allow the patient's death.

   D. Executing and implementing an Advance Directive is a process, not a one (1)-time event. On an ongoing basis, personnel will keep the patient, family/caregiver, and patient's representative up to date concerning the patient's medical condition. They will discuss the patient's preferred course of treatment as his/her condition changes. The discussions will be documented in the clinical/service record.

10. Educational information about Advance Directives and the hospice's policies and procedures regarding Advance Directives will be provided to the medical, nursing, and allied health professionals, as well as home care personnel and volunteers during the orientation period.

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11. In order to educate the community about Advance Directives, the hospice will participate in community forums, as appropriate, and make written materials available regarding Advance Directives.

12. If the state and/or region has endorsed the use of POLST/MOLST, the hospice will utilize the state and regional specific forms and guidelines. (For more information: www.ohsu.edu/polst.)

13. The hospice will update and disseminate changes to state law on advance directives no later than ninety (90) days from the effective date.

14. If the hospice cannot implement an advance directive based on conscience, it has a clear statement of any limitations. The statement includes:

    A. Clarification of any differences between organization-wide conscience objections and those raised by an individual physician;

    B. Identification of the state legal authority permitting such objection;

    C. A description of the range of medical conditions or procedures affected by conscience objection.

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BILL OF RIGHTS (WASHINGTON)

Policy No. 9-005

PURPOSE

To encourage awareness of patient rights and provide guidelines to assist patients in making decisions regarding care and for active participation in care planning.

POLICY

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights and responsibilities as described. A patient, who has not been judged to lack legal capacity, may designate someone (surrogate decision maker), to act as his/her representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the hospice.

If the patient has been judged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction:

1. The rights of the patient may be exercised by the person appointed by the state court to act on the patient's behalf, OR

2. The patient may exercise his or her rights or designate a legal representative to exercise his or her rights to the extent allowed by court order

3. The hospice will inform the patient/caregiver of the Washington DSHS end harm hotline number (1-866-ENDHARM) 1-866-363-4276 to report suspected abuse of children or vulnerable adults.

4. The hospice will inform the patient/caregiver of the Washington Department of Health complainant hotline number (1-800-562-6078) to report complaints about the licensed agency or credentialed health care professionals.

To assist with fully understanding patient rights, all policies will be available to the hospice personnel, patients, and his/her representatives as well as other hospices and the interested public. The hospice will ensure implementation and updating as appropriate.

PROCEDURE

1. The Bill of Rights statement defines the right of the patient to:

   A. Have his or her property and person treated with consideration, respect, dignity and individuality, including privacy for treatment and personal care needs.

   B. Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on

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behalf of the hospice and must not be subjected to discrimination or reprisal for doing so.

C. Receive effective pain management and symptom control and quality services from the hospice for conditions related to the terminal illness identified in the plan of care.

D. Be advised in advance of the right to participate in planning the care or service and in planning changes in the care and service; hospice patients have the right to refuse care or treatment.

E. Be involved in the ongoing development his or her hospice plan of care.

F. Choose his or her attending physician.

G. A statement advising of the right to have access to the state department listing of licensed hospice agencies and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations.

H. A listing of the total services offered by the hospice agency and those being provided to the patient.

I. The name of the individual within the hospice agency responsible for supervising the patient's care and the manner in which that individual may be contacted.

J. Have a confidential personal and clinical record maintained by the hospice. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.

K. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries from unknown source, misappropriation of patient property and corporal punishment.

L. Access to care/service is based upon nondiscrimination.

M. Have communication needs met.

N. Receive information about the services covered under the hospice benefit.

O. Receive information about the scope of services that the hospice will provide and by what discipline and specific limitations on those services.

P. Be advised that the hospice complies with Subpart 1 of 42 CFR 489 and receive a copy of the hospice's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law and how such rights are implemented by the hospice.

Q. Use the hotlines to lodge complaints concerning the implementation of Advance Directive requirements.

R. Receive written information describing the hospice's grievance procedure which includes the contact information, contact phone number, hours of operation, and mechanism(s) for communication problems.

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S. The program shall describe in writing patient and family responsibilities and the mechanism to file a grievance and obtain a receipt that the information has been received by the patient or family.

T. Receive an investigation by the hospice of complaints made by the patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the hospice; and that the hospice will document the existence of the complaint and the resolution of the complaint.

U. Receive information addressing any beneficial relationship between the hospice and referring entities.

V. Be informed verbally and in writing of any changes in payment information, including charges for services not covered under Titles XVIII or XIX of the Social Security Act, as soon as possible, but no later than 30 days from the date that the hospice becomes aware of the change.

W. Be informed, verbally and in writing, of billing and reimbursement methodologies prior to the start of care/service and as changes occur, including fees for services/products provided, direct pay responsibilities, and notification of insurance coverage.

X. Right to a fully itemized billing statement upon request, including the date of each service and the charge. Agencies providing services through a managed care plan are not required to provide itemized billing statements.

Y. Be informed of what the hospice agency charges for services, to what extent payment may be expected from health insurance, public programs, or other sources, and what charges the patient may be responsible for paying.

Z. Be informed of the department's complaint hotline number to report complaints about the licensed agency or credentialed health care professionals and be informed of the DSHS end harm hotline number to report suspected abuse of children or venerable adults.

AA. A description of the agency's process for patients and family to submit complaints to the hospice agency about the services and care they are receiving and to have those complaints addressed without retaliation.

BB. Be cared for by appropriately trained or credentialed personnel, contractors and volunteers with coordination of services.

CC. To be treated with courtesy, respect, and privacy.

DD. Be free from verbal, mental, sexual, fand physical abuse, neglect, exploitation, discrimination, and the unlawful use of restraint or seclusion.

EE. Have property treated with respect.

FF. Have privacy and confidentiality of personal information and health care related records.

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GG. Be informed about advanced directives ad POLST and the agency's scope of responsibility

HH. Be informed of the agency's policies and procedures regarding the circumstances that ay cause the agency to discharge a patient

II. Be informed of the agency's policies and procedures regarding providing backup care when services cannot be provided as scheduled.

2. The patient and family/caregiver responsibilities will be explained upon admission and as needed. The patient and family/caregiver are responsible for:

   A. Being fully informed by a physician of his or her medical condition, unless medically contraindicated and to be afforded the opportunity to participate in the planning of his or her medical treatment, including pain and symptom management and to refuse to participate in experimental research.

   B. Cooperating with the primary doctor, program staff and other caregivers.

   C. Advising the program of any problems or dissatisfaction with patient care.

   D. Inform the hospice of any advance directives or any changes to advance directives and provide the hospice with a copy.

   E. Notifying the program of address or telephone changes or when unable to keep appointments.

   F. Providing a safe environment in which care can be given. In the event that conduct occurs such that the patient's or staff's welfare or safety is threatened, service may be terminated.

   G. Obtaining medications, supplies and equipment ordered by the patient's physician if they cannot be obtained or supplied by the program.

   H. Reporting unexpected changes in the patient's condition.

   I. Understanding and accepting the consequences for outcomes if the care, services and/or treatment plan are not followed.

   J. Treat hospice personnel with respect and consideration

   K. Sign required consent and release forms for insurance billing and provide insurance and financial records as requested.

3. Upon admission, the admitting clinician will provide each patient or his/her representative with a written copy of the Bill of Rights.

4. The Bill of Rights statement will be explained and distributed to the patient prior to the initiation of hospice services. This explanation will be in a language or communication method he/she can reasonably be expected to understand.

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5. The patient will be requested to sign the Bill of Rights form. The original form will be kept in the patient's clinical record. A copy will be maintained by the patient. The patient's refusal to sign will be documented in the clinical record, including the reason for refusal.

6. The admitting clinician will document that the patient has received a copy of the Bill of Rights.

   A. If the patient is unable to understand his/her rights and responsibilities, documentation in the clinical note will be made.

   B. In the event a communication barrier exists, if possible, special devices or interpreters will be made available.

   C. Written information will be provided to patients in English and predominant non-English languages of the population served.

7. When the patient's representative signs the Bill of Rights form, an explanation of that relationship must be documented and kept on file in the clinical record.

8. The family or guardian may exercise the patient's rights when a patient is incompetent or a minor.

9. All hospice personnel, both clinical and non-clinical, will be oriented to the patient's rights and responsibilities prior to the end of their orientation program, as well as annually.

10. The hospice will ensure that the patient rights are implemented and updated as appropriate.

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EQUAL OPPORTUNITY EMPLOYER
Washington Policy No. 1-003-HR

PURPOSE

To assure that all persons have equal employment opportunity.

POLICY

In accordance with Title VI of the Civil Rights Act of 1964 and its implementing regulation, Bristol Hospice – Pierce, L.L.C. is an EQUAL OPPORTUNITY EMPLOYER and WILL NOT DISCRIMINATE AGAINST RACE, COLOR, RELIGION, AGE, GENDER, SEXUAL ORIENTATION, DISABILITY (MENTAL OR PHYSICAL), COMMUNICABLE DISEASE, OR PLACE OF NATIONAL ORIGIN AS DEFINED IN SECTION 504 OF TITLE VI.

In accordance with Section 504 of the Rehabilitation Act of 1973 and its implementing regulation, Bristol Hospice – Pierce, L.L.C. *WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF DISABILITY.*

In accordance with the Age Discrimination Act of 1975 and its implementing regulation, Bristol Hospice – Pierce, L.L.C. *WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF AGE* in the provision of services, unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

In accordance with the Americans with Disabilities Act of 1992 (42 USC §12101) and its implementing regulations, (private employers with more than 25 hospice personnel), Bristol Hospice – Pierce, L.L.C. *WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF DISABILITY.* A disability is a physical or mental impairment that substantially limits a major life activity, or for which there is a record of impairment or which causes the individual to be regarded as impaired.

In accordance with the Genetic Information Nondiscrimination Act (GINA), the hospice *WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF GENETIC INFORMATION.*

In accordance with the Vietnam Era Veterans' Readjustment Assistance Act (VEVRAA), the hospice *WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF VETERAN STATUS.*

Note: All statutes include provisions regarding retaliation.

Bristol Hospice – Pierce, L.L.C. operates in alignment with employment criteria regarding discrimination consistent with chapter 49.60 RCW-Washington.

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PROCEDURE

1. All employees will receive information regarding nondiscrimination in the workplace during new employee orientation.

2. The hospice will inform the employee of his or her rights protecting employees affected by domestic violence (including sexual assault and stalking), by providing the information in writing to new employees during orientation and to other employees upon request.

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ADMISSION CRITERIA AND PROCESS
Policy No. H:2-024.1

PURPOSE

To establish standards and a process by which a patient can be evaluated and accepted for admission.

POLICY

Bristol Hospice - Pierce, L.L.C. will admit any patient with a life-limiting illness that meets the admission criteria.

Patients will be accepted for care without discrimination on the basis of race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

Patients will be accepted for care based on need for hospice services. Consideration will be given to the adequacy and suitability of hospice personnel, resources to provide the required services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence.

The patient's life-limiting illness and prognosis of six (6) months or less will be determined by utilizing standard clinical prognosis criteria developed by the fiscal intermediary's Local Coverage Determinations (LCDs).

Bristol Hospice - Pierce, L.L.C. reserves the right not to accept any patient who does not meet the admission criteria.

A patient will be referred to other resources if Bristol Hospice - Pierce, L.L.C. cannot meet his/ her needs.

Once a patient is admitted to service, the organization will be responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations.

The hospice registered nurse will contact at least one (1) other member of the interdisciplinary group for input into the plan of care, prior to the delivery of care. The two (2) remaining core services must be contacted and provide input into the plan of care within two (2) days of start of care; this may be in person or by phone.

If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than 5 calendar days after the election of hospice care. A plan of care will be developed by the attending hospice physician, the Medical Director or physician designee, and the hospice team. It will then be submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care. (See "Comprehensive Assessment" Policy No. H:2-046.)

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Exhibit 12

	2023	2024	2025	Assumptions
Admissions	110	158	205	Admissions from our projection provided in Exhibit 7
ADC	19	27	35	Patient days divided by 365 days (a full year)
Patient Days	6833	9815	12735	Admissions multiplied by an average length of stay of 62.12 days per the washington state need study.
Avg. Daily Rate	$197	$197	$197	This is the average 2021 daily rate of the current providers in Pierce County back up is in tab two of Exhibit 7
Revenue	**$1,346,140.40**	**$1,933,547.12**	**$2,508,716.20**	
Medicare, Medicare HMO	$ 1,319,217.59	$ 1,894,876.18	$ 2,458,541.88	Assumed this as 98% of revenue
Medicaid	$ 13,461.40	$ 19,335.47	$ 25,087.16	Assumed this as 1% of revenue
Third Party Insurance	$ 13,461.40	$ 19,335.47	$ 25,087.16	Assumed this as 1% of revenue
Total Revenue	**$ 1,346,140.40**	**$ 1,933,547.12**	**$2,508,716.20**	
Deductions From Revenue				
Charity Care	$ 26,922.81	$ 38,670.94	$ 50,174.32	Assumed this as 2% of revenue
Net Room and Board Expense	$ 13,461.40	$ 19,335.47	$ 25,087.16	Assumed that 20% of our revenue will come from Room and Board and of that we will loose 5% to make the Skilled Nursing Facility whole (see additional notes on this below)
Bed Debt	$ 13,461.40	$ 19,335.47	$ 25,087.16	Assumed this as 1% of revenue
Net revenue	**$ 1,292,294.78**	**$ 1,856,205.24**	**$2,408,367.55**	
Expenses				
Advertising	$ 5,000.00	$ 7,000.00	$ 10,000.00	Assumed $5,000 in 2022, $7,000 in 2023 and $10,000 in 20
B & O Taxes	$ 20,192.11	$ 29,003.21	$ 37,630.74	Assumed 1.5% of Revenue
Depreciation and Amortization	$ 10,000.00	$ 10,000.00	$ 10,000.00	Based off a 36 month flat line depreciate for $30,000 of capital expense
Dues and Subscriptions	$ 4,000.00	$ 4,000.00	$ 4,000.00	Assumed to be 4,000 per year
Education and Training	$ 1,500.00	$ 1,500.00	$ 1,500.00	As part of the corporate overhead allocation the staff will have access to Relias an online training system, this additional amount of 1,500 year is for local in-services
Employee Benefits	$ 57,561.44	$ 85,216.00	$ 101,479.28	Assumed to be 11% of wages
Equipment Rental (DME)	$ 44,415.80	$ 63,797.24	$ 82,774.90	Assumed to be $6.50 per patient day
Information Technology/Computers	$ 3,416.60	$ 4,907.48	$ 6,367.30	Assumed to be $0.50 per patient day
Insurance	$ 13,200.00	$ 13,200.00	$ 13,200.00	Assumed to be $1,100 per month insurance policy
Interest	$ -	$ -	$ -	The business will not have any debt
Licenses and Fees	$ 205.00	$ 294.45	$ 382.04	Assumed to be $0.03 per patient day
Medical Supplies	$ 24,531.19	$ 35,235.71	$ 45,717.21	Assumed to be 3.59 per patient day
Payroll Taxes	$ 48,665.58	$ 72,046.26	$ 85,796.12	Assumed to be 9.3% of wages
Postage	$ 1,161.64	$ 1,668.54	$ 2,164.88	Assumed to be $0.17 per patient day
Purchased Services (utilities, other)	$ 2,400.00	$ 2,400.00	$ 2,400.00	$200 per month per sublease
Rental/Lease	$ 9,600.00	$ 9,600.00	$ 9,600.00	$800 per month per the sublease
Repairs and Maintenance	$ 1,366.64	$ 1,962.99	$ 2,546.92	Assumed to be $0.20 per patient day
Salaries and Wages	$ 523,285.79	$ 774,690.95	$ 922,538.93	This amount ties back to our Employee Detail table in Exhbit 12. It includes contracted wages.
Supplies	$ 341.66	$ 490.75	$ 636.73	Assumed to be $0.05 per patient day
Telephone	$ 6,354.88	$ 9,127.91	$ 11,843.18	Assumed to be $0.93 per patient day
Travel (patient care, other)	$ 27,332.80	$ 39,259.84	$ 50,938.40	Assumed to be $4.00 per patient day
Pharmacy	$ 44,415.80	$ 63,797.24	$ 82,774.90	Assumed to be $6.50 per patient day
Overhead Allocation	$ 45,304.12	$ 65,073.18	$ 84,430.40	Assumed to be $6.63 per patient day - Includes: HR, Legal, Billing, Finance Services, Online training system, IT help desk, Reginal Leadership support, and Software
Total General Expenses	**$ 894,251.04**	**$ 1,294,271.75**	**$1,568,721.94**	
Profit/(loss)	**$ 398,043.75**	**$ 561,933.48**	**$ 839,645.61**	

Room and Board Expense
This revenue pertains to Medicaid patients residing in skilled nursing facilities ("SNF"). Instead of paying the SNF for these patients the state of WA will pay Bristol 95% of the Medicaid rate for that specific SNF. Bristol, in turn, will pay the SNF 100% of the Medicaid rate and then will bill Medicare for their hospice services. This keeps the SNF whole in terms of revenue but Bristol will show a small loss as we receive less from the state than we will pay. For example, if the SNF was being paid $100 per day by the state for a Medicaid patient and that patient signs up for hospice services the SNF will now receive $0 from the state. The state will pay Bristol $95 per day and Bristol will pay the SNF $100 per day. We estimate that between 20% of our total average revenue will come from patients in SNF's.

Bristol Hospice - WA CON
Balance Sheets
FYE 2023 - 2025

	12/31/2023		12/31/2024		12/31/2025	
ASSETS						
Current Assets						
Cash		$ 229,171		$ 734,136		$ 1,513,199
Inventory (supplies)		5,000		5,000		5,000
Accounts Receivable (DSO=55 days)		194,729		279,702		362,905
Total Current Assets		428,900		1,018,839		1,881,104
Fixed and Other Assets						
Equipment	$ 25,000		$ 25,000		$ 25,000	
Less Acc. Depreciation	7,000		14,000		21,000	
Net Equipment		18,000		11,000		4,000
Total Fixed and Other Assets		18,000		11,000		4,000
Total Assets		$ 446,900		$ 1,029,839		$ 1,885,104
LIABILITIES AND NET ASSETS						
Current Liabilities						
Accounts Payable (30 day terms)		$ 26,858		$ 37,295		$ 46,699
Wages Payable (14 days of payroll unpaid)		21,998		32,567		38,782
Total Current Liabilities		48,856		69,861		85,481
Long-Term and Other Liabilities						
Total Long-Term and Other Liabilities		48,856		69,861		85,481
Equity						
Retained Earnings		-		398,044		959,977
Other: Current Earnings		398,044		561,933		839,646
Total Equity		398,044		959,977		1,799,623
Total Liabilities and Equity		$ 446,900		$ 1,029,839		$ 1,885,104

Staff	2023					2024					2025					Assumptions
	FTE	Hourly Wage	Contracted	Hourly Wage	Total Wages	FTE	Hourly Wage	Contracted	Hourly Wage	Total Wages	FTE	Hourly Wage	Contracted	Hourly Wage	Total Wages	
Registered Nurse	1.61	$ 44.00			$ 147,278.25	2.25	$ 44.00			$ 205,920.00	2.92	$ 44.00			$ 266,933.33	1 Registered Nurse for every 12 ADC
Nurse Practitioner	0.05	$ 60.00			$ 6,025.02	0.07	$ 60.00			$ 8,424.00	0.09	$ 60.00			$ 10,920.00	.05 FTE Nurse Practitioner for every 20 ADC
Hospice Aid (CNA)	1.93	$ 20.00			$ 80,333.59	2.70	$ 20.00			$ 112,320.00	3.50	$ 20.00			$ 145,600.00	1 CNA for every 10 ADC
Executive Director	1.00	$ 60.00			$ 124,800.00	1.00	$ 60.00			$ 124,800.00	1.00	$ 60.00			$ 124,800.00	1 Registered Nurse Executive Director for the Program
Medical Director			0.02	$ 300.00	$ 12,050.04			0.03	$ 300.00	$ 16,848.00			0.04	$ 300.00	$ 21,840.00	.02 FTE Medical Director for every 20 ADC
Director of Nursing Services	-	$ 52.55			$ -	1.00	$ 52.55			$ 109,304.00	1.00	$ 52.55			$ 109,304.00	1 Director of Nursing Services for the Program starting in year two
Business/Clerical	1.00	$ 20.00			$ 41,600.00	1.00	$ 20.00			$ 41,600.00	1.00	$ 20.00			$ 41,600.00	1 Business/Clerical team member for the program
Physical Therapist			0.03	$ 41.00	$ 2,744.73			0.05	$ 41.00	$ 3,837.60			0.06	$ 41.00	$ 4,974.67	.05 FTE Physical Therapist for every 30 ADC
Occupational Therapist			0.03	$ 41.00	$ 2,744.73			0.05	$ 41.00	$ 3,837.60			0.06	$ 41.00	$ 4,974.67	.05 FTE Occupational Therapist for every 30 ADC
Speech Therapist			0.03	$ 41.00	$ 2,744.73			0.05	$ 41.00	$ 3,837.60			0.06	$ 41.00	$ 4,974.67	.05 FTE Speech Therapist for every 30 ADC
Medical Social Worker	0.55	$ 33.72			$ 38,697.84	0.77	$ 33.72			$ 54,106.15	1.00	$ 33.72			$ 70,137.60	1 Medical Social Worker per 35 ADC
Pastoral/ Other Counselor	0.39	$ 35.75			$ 28,719.26	0.54	$ 35.75			$ 40,154.40	0.70	$ 35.75			$ 52,052.00	1 Pastoral/Other Counselor for every 50 ADC
Volunteer Coordinator	0.24	$ 26.00			$ 13,054.21	0.34	$ 26.00			$ 18,252.00	0.44	$ 26.00			$ 23,660.00	1 Volunteer Coordinator for every 80 ADC
Bereavement Specialist	0.39	$ 28.00			$ 22,493.40	0.54	$ 28.00			$ 31,449.60	0.70	$ 28.00			$ 40,768.00	1 Bereavement Specialist for every 50 ADC
Hospice Liaison	1.00	$ 36.87			$ 76,689.60	1.00	$ 36.87			$ 76,689.60	1.00	$ 36.87			$ 76,689.60	1 Hospice Liaison for the Program
Total Staffing	7.15		0.12		$ 523,285.79	10.21		0.16		$ 774,690.95	12.34		0.21		$ 922,538.93	

	2023	2024	2025
ADC	19	27	35

Source: "HealthPrvots DataLab," *HealthPrvots DataLab*, https://datalab.healthprvola.com/.

The below medicare claims data of the current Providers in Pierce County was used to assume the ALOS (Average Length of Stay) as well as the daily rate in the financial assumptions.

Average of the below ALOS 55.5

Average of the below Daily Rate $197

FRANCISCAN HOSPICE - 501526

NOTE: 2021 data are for Jul 2020 to Jun 2021

Year	Patients	Se Admissions	ADC	ALOS	Median LO	GIP Patient %	GIP Patie	GIP ADC	% GIP Days	CHC Patien	% CHC Day	HMO Patie	% HMO	Deaths	Live Discha	% Deaths	% Live Disc	Payments ;	Payments ;	% Cap Use
2007	2,303	1,924	438	69	26	567	24.60%	10.8	2.50%	32	0.00%	483	21%	1,563	274	85%	15%	$161	$11,188	86%
2008	2,473	2,009	445	66	28	500	20.20%	9.7	2.20%	34	0.10%	491	20%	1,684	408	80%	20%	$166	$10,944	84%
2009	2,445	2,022	423	63	27	489	20.00%	9.6	2.30%	34	0.10%	511	21%	1,680	362	82%	18%	$174	$10,979	81%
2010	2,696	2,305	367	50	23	548	20.30%	8.8	2.40%	13	0.00%	562	21%	1,822	515	78%	22%	$178	$8,857	46%
2011	2,608	2,256	382	53	25	472	18.10%	8.5	2.20%	0	0.00%	524	20%	1,716	508	77%	23%	$180	$9,620	50%
2012	2,681	2,289	411	56	28	422	15.70%	7.8	1.90%	-1	0.00%	617	23%	1,711	527	76%	24%	$182	$10,232	52%
2013	2,932	2,513	440	55	28	454	15.50%	7.3	1.70%	-1	0.00%	707	24%	1,892	581	77%	23%	$181	$9,928	48%
2014	3,219	2,782	473	54	24	584	18.10%	9.7	2.10%	0	0.00%	815	25%	2,171	545	80%	20%	$186	$9,962	47%
2015	3,189	2,696	558	64	31	563	17.70%	9.9	1.80%	0	0.00%	816	26%	2,119	436	83%	17%	$185	$11,779	54%
2016	3,395	2,801	709	76	37	618	18.20%	11.2	1.60%	0	0.00%	927	27%	2,272	348	87%	13%	$186	$14,210	65%
2017	3,752	3,014	785	76	31	739	19.70%	13	1.70%	-1	0.00%	1,012	27%	2,525	401	86%	14%	$190	$14,521	67%
2018	3,973	3,172	804	74	34	680	17.10%	10.1	1.30%	19	0.00%	1,113	28%	2,510	645	80%	20%	$190	$14,024	66%
2019	4,193	3,398	767	67	29	696	16.60%	8.2	1.10%	-1	0.00%	1,257	30%	2,855	620	82%	18%	$193	$12,868	58%
2020	3,972	3,266	714	66	28	477	12.00%	4.8	0.70%	0	0.00%	1,373	35%	2,725	626	81%	19%	$194	$12,768	54%
2021	3,540	2,803	584	60	30	335	9.50%	3.2	0.60%	0	0.00%	1,251	35%	2,400	705	77%	23%	$197	$11,850	52%

MULTICARE HOSPICE - 501508

NOTE: 2021 data are for Jul 2020 to Jun 2021

Year	Patients	Se Admissions	ADC	ALOS	Median LO	GIP Patient %	GIP Patie	GIP ADC	% GIP Days	CHC Patien	% CHC Day	HMO Patie	% HMO	Deaths	Live Discha	% Deaths	% Live Disc	Payments ;	Payments ;	% Cap Use
2007	424	367	61	53	24	30	7.10%	0.4	0.60%	0	0.00%	33	8%	307	53	85%	15%	$149	$7,902	44%
2008	515	454	64	45	17	13	2.50%	0.2	0.20%	0	0.00%	54	10%	304	70	81%	19%	$154	$6,982	36%
2009	802	665	156	71	31	17	2.10%	0.2	0.10%	0	0.00%	144	18%	525	110	83%	17%	$159	$11,303	61%
2010	878	718	140	58	26	11	1.30%	0.1	0.10%	0	0.00%	185	21%	611	134	82%	18%	$163	$9,482	51%
2011	836	702	131	57	24	35	4.20%	0.3	0.20%	0	0.00%	170	20%	620	95	87%	13%	$167	$9,575	49%
2012	829	712	132	58	23	51	6.20%	0.4	0.30%	0	0.00%	177	21%	602	84	88%	12%	$172	$9,986	48%
2013	844	705	135	58	23	29	3.40%	0.3	0.30%	0	0.00%	204	24%	595	118	83%	17%	$172	$10,019	49%
2014	716	587	110	56	22	31	4.30%	0.4	0.30%	0	0.00%	163	23%	535	66	89%	11%	$176	$9,832	47%
2015	843	730	131	57	25	25	3.00%	0.3	0.20%	0	0.00%	225	27%	614	85	88%	12%	$175	$9,930	44%
2016	1,389	1,233	199	51	23	31	2.20%	0.3	0.10%	0	0.00%	298	21%	1,036	139	88%	12%	$184	$9,329	41%
2017	1,564	1,354	224	52	20	56	3.60%	0.5	0.20%	0	0.00%	394	25%	1,176	148	89%	11%	$188	$9,842	42%
2018	1,511	1,280	265	64	24	22	1.50%	0.2	0.10%	0	0.00%	405	27%	1,098	171	87%	13%	$187	$11,944	52%
2019	1,395	1,157	236	62	24	-1	-100.00%	0.1	0.00%	0	0.00%	402	29%	1,016	161	86%	14%	$187	$11,499	50%
2020	1,417	1,205	228	58	24	-1	-100.00%	0	0.00%	0	0.00%	471	33%	1,039	165	86%	14%	$190	$11,204	46%
2021	1,509	1,269	222	54	24	-1	-100.00%	0	0.00%	0	0.00%	527	35%	1,099	175	86%	14%	$195	$10,450	43%

KAISER FOUNDATION HEALTH PLAN OF WASHINGTON - 501521

NOTE: 2021 data are for Jul 2020 to Jun 2021

Year	Patients	Se Admissions	ADC	ALOS	Median LO	GIP Patient %	GIP Patie	GIP ADC	% GIP Days	CHC Patien	% CHC Day	HMO Patie	% HMO	Deaths	Live Discha	% Deaths	% Live Disc	Payments ;	Payments ;	% Cap Use
2007	1,123	948	189	61	27	114	10.20%	1.7	0.90%	20	0.10%	1,072	95%	834	100	89%	11%	$157	$9,622	55%
2008	1,200	1,008	202	62	30	179	14.90%	2.7	1.40%	24	0.10%	1,136	95%	831	154	84%	16%	$165	$10,184	56%
2009	1,354	1,139	230	62	29	153	11.30%	2.1	0.90%	32	0.10%	1,288	95%	935	186	85%	15%	$169	$10,460	57%
2010	1,420	1,172	249	64	30	125	8.80%	1.9	0.80%	27	0.10%	1,333	94%	990	176	85%	15%	$171	$10,921	58%
2011	1,448	1,201	213	54	24	78	5.40%	1.1	0.50%	15	0.10%	1,379	95%	1,011	200	83%	17%	$172	$9,235	48%
2012	1,467	1,233	254	63	30	180	12.30%	3.1	1.20%	17	0.10%	1,391	95%	1,027	187	85%	15%	$180	$11,353	56%
2013	1,317	1,067	245	68	31	193	14.70%	3	1.20%	15	0.00%	1,254	95%	923	183	83%	17%	$179	$12,156	60%
2014	1,251	1,052	200	58	30	108	8.60%	1.7	0.90%	13	0.00%	1,178	94%	848	219	79%	21%	$179	$10,457	50%
2015	1,236	1,058	202	60	29	61	4.90%	1.2	0.60%	-1	0.00%	1,177	95%	845	189	82%	18%	$179	$10,655	48%
2016	1,199	1,009	189	58	29	51	4.30%	0.7	0.40%	0	0.00%	1,142	95%	859	146	85%	15%	$185	$10,681	48%
2017	1,005	820	165	60	26	59	5.90%	1	0.60%	0	0.00%	948	94%	718	119	86%	14%	$189	$11,305	50%
2018	950	799	129	50	26	57	6.00%	0.9	0.70%	0	0.00%	880	93%	680	158	81%	19%	$194	$9,610	42%
2019	940	836	113	44	21	39	4.10%	0.6	0.60%	0	0.00%	860	91%	687	115	86%	14%	$201	$8,823	38%
2020	950	820	139	54	25	37	2.80%	0.4	0.30%	0	0.00%	865	91%	702	127	85%	15%	$199	$10,640	43%
2021	830	706	123	54	24	25	3.00%	0.4	0.40%	0	0.00%	771	93%	621	98	86%	14%	$202	$10,894	43%

PROVIDENCE SOUNDHOMECARE AND HOSPICE - 501511

NOTE: 2021 data are for Jul 2020 to Jun 2021

Year	Patients	Se Admissions	ADC	ALOS	Median LO	GIP Patient %	GIP Patie	GIP ADC	% GIP Days	CHC Patien	% CHC Day	HMO Patie	% HMO	Deaths	Live Discha	% Deaths	% Live Disc	Payments ;	Payments ;	% Cap Use
2007	880	768	136	56	26	25	2.80%	0.2	0.20%	0	0.00%	299	34%	623	118	84%	16%	$147	$8,296	46%
2008	905	766	152	61	25	26	2.90%	0.3	0.20%	0	0.00%	294	32%	658	108	86%	14%	$153	$9,410	52%
2009	857	722	144	61	31	19	2.20%	0.2	0.10%	0	0.00%	313	37%	579	123	82%	18%	$160	$9,850	53%
2010	970	817	152	57	28	32	3.30%	0.4	0.30%	0	0.00%	345	36%	696	133	84%	16%	$163	$9,331	48%
2011	1,098	966	170	57	29	41	3.70%	0.4	0.30%	0	0.00%	364	33%	771	136	85%	15%	$165	$9,346	45%
2012	1,111	926	186	61	28	56	5.00%	0.6	0.30%	0	0.00%	403	36%	790	157	83%	17%	$169	$10,352	51%
2013	1,058	893	166	57	26	63	6.00%	0.7	0.40%	0	0.00%	396	37%	755	141	84%	16%	$169	$9,687	47%
2014	1,054	895	167	58	27	65	6.20%	0.7	0.40%	0	0.00%	393	37%	757	132	85%	15%	$171	$9,902	46%
2015	1,150	985	196	62	28	59	5.10%	0.6	0.30%	0	0.00%	419	36%	859	127	87%	13%	$176	$10,929	49%
2016	1,154	970	212	67	33	44	3.80%	0.7	0.30%	0	0.00%	425	37%	816	145	85%	15%	$184	$12,338	55%
2017	1,280	1,087	219	62	29	39	3.00%	0.4	0.20%	0	0.00%	475	37%	872	174	83%	17%	$187	$11,659	52%
2018	1,213	982	210	63	25	36	3.00%	0.4	0.20%	0	0.00%	454	37%	871	139	86%	14%	$184	$11,610	54%
2019	1,170	977	202	62	27	22	1.90%	0.3	0.10%	0	0.00%	471	40%	845	115	88%	12%	$186	$11,757	50%
2020	1,316	1,114	241	67	29	28	2.10%	0.4	0.20%	-1	0.00%	542	41%	924	138	87%	13%	$187	$12,517	51%
2021	1,353	1,113	251	68	32	31	2.30%	0.4	0.20%	0	0.00%	584	43%	970	150	87%	13%	$189	$12,777	52%

ENVISION HOSPICE - 501544

NOTE: 2021 data are for Jul 2020 to Jun 2021

Year	Patients	Se Admissions	ADC	ALOS	Median LO	GIP Patient %	GIP Patie	GIP ADC	% GIP Days	CHC Patien	% CHC Day	HMO Patie	% HMO	Deaths	Live Discha	% Deaths	% Live Disc	Payments ;	Payments ;	% Cap Use
2007																				
2008																				
2009																				
2010																				
2011																				
2012																				
2013																				
2014																				
2015																				
2016																				
2017																				
2018																				
2019																				
2020	99	99	11	39	18	0	0.00%	0	0.00%	-1	0.00%	37	37%	67	-1	-100%	-100%	$203	$7,920	28%
2021	152	147	20	49	24	0	0.00%	0	0.00%	-1	0.00%	48	32%	110	18	86%	14%	$202	$9,938	36%

EVERGREEN HEALTH HOSPICE CARE - 501523

NOTE: 2021 data are for Jul 2020 to Jun 2021

Year	Patients	Se Admissions	ADC	ALOS	Median LO	GIP Patient %	GIP Patie	GIP ADC	% GIP Days	CHC Patien	% CHC Day	HMO Patie	% HMO	Deaths	Live Discha	% Deaths	% Live Disc	Payments ;	Payments ;	% Cap Use
2007	1,234	1,086	173	51	16	509	41.20%	9.8	5.70%	0	0.00%	184	15%	941	109	90%	10%	$184	$9,380	51%
2008	1,443	1,257	217	55	18	541	37.50%	9.3	4.30%	0	0.00%	233	16%	1,090	119	90%	10%	$182	$10,020	52%
2009	1,711	1,482	263	56	21	554	32.40%	9.4	3.60%	0	0.00%	287	17%	1,230	195	86%	14%	$185	$10,369	54%
2010	1,874	1,595	266	52	23	397	21.20%	5.7	2.20%	0	0.00%	307	16%	1,317	300	81%	19%	$180	$9,308	48%
2011	2,049	1,795	281	50	20	419	20.40%	6.3	2.30%	0	0.00%	430	21%	1,492	229	87%	13%	$183	$9,344	45%
2012	2,472	2,152	384	57	24	480	19.40%	7.9	2.10%	0	0.00%	598	24%	1,728	335	84%	16%	$185	$10,484	51%
2013	2,692	2,291	410	56	25	487	18.10%	7.6	1.90%	-1	0.00%	688	26%	1,872	426	81%	19%	$183	$10,191	49%
2014	2,850	2,470	411	52	22	571	20.00%	8.2	2.00%	-1	0.00%	776	27%	2,023	415	83%	17%	$188	$9,842	46%
2015	3,064	2,649	460	55	22	693	22.60%	10.2	2.20%	-1	0.00%	800	26%	2,165	402	84%	16%	$191	$10,482	47%
2016	3,412	2,918	502	54	23	697	20.40%	10.2	2.00%	0	0.00%	948	28%	2,389	559	81%	19%	$197	$10,583	49%
2017	3,321	2,866	465	51	21	704	21.20%	10	2.20%	0	0.00%	983	30%	2,429	445	85%	15%	$202	$10,323	45%
2018	3,200	2,756	468	53	21	571	17.80%	6.6	1.40%	0	0.00%	1,018	32%	2,308	441	84%	16%	$197	$10,481	45%
2019	3,127	2,672	477	56	23	517	16.50%	6.2	1.30%	-1	0.00%	1,010	32%	2,220	455	83%	17%	$201	$11,162	48%
2020	3,306	2,864	482	53	19	624	18.90%	7.5	1.60%	0	0.00%	1,122	34%	2,433	376	87%	13%	$210	$11,205	46%
2021	3,223	2,749	496	56	24	503	15.60%	6	1.20%	0	0.00%	1,140	35%	2,291	422	84%	16%	$211	$11,833	48%

WESLEY HOMES HOSPICE, LLC - 501543

NOTE: 2021 data are for Jul 2020 to Jun 2021

Year	Patients	Se Admissions	ADC	ALOS	Median LO	GIP Patient %	GIP Patie	GIP ADC	% GIP Days	CHC Patien	% CHC Day	HMO Patie	% HMO	Deaths	Live Discha	% Deaths	% Live Disc	Payments ;	Payments ;	% Cap Use
2007																				
2008																				
2009																				
2010																				
2011																				
2012																				
2013																				
2014																				
2015																				
2016																				
2017																				
2018	73	71	9	45	24	0	0.00%	0	0.00%	0	0.00%	38	52%	51	-1	-100%	-100%	$198	$8,808	34%
2019	99	82	16	60	23	0	0.00%	0	0.00%	0	0.00%	38	38%	70	14	83%	17%	$190	$11,388	48%
2020	128	114	12	36	15	0	0.00%	0	0.00%	0	0.00%	63	49%	95	14	87%	13%	$200	$7,129	29%
2021	142	135	16	41	15	0	0.00%	0	0.00%	0	0.00%	70	49%	106	20	84%	16%	$200	$8,281	32%

ASSURED HOME HEALTH, HOSPICE & HOME CARE - 501512

NOTE: 2021 data are for Jul 2020 to Jun 2021

Year	Patients	Se Admissions	ADC	ALOS	Median LO	GIP Patient %	GIP Patie	GIP ADC	% GIP Days	CHC Patien	% CHC Day	HMO Patie	% HMO	Deaths	Live Discha	% Deaths	% Live Disc	Payments ;	Payments ;	% Cap Use
2007	420	361	68	59	23	-1	-100.00%	0	0.10%	0	0.00%	47	11%	306	43	88%	12%	$143	$8,482	47%
2008	414	349	66	58	22	-1	-100.00%	0	0.00%	-1	0.00%	55	13%	289	53	85%	15%	$148	$8,608	47%
2009	498	430	69	51	20	-1	-100.00%	0	0.10%	0	0.00%	73	15%	350	73	83%	17%	$154	$7,795	41%
2010	480	412	78	60	22	-1	-100.00%	0	0.00%	0	0.00%	87	18%	333	61	85%	15%	$156	$9,283	47%
2011	533	451	75	51	24	11	2.10%	0.1	0.20%	0	0.00%	98	18%	353	87	80%	20%	$159	$8,157	42%
2012	611	522	90	54	21	18	2.90%	0.2	0.20%	-1	0.00%	136	22%	443	68	88%	12%	$162	$8,760	42%
2013	731	628	111	55	21	20	2.70%	0.2	0.20%	15	0.10%	138	19%	529	80	87%	13%	$162	$8,928	41%
2014	736	620	130	64	27	22	3.00%	0.2	0.10%	12	0.10%	147	20%	544	74	88%	12%	$162	$10,442	48%
2015	718	604	124	64	25	16	2.20%	0.2	0.20%	-1	0.00%	156	22%	540	59	90%	10%	$168	$10,706	48%
2016	785	651	133	63	28	21	2.70%	0.2	0.20%	0	0.00%	167	22%	527	86	86%	14%	$177	$11,231	49%
2017	845	699	149	64	29	24	2.80%	0.2	0.20%	-1	0.00%	168	20%	593	95	86%	14%	$180	$11,549	51%
2018	961	810	164	62	27	16	1.70%	0.2	0.10%	0	0.00%	195	20%	679	125	84%	16%	$179	$11,109	49%
2019	924	777	161	64	26	23	2.50%	0.4	0.20%	0	0.00%	189	20%	668	107	86%	14%	$179	$11,445	49%
2020	1,002	859	172	63	23	17	1.70%	0.2	0.10%	0	0.00%	219	22%	730	96	88%	12%	$179	$11,258	45%
2021	1,066	893	180	62	24	15	1.40%	0.1	0.10%	0	0.00%	236	22%	776	105	88%	12%	$182	$11,205	46%

Exhibit 13

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LIMITED LIABILITY COMPANY AGREEMENT
OF
BRISTOL HOSPICE – PIERCE, L.L.C.

This Limited Liability Company Agreement (as amended, modified or supplemented from time to time, this "**Agreement**") of Bristol Hospice – Pierce, L.L.C., a Washington limited liability company (the "**Company**"), is entered into on January 18, 2022 by Bristol Hospice, L.L.C., a Utah limited liability company, as the sole manager of the Company (the "**Manager**").

1. **Formation**. The Certificate of Formation of the Company was filed with the Secretary of State of the State of Washington on January 18, 2022, solely for the purpose of forming a limited liability company pursuant to and in accordance with the provisions of the act governing limited liability companies in the State of Washington (as amended from time to time, the "**Act**").

2. **Name**. The name of the Company is Bristol Hospice – Pierce, L.L.C., or such other name as the Manager may from time to time hereafter designate.

3. **Term**. The Company shall continue to exist in perpetuity until the first of the following to occur: (i) the dissolution and termination of the Company upon the determination of the Manager, or (ii) the dissolution and termination of the Company in accordance with the Act.

4. **Purpose**. The Company is formed to engage in any lawful act or activity for which limited liability companies may be formed under the Act.

5. **No Separate Entity for Tax Purposes**. The Company shall not be treated as a separate entity for federal income tax purposes and, to the extent permitted by law, for state and local tax purposes and shall prepare and file all tax returns and other tax statements in a manner consistent therewith. The Company shall make, or shall refrain from making, any election or other filing in order to disregard the Company as a separate entity for tax purposes.

6. **Offices**.

(a) The principal business office of the Company, and such additional offices as the Manager may determine to establish, shall be located at such place or places inside or outside the State of Washington as the Manager may designate from time to time.

(b) The principal office of the Manager is located at 206 North 2100 West, Suite 202, Salt Lake City, Utah 84116.

7. **Capital; Percentage Interest**. The Manager owns one hundred percent of the interest in the Company and may contribute capital to the Company in such amounts and at such times as the Manager may deem appropriate. The initial capital contribution and any additional capital contribution of the Manager shall be set forth in the Company's books and records.

8. **Management by Manager; Officers**.

(a) Subject to the delegation of rights and powers provided for herein, the Manager shall have the sole right to manage the business of the Company and shall have all powers and rights necessary, desirable, appropriate or advisable to effectuate and carry out the purposes and business of the Company, and is hereby granted the sole and complete discretion and authority to exercise the rights of the Company, and to take all actions related thereto, including without limitation, the Manager is expressly authorized to execute any document on behalf of the Company in all cases consistent with this Agreement

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as in effect from time to time, amend or waive rights of the Company under any agreements, documents or otherwise, and cause the Company to perform its obligations under any agreement, document or otherwise. The Manager may from time to time appoint such officers of the Company, to hold such positions and with such powers, as the Manager from time to time shall deem necessary or desirable. Each officer shall serve until such time as he or she is removed by the Manager. The same individual may hold any two or more offices.

(b) The Manager hereby initially designates (i) Hyrum Kirton as Chief Executive Officer and President, (ii) David Malm as Vice President, (iii) John Garbarino as Treasurer and Secretary, (iv) Gerry Christensen as Chief Financial Officer and (v) Sonnie Linebarger as Chief Operating Officer.

9. **Limitation on Liability**. Except as otherwise provided by the Act, the debts, obligations and liabilities of the Company, whether arising in contract, tort or otherwise, shall be solely the debts, obligations and liabilities of the Company, and the Manager shall not be obligated personally for any such debt, obligation or liability of the Company solely by reason of being a manager of the Company.

10. **No Opt-In to Article 8 of the Uniform Commercial Code.** So long as any pledge of any interest of the Company is in effect, unless the express prior written consent of the pledgee under such pledge has been provided with respect to such action: (i) the Company shall not elect to have any interest in the Company be securities governed by Article 8 of the Uniform Commercial Code as in effect in the State of Washington and each other applicable jurisdiction and (ii) this Section 10 shall not be amended, and any purported amendment to this provision shall not take effect until all security interests granted in any interest of the Company have been terminated.

11. **Exculpation and Indemnification of the Manager and/or Authorized Persons**. The Company shall indemnify and hold harmless the Manager and any other authorized persons acting on behalf of the Manager against any and all claims and demands whatsoever, to the fullest extent permitted by the Act.

12. **Governing Law**. This Agreement shall be governed by, and construed under, the laws of the State of Washington (without regard to conflict of laws principles).

[*Signature Page Follows*]

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IN WITNESS WHEREOF, the undersigned, intending to be legally bound hereby, has duly executed this Agreement as of the date first set forth above.

MANAGER:

BRISTOL HOSPICE, L.L.C.

DocuSigned by:
By: Hyrum Kirton
9C69EDA79DB7475...
Name: Hyrum Kirton
Title: Chief Executive Officer

MEDICAL DIRECTOR AND PHYSICIAN SERVICES AGREEMENT

THIS MEDICAL DIRECTOR AND PHYSICIAN SERVICES AGREEMENT ("Agreement") is entered into ~~this~~ 25 day of October, 2019 ("Effective Date"); by and between Dr. Voutsas-Friedman ("Medical Director"); and Bristol Hospice - Pierce, L.L.C. ("Hospice") a duly-licensed healthcare provider.

RECITALS

WHEREAS, Hospice presently operates a Medicare-certified hospice at which the services of a qualified medical director are required; and

WHEREAS, Medical Director is qualified to act as a medical director for Hospice and provide physician services as described in this Agreement; and

WHEREAS, Hospice and Medical Director (each a "Party" and collectively "Parties") have determined that, by entering into this Agreement, Hospice can better meet the needs of current and prospective patients of Hospice.

[ ] This Document covers both Medical Director and Physician Services. If the box at the beginning of this paragraph IS marked, Medical Director will NOT BE PROVIDING PHYSICIAN SERVICES.

NOW, THEREFORE, in consideration of the mutual promises herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

ARTICLE 1
DEFINITIONS

1.1 "Attending Physician" shall mean the doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State or the nurse practitioner who meets the training, education, and experience requirements outlined in 1.1.1 herein, if permissible in the State, who is designated by the Patient, or such Patient's legal representative, at the time the Patient elects to receive hospice care, as having the most significant role in the determination and delivery of the Patient's medical care.

1.1.1 Nurse Practitioner Qualifications. For Medicare Part B coverage of his or her services, a nurse practitioner must be a registered professional nurse who is authorized by the State to practice as a nurse practitioner in accordance with State law, and must meet one of the following: (1) obtained Medicare billing privileges as a nurse practitioner for the first time on or after January 1, 2003, and meets the following requirements: (i) be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners. (ii) possess a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree; (2) obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2003, and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or (3) obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2001.

1.2 "CHAP" shall mean the Community Health Accreditation Program or such other accrediting organization with deemed status for Medicare program participation as is designated from time to time by the Governing Body.

1.3 "Consulting Physician Services" shall mean the one-time evaluation and counseling services furnished by Medical Director directly to a Medicare beneficiary who has been diagnosed as terminally ill, has not previously elected hospice care, and has not previously received the pre-election evaluation and counseling services.

1.4 "Interdisciplinary Group" shall mean those individuals designated by Hospice to provide or direct, coordinate and supervise the care and services offered by Hospice, as required by Conditions of Participation.

1.5 "Governing Body" shall mean the Governing Body of Hospice appointed in accordance with its Operating Agreement.

1.6 "Medical Director Services" shall mean the "Medical Director Professional Responsibilities" described in Exhibit A, which are furnished by the Medical Director to Hospice.

1.7 "Patient" shall mean an inpatient or outpatient of Hospice who is entitled and eligible to receive hospice services from Hospice.

1.8 "Physician services" shall mean physician services furnished directly to a Patient by Medical Director and billed by Hospice.

1.9 "Policies and Procedures" shall mean the written policies, procedures, regulations or other guidelines, however captioned, established by the Governing Body of Hospice or its designee from time to time for the operation and management of Hospice.

1.10 "State" shall mean the state in which Hospice is located and licensed.

ARTICLE 2
HOSPICE'S OBLIGATIONS

2.1 Responsibilities of Hospice.

2.1.1 Hospice shall be solely responsible for all activities necessary or required for the operation of a licensed and certified hospice in the State and under Medicare and Medicaid laws, rules and regulations and federal, state and local laws, rules and regulations. Hospice will provide hospice services to Patients admitted by Hospice according to Hospice's policies on acceptance of Patients for service.

2.1.2 Hospice, through its Administrator/Executive Director will provide Medical Director with an orientation to the hospice program as provided at Hospice, inclusive of the hospice philosophy. Additional informational materials will be provided, as needed, throughout the term of the Agreement. The Administrator/Executive Director of Hospice will be accessible to the Medical Director for matters related to the day-to-day implementation of this Agreement and will facilitate coordination and continuity of services to Patients. Hospice will assess the skills and competence of Medical Director, and, as necessary, provide in-service training and education programs where required, in accordance with Hospice's written policies and procedures describing its method(s) of assessment of competency, including education on infection control and drug management. Hospice will maintain a written description of the in-service training provided during the previous 12 months.

2.1.3 Hospice retains full authority for the patient admission process; patient assessment and reassessment; ensuring the proper review and revision of the plan of care; ensuring the coordination, supervision and evaluation of the patient care provided; the scheduling of visits or hours; and discharge planning. Hospice shall retain administrative and financial management and oversight of Medical Director and all services provided hereunder, to ensure the provision of quality care. Notwithstanding the foregoing, Medical Director shall not be relieved of his or her obligation to perform the specific responsibilities of Medical Director as set forth in this Agreement, including Exhibits A and B. Notwithstanding the above; Hospice shall not attempt to direct the medical care provided by Medical Director to Hospice patients; Hospice shall only admit a Patient on the recommendation of the Medical Director in consultation with, or with input from, the Patient's Attending Physician (if any); and prior to discharging a Patient for any reason listed in paragraph (a) of 42 CFR 418.26, Hospice must obtain a written physician's discharge order from the Medical Director (if such Patient has an Attending Physician

involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.)

2.1.4 Hospice will ensure the utilization of services and appropriateness and quality of medical direction in accordance with its quality assessment and performance improvement program. The Administrator/Executive Director of Hospice is responsible for the monitoring and control of services provided.

2.15 Hospice shall retain professional management responsibility to ensure that all services are (i) authorized by Hospice; (ii) furnished in a safe and effective manner by qualified personnel; and (iii) delivered in accordance with the patient's plan of care in all settings. Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as coordinating the provision of services.

2.1.6 Hospice will provide Medical Director with any amendments to the Policies and Procedures, upon which the amended Policies and Procedures will become a binding part of this Agreement.

2.1.7 Hospice shall pay Medical Director as specified in Sections 3.3 and 3.4 of this Agreement.

ARTICLE 3
MEDICAL DIRECTOR'S OBLIGATIONS

3.1 Status and Membership. Medical Director represents, warrants and covenants that he or she will remain in full compliance with all of the following conditions continuously during the entire term of this Agreement. Failure of Medical Director to satisfy any or all of the following conditions will constitute grounds for immediate termination of this Agreement by Hospice.

3.1.1 Medical Director is and shall remain licensed as a doctor of medicine or osteopathy in the State without restriction or subject to any disciplinary or corrective action. Medical Director must be legally authorized in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license during the term of this Agreement. In the event Medical Director is subject to proceedings that could lead to disciplinary action, in the sole discretion of Hospice, Hospice may suspend Medical Director from providing services under this Agreement, without compensation, during the pendency of such proceedings. In addition, to the extent reasonably requested by Hospice, Medical Director will maintain continuing medical education hours as required by applicable industry standards for Hospices; and have been appropriately tested for tuberculosis and other appropriate illnesses that, under current industry standards, are consistent with service as a Medical Director of a facility such as Hospice. Medical Director shall provide copies to Hospice of any current licenses, registrations, and/or renewals, upon execution of this Agreement and thereafter at any time upon Hospice's request.

3.1.2 Intentionally Blank.

3.1.3 Medical Director will abide by Hospice's Policies and Procedures; the applicable hospice laws, rules and regulations of the State and other applicable state, federal, local, CHAP and other applicable accrediting body laws, rules, regulations, and standards, including those related to the health and safety of patients; ethics and professional standards of the medical profession; the rules and regulations that are applicable to Hospice, including accreditation and certification (and recertification) requirements. Medical Director represents that he or she has appropriate expertise in the medical care of the terminally ill.

3.1.4 Medical Director has and shall maintain registration with the Drug Enforcement Administration ("DEA") and any applicable state agency without any limitation on Medical Director's authority to prescribe drugs under such registration and shall provide current proof of such registration upon Hospice's request.

3.1.5 Medical Director is and shall remain a participating Medicare and Medicaid provider without any restriction or limitation. Medical Director represents and warrants that he or she has never been excluded from participation in any federally funded health care program including, without limitation, Medicare, Medicaid or TRICARE nor has been convicted or found to have violated any federal or state fraud and abuse law or illegal

remuneration law. Medical Director is and shall remain a participating provider for those third party payors designated by Hospice from time to time.

3.1.6 Medical Director has not and will not be listed by a federal agency as debarred, suspended or excluded from, or otherwise ineligible for, participation in federal procurement and non-procurement programs or federally funded health care programs. This is a continuing representation and Medical Director shall notify Hospice if Medical Director is no longer able to make such representation.

3.1.7 Medical Director shall remain eligible to work and access patients in accordance with all local, State and federal laws, rules, regulations and standards.

3.1.8 Medical Director shall comply with all local, State and federal laws, rules and regulations regarding health screenings and shall maintain compliance with same.

3.2 Duties and Responsibilities of Medical Director.

3.2.1 Medical Director will fulfill those specific responsibilities set forth on Exhibit A to this Agreement, the "Medical Director Professional Responsibilities," and Exhibit B to this Agreement, the "Consulting Physician or Physician Services." Hospice may amend Exhibits A and B from time-to-time when required to maintain Hospice's compliance with applicable laws, rules and regulations and the requirements of CHAP and other applicable accrediting bodies by providing a copy of an amended Exhibit A and Exhibit B to Medical Director, upon which the amended Exhibit A and/or Exhibit B will become a binding part of this Agreement.

3.2.2 Medical Director will devote such time and attention as is necessary to fulfill his or her duties and responsibilities, and obligations hereunder. Medical Director will be available for on–call consultation, assistance and decisions regarding patient care. Medical Director will be responsible for arranging coverage when he/she is unavailable, subject to Hospice's prior approval. Medical Director will be solely responsible for compensating any substitute Medical Director he/she obtains in accordance with this Section 3.2.2.

3.2.3 If requested by Hospice, in Hospice's sole discretion, Medical Director will cooperate with Hospice in identifying a qualified Associate Medical Director, who shall be acceptable to Hospice in Hospice's sole discretion. If Hospice elects to utilize an Associate Medical Director, Hospice will enter into a separate agreement with the Associate Medical Director.

3.2.4 Medical Director will work coordinate and work administratively with Hospice's Administrator/Executive Director, as the representative of Hospice, in the fulfillment of his/her day-to-day responsibilities under this Agreement.

3.2.5 Medical Director may serve as Attending Physician to Patients whom Medical Director refers to Hospice. Medical Director shall submit to Hospice written clinical notes describing the medical visits as Attending Physician within seven (7) days from the date of the medical visit to assist Hospice in meeting its legal obligations regarding record maintenance.

3.3 Medical Director Fees. Medical Director shall receive a fee of $300 per hour, payable on a prospective basis on or before the first day of each month, for the provision of Medical Director Professional Responsibilities specified in this Agreement, assuming all timesheets and required documentation have been completed and submitted. Travel and other expenses are included under this rate, unless separately approved by Hospice.

3.5 Documentation. Medical Director shall accurately document Medical Director Services actually provided each month by Medical Director and follow all Hospice billing policies and procedures regarding same.

3.6 Governing Body Responsibility. Medical Director shall at all times be under the general administrative control and supervision of the Governing Body as to the end results (but not the manner and means) by which Medical Director Services are furnished at Hospice and for purposes of ensuring compliance with this Agreement. The Governing Body (or designated persons so functioning) assumes full legal authority and responsibility for the management of Hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. Nothing in this Section 3.6 shall empower or require the Governing Body to direct or control the exercise of medical judgment by the Medical Director. Services shall be furnished in a safe and effective manner, and, when applicable, delivered in accordance with the patient's plan of care.

3.7 Confidential Information and Ownership. Medical Director recognizes and acknowledges that he will have access to certain confidential information of Hospice and that such information constitutes valuable, special and unique property of Hospice. Such information includes, but is not limited to, Hospice's Policies and Procedures, business and managed care arrangements and strategies, patient care procedures and policies and any specific forms or systems developed and used by or for Hospice. Medical Director will not, during or after the term of this Agreement, without the consent of Hospice disclose any such confidential information to any other person, firm, corporation, association, or other entity for any reason or purpose whatsoever except as may be ordered by a court or governmental agency or as may otherwise be required by law (provided that Hospice receives prior written notice of such disclosure and the Medical Director takes all reasonable and lawful actions to obtain confidential treatment for such disclosure and if possible, to minimize the extent of such disclosure). In the event of a breach or a threatened breach by Medical Director of the provisions of this paragraph, Hospice will be entitled to an injunction restraining Medical Director from disclosing in whole or in part any confidential information without the necessity of posting a bond or other security. Nothing herein will be construed as prohibiting Hospice from pursuing any other remedies available to it for such breach or threatened breach, including the recovery of damages from Medical Director. In addition, any Confidential Information of Hospice developed in whole or in part by Medical Director, and any derivations thereof, will be the sole and exclusive property of Hospice. This provision shall survive the termination or expiration of this Agreement.

Upon the termination of this Agreement or at any time upon the request of Hospice, Medical Director shall promptly deliver to Hospice all confidential information and all correspondence, manuals, letters, notes, notebooks, reports or any other documents embodying or concerning confidential information in Medical Director's possession and destroy or erase all other embodiments of confidential information under Medical Director's control, as directed by Hospice. This provision shall survive the termination or expiration of this Agreement.

3.8 Financial Obligation. Medical Director will incur no financial obligation on behalf of Hospice or for which Hospice will be responsible without prior approval of the Administrator/Executive Director.

3.9 Insurance. Throughout the term of this Agreement Hospice will maintain professional liability insurance in an amount no less than $1,000,000 per occurrence and $3,000,000 in the aggregate, so long as Medical Director remains qualified and eligible for same. This insurance will cover all of the Medical Director's professional activities as Medical Director, Consulting Physician and Physician Services under this Agreement but WILL NOT extend to any private medical practice, consulting or physician services of Medical Director unrelated to the responsibilities of Medical Director under this Agreement.

3.10 Records. All records of Medical Director Services, Consulting Physician or Physician Services shall be the property of Hospice. Originals of all records shall be maintained at Hospice. Copies of those records shall be made available to Medical Director, upon Medical Director's reasonable request, subject to applicable laws, rules and regulations. Medical Director shall maintain the confidentiality of all records, including patient records, and other documents generated or provided under this Agreement in accordance

with all relevant state and federal laws, rules and regulations. This provision shall survive the termination or expiration of this Agreement.

3.11 Medical Director acknowledges that in the provision of his/her services as Medical Director, Consulting Physician or Physician Services, he/she may be acting as a "business associate" of Hospice for purposes of Hospice's compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 as amended and related regulations ("HIPAA") and that, when Medical Director is acting as a business associate, the provisions of the Exhibit D, "Business Associate Agreement" will apply and Medical Director agrees to abide by all policies and procedures implemented by Hospice to ensure compliance with HIPAA and other patient privacy and confidentiality requirements of Hospice. This provision shall survive the termination or expiration of this Agreement.

3.12 Notifications. In addition to all other notification requirements in this Agreement, Medical Director shall immediately notify Hospice if any of the following events occur: (a) the occurrence of any of the circumstances described in this Agreement that entitle Hospice to terminate this Agreement; (b) Medical Director is the subject of any complaint or a disciplinary or other proceeding or action before any agency or board; (c) any threatened or proposed exclusion of Medical Director from any government program or any private insurance program, including, but not limited to, Medicare or Medicaid; and (d) all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, or physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of Hospice, to the extent that Medical Director has knowledge of such events.

ARTICLE 4
TERM AND TERMINATION

4.1 Term. The term of this Agreement shall be for one (1) year, commencing on the Effective Date and ending on one year following Effective Date ("Initial Term"). Thereafter, this Agreement shall renew automatically for additional one (1) year terms (each, a "Renewal Term"), unless either Party gives the other Party thirty (30) days prior written notice of its intent not to renew before the end of the Initial Term or a Renewal Term, as appropriate.

4.2 Terminations.

4.2.1 Immediate Termination for Cause. Notwithstanding Section 4.1, this Agreement may be terminated immediately by Hospice, upon notice to Medical Director, upon the occurrence of any of the following:

4.2.1.1 the dissolution, bankruptcy or liquidation of either Party;

4.2.1.2 the conviction of Medical Director of a felony or of any crime involving moral turpitude, or the institution of civil, criminal or administrative proceedings that could result in the exclusion of Medical Director from participation in the Medicare or Medicaid programs;

4.2.1.3 Hospice makes a good faith determination Medical Director's personal misconduct is of such a serious nature that his/her continued provision of Medical Director Services pursuant to this Agreement would create a substantial likelihood of injury or damage to the health or safety of any Patient;

4.2.1.4 If, in the determination of Hospice, Medical Director fails to maintain a good reputation or character, or fails to work harmoniously with others such that Medical Director is not able to provide the Medical Director Services in an efficient and orderly manner;

4.2.1.5 As expressly provided for in Section 3.1 or otherwise in this Agreement;

4.2.1.6 The cancellation, termination or non-renewal of any of Medical Director's insurances as required hereunder or by law, rule or regulation;

4.2.1.7 The death or disability of Medical Director. For purposes of this Agreement, the term "disability" shall mean Medical Director's inability to perform his or her duties under this Agreement with reasonable accommodation for three (3) consecutive months during the term of this Agreement due to illness, accident or other incapacity (but not including pregnancy) as determined in good faith by Hospice;

4.2.1.8 The revocation, suspension, limitation or restriction of Medical Director's participation in the Medicare or Medicaid programs;

4.2.1.9 Medical Director's failure to provide the notifications required by this Agreement; or

4.2.1.10 any other action or omission of Medical Director that Hospice deems to have a material adverse effect on the interests of Hospice.

4.2.2 Upon Material Breach. In addition, and notwithstanding Section 4.1, the non-breaching Party may terminate this Agreement upon a material default or breach by the other Party upon thirty (30) days' prior written notice, which notice shall set forth the grounds for termination in reasonable detail. This Agreement may terminate at the election of the non-defaulting party: (a) if curable, in the event such breach is not cured within thirty (30) days after service of the default notice; or (b) if non-curable, upon service of the default notice.

4.2.3 Without Cause. After the Initial Term, either Party may terminate this Agreement without cause by providing the other Party sixty (60) days advance written notice of the date of termination; provided, however, that if this Agreement is terminated by either Party pursuant to this Section 4.2.3, the Parties will not re-contract for the same services within one (1) year of such termination.

4.3 Termination Due to Change in Law. In the event there are substantial changes or clarifications to any applicable laws, rules or regulations that materially affect, in the opinion of either party's legal counsel, any party's right to reimbursement from third party payors or any other legal right of any party to this Agreement, the affected party may, by written notice to the other party, propose such modifications to this Agreement as may be necessary to comply with such change or clarification. Upon receipt of such notice, the parties shall engage in good faith negotiations regarding any appropriate modifications to this Agreement. If such notice is given and the parties are unable within 15 days thereafter to agree to appropriate modifications to this Agreement, either party may terminate this Agreement by providing notice to the other party. This provision shall not apply to those amendments made unilaterally by Hospice as authorized pursuant to Section 5.7 hereof.

4.4 Continuing Obligations. Notwithstanding the termination of this Agreement, the Parties shall be required to carry out any provision which contemplates performance by them subsequent to termination. Termination shall not affect any liability or obligation which shall have accrued prior to such termination, including but not limited to, accrued but unpaid compensation. Following any termination of this Agreement, or notice thereof, the Parties shall fully cooperate with each other in all matters relating to the winding up of their pending work. Specifically, the Medical Director shall assist in the transition of care and shall complete all timesheets, patient records and other documentation required hereunder, by Hospice and by law, rule and regulation. This provision shall survive the termination or expiration of this Agreement.

ARTICLE 5
GENERAL PROVISIONS

5.1 Billing and Collection. All revenue and income resulting from services rendered by Medical Director pursuant to this Agreement, including the professional, technical and administrative charges associated with the provision of the Medical Director Services, Consulting Physician and Physician Services shall belong to and accrue to the benefit of Hospice. It is agreed that only Hospice will bill and receive any fees or charges for the Medical Director Services furnished to Patients by Medical Director. Medical Director shall not bill Medicare, Medicaid, or any other third party payor for any Medical Director Services, Consulting Physician and Physician Services provided to Patients pursuant to this Agreement. If deemed necessary by Hospice, Medical Director will execute a reassignment agreement under Medicare

permitting Hospice to bill and receive payment from Medicare for services provided pursuant to this Agreement. Notwithstanding the foregoing, Hospice shall not bill or receive any fees or charges arising from physician services provided by Medical Director as Attending Physician to patients whom Medical Director refers to Hospice. This provision shall survive the termination or expiration of this Agreement.

5.2 Notices. All notices and other communication required or permitted to be given hereunder shall be in writing and shall be considered given and delivered when personally delivered to the Party, facsimile transmitted to the Party or delivered by courier or deposited in the United States mail, postage prepaid, return receipt requested, properly addressed to a Party at the address set forth below, or at such other address as such Party shall have specified by notice given in accordance herewith:

Hospice
c/o Bristol Hospice, L.L.C.
206 N 2100 W. Suite 202
Salt Lake City, UT 84116

Medical Director
10573-14th Ave NW
Seattle, WA 98177

5.3 Independent Contractor. In the performance of all Medical Director Services, Consulting Physician or Physician Services pursuant to this Agreement, Medical Director is at all times acting as an independent contractor engaged in the profession and practice of medicine. Medical Director will employ his or her own manner, means and methods and exercise his or her own professional judgment in the performance of all Medical Director Services, Consulting Physician and Physician Services. Hospice will have no right of control or direction with respect to such manner, means, methods or judgments, or with respect to the details of Medical Director Services, Consulting Physician Services or Physician Services. The only concern of Hospice under this Agreement or otherwise is that, irrespective of the manner and means selected, such Medical Director Services, Consulting Physician Services or Physician Services will be provided in a competent, efficient and satisfactory manner in accordance with the terms and conditions of this Agreement. It is expressly agreed that Medical Director will not for any purpose be deemed to be an employee, agent, partner, joint venture, ostensible or apparent agent, servant, or borrowed servant of Hospice. In recognition of his/her status as an independent contractor, Medical Director will not have any claim against Hospice for vacation pay, sick leave, retirement benefits, social security, workers' compensation, disability or unemployment insurance benefits, or employee benefits of any kind and Hospice will not withhold for taxes from Medical Director's fees paid pursuant to Sections 3.3 and 3.4. Medical Director agrees to make all state and federal estimated or final tax payments due on account of said fees in a timely manner.

5.4 Indemnification. Medical Director shall, at his/her own cost and expense, pay, protect, indemnify, defend, and hold Hospice (and Hospice's trustees, officers, directors, contractors, employees, agents, subcontractors, invitees and/or affiliates) harmless, from and against all claims, causes of action, suits, demands, liabilities, damages, penalties, injury, judgments, and costs and expenses, including reasonable attorneys' fees and court costs, which may be imposed upon, incurred by, or asserted against Hospice (and/or Hospice's trustees, officers, directors, contractors, employees, agents, subcontractors, invitees and/or affiliates) arising out of acts or omissions caused or contributed to by the negligence or willful misconduct of Medical Director or his/her representatives. This provision shall survive the termination or expiration of this Agreement.

5.5 Governing Law. This Agreement shall be construed, and the rights and liabilities of the Parties hereto determined, in accordance with the laws of the State. This provision shall survive the termination or expiration of this Agreement.

5.6 Arbitration of Disputes. Any controversy, dispute or disagreement arising out of, or relating to this Agreement or the breach thereof, shall be settled by arbitration in the State where the services are performed and, in accordance with the rules then existing of the American Health Lawyers Association, Alternative Dispute Resolution Rules, and judgment upon the award rendered may be entered in any court having jurisdiction thereof. Such arbitration shall be binding and the expense and costs thereof shall be borne by each party as incurred; and following arbitration, the prevailing party shall be entitled to all costs incurred, including reasonable attorneys' fees. The foregoing shall not prevent either Party from seeking interim or equitable relief in a court to the extent provided for or otherwise appropriate under this Agreement.

5.7 Amendments. This Agreement may be amended only by a writing signed by both Parties setting forth the specific terms of such amendment, except as expressly provided otherwise herein. Amendments required by legislative, regulatory or other legal authority, as reasonably determined by Hospice, shall not require the consent of the Medical Director and shall be effective immediately upon Medical Director's receipt of notice of amendment from Hospice.

5.8 Waiver. A Party's failure, at any time or times hereafter, to require performance by the other Party of any provision of this Agreement shall not constitute a waiver or affect or diminish any right of the Party thereafter to demand such performance.

5.9. Intentionally Blank.

5.10 Headings. The paragraph headings contained in this Agreement are for reference purposes only and should not affect in any way the meaning or interpretation of this Agreement.

5.11 Records. Upon written request, for a period of up to six (6) years following the furnishing of services under this Agreement, either Party shall make available to the Secretary of the Department of Health and Human Services ("Secretary") or, upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, the contract, books, documents and records of either Party that are necessary to certify the nature and extent of the services and costs hereunder. In addition, Hospice shall have the same rights of access during the term of this Agreement and for the six year period following termination. This provision shall survive the termination or expiration of this Agreement.

5.12 Private Practice of Medical Director. Nothing in this Agreement shall limit the ability of Medical Director to engage in the private practice of medicine, outside the scope of this Agreement; provided that Medical Director hereby acknowledges that, in the provision of such private practice of medicine, Medical Director shall not and shall not represent that he or she is providing such services on behalf of or at the direction of Hospice. Medical Director shall not make use of Hospice's resources for any professional activities outside the scope of this Agreement.

5.13 Entire Agreement. This Agreement constitutes the complete agreement of the Parties hereto with respect to the subject matter hereof and shall supersede and render null and void all prior and contemporaneous agreements between the Parties hereto regarding the subject matter hereof. All exhibits attached and referred to herein are fully incorporated by this reference into this Agreement.

5.14 Assignment. Medical Director shall not assign Medical Director's rights or delegate his or her duties or obligations of this Agreement, or any portion hereof, without the prior written consent of Hospice and, to the extent required, any applicable payor.

5.15 Third-Party Beneficiaries. There shall be no third-party beneficiaries to this Agreement.

5.16 Fair Market Value. The amounts to be paid by Hospice to Medical Director pursuant to this Agreement have been determined through good faith bargaining, in an arms length process, to be the fair market value of the Medical Director Services specified herein. No amount to be paid hereunder is intended to be a direct or indirect, covert or overt offer, inducement or payment for referrals of patients or services.

5.17 Severability. In the event that any provision of the Agreement is held to be unenforceable for any reason, the unenforceability of that provision will not affect the remainder of this Agreement, which will remain in full force and effect in accordance with its terms.

5.18 Legal Compliance. Nothing contained in this Agreement or in any other written or oral agreement between the Parties, or any consideration offered or paid in connection with this Agreement, contemplates or requires Medical Director or any physician to admit or refer any patients to Hospice as a precondition to receiving the benefits set forth. In the event that either Party reasonably determines that compliance with the terms

of this Agreement by either party would pose a clear and present risk of causing a Party to violate an applicable law, rule or regulation of any kind, including but not limited to laws, rules and regulations relating to relationships between referral sources or relating to availability of reimbursement to Hospice from governmental payers, the Party will provide notice of the potential violation and proposed modifications to the Agreement to remediate the potential violation and for the fifteen (15) day period after the other party received the foregoing notice the Parties will negotiate in good faith for an appropriate amendment to this Agreement. If the parties are not able to agree within that time, either Party may terminate this Agreement immediately on written notice to the other party. Such notice shall not be deemed an admission by either Party that a violation of a law, rule, or regulation has occurred.

5.19 Access to Books and Records of Subcontractor. Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, the Medical Director will make available those contracts, books, documents, and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection will be available up to four (4) years after the rendering of such services. If the Medical Director carries out any of the duties of this Agreement through a subcontract with a value of $10,000 or more over a 12-month period with a related individual or Hospice, the Medical Director agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of Public Law 96+99, Sec. 952 (Sec. 1861(v) (1) of the Social Security Act) and the regulations promulgated there under. No attorney-client, accountant-client or other legal privilege will be deemed to have been waived by Hospice or the Medical Director by virtue of this Agreement. Notwithstanding the foregoing, Medical Director shall not subcontract any of his or her rights or obligations hereunder without the prior written consent of Hospice. This provision shall survive the termination or expiration of this Agreement.

5.20 Criminal Background Check.

5.20.1 Hospice agrees that it will obtain or cause to be obtained, criminal background checks in accordance with state and federal requirements on all employees or contract personnel who have direct patient contact or access to patient information and may obtain other forms of verification, such as fingerprinting, in accordance with local, State and federal laws, rules and regulations. Hospice shall obtain a criminal background check on Medical Director in accordance with State and federal requirements and Medical Director shall cooperate in the completion of all criminal background check documentation requested by Hospice, shall be eligible to work with patients and shall not be found to have engaged in any improper or illegal conduct with the elderly or vulnerable individuals.

5.20.2 Medical Director agrees that he/she will obtain or cause to be obtained, criminal background checks in accordance with state and federal requirements on all Medical Director employees or contract personnel who have direct hospice patient contact or access to hospice patient records.

5.20.3 The parties agree that in the absence of state requirements, criminal background checks are to be obtained within three months of the date of employment for all states that the individual has lived or worked in for the past three years.

5.21 Binding Effect. This Agreement shall be binding upon and inure to the benefit of the Parties hereto and their respective successors and permitted assigns.

5.22 Counterparts. This Agreement may be executed in any number of counterparts, all of which together shall constitute one and the same instrument.

5.23 Nondiscrimination. In the performance of this Agreement, the Parties will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, sex, age, religion, national origin or other protected class in any manner prohibited by federal, state or local laws, rules or regulations.

IN WITNESS WHEREOF, the Parties have duly executed this Agreement on the dates set forth below effective as of the date specified at the beginning of this Agreement.

Bristol Hospice – Pierce, L.L.C.

By: _____

Its: CEO

Date: 10-25-19

MEDICAL DIRECTOR

By: _____

Its: _____

Date: 10/25/19

EXHIBIT A
MEDICAL DIRECTOR PROFESSIONAL RESPONSIBILITIES

1. Medical Director has overall responsibility for the medical direction of Hospice and has responsibility for the medical component of Hospice's patient care program.

2. Medical director, physician employees, and contracted physician(s) of Hospice, in conjunction with the Patient's Attending Physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.

3. Medical Director shall supervise all physician and nurse practitioner employees and those under contract, of Hospice. All physician and nurse practitioner employees and those under contract with Hospice shall meet this requirement by either providing the services directly or through coordinating patient care with the Attending Physician. If the Attending Physician is unavailable, Medical Director, contracted physician, and/or Hospice physician employees are responsible for meeting the medical needs of the Patient.

4. Medical Director directs Hospice's quality assurance program and participates in all appropriate quality assurance activities and regularly apprises Hospice regarding same.

5. Medical Director participates in Hospice's Interdisciplinary Group, attends all Interdisciplinary Group meetings and participates in the annual evaluation.

6. Medical Director, along with Hospice's Interdisciplinary Group, in consultation with the Patient's Attending Physician, prepares a written plan of care for each Patient, which specifies the hospice care and services necessary to meet the Patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions. The plan of care must be periodically reviewed by the Attending Physician, Medical Director, and the Interdisciplinary Group of Hospice. The Interdisciplinary Group (in collaboration with the individual's Attending Physician, if any) will review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. Medical Director and the Interdisciplinary Group will keep Hospice apprised of the patient's needs and condition.

7. Medical Director provides in-service education to Hospice associates as requested.

8. Medical Director participates in the development and implementation of Hospice policies and medical protocols, including but not limited to those regarding emergency preparedness.

9. Medical Director will consult and coordinate Patient care with Attending Physicians, including the establishment and maintenance of a plan of care for each Patient and in the review and updating of that plan at appropriate intervals.

10. Medical Director will, along with the Interdisciplinary Group generally, ensure that in addition to palliation and management of terminal illness and related conditions, the physical, medical, psychosocial, emotional, and spiritual needs of the Hospice Patients and families facing terminal illness and bereavement are also met.

11. Medical Director is responsible for the submission to Hospice of documentation of services provided as appropriate.

12. Medical Director will advise and/or assist in the resolution of concerns/conflicts involving physicians utilizing the services of Hospice.

13. Medical Director will review and sign, as appropriate, initial hospice certifications of terminal illness, and re-certifications as indicated. Medical Director or the physician designee approved by Hospice reviews

the clinical information for each Hospice Patient and provides written certification that it is anticipated that the Patient's life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following when making this determination: (1) The primary terminal condition; (2) Related diagnosis(es), if any; (3) Current subjective and objective medical findings; (4) Current medication and treatment orders; and (5) Information about the medical management of any of the Patient's conditions unrelated to the terminal illness. Before the recertification period for each Patient, Medical Director or the physician designee approved by Hospice must review the Patient's clinical information. The foregoing shall be subject to all applicable local, state and federal rules, laws and regulations and the Conditions of Participation.

14. Medical Director will keep abreast of local, State and Federal rules, regulations, policies and procedures which affect the provision of patient care services by Hospice and take reasonable steps to ensure compliance with such rules, regulations, policies and procedures. Medical Director will maintain current knowledge of the latest research and trends in hospice care and pain/symptom management. Medical Director will cooperate with Hospice to ensure ongoing Hospice compliance with all applicable State licensure laws, and Federal and State certification and accreditation requirements and perform such other services as are required for maintenance of necessary Hospice licenses, certifications and accreditations.

15. Medical Director will perform such other responsibilities as are, in the judgment of the Governing Body or its designee, reasonable and required of or appropriate for a Hospice medical director under applicable laws, rules and regulations, payer contracts or conditions of participation, and/or CHAP and other applicable accreditation body standards or requirements.

EXHIBIT B
CONSULTING PHYSICIAN OR PHYSICIAN SERVICES RESPONSIBILITIES

1. At the written request or referral of the Attending Physician or other appropriate source, Medical Director will provide Consulting Physician and Physician Services which may include, as appropriate:

(a) Evaluating the individual's need for pain and symptom management;

(b) Counseling the individual regarding hospice and other care options;

(c) Advising the individual regarding advanced care planning; and

2. Medical Director will document the written request or referral for the Consulting Physician and/or Physician Services by the Attending Physician or other appropriate source in the Patients' medical record.

3. If the services are initiated by the beneficiary, Hospice will maintain a record of the services and documentation that communication between the Medical Director or physician and the beneficiary's physician occurs, with the beneficiary's permission, to the extent necessary to ensure continuity of care.

4. If other than the Attending Physician institutes the request for service, Medical Director should communicate with the Attending Physician, with the beneficiary's permission, to the extent necessary to ensure continuity of care.

5. If Medical Director is the Attending Physician to a Patient, then the Attending Physician may not provide nor may the Hospice bill for this service because that physician already possesses the expertise necessary to furnish end-of-life evaluation and management, and counseling services.

6. Medical Director is responsible for the submission to Hospice of documentation of services provided under this Exhibit B as appropriate.

EXHIBIT D
BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (the "Addendum") is made part of the Agreement to which this document is attached by the parties to that Agreement. Hospice is referred to herein as Covered Entity and Medical Director is referred to herein as Business Associate.

1. DEFINITIONS

(a) Terms capitalized but not otherwise defined in this Addendum shall have the same meaning as set forth in HIPAA and HITECH (each as defined herein). A change to HIPAA or HITECH which modifies any defined HIPAA or HITECH term, or which alters the regulatory citation for the definition shall be deemed incorporated into this Addendum.

(b) "Business Associate" shall mean the above-stated "Business Associate." It shall also have the meaning given to such term under the Privacy Rule, including but not limited to 45 CFR Section 160.103.

(c) "Covered Entity" shall mean the above stated "Covered Entity". It shall also have the meaning given to the term under the Privacy Rule, including but not limited to 45 CFR Section 160.103.

(d) "Data Aggregation" shall have the meaning given to the term under the Privacy Rule, including but not limited to 45 CFR Section 164.501.

(e) "Designated Record Set" shall have the meaning given to the term under the Privacy Rule, including but not limited to 45 CFR Section 164.501.

(f) "Electronic Protected Health Information" or "EPHI" shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.

(g) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, as amended, and related HIPAA regulations (45 C.F.R. Parts 160-164).

(h) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005 and any regulations promulgated thereunder.

(i) "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

(j) "Privacy Rule" shall 45 C.F.R. part 160 and part 164, subparts A and E.

(k) "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103. All references to PHI shall also include EPHI, unless otherwise stated in the Agreement.

(l) "Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.

(m) "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

(n) "Security Incident" shall have the same meaning as the term "security incident" in 45 C.F.R. § 164.304.

(o) "Security Rule" shall mean 45 C.F.R. part 160 and part 164, subparts A and C.

(p) "Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" in 45 C.F.R. § 164.402.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

Business Associate agrees to:

(a) Not use or disclose PHI other than as permitted or required by the Agreement, or as required by law.

(b) Use appropriate safeguards, and comply, where applicable, with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI other than as provided for by the Agreement.

(c) Report to Covered Entity any use or disclosure of PHI or EPHI not provided for by the Agreement of which it becomes aware or should have known, and any Security Incident of which it becomes aware, including breaches of Unsecured PHI. Business Associate will make the report to the Covered Entity's designated privacy official and security officer or to a designated authorized person in the Covered Entity's legal department immediately. This report will include at least the following information: (i) the nature of the non-permitted or violating use or disclosure or Security Incident; (ii) the PHI and EPHI used or disclosed; (iii) information required to be provided by the Covered Entity in notifications to affected individuals should Covered Entity need to make such a notification.

(d) Develop, implement, maintain, and use reasonable and appropriate safeguards to prevent any use or disclosure of the PHI or EPHI other than as provided by the Agreement, and to implement administrative, physical, and technical safeguards as required by HIPAA and HITECH to protect the security, confidentiality, integrity, and availability of EPHI and PHI.

(e) Comply with any additional requirements of Title XIII of HITECH that relate to privacy and security and that are made applicable with respect to covered entities.

(f) Adopt the technology and methodology standards required in any guidance issued by the Secretary pursuant to HITECH.

(g) Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of the Agreement or applicable federal or state laws. Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of any Security Incident involving EPHI.

(h) In the case of a breach of Unsecured PHI, following the discovery of a breach of such information, immediately notify Covered Entity of such breach. The notice shall include the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during the breach.

(i) Enter into an agreement with each of its subcontractors that is appropriate and sufficient to require each such subcontractor to protect PHI and otherwise comply with the requirements set forth in this Addendum to the same extent required by Business Associate hereunder.

(j) Along with its agents and subcontractors, if any, only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure. Business Associate agrees to comply with the Secretary's guidance on what constitutes "minimum necessary".

(k) Ensure that any agent, including a subcontractor, to whom it provides PHI or EPHI agrees in writing to the same restrictions and conditions that apply to Business Associate in the Agreement related to such information.

(l) Provide, at the request of Covered Entity, within the reasonable time period specified by Covered Entity, access to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. 164.524 if Business Associate maintains PHI in a designated record set as defined by the Privacy Rule.

(m) Make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. 164.526 at the request of an Individual, within the reasonable time period specified by Covered Entity, if Business Associate maintains PHI in a designated record set as defined by the Privacy Rule.

(n) Make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity available to the Covered Entity, or to the Secretary or person designated by the Secretary, within 10 days of receipt of a request from the Covered Entity for such disclosure, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule and Security Rule.

(o) Document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. 164.528.

(p) Provide to Covered Entity or an Individual as directed by Covered Entity, within the reasonable time period specified by Covered Entity for an accounting of disclosures, information collected in accordance with subsection (2)(o) of this Addendum, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. 164.528. With the exception of the limited circumstances whereby Business Associate shall make an accounting directly to an individual in accordance with HITECH § 13405(c), Business Associate shall promptly, but no later than within ten (10) business days of a request, notify Covered Entity about such request. Covered Entity shall either request that Business Associate provide such information directly to the Individual, or it shall request that the information be immediately forwarded to Covered Entity for compilation and distribution to such Individual. Business Associate shall not disclose any PHI unless such disclosure is required by Law or is in accordance with the Agreement. Business Associate shall document such disclosures. Notwithstanding anything in the Agreement to the contrary, Business Associate and any agents or subcontractors shall continue to maintain the information required for purposes of complying with subsection 2(o) and this subsection 2(p) for a period of six (6) years after termination of the Agreement.

(q) To the extent Business Associate is to carry out Covered Entity's obligation under the Privacy Rule, comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligation.

3. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

(a) Except as otherwise limited in the Agreement, Business Associate may use or disclose PHI on behalf of, or to provide services to, Covered Entity as long as such use or disclosure of PHI would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

(b) Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate provided that the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(c) Except as otherwise limited in the Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).

(d) Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with Sec. 164.502(j)(1).

4. OBLIGATIONS OF COVERED ENTITY TO INFORM BUSINESS ASSOCIATE OF PRIVACY PRACTICES AND RESTRICTIONS

(a) Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

(b) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

(c) Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to or must comply with in accordance with 45 C.F.R. 164.522 and/or HITECH § 13405(a), to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(d) Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule or Security Rule if done by Covered Entity.

5. TERMS AND TERMINATION

(a) Term. The Term of this Addendum shall be effective as of the date of the Agreement, and shall terminate after the termination or expiration of the Agreement, but only when all of the PHI and EPHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, as directed by Covered Entity.

(b) Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, in its sole discretion, either:

(1) Provide notice and an opportunity for Business Associate to cure the breach or end the violation and then terminate the Agreement if Business Associate does not cure the breach or end the violation within the time period specified by Covered Entity; or

(2) Immediately terminate the Agreement.

(c) Effect of Termination.

(1) Except as provided in paragraph (2) of this Section 5(c), upon termination of the Agreement, for any reason, Business Associate shall, at Covered Entity's direction, return or destroy all PHI and EPHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. Business Associate shall retain no copies of the PHI or EPHI. This provision shall apply to PHI and EPHI that is in the possession of subcontractors or agents of Business Associate.

(2) In the event that Business Associate determines that returning or destroying the PHI or EPHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. If Covered Entity agrees in writing that returning or destroying the PHI or EPHI is infeasible, Business Associate shall extend the protections of this Addendum to such PHI or EPHI. For the avoidance of doubt, in the event Business Associate retains such PHI or EPHI pursuant to this provision after termination or expiration of the Agreement, the provisions of this Addendum shall continue in full force and effect;

provided, however, that Business Associate may use and disclose PHI and EPHI retained by Business Association after termination or expiration of the Agreement only for those purposes that make return or destruction of such PHI or EPHI infeasible and are authorized by Covered Entity in writing, for so long as Business Associate maintains such PHI or EPHI.

6. STATE STANDARDS

In addition to the privacy and security obligations set forth in this Addendum, to the extent Business Associate will receive, store, maintain, process or otherwise have access to any personal information as defined under any breach notification or information security rule of any state applicable to a resident of such state through its provision of services to Covered Entity, Business Associate shall implement and maintain security measures to protect such personal information in accordance with any statute applicable to personal information received, stored, maintained, processed or otherwise accessible to Business Associate through its provision of services to Covered Entity. Business Associate shall also comply with any provision applicable to personal information of a resident of any state, as applicable, when disposing of any records, whether in paper, digital, electronic or other form, that contain such personal information, patient information, or any other personally identifiable information. Business Associate agrees to ensure that any subcontractors that create, receive, maintain or transmit personal information on behalf of Business Associate agree to comply with the same or similar restrictions and conditions that apply to Business Associate with respect to such information.

7. INDEMNIFICATION

In addition to the indemnification obligations of Business Associate outlined in the Agreement, the following indemnification obligation shall apply to this Addendum. Business Associate shall defend and indemnify Covered Entity against, and hold Covered Entity (including officers, directors, and employees) harmless from any and all loss, damage, penalty, liability, cost and expense, including without limitation, reasonable attorneys fees and disbursements, that may be incurred, imposed upon, or asserted against Covered Entity by reason of any claim, regulatory proceeding, or litigation arising directly or indirectly from any act or omission of Business Associate and its officers, directors, employees, subcontractors, agents, representatives and other persons acting on its behalf, with respect to using or disclosing patient information, or maintaining the security, confidentiality, integrity and availability of EPHI, in accordance with this Addendum or applicable federal or state law.

8. MISCELLANEOUS

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Privacy Rule or Security Rule or HITECH means the section as in effect or as amended.

(b) Agreement. Any provision of applicable statutes and regulation that invalidates any term of the Agreement, that is inconsistent with any term of the Agreement, or that would cause performance thereunder by one or both of the parties to be in violation of law shall be deemed to have superseded the terms of the Agreement; provided, however, that the parties shall use their best efforts to accommodate the terms and intent of the Agreement to the greatest extent possible consistent with the requirements of applicable statutes and regulation and negotiate in good faith toward amendment of the Agreement. Covered Entity may terminate the Agreement upon thirty (30) days written notice in the event that Business Associate does not promptly enter into an amendment that Covered Entity, in its sole discretion, deems sufficient to ensure that Covered Entity will be able to comply with applicable statutes and regulations.

(c) Conflict. The Agreement, inclusive of this Addendum, is the only agreement between the parties related to the subject matter in the Agreement. To the extent there is any inconsistency between the terms and conditions of the Agreement and this Addendum, the terms and conditions of this Addendum shall govern. Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits Covered Entity to comply with applicable law protecting the privacy, security and confidentiality of PHI and EPHI, including, without limitation, HIPAA and HITECH.

(d) Binding Effect. This Addendum is binding upon the successors and assigns of the parties herein. This Addendum is intended to confer rights and responsibilities only on the Covered Entity and Business Associate and does not create or vest rights or remedies in any third party.

(e) Enforceability. If any provision hereof shall be declared to be invalid or unenforceable, such declaration of invalidity or unenforceability shall not affect any remaining provisions hereof which can be given effect.

(f) Relationship of the Parties. Nothing in this Addendum shall create any relationship between Covered Entity and Business Associate other than as independent contractors. No employee or agent of either party may be deemed an employee or agent of the other party by reason of this Addendum.

(g) Survival. Business Associate's obligation to protect the confidentiality of the PHI and EPHI shall survive the termination of this Addendum and shall continue for as long as Business Associate maintains PHI or EPHI.

(h) Construction. This Addendum shall be construed, and the rights and liabilities of the Parties hereto determined, in accordance with the laws of the State. This provision shall survive the termination or expiration of this Addendum.

Exhibit 14

Sublease Agreement

Between

Bristol Hospice – Pierce, L.L.C.

and

Bristol Hospice, L.L.C. dba Bristol Hospice - Thurston

This Sublease Agreement ("Sublease") is entered into as of January 1, 2023, by and between Bristol Hospice, L.L.C. dba Bristol Hospice – Thurston ("Sublandlord"), and Bristol Hospice – Pierce, L.L.C. ("Subtenant").

RECITALS:

A. On August 17, 2021, Lacey Professional Plaza LLC ("Landlord") and Sublandlord entered into a lease agreement (the "Lease") for the property located at 4160 6th Ave. SE, Suite 200, Lacey, WA 98503 (the "Premises");

B. Sublandlord desires to sublease the Subleased Premises (as defined below) to Subtenant; and

C. Subtenant desires to sublease such Subleased Premises from Sublandlord at the rental rate and upon the covenants, conditions and provisions set forth herein.

NOW THEREFORE, for and in consideration of the foregoing and for other good and valuable consideration and the mutual agreements herein contained, the parties agree as follows:

1. **Incorporation of Recitals**. The recitals set forth above are hereby incorporated into and made a part of this Sublease.

2. **Subleased Premises**. Sublandlord hereby subleases to Subtenant, on the terms and conditions set forth in this Sublease and the Lease, two office rooms (the "Subleased Premises") along with shared access to the conference room in the Premises, the Furniture (as defined herein), and non-exclusive access to certain common areas as set forth herein.

3. **Lease**. Subtenant agrees to be bound by the terms of the Lease during the Sublease Term (as defined below).

4. **Term.** The term of this Sublease shall commence effective as of January 1, 2023 ("Commencement Date") and shall be for a three-year term that expires December 31, 2025 ("Sublease Term"). Subtenant shall have one (1) option to extend the term of this Lease for an additional two (2) years. Subtenant is required to provide written notice to Sublandlord regarding such extension no later than sixty (60) days prior to the expiration of the then-current lease term.

5. **Rent**. For its use and possession of the Subleased Premises, Subtenant will pay Sublandlord $800.00 per month (the "Rent"). The parties acknowledge that the Rent is intended to reflect fair market value for Subleased Premises leased by Subtenant pursuant to this Sublease and does not and shall not be modified to take into account the volume or value of any referrals or business generated between the parties.

6. **Use of Premises.** Subtenant shall have exclusive use of the Subleased Premises during the Sublease Term and agrees to use the Subleased Premises for general office purposes only and for no other purpose unless Subtenant obtains Sublandlord's prior written consent as to a purpose other than as set forth in this Sublease. Subtenant shall have access to and the right to use, in common with others, the common indoor and outdoor areas of the office building designated by Landlord for common use by occupants of the office building.

7. **Alterations, Additions and Changes.**

   A. Sublandlord's Prior Written Consent Required. Subtenant shall not, without Landlord's and Sublandlord's prior written consent, make any alterations, additions or changes to the Premises or any part thereof, except alterations, additions or changes, pre-approved in writing by Landlord and Sublandlord, which will not be unreasonably withheld or delayed ("Approved Alterations").

   B. Plans, Supervision and Quality of Work. Any and all Approved Alterations shall be supervised by an architect or licensed structural engineer in accordance with plans and specifications, approved in writing by Sublandlord, prior to the commencement of work. Subtenant shall ensure that all work is completed in a good, workmanlike manner and is diligently performed to completion.

   C. Notice of Non-Responsibility. Prior to the commencement of any work under this Section of the Sublease, Subtenant shall post, on Landlord's and Sublandlord's behalf, a duly executed owner's notice of on-responsibility as may be required by law.

   D. Inurement. Upon the termination of this Sublease, any and all Approved Alterations shall be considered as improvements and shall not be removed by the Subtenant but shall become part of the Premises and shall insure to Sublandlord's reversionary interest.

8. **Utilities.** Subtenant shall pay a flat amount of $200.00 per month for utilities.

9. **Furniture.** In consideration of the obligations of Subtenant under this Sublease, Sublandlord grants Subtenant a fully paid right to use the furniture, fixtures, appliances and equipment located with the Subleased Premises as of the Commencement Date (the "Furniture").

10. **Signage.** Following Sublandlord's consent, Subtenant shall have the right to place on the Premises, at locations selected by Subtenant, any signs which are permitted by applicable zoning ordinances and private restrictions. The foregoing shall be subject to the terms of the Lease relating to signs.

11. **Attorney's Fees.** In the event any action or proceeding is brought to enforce any term, covenant or condition of this Sublease on the part of the Sublandlord or Subtenant, the prevailing party in such litigation shall be entitled to recover reasonable attorney's fees and costs.

12. **Quiet Possession/Waste or Nuisance.** Sublandlord covenants and warrants that upon performance by Subtenant of its obligations hereunder, Sublandlord will keep and maintain Subtenant in exclusive, quiet, peaceful, undisturbed and uninterrupted possession of the Subleased Premises during the Sublease Term. Subtenant covenants and warrants that

Subtenant shall not commit, or suffer to be committed, any waste upon the Subleased Premises, or any nuisance or other act or thing which may disturb the quiet enjoyment of any person within the building of which the Subleased Premises form a part.

13. **Condemnation.** If any legally constituted authority condemns the Premises or such part thereof which shall make the Subleased Premises unsuitable for leasing, this Sublease shall cease when the public authority takes possession and Sublandlord and Subtenant shall account for rental compensation from the condemning authority for any loss or damage caused by the condemnation. Neither party shall have any rights in or to any award made to the other by the condemning authority.

14. **Notice.** Any notice required or permitted under this Sublease shall be sufficiently given or served if sent by United States certified mail, return receipt requested or by email, addressed as follows:

If to Sublandlord:
c/o Bristol Hospice
206 N 2100 W, Ste. 202
Salt Lake City, Utah 84116
Attention: Gerry Christensen
Email: Gerry.christensen@bristolhospice.com

If to Subtenant:
c/o Bristol Hospice
206 N 2100 W, Ste. 202
Salt Lake City, Utah 84116
Attention: Hyrum Kirton
Email: hyrum.kirston@bristolhospice.com

15. **Severability.** The terms, conditions, covenants and provisions of this Sublease shall be deemed to be severable. If any clause or provision herein contained shall be adjudged to be invalid or unenforceable by a court of competent jurisdiction or by operation of any applicable law, it shall not affect the validity of any other clause or provision herein.

16. **Entire Agreement.** This Sublease contains the entire agreement of the parties hereto and not representations, inducements, promises or agreements, oral or otherwise, between the parties, not embodied herein, shall be of any force or effect. No alteration, amendment, change or addition to this Sublease shall be binding upon Sublandlord or Subtenant unless reduced to writing and signed by Sublandlord and Subtenant.

17. **Governing Law.** This Sublease shall be governed, construed and interpreted by, through and under the laws of the State of Michigan.

18. **Electronic Record Keeping.** Sublandlord and Subtenant agree and acknowledge that this Sublease may be kept in electronic form and that a fully executed electronic version of this Sublease will be just as valid and enforceable as the original.

[Remainder of Page Left Blank; Signature Page Follows]

In witness whereof, the parties have executed this Sublease as of the date first written above.

Sublandlord - Bristol Hospice, L.L.C.

dba Bristol Hospice – Thurston

By: _____

Name: Gerry Christensen

Title: CFO

Date: January 28, 2022

Subtenant - Bristol Hospice – Pierce, L.L.C.

By: _____

Name: Hyrum Kirton

Title: Chief Executive Officer

Date: 1/28/22

Exhibit 15

Bristol Hospice
embracing a reverence for life

January 25, 2022

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

RE: Bristol Hospice – Pierce, L.L.C.
Certificate of Need Application to Establish a Hospice Program in Pierce County, Washington

Department of Health:

As Chief Financial Officer of Bristol Hospice Parent, LLC, which is the parent entity of (i) Bristol Hospice Topco, Inc., (ii) Bristol Hospice Holdings, Inc., (iii) Bristol Hospice, L.L.C., and (iv) Bristol Hospice – Pierce, L.L.C., this letter hereby expresses commitment to the funds for the development and operation of the proposed hospice program in Pierce County, Washington.

The December 31, 2020 Consolidated Audited Financial Statements for Bristol Hospice Parent, LLC included with the CON application document available net working capital of approximately $59 million including $38.8 million in cash and cash equivalents and approximately $10.7 million in operating income.

As the CFO, I hereby authorize the release of such funds to Bristol Hospice – Pierce, L.L.C., as needed, to accomplish the project as proposed within its CON application.

Sincerely,

Gerry Christensen
Chief Financial Officer

Exhibit 16

Bristol Hospice Parent, LLC

Independent Auditor's Report and Consolidated Financial Statements

December 31, 2020

Bristol Hospice Parent, LLC

December 31, 2020

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BKD
CPAs & Advisors

910 E. St. Louis Street, Suite 200 | P.O. Box 1190 | Springfield, MO 65801-1190
417.865.8701 | Fax 417.865.0682 | bkd.com

Independent Auditor's Report

Board of Managers
Bristol Hospice Parent, LLC
Salt Lake City, Utah

We have audited the accompanying consolidated financial statements of Bristol Hospice Parent, LLC (the "Company") and its subsidiaries, which comprise the consolidated balance sheet as of December 31, 2020, and the related consolidated statements of operations, members' equity, and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

PRAXITY
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Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Bristol Hospice Parent, LLC and its subsidiaries, as of December 31, 2020, and the results of their operations and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in *Note 14* to the consolidated financial statements, on July 1, 2020, a new parent company was created and, through an exchange of equity interests, a common control transaction was completed. The consolidated financial statements have been presented to reflect the common control transaction as of the beginning of the year. Our opinion is not modified with respect to this matter.

Consolidating Information

Our audit was performed for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated financial statements, and accordingly, we do not express an opinion or provide any assurance on it.

BKD, LLP

Springfield, Missouri
May 26, 2021

Bristol Hospice Parent, LLC
Consolidated Balance Sheet
December 31, 2020

Assets	
Current Assets	
Cash	$ 38,803,864
Patient accounts receivable	53,358,481
Other receivables	2,645,872
Prepaid expenses and other	4,271,626
Total current assets	99,079,843
Property and Equipment, At Cost	
Leasehold improvements	882,974
Equipment	607,657
Furniture and fixtures	1,522,543
Buildings	397,673
	3,410,847
Less accumulated depreciation	1,641,388
	1,769,459
Other Assets	
Goodwill, net of accumulated amortization of $74,765,749	345,872,899
Other intangible assets, net of accumulated amortization of $5,675,933	30,000,517
Deposits	257,853
Deferred tax assets, net	346,390
	376,477,659
Total assets	$ 477,326,961
Liabilities and Members' Equity	
Current Liabilities	
Outstanding checks in excess of bank balances	$ 692,008
Current maturities of long-term debt	2,650,000
Accounts payable	10,283,282
Accrued payroll and related liabilities	14,409,001
Contract liabilities - current	2,116,856
Other accrued expenses	9,860,569
Total current liabilities	40,011,716
Long-Term Liabilities	
Contract liabilities	4,233,711
Long-term debt, net of current portion and debt issuance costs	258,119,626
Total liabilities	302,365,053
Members' Equity	174,961,908
Total liabilities and members' equity	$ 477,326,961

See Notes to Consolidated Financial Statements

Bristol Hospice Parent, LLC
Consolidated Statement of Operations
Year Ended December 31, 2020

Operating Revenue	
Patient service revenue	$ 286,875,446
CARES Act Provider Relief Funds	13,182,950
	300,058,396
Operating Expenses	
Salaries and benefits	171,257,505
Purchased services	10,840,205
Supplies	16,685,053
Transportation	6,756,735
General and administrative	29,148,007
Rents and leases	14,173,204
Contract services	1,375,468
Utilities	2,792,675
Depreciation	551,162
Amortization of intangible assets and goodwill	35,756,358
	289,336,372
Operating Income	10,722,024
Other Income (Expense)	
Gain on sale of assets	684,388
Interest and other income	44,732
Loss on extinguishment of debt	(4,378,890)
Interest expense	(17,587,365)
	(21,237,135)
Income Before Income Taxes	(10,515,111)
Provision for Income Taxes	(2,252,144)
Net Loss	$ (12,767,255)

See Notes to Consolidated Financial Statements

Bristol Hospice Parent, LLC

Consolidated Statement of Members' Equity

Year Ended December 31, 2020

Balance, January 1, 2020	$ 136,884,624
Contributions	39,809,330
Share-based compensation	11,035,209
Net loss	(12,767,255)
Balance, December 31, 2020	$ 174,961,908

Bristol Hospice Parent, LLC
Consolidated Statement of Cash Flows
Year Ended December 31, 2020

Operating Activities	
Net loss	$ (12,767,255)
Items not requiring (providing) operating cash flow	
Depreciation	551,162
Amortization of intangible assets and goodwill	35,756,358
Amortization of debt issuance costs	1,240,057
Loss on extinguishment of debt	4,378,890
Deferred income taxes	(5,012,957)
Deferred tax asset valuation allowance	5,188,314
Gain on sale of assets	(684,388)
Share-based compensation	11,035,209
Changes in	
Patient accounts receivable	20,164,275
Other receivables	(1,401,234)
Accounts payable and accrued expenses	145,942
Contract liabilities	6,350,567
Other assets and liabilities	(2,353,526)
Net cash provided by operating activities	62,591,414
Investing Activities	
Purchase of property and equipment	(216,195)
Proceeds from sale of assets	750,000
Payment for business acquisitions	(146,305,735)
Net cash used in investing activities	(145,771,930)
Financing Activities	
Principal payments on long-term debt	(207,173,125)
Principal payments on related party long-term debt	(55,500,000)
Decrease in outstanding checks in excess of bank balance	(458,816)
Proceeds from issuance of long-term debt	332,800,000
Proceeds from issuance of related party long-term debt	21,500,000
Payment of debt issuance costs	(10,639,678)
Capital contributions	39,809,330
Net cash provided by financing activities	120,337,711
Increase in Cash	37,157,195
Cash, Beginning of Year	1,646,669
Cash, End of Year	$ 38,803,864

Bristol Hospice Parent, LLC
Consolidated Statement of Cash Flows
Year Ended December 31, 2020

Supplemental Cash Flows Information	
Interest paid	$ 14,319,596
Non-cash consideration	$ 652,000
The Company purchased all of the equity interests of New Dawn Health and Hospice, Inc. for $1,481,097.	
In conjunction with the acquisition, liabilities were assumed as follows:	
Fair value of assets acquired	$ 1,538,159
Cash paid	(1,481,097)
Liabilities assumed	$ 57,062
The Company purchased all of the equity interests of Front Range Hospice & Palliative Care for $2,319,615.	
In conjunction with the acquisition, liabilities were assumed as follows:	
Fair value of assets acquired	$ 2,424,204
Cash paid	(2,319,615)
Liabilities assumed	$ 104,589
The Company purchased certain assets or all of the equity interests of Sojourn portfolio entities for $38,623,923.	
In conjunction with the acquisition, liabilities were assumed as follows:	
Fair value of assets acquired	$ 41,366,582
Cash paid	(38,623,923)
Liabilities assumed	$ 2,742,659
The Company purchased certain assets of Pro Hospice Agency, Inc. for $4,500,000.	
In conjunction with the acquisition, liabilities were assumed as follows:	
Fair value of assets acquired	$ 4,500,000
Cash paid	(4,500,000)
Liabilities assumed	$ -

Bristol Hospice Parent, LLC
Consolidated Statement of Cash Flows
Year Ended December 31, 2020

The Company purchased certain assets of Visiting Nurse Association of the Inland Counties for $7,100,000.	
In conjunction with the acquisition, liabilities were assumed as follows:	
Fair value of assets acquired	$ 7,100,000
Cash paid	(7,100,000)
Liabilities assumed	$ -
The Company purchased all of the equity interests of Health Essentials Holdings, Inc. for $37,236,982.	
In conjunction with the acquisition, liabilities were assumed as follows:	
Fair value of assets acquired	$ 41,588,423
Cash paid	(37,236,982)
Liabilities assumed	$ 4,351,441
The Company purchased certain assets of NEMM, Inc. for $3,612,817.	
In conjunction with the acquisition, liabilities were assumed as follows:	
Fair value of assets acquired	$ 3,738,348
Cash paid	(3,612,817)
Liabilities assumed	$ 125,531
The Company purchased certain assets of Companion portfolio entities for $52,083,301.	
In conjunction with the acquisition, liabilities were assumed as follows:	
Fair value of assets acquired	$ 56,102,878
Non-cash consideration	(652,000)
Cash paid	(51,431,301)
Liabilities assumed	$ 4,019,577

Bristol Hospice Parent, LLC
Notes to Consolidated Financial Statements
December 31, 2020

Note 1: Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Bristol Hospice Parent, LLC is a private equity-owned Delaware Company and the 100 percent owner of its subsidiary Bristol Hospice Topco, Inc., which is likewise the 100 percent owner of Bristol Hospice Holdings, Inc., which is likewise the 100 percent owner of Bristol Hospice, LLC. Bristol Hospice, LLC operates Medicare-certified hospice and home health agencies in California, Hawaii, Oregon, Utah, Colorado, Texas, Georgia, Arizona, Nevada, and Florida. The Company was formed in 2020, see *Note 14*, and is headquartered in Salt Lake City, Utah.

Additionally, Bristol Hospice Parent, LLC is the 100 percent owner of its subsidiary NCP Parent, LLC (NCP), which is likewise the 100 percent owner of Nuclear Care Partners Holdings, Inc., which is likewise the 100 percent owner of NCP Investor, Inc., which is likewise the 100 percent owner of Nuclear Care Partners, LLC. Nuclear Care Partners, LLC provides healthcare services to former Department of Energy workers who have been diagnosed with work-related illnesses throughout the United States. As an approved provider under U.S. Department of Labor (DOL) programs, the NCP's services qualify for no-cost, in-home medical benefits.

The Company executed multiple transactions throughout 2020 that significantly expanded the operations of the Company. See further discussion of the business combinations at *Note 13*.

Principles of Consolidation

The consolidated financial statements include the following (collectively, "the Company"):

- Bristol Hospice Parent, LLC and its wholly owned subsidiaries:
  - NCP Parent, LLC (common control transaction in March 2020, see *Note 14*)
    - Nuclear Care Partners Holdings, Inc.
      - NCP Investor, Inc.
        - Nuclear Care Partners, LLC
  - Bristol Hospice Topco, Inc.
    - Bristol Hospice Holdings, Inc.
      - Bristol Hospice, L.L.C. and its wholly owned subsidiaries:
        - Bristol Hospice – Coachella Valley, L.L.C. (acquired in June 2020, see *Note 13*)
        - Bristol Hospice – San Jose, L.L.C. (acquired in March 2020, see *Note 13*)
        - Bristol Hospice – California, L.L.C.
        - Bristol Hospice – Hawaii, L.L.C.
        - Bristol Hospice – Inland Valley, L.L.C. (acquired in September 2020, see *Note 13*)
        - Bristol Hospice – Inland Empire, L.L.C. (acquired in June 2020, see *Note 13*)
        - Bristol Hospice – Utah, L.L.C.
        - Bristol Hospice – Utah II, L.L.C. (formerly Brighton Hospice, LLC)
        - Bristol Hospice – Sacramento, L.L.C.

- Bristol Hospice – Miami Dade, LLC
- Bristol Hospice – Eugene, L.L.C.
- Bristol Hospice – East Bay, L.L.C.
- Bristol Hospice – San Diego, L.L.C.
- Bristol Hospice – Rogue Valley, L.L.C .
- Bristol Hospice – Simi Valley, LLC (acquired in December 2020, see *Note 13*)
- Bristol Consulting and Management Services, L.L.C.
- BH Ventures, L.L.C.
  - Bristol Hospice – East, L.L.C.
    - Bristol Hospice – Georgia, L.L.C.
  - Bristol Hospice and Homecare – South Central, L.L.C.
    - Bristol Hospice – Pathways, L.L.C.
    - Bristol Hospice – Texas, L.L.C.
  - Bristol Hospice and Homecare – Northwest, L.L.C.
    - Bristol Hospice – Oregon, L.L.C.
- Optimal Health Services, Inc.
  - Optimal Home Health Care, Inc. (1)
  - Optimal Hospice, Inc.
    - Optimal Hospice Care, Inc.
- Suncrest Hospice, LLC
- Suncrest Hospice – NOCO, L.L.C. (acquired in February 2020, see *Note 13*)
- Brighton Home Health, LLC (2)
- Comfort Hospice and Palliative Care, LLC
- New Dawn Health and Hospice, Inc. (acquired in January 2020, see *Note 13*)
- Sojourn Redding Holdings, LLC (acquired in March 2020, see *Note 13*)
  - Sojourn Hospice and Palliative Care Redding, LLC
- Sojourn Modesto Holdings, LLC (acquired in March 2020, see *Note 13*)
  - Sojourn Hospice and Palliative Care Modesto, LLC
- Sojourn Fresno Holdings, LLC (acquired in March 2020, see *Note 13*)
  - Sojourn Hospice and Palliative Care Fresno, LLC
- Sojourn San Diego Holdings, LLC (acquired in March 2020, see *Note 13*)
  - Sojourn Hospice and Palliative Care San Diego, LLC
- Sojourn East Bay Holdings, LLC (acquired in March 2020, see *Note 13*)

- Sojourn Hospice and Palliative Care East Bay, LLC
- Health Essentials Holdings, Inc. (acquired in September 2020, see *Note 13*)
  - Health Essentials Acquisition Corp.
    - Remita Health Management, LLC
    - Gerinet Physician Services, Inc.
      - Hospice Touch, LLC
      - Gerinet Palliative Care, LLC
    - HealthEssentials, LLC
    - Hospice Touch, Inc.

(1) During 2020, the Company completed a sale of property and equipment and transferred operations of a portion of the entity for a sales price of $375,000. The sale resulted in a gain on disposal of assets of $370,039, included in the consolidated statement of operations. Total assets and total revenues of this entity were approximately $5,000 and $3,000, respectively, as of the time of sale and for the year ended December 31, 2020.

(2) During 2020, the Company completed a sale of property and equipment and transferred operations of the entity for a sales price of $375,000. The sale resulted in a gain on disposal of assets of $314,349, included in the consolidated statement of operations. Total assets and total revenues of this entity were approximately $61,000 and $465,000, respectively, as of the time of sale and for the year ended December 31, 2020.

When the Company acquires entities through business acquisitions (see *Note 13*), those entities are brought on either as new consolidated entities, as noted above, or the patients related to those entities are subsumed into pre-existing entities. As such, not all acquired entities are listed above depending on the treatment.

All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Limited Liability Company

The Company operates as a limited liability company. The liability of the members is limited to their capital contributions. Members are treated equally with respect to rights, preferences, and privileges.

Cash

At December 31, 2020, the Company's cash accounts exceeded federally insured limits by approximately $37,000,000.

Patient Accounts Receivable

Patient accounts receivable reflects the outstanding amount of consideration to which the Company expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others. As a service to the patient, the Company bills third-party payors directly and bills the patient when the patient's responsibility for co-pays, coinsurance, and deductibles is determined. Patient accounts receivable are due in full when billed.

The Company performs individual credit risk assessments which evaluate the individual circumstances, abilities, and intentions of each patient prior to providing the patient services. If subsequent to providing the services the Company becomes aware of patient-specific events, facts, or circumstances indicating patients no longer have the ability or intention to pay the amount of consideration to which the Company expected to be entitled for providing the patient services, then the related patient receivable balances are written off as bad debt expense and reported in the consolidated statement of operations as a component of operating expenses.

Property and Equipment

Property and equipment acquisitions are recorded at cost or fair value for assets acquired as part of business combinations and are depreciated on a straight-line basis over the estimated useful life of each asset. Leasehold improvements are amortized over the shorter of the lease term or respective estimated useful lives.

The estimated useful lives for each major depreciable classification of property and equipment are as follows:

Leasehold improvements	5 - 20 years
Equipment	2 - 15 years
Furniture and fixtures	5 - 10 years
Building	40 years

Goodwill and Indefinite-Lived Intangible Assets

The Company has elected the private company accounting alternative for identifiable intangible assets in a business combination. Under this alternative, certain customer-related intangible assets and noncompetition agreements are subsumed into goodwill and are no longer required to be recognized separately in the accounting for a business combination.

The Company has also elected the private company accounting alternative for the subsequent measurement of goodwill. Under this alternative, goodwill is amortized on a straight-line basis over 10 years. The Company evaluates the recoverability of the carrying value of goodwill and indefinite-lived intangibles at the entity level whenever events or circumstances indicate the carrying amount may not be recoverable.

In testing goodwill and indefinite-lived intangibles for impairment, the Company has the option first to perform a qualitative assessment to determine whether it is more likely than not that goodwill or indefinite-lived intangible assets are impaired or the Company can bypass the qualitative assessment and proceed directly to the quantitative test by comparing the carrying amount to the fair value of goodwill or indefinite-lived intangibles. If the implied fair value of goodwill or the fair value of the indefinite-lived intangibles is lower than its carrying amount, an impairment loss is recognized in an amount equal to the difference. Subsequent increases in value are not recognized in the consolidated financial statements.

Intangible Assets

Intangible assets with finite lives are being amortized on the straight-line basis over 10 years. Such assets are periodically evaluated as to the recoverability of their carrying values.

Long-Lived Asset Impairment

The Company evaluates the recoverability of the carrying value of long-lived assets whenever events or circumstances indicate the carrying amount may not be recoverable. If a long-lived asset is tested for recoverability and the undiscounted estimated future cash flows expected to result from the use and eventual disposition of the asset is less than the carrying amount of the asset, the asset cost is adjusted to fair value and an impairment loss is recognized as the amount by which the carrying amount of a long-lived asset exceeds its fair value.

No asset impairment was recognized during the year ended December 31, 2020.

Debt Issuance Costs

Debt issuance costs represent costs incurred in connection with the issuance of long-term debt. Such costs are being amortized over the term of the respective debt using the effective interest method.

Contract Liabilities

Amounts received related to health care services that have not yet been provided to patients are contract liabilities. Contract liabilities consist of payments made by third-party payors for services not yet performed.

Patient Service Revenue

Patient service revenue is recognized as the Company satisfies performance obligations under its contracts with patients. Patient service revenue is reported at the estimated transaction price or amount that reflects the consideration to which the Company expects to be entitled in exchange for providing patient care. The Company determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Company's policies, and implicit price concessions provided to uninsured patients. The Company determines its estimates of explicit price concessions which represent adjustments and discounts based on contractual agreements, its discount policies, and historical experience by payor groups. The Company determines its estimate of implicit price concessions based on its historical collection experience by classes of patients. The estimated amounts also include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations by third-party payors.

Self-Insurance

The Company has elected to self-insure certain costs related to employee accident benefit programs. Costs resulting from noninsured losses are charged to income when incurred. The Company has purchased insurance that limits its exposure for individual claims and limits its aggregate exposure to $250,000.

Professional Liability Claims

The Company recognizes an accrual for claim liabilities based on estimated ultimate losses and costs associated with settling claims and a receivable to reflect the estimated insurance recoveries, if any. Professional liability claims are described more fully in *Note 9*.

Share-Based Compensation

At December 31, 2020, the Company has a share-based employee compensation plan, which is described more fully in *Note 11*. The Company's accounting policy is to recognize forfeitures as they occur.

Income Taxes

Bristol Hospice Topco, Inc. and Nuclear Care Partners Holdings, Inc. account for income taxes in accordance with income tax accounting guidance (Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 740, *Income Taxes*). The income tax accounting guidance results in two components of income tax expense: current and deferred. Current income tax expense reflects taxes to be paid or refunded for the current period by applying the provisions of the enacted tax law to the taxable income or excess of deductions over revenues. Bristol Hospice Topco, Inc. and NCP Holdings, Inc. will each file consolidated C corporation tax returns with their respective subsidiary entities.

Bristol Hospice Parent, LLC is not directly subject to income taxes under the provision of the Internal Revenue Code and applicable state laws. Therefore, taxable income or loss is reported to the individual members for inclusion in their respective tax returns and no provision for federal and state income taxes has been included in the accompanying consolidated financial statements for these entities.

Note 2: Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which the Company expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Company bills the patients and third-party payors several days after the services are performed or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance Obligations

Performance obligations are determined based on the nature of the services provided by the Company. Revenue for performance obligations satisfied over time is recognized on a pro-rata basis over the estimated average length of episode for episodic home health services and based on actual charges incurred in relation to total expected or actual charges for nonepisodic home health services and hospice services. The Company believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving home health and hospice care services. The Company measures the performance obligation from commencement of services, to the point when it is no longer required to provide services to that patient, which is generally at the time of completion of a hospice care day, completion of a home care hourly unit, or completion of a home care episode of care.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Company has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to incomplete home health episodes of care at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

Transaction Price

The Company determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors and other discounts and implicit price concessions provided to patients in accordance with the Company's policy and estimates an allowance for uncollectible accounts based on an upfront assessment of patient credit risk. The Company determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The Company determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

Third-Party Payors

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

Medicare. Home health services rendered to Medicare program beneficiaries are reimbursed under a prospective methodology and no additional settlement will be made on the difference between the interim prospective amounts paid and actual cost. Hospice services rendered to Medicare program beneficiaries are reimbursed prospectively subject to certain limitations, and no additional settlement will be made on the difference between the interim per diem rates and actual costs.

The Company's Medicare hospice revenue is subject to an annual per-beneficiary limit (Medicare cap). The Medicare cap limits total Medicare payments to each of the Company's hospice licenses to a specified dollar amount multiplied by the pro-rated number of Medicare beneficiaries receiving services from that provider during the cap year. Pro-rated beneficiaries are calculated by determining the ratio of the hospice services provided by the Company to each beneficiary as a proportion of the total past, current, and future hospice services that beneficiary receives from any hospice provider. The cap year ends on September 30 each year.

Since the calculation of pro-rated beneficiaries relies upon projections of each beneficiary's future use of hospice services, the calculation of Medicare cap involves significant judgment. Accordingly, these estimates may change materially over time.

The Company monitors each of its licenses carefully and at December 31, 2020, the estimated Medicare cap liability included in other accrued liabilities in the consolidated balance sheet was approximately $2,008,000, which related to the 2020, 2019, and 2018 cap.

Medicaid. Home health and hospice services rendered to Medicaid program beneficiaries are reimbursed prospectively at rates established by the state Medicaid program with no settlement made on the difference between the interim prospective amounts paid and actual costs.

Department of Labor. Home health services rendered to former Department of Energy workers are reimbursed by the DOL based on the Office of Workers' Compensation Programs (OWCP) Medical Fee Schedule, which is administered by the DOL and is nonnegotiable. This schedule outlines the Current Procedural Terminology (CPT) codes developed by the American Medical Association (AMA) as a listing of descriptive terms and codes for reporting medical services and procedures being performed.

Other. Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Company's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Company. In addition, the contracts the Company has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and the Company's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known based on newly available information or as years are settled or are no longer subject to such audits, reviews and investigations.

Patients and Uninsured Payors

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Company assesses the patient's ability to pay for their services at the time of patient admission and an allowance for uncollectible accounts is estimated based on credit risk experience. After the initial credit risk assessment, the Company estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any discounts or adjustments of charges that are not due to credit risk, such as contractual adjustments, discounts and implicit price concessions based on historical collections experience. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. For the year ended December 31, 2020, a reduction in revenue of approximately

$2,030,000 was recognized due to changes in its estimates of implicit price concessions, discounts, and contractual adjustments for performance obligations satisfied in prior years. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense.

Refund Liabilities

From time to time, the Company will receive overpayments of patient balances from third-party payors or patients resulting in amounts owed back to either the patients or third-party payors. These amounts are excluded from revenues and are recorded as liabilities until they are refunded. As of December 31, 2020, the Company has a liability for refunds to third-party payors and patients recorded of approximately $1,575,000, included in other accrued expenses on the consolidated balance sheet.

Revenue Composition

The Company has determined that the nature, amount, timing, and uncertainty of revenue and cash flows are affected by the following factors:

- Payors (for example, Medicare, Medicaid, managed care, or other insurance, DOL, patient) have different reimbursement and payment methodologies
- Length of the patient's service or episode of care
- Geography of the service location
- Method of reimbursement
- Company's line of business that provided the service (for example, home health, hospice, etc.)

For the year ended December 31, 2020, the Company recognized revenue of $286,875,446, from services that transfer to the patient over time.

Contract Balances

The following table provides information about the Company's receivables from contracts with customers:

Accounts receivable, beginning of year	$ 58,793,394
Accounts receivable, end of year	53,358,481

Contract Liabilities

Contract liabilities represent the Company's obligation to provide services to patient when consideration has already been received from the patient or third-party payor.

Significant changes in contract liabilities during the year ended December 31, 2020, include cash received of $6,350,567, which has not yet been recognized as revenue. See further described at *Note 15*.

Note 3: Concentration of Credit Risk

The Company grants credit without collateral to its patients, most of whom are residents of the various geographies serviced and are insured under third-party payor agreements.

The mix of net receivables from patients and third-party payors at December 31, 2020, is:

Medicare	58%
Medicaid	9%
Department of Labor	11%
Other third-party payors	22%
Patients	0%
	100%

Note 4: Acquired Intangible Assets and Goodwill

The carrying basis and accumulated amortization of recognized intangible assets and goodwill at December 31, 2020, was:

	Gross Carrying Amount	Accumulated Amortization
Amortized intangible assets		
Goodwill	$ 420,638,648	$ 74,765,749
Trade names	23,971,000	5,675,933
	$ 444,609,648	$ 80,441,682
Unamortized intangible assets		
State licenses and provider numbers	$ 11,705,450	

Amortization expense for the year ended December 31, 2020, was $35,756,358. Estimated amortization expense for each of the following five years is:

2021	$ 44,460,965
2022	44,460,965
2023	43,949,757
2024	41,393,714
2025	41,393,714

The changes in the carrying amount of goodwill for the year ended December 31, 2020, were:

Balance as of January 1, 2020	$ 243,484,386
Goodwill acquired during the year	135,747,774
Amortization expense	(33,359,261)
Balance as of December 31, 2020	$ 345,872,899

Note 5: Long Term Debt

Note payable (A)	$ 265,000,000
Revolver payable (B)	3,500,000
	268,500,000
Less unamortized debt issuance costs	7,730,374
Less current maturities	2,650,000
	$ 258,119,626

(A) Secured note payable with quarterly principal payments of $662,500. Remaining principal due at maturity on December 22, 2026, with interest payments varying from 5.25 percent to 5.75 percent based on the applicable consolidated secured net leverage ratio required. At December 31, 2020 the interest rate was 5.50 percent. Note is secured by substantially all of the Company's assets. Unamortized debt issuance costs were $7,730,374 at December 31, 2020.

In connection with this note payable, the Company is required, among other things, to maintain certain financial conditions, including a maximum consolidated total net leverage ratio of 7.25 to 1.00 for quarters ending in 2021 and 2022, 6.75 to 1.00 for 2023, and 6.25 to 1.00 from 2024 to maturity.

(B) Revolving note payable with principal due at maturity on December 22, 2026; with interest payments due monthly that vary from 3.75 percent to 4.00 percent based on the applicable consolidated secured net leverage ratio required. At December 31, 2020 the interest rate was 4 percent. Note is secured by substantially all of the Company's assets.

The agreement provides for maximum borrowings of $30,000,000, with $26,500,000 remaining as of December 31, 2020.

In connection with this note payable, the Company is required, among other things, to maintain certain financial conditions, including a maximum consolidated total net leverage ratio of 7.25 to 1.00 for quarters ending in 2021 and 2022, 6.75 to 1.00 for 2023, and 6.25 to 1.00 from 2024 to maturity.

Aggregate annual maturities of long-term debt at December 31, 2020, are:

2021	$ 2,650,000
2022	2,650,000
2023	2,650,000
2024	2,650,000
2025	2,650,000
Thereafter	255,250,000
	$ 268,500,000

The Company also maintains letters of credit of approximately $1,225,000 as security for certain insurance policies. No amounts have been drawn on the letters of credit as of December 31, 2020.

Note 6: Operating Leases

Noncancelable operating leases for office space expire in various years through 2028. These leases generally require the Company to pay for utilities, insurance, and internal maintenance.

Future minimum lease payments at December 31, 2020, were:

2021	$ 5,799,435
2022	4,820,223
2023	3,414,683
2024	1,914,929
2025	996,055
Later years	536,344
	$ 17,481,669

In addition to these noncancelable leases, the Company rents various equipment to care for patients, as needed.

Rent expense for all operating leases was $14,173,204 for the year ended December 31, 2020.

Note 7: Income Taxes

The provision for income taxes on the consolidated financial statements relates to the accounts of Bristol Hospice Topco, Inc. and Nuclear Care Partners Holdings, Inc.

The provision for income taxes includes these components:

Taxes currently payable	$ 2,076,786
Deferred income taxes	(5,012,957)
Adjustment of deferred tax asset valuation allowance	5,188,314
Income tax provision	$ 2,252,143

A reconciliation of income tax expense at the statutory rate to the Company's actual income tax expense is shown below:

Computed at the statutory rate (21%)	$ (2,208,173)
Increase (decrease) resulting from	
Tax exempt income	(2,768,419)
Nondeductible expenses	413,665
State income taxes and other	(690,638)
Changes in the deferred tax asset valuation allowance	5,188,314
Share-based compensation	2,317,394
Actual tax provision	$ 2,252,143

The tax effects of temporary differences related to deferred taxes shown on the consolidated balance sheet were:

Deferred tax assets	
Allowance for doubtful accounts	$ 2,632,222
Amortization	8,500,754
Net operating loss carryforwards	154,023
Other	840,470
	12,127,469
Deferred tax liabilities	
Depreciation	(361,168)
Prepaid expenses	(437,284)
Net deferred tax asset before valuation allowance	11,329,017
Valuation allowance	
Beginning balance	(5,794,313)
Increase during the period	(5,188,314)
Ending balance	(10,982,627)
Net deferred tax asset (liability)	$ 346,390

Note 8: Profit-Sharing Plan

The Company has a 401(k) profit-sharing plan covering its full-time employees who are at least 21 years of age and meet certain length-of-service requirements. The Company may make discretionary matching contributions of eligible employees' annual compensation. The Company made discretionary contributions for the year ended December 31, 2020, of approximately $1,106,000.

Note 9: Professional Liability Claims

The Company purchases medical malpractice insurance under a claims-made policy on a fixed premium basis. Based upon the Company's claims experience, no accrual has been made for the Company's medical malpractice costs as of December 31, 2020. It is reasonably possible that this estimate could change materially in the near term.

Note 10: Related-Party Transactions

Management Fees

The Company receives certain advisory services from private equity members for which it pays a quarterly management fee. Total management fee expense was $1,125,000 for the year ended December 31, 2020, and is included in general and administrative expense in the Company's consolidated statement of operations.

Other Receivables

The Company has receivables for reimbursement of amounts paid on behalf of related party palliative care start-ups owned by Bristol-employed physicians. At December 31, 2020, the outstanding receivables were $2,467,626 and are included in other receivables in the Company's consolidated balance sheet.

Note Payable

The Company had a note payable with a related party through common ownership. At December 31, 2020, the outstanding balance on the note payable was $0, as the note was paid in full in December 2020 (see *Note 5* (A)). Related party interest expense for the year ended December 31, 2020, totaled $5,309,020.

Note 11: Share-Based Compensation

Profits Interest Plan

In connection with the profits interest plan (the "Plan") issued by the Company, employees of the Company were granted Class B class units. The Company believes such awards better align the interests of its employees with those of its unitholders. A total of 10,000 of the units were fully vested upon grant date and 12,503,688 of the units granted generally vest based on 5 years of continuous service. The remaining 12,503,683 of the units granted contain performance vesting conditions related to change in control events that management has determined are not probable of achievement at this time as a change in control event has not yet occurred. As of December 31, 2020, the Company has recorded $11,035,209 in award-based compensation expense for the time-based vesting awards which is included within salaries and benefits expenses in the Company's consolidated statement of operations. As of December 31, 2020, there was approximately $7,446,734 and $9,569,975 of total unrecognized compensation cost related to nonvested time-based and performance-based awards granted under the Plan, respectively.

The fair value of each award was estimated on the grant date using a market approach for an estimated valuation of the enterprise based on an EV/EBITDA multiple of 15x. This multiple was based on historical transactions for guideline companies that operate in the Company's industry. The profits interest calculation was performed using the current value method by allocating the enterprise valuation to the units granted under the Plan. In addition, management considered the distribution priority schedule or "waterfall calculation" in its estimation process.

A summary of the status of the Company's nonvested units as of December 31, 2020, and changes during the year then ended, is presented below:

	Specified Class B Units		Other Class B Units	
	Units	Weighted-Average Grant-Date Fair Value	Units	Weighted-Average Grant-Date Fair Value
Nonvested, beginning of year	-	$ -	-	$ -
Granted	10,000	252.90	25,007,373	1.28
Vested	(10,000)	252.90	(6,346,828)	1.28
Forfeited	-	-	-	-
Nonvested, end of year	-	$ -	18,660,545	$ 1.28

Note 12: Significant Estimates and Concentrations

Accounting principles generally accepted in the United States of America require disclosure of certain significant estimates and current vulnerabilities due to certain concentrations. Those matters include the following:

Variable Consideration

Estimates of variable consideration in determining the transaction price for patient service revenue are described in *Notes 1* and *2*.

Malpractice Claims

Estimates related to the accrual for medical malpractice claims are described in *Notes 1* and *9*.

Litigation

In the normal course of business, the Company is, from time to time, subject to allegations that may or do result in litigation. Some of these allegations are in the areas not covered by the Company's commercial insurance; for example, allegations regarding employment practices or performance of contracts. The Company evaluates such allegations by conducting investigations to determine the validity of each potential claim. Based upon the advice of counsel, management records an estimate of the amount of ultimate expected loss, if any, for each of these matters. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

During the year ended December 31, 2020, the Company received a repayment demand letter from the Centers for Medicare and Medicaid Services (CMS), related to a hospice provider acquired in 2019, seeking repayment for certain amounts due to a retroactive termination of the acquired hospice provider's Medicare enrollment. The Medicare enrollment is believed to have been terminated in error due to a misunderstanding at the state level and the matter is currently being resolved with regulatory authorities to retroactively reinstate the Medicare enrollment for this provider.

Current Economic Conditions

Due to the current regulatory environment, economic uncertainties, and the growing pressure on the budgets of both the state and federal governments, it is possible that Medicare and Medicaid reimbursement could change in the near term which could impact the financial results and cash flows of the Company. The values of assets and liabilities recorded in the consolidated financial statements could change rapidly, resulting in material future adjustments to certain assets and allowances for accounts receivable that could negatively impact the Company's ability to maintain sufficient liquidity.

Note 13: Business Acquisitions

New Dawn Health and Hospice, Inc.

On January 21, 2020, the Company acquired 100 percent of the outstanding equity interests of New Dawn Health and Hospice, Inc., a hospice provider serving the state of Texas. As a result of the acquisition, the Company will have an opportunity to increase its hospice market share. The Company also expects to reduce costs through economies of scale.

The Company incurred approximately $135,000 of acquisition-related third-party costs related to this acquisition. The expenses are included in general and administrative expense in the Company's consolidated statement of operations for the year ended December 31, 2020.

The goodwill of $952,943 arising from the acquisition consists largely of the synergies and economies of scale expected from combining the operations of the Company and New Dawn Health and Hospice, Inc. All of the goodwill was assigned to the Company as a whole. The full amount of goodwill is expected to be deductible for tax purposes.

The following table summarizes the consideration paid for New Dawn Health and Hospice, Inc., and the amounts of the assets acquired and liabilities assumed recognized at the acquisition date.

Fair value of consideration transferred	
Cash paid to seller	$ 1,481,097
Recognized amounts of identifiable assets acquired and liabilities assumed	
Accounts receivable	285,216
Identifiable intangible assets - licenses	300,000
Accounts payable	(25,236)
Accrued expenses	(31,826)
Total identifiable net assets acquired	528,154
Goodwill	$ 952,943

The fair value of the assets acquired includes receivables with a fair value of $285,216 with no amounts expected to be uncollectible.

The weighted-average amortization period of acquired intangible assets is 10 years.

Front Range Hospice and Palliative Care

On February 27, 2020, the Company acquired 100 percent of the outstanding equity interests of Front Range Hospice & Palliative Care, a hospice provider serving the state of Colorado. As a result of the acquisition, the Company will have an opportunity to increase its hospice market share. The Company also expects to reduce costs through economies of scale.

The Company incurred approximately $140,000 of acquisition-related third-party costs related to this acquisition. The expenses are included in general and administrative expense in the Company's consolidated statement of operations for the year ended December 31, 2020.

The goodwill of $1,828,690 arising from the acquisition consists largely of the synergies and economies of scale expected from combining the operations of the Company and Front Range Hospice & Palliative Care. All of the goodwill was assigned to the Company as a whole. The full amount of goodwill is expected to be deductible for tax purposes.

The following table summarizes the consideration paid for Front Range Hospice & Palliative Care, and the amounts of the assets acquired recognized at the acquisition date.

Fair value of consideration transferred	
Cash paid to seller	$ 2,319,615
Recognized amounts of identifiable assets acquired and liabilities assumed	
Accounts receivable	295,514
Identifiable intangible assets - licenses	300,000
Accounts payable	(77,417)
Accrued expenses	(27,172)
Total identifiable net assets acquired	490,925
Goodwill	$ 1,828,690

The fair value of the assets acquired includes receivables with a fair value of $295,514 with no amounts expected to be uncollectible.

The weighted-average amortization period of acquired intangible assets is 10 years.

Sojourn Portfolio

On March 9, 2020, the Company purchased a portfolio of hospice entities through acquisition of 100 percent of the outstanding equity interests for five portfolio entities and through the acquisition of certain assets for three additional portfolio entities, collectively referred to as "Sojourn" and recapped below. The Sojourn Portfolio consists of hospice providers serving the states of California and Utah.

- Securities Transactions:
  - Sojourn East Bay
  - Sojourn Fresno
  - Sojourn Modesto
  - Sojourn Redding
  - Sojourn San Diego

- Asset Transactions:
  - Sojourn San Jose
  - Sojourn Sacramento
  - One Care Utah

As a result of the acquisition, the Company will have an opportunity to increase its hospice market share. The Company also expects to reduce costs through economies of scale.

The Company incurred approximately $1,615,000 of acquisition-related third-party costs related to this acquisition. The expenses are included in general and administrative expense in the Company's consolidated statement of operations for the year ended December 31, 2020.

The goodwill of $36,475,540 arising from the acquisition consists largely of the synergies and economies of scale expected from combining the operations of the Company and the Sojourn Portfolio. All of the goodwill was assigned to the Company as a whole. The full amount of goodwill is expected to be deductible for tax purposes.

The following table summarizes the consideration paid for the Sojourn Portfolio, and the amounts of the assets acquired recognized at the acquisition date.

Fair value of consideration transferred	
Cash paid to seller	$ 38,623,923
Recognized amounts of identifiable assets acquired and liabilities assumed	
Accounts receivable	3,091,042
Identifiable intangible assets - licenses	1,800,000
Accounts payable	(2,015,292)
Accrued payroll and related liabilities	(727,367)
Total identifiable net assets acquired	2,148,383
Goodwill	$ 36,475,540

The fair value of the assets acquired includes receivables with a fair value of $3,091,042 with no amounts expected to be uncollectible.

The weighted-average amortization period of acquired intangible assets is 10 years.

Pro Hospice Agency, Inc.

On May 18, 2020, the Company acquired certain assets of Pro Hospice Agency, Inc., a hospice provider serving the state of California. As a result of the acquisition, the Company will have an opportunity to increase its hospice market share. The Company also expects to reduce costs through economies of scale.

The Company incurred approximately $359,000 of acquisition-related third-party costs related to this acquisition. The expenses are included in general and administrative expense in the Company's consolidated statement of operations for the year ended December 31, 2020.

The goodwill of $3,800,000 arising from the acquisition consists largely of the synergies and economies of scale expected from combining the operations of the Company and Pro Hospice Agency, Inc. All of the goodwill was assigned to the Company as a whole. The full amount of goodwill is expected to be deductible for tax purposes.

The following table summarizes the consideration paid for Pro Hospice Agency, Inc., and the amounts of the assets acquired recognized at the acquisition date.

Fair value of consideration transferred	
Cash paid to seller	$ 4,500,000
Recognized amounts of identifiable assets acquired and liabilities assumed	
Property and equipment	400,000
Identifiable intangible assets - licenses	300,000
Total identifiable net assets acquired	700,000
Goodwill	$ 3,800,000

The weighted-average amortization period of acquired intangible assets is 10 years.

Visiting Nurse Association of the Inland Counties

On August 5, 2020, the Company acquired certain assets of Visiting Nurse Association of the Inland Counties, a hospice provider serving the state of California. As a result of the acquisition, the Company will have an opportunity to increase its hospice market share. The Company also expects to reduce costs through economies of scale.

The Company incurred $297,000 of acquisition-related third-party costs related to this acquisition. The expenses are included in general and administrative expense in the Company's consolidated statement of operations for the year ended December 31, 2020.

The goodwill of $7,100,000 arising from the acquisition consists largely of the synergies and economies of scale expected from combining the operations of the Company and Visiting Nurse Association of the Inland Counties. All of the goodwill was assigned to the Company as a whole. The full amount of goodwill is expected to be deductible for tax purposes.

The following table summarizes the consideration paid for Visiting Nurse Association of the Inland Counties and the amounts of the assets acquired recognized at the acquisition date.

Fair value of consideration transferred	
Cash paid to seller	$ 7,100,000
Goodwill	$ 7,100,000

The weighted-average amortization period of acquired intangible assets is 10 years.

Health Essentials Holdings, Inc.

On September 4, 2020, the Company acquired 100 percent of the outstanding equity interests of Health Essentials Holdings, Inc, a hospice provider serving the states of California, Nevada, and Arizona. As a result of the acquisition, the Company will have an opportunity to increase its hospice market share. The Company also expects to reduce costs through economies of scale.

The Company incurred $2,286,000 of acquisition-related third-party costs related to this acquisition. The expenses are included in general and administrative expense in the Company's consolidated statement of operations for the year ended December 31, 2020.

The goodwill of $34,572,800 arising from the acquisition consists largely of the synergies and economies of scale expected from combining the operations of the Company and Health Essentials Holdings, Inc. All of the goodwill was assigned to the Company as a whole. The full amount of goodwill is expected to be deductible for tax purposes.

The following table summarizes the consideration paid for Health Essentials Holdings, Inc. and the amounts of the assets acquired and liabilities assumed recognized at the acquisition date.

Fair value of consideration transferred	
Cash paid to seller	$ 37,236,982
Recognized amounts of identifiable assets acquired and liabilities assumed	
Accounts receivable	4,615,623
Identifiable intangible assets - licenses	2,400,000
Accounts payable	(1,631,611)
Accrued payroll and related liabilities	(2,719,830)
Total identifiable net assets acquired	2,664,182
Goodwill	$ 34,572,800

The fair value of the assets acquired includes receivables with a fair value of $4,615,623 with no amounts expected to be uncollectible.

The weighted-average amortization period of acquired intangible assets is 10 years.

NEMM, Inc.

On September 30, 2020, the Company acquired certain assets of NEMM, Inc, a hospice provider serving the state of California. As a result of the acquisition, the Company will have an opportunity to increase its hospice market share. The Company also expects to reduce costs through economies of scale.

The Company incurred $46,000 of acquisition-related third-party costs related to this acquisition. The expenses are included in general and administrative expense in the Company's consolidated statement of operations for the year ended December 31, 2020.

The goodwill of $2,915,500 arising from the acquisition consists largely of the synergies and economies of scale expected from combining the operations of the Company and NEMM, Inc. All of the goodwill was assigned to the Company as a whole. The full amount of goodwill is expected to be deductible for tax purposes.

The following table summarizes the consideration paid for NEMM, Inc. and the amounts of the assets acquired and liabilities assumed recognized at the acquisition date.

Fair value of consideration transferred	
Cash paid to seller	$ 3,612,817
Recognized amounts of identifiable assets acquired and liabilities assumed	
Prepaid expenses	27,817
Accounts receivable	495,031
Identifiable intangible assets - licenses	300,000
Accounts payable	(36,806)
Accrued expenses	(88,725)
Total identifiable net assets acquired	697,317
Goodwill	$ 2,915,500

The fair value of the assets acquired includes receivables with a fair value of $495,031 with no amounts expected to be uncollectible.

The weighted-average amortization period of acquired intangible assets is 10 years.

Companion Portfolio

On December 30, 2020, the Company acquired certain assets of:

- Companion Hospice and Palliative Care of the Valley, LLC
- Companion Hospice, LLC
- Companion Hospice Care, LLC
- Companion Home Health and Hospice Corporation
- Companion Hospice and Palliative Care, LLC
- California Companion Hospice and Palliative Care Services, LLC

The Companion Portfolio consists of hospice providers serving the state of California. As a result of the acquisition, the Company will have an opportunity to increase its hospice market share. The Company also expects to reduce costs through economies of scale.

The Company incurred $1,489,000 of acquisition-related third-party costs related to this acquisition. The expenses are included in general and administrative expense in the Company's consolidated statement of operations for the year ended December 31, 2020.

The goodwill of $48,102,301 arising from the acquisition consists largely of the synergies and economies of scale expected from combining the operations of the Company and the Companion Portfolio. All of the goodwill was assigned to the Company as a whole. The full amount of goodwill is expected to be deductible for tax purposes.

The following table summarizes the consideration paid for the Companion Portfolio and the amounts of the assets acquired and liabilities assumed recognized at the acquisition date.

Fair value of consideration transferred	
Cash paid to seller	$ 51,431,301
Non-cash consideration	652,000
Total consideration transferred	52,083,301
Recognized amounts of identifiable assets acquired and liabilities assumed	
Prepaid expenses	253,641
Accounts receivable	5,946,936
Identifiable intangible assets - licenses	1,800,000
Accounts payable	(2,291,726)
Accrued expenses	(175,654)
Accrued payroll and related liabilities	(1,552,197)
Total identifiable net assets acquired	3,981,000
Goodwill	$ 48,102,301

The fair value of the assets acquired includes receivables with a fair value of $5,946,936 with no amounts expected to be uncollectible.

The weighted-average amortization period of acquired intangible assets is 10 years.

Note 14: Common Control Transaction

On July 1, 2020, a new parent company was created, Bristol Hospice Parent, LLC. Through an exchange of equity interests on July 1, 2020, Bristol Hospice Parent, LLC, became the sole owner of Bristol Hospice Topco, Inc. and NCP Parent, LLC. As the majority ownership of each company is the same, this transaction was accounted for in a similar manner to a pooling of interests, using the historical book values of each entity. The consolidated financial statements have been presented to reflect the common control transaction as of the beginning of the year.

Note 15: COVID-19 Pandemic and CARES Act Funding

On March 11, 2020, the World Health Organization designated the SARS-CoV-2 virus and the incidence of COVID-19 (COVID-19) as a global pandemic. Patient volumes and the related revenues were significantly affected by COVID-19 as various policies were implemented by federal, state, and local governments in response to the pandemic that led many people to remain at home and forced the closure of or limitations on certain businesses.

While some of these policies have been eased and states have lifted moratoriums on nonemergent procedures, some restrictions remain in place, and some state and local governments reimposed certain restrictions due to increasing rates of COVID-19 cases prior to the widespread availability of a vaccine.

The Company's pandemic response plan has multiple facets and continues to evolve as the pandemic unfolds. The Company has taken precautionary steps to enhance its operational and financial flexibility, and react to the risks the COVID-19 pandemic presents to its business, including the following:

- Implementation of targeted cost reduction initiatives
- Increased training and personal protective equipment for clinical field employees and administrative employees

In addition, the Company received $6,350,567 of accelerated Medicare payments and $13,182,950 in general Provider Relief Fund distributions, both as provided for under the *Coronavirus Aid, Relief, and Economic Security* (CARES) *Act.*

The extent of the COVID-19 pandemic's potential adverse effect on the Company's operating results and financial condition has been and will continue to be driven by many factors, most of which are beyond the Company's control and ability to forecast. Such factors include, but are not limited to, the scope and duration of stay-at-home practices and business closures and restrictions, government-imposed or recommended suspension of elective procedures, declines in patient volumes for an indeterminable length of time, increases in the number of uninsured and

underinsured patients as a result of higher sustained rates of unemployment, incremental expenses required for supplies and personal protective equipment, and changes in professional and general liability exposure.

Because of these and other uncertainties, the Company cannot estimate the length or severity of the effect of the pandemic on the Company's business. Potential decreases in cash flows and results of operations may have an effect on debt covenant compliance and inputs and assumptions used in significant accounting estimates, including estimated implicit price concessions related to uninsured patient accounts, and potential impairments of goodwill and long-lived assets.

Provider Relief Funds

During the year ended December 31, 2020, the Company received $13,182,950 of distributions from the CARES Act Provider Relief Fund (the "Provider Relief Fund"). These distributions from the Provider Relief Fund are not subject to repayment, provided the Company is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for qualifying expenses or lost revenue attributable to COVID-19, as defined by the Department of Health and Human Services.

The Company accounts for such payments as conditional contributions in accordance with ASC Topic 958-605 – *Revenue Recognition.* Payments are recognized as contribution revenue once the applicable terms and conditions required to retain the funds have been substantially met. Based on an analysis of the compliance and reporting requirements of the Provider Relief Fund and the effect of the pandemic on the Company's revenues and expenses through December 31, 2020, the Company recognized $13,182,950 and these payments are recorded in CARES Act Provider Relief Funds in the Company's consolidated statement of operations.

The Company will continue to monitor compliance with the terms and conditions of the Provider Relief Fund and the effect of the pandemic on the Company's revenues and expenses. The terms and conditions governing the Provider Relief Funds are complex and subject to interpretation and change. If the Company is unable to attest to or comply with current or future terms and conditions the Company's ability to retain some or all of the distributions received may be affected. Additionally, the amounts recorded in the consolidated financial statements compared to the Company's Provider Relief Fund reporting could differ. Provider Relief Fund payments are subject to government oversight, including potential audits.

Medicare Accelerated and Advanced Payment Program

During the year ended December 31, 2020, the Company requested accelerated Medicare payments as provided for in the CARES Act, which allows for eligible health care providers to request up to three months of advance Medicare payments for other health care providers. These amounts are expected to be recaptured by the Centers for Medicare and Medicaid Services (CMS) according to the payback provisions.

The payback period begins one year after the issuance of the advance payments through a phased payback period approach. The first 11 months of the payback period will be at 25 percent of the remittance advice payment followed by a six-month payback period at 50 percent of the remittance advice payment. After 29 months, CMS expects any amount not paid back through the withhold amounts to be paid back in a lump sum or interest will begin to accrue subsequent to 29 months at a rate of 4 percent.

During the year ended December 31, 2020, the Company received $6,350,567 from these accelerated Medicare payment requests. The unapplied amount of accelerated Medicare payment requests are recorded as current and noncurrent contract liabilities in the Company's consolidated balance sheet.

Note 16: Future Change in Accounting Principle

Accounting for Leases

The Financial Accounting Standards Board amended its standard related to the accounting for leases. Under the new standard, lessees will now be required to recognize substantially all leases on the balance sheet as both a right-of-use asset and a liability. The standard has two types of leases for income statement recognition purposes: operating leases and finance leases. Operating leases will result in the recognition of a single lease expense on a straight-line basis over the lease term similar to the treatment for operating leases under existing standards. Finance leases will result in an accelerated expense similar to the accounting for capital leases under existing standards. The determination of lease classification as operating or finance will be done in a manner similar to existing standards. The new standard also contains amended guidance regarding the identification of embedded leases in service contracts and the identification of lease and nonlease components in an arrangement. The new standard is effective for the Company for the year ended December 31, 2022. The Company is evaluating the impact the standard will have on the consolidated financial statements; however, the standard is expected to have a material impact on the consolidated financial statements due to the recognition of additional assets and liabilities for operating leases.

Note 17: Subsequent Events

On February 1, 2021, the Company acquired certain assets of a hospice company at a purchase price of $1,450,000. The purchase price and transaction costs were funded by cash from the Company.

On March 1, 2021, the Company acquired certain assets of a hospice company at a purchase price of $3,500,000. The purchase price and transaction costs were funded by cash from the Company.

The initial accounting for these business combinations has not yet been completed as of the date the consolidated financial statements were available to be issued.

Subsequent events have been evaluated through May 26, 2021, which is the date the consolidated financial statements were available to be issued.

Consolidating Information

Bristol Hospice Parent, LLC
Consolidating Schedule - Balance Sheet Information
December 31, 2020

	Bristol	NCP	Eliminations	Total
Assets				
Current Assets				
Cash	$ 30,372,927	$ 8,430,937	$ -	$ 38,803,864
Patient accounts receivable, net of allowance Bristol - $8,454,930 and NCP - $827,548	47,040,492	6,317,989	-	53,358,481
Other receivables	2,645,275	597	-	2,645,872
Prepaid expenses and other	3,886,449	385,177	-	4,271,626
Intercompany receivable	23,074,989	-	(23,074,989)	-
Total current assets	107,020,132	15,134,700	(23,074,989)	99,079,843
Property and Equipment, At Cost				
Leasehold improvements	882,974	-	-	882,974
Equipment	607,155	502	-	607,657
Furniture and fixtures	1,459,031	63,512	-	1,522,543
Buildings	397,673	-	-	397,673
	3,346,833	64,014	-	3,410,847
Less accumulated depreciation	1,599,863	41,525	-	1,641,388
	1,746,970	22,489	-	1,769,459
Other Assets				
Goodwill, net of accumulated amortization Bristol - $68,021,094 and NCP - $6,744,655	321,945,040	23,927,859	-	345,872,899
Other intangible assets, net of accumulated amortization Bristol - $5,675,933 and NCP - $0	30,000,067	450	-	30,000,517
Deposits	241,969	15,884	-	257,853
Deferred tax assets, net	-	346,390	-	346,390
	352,187,076	24,290,583	-	376,477,659
Total assets	$ 460,954,178	$ 39,447,772	$ (23,074,989)	$ 477,326,961
Liabilities and Members' Equity				
Current Liabilities				
Outstanding checks in excess of bank balances	$ 692,008	$ -	$ -	$ 692,008
Current maturities of long-term debt	2,650,000	-	-	2,650,000
Accounts payable	10,231,461	51,821	-	10,283,282
Accrued payroll and related liabilities	12,079,119	2,329,882	-	14,409,001
Contract liabilities - current	2,116,856	-	-	2,116,856
Other accrued expenses	8,670,832	1,189,737	-	9,860,569
Intercompany payable	-	23,074,989	(23,074,989)	-
Total current liabilities	36,440,276	26,646,429	(23,074,989)	40,011,716
Long-Term Liabilities				
Contract liabilities	4,233,711	-	-	4,233,711
Long-term debt, net of current portion and debt issuance costs	258,119,626	-	-	258,119,626
Total liabilities	298,793,613	26,646,429	(23,074,989)	302,365,053
Members' Equity	162,160,565	12,801,343	-	174,961,908
Total liabilities and members' equity	$ 460,954,178	$ 39,447,772	$ (23,074,989)	$ 477,326,961

Bristol Hospice Parent, LLC

Consolidating Schedule - Statement of Operations Information

Year Ended December 31, 2020

	Bristol	NCP	Total
Operating Revenue			
Patient service revenue	$ 246,320,300	$ 40,555,146	$ 286,875,446
CARES Act Provider Relief Funds	13,182,950	-	13,182,950
	259,503,250	40,555,146	300,058,396
Operating Expenses			
Salaries and benefits	142,937,688	28,319,817	171,257,505
Purchased services	10,577,090	263,115	10,840,205
Supplies	16,565,690	119,363	16,685,053
Transportation	6,174,674	582,061	6,756,735
General and administrative	25,190,074	3,957,933	29,148,007
Rents and leases	13,742,120	431,084	14,173,204
Contract services	1,375,468	-	1,375,468
Utilities	2,481,853	310,822	2,792,675
Depreciation	536,188	14,974	551,162
Amortization of intangible assets and goodwill	32,689,107	3,067,251	35,756,358
	252,269,952	37,066,420	289,336,372
Operating Income	7,233,298	3,488,726	10,722,024
Other Income (Expense)			
Gain on sale of assets	684,388	-	684,388
Interest and other income	28,154	16,578	44,732
Loss on extinguishment of debt	(4,171,325)	(207,565)	(4,378,890)
Interest expense	(15,980,449)	(1,606,916)	(17,587,365)
	(19,439,232)	(1,797,903)	(21,237,135)
Income (Loss) Before Income Taxes	(12,205,934)	1,690,823	(10,515,111)
Provision for Income Taxes	(1,286,957)	(965,187)	(2,252,144)
Net Income (Loss)	$ (13,492,891)	$ 725,636	$ (12,767,255)

Exhibit 17

COMPANY	CONTACT	ADDRESS1	CITY	STATE	ZIP	PHONE	FAX	SIZE	LEVELOFCARE	COUNTY
Bridgeport Place	Letitia London	5250 Bridgeport Way W	University Place	WA	98467	(253)565-1960	(253)565-1996	77	ASL	Pierce
Brookdale Allenmore Assisted Living	James Coumbs	3615 S 23rd St	Tacoma	WA	98405	(253)759-7770	(253)759-7776	80	ASL	Pierce
Brookdale Courtyard Puyallup	Ruthmarie Zimmerman	4610 6th Pl SE	Puyallup	WA	98374	(253)841-9722	(253)435-5466	120	ASL	Pierce
Brookdale Harbor Bay	Jerry Lee	9324 N Harborview Dr	Gig Harbor	WA	98332	(253)858-7790	(253)858-7041	44	ASL	Pierce
Cascade Park Gardens	Kristina Singh	4347 S Union Ave	Tacoma	WA	98409	(253)475-3702		85	ASL	Pierce
Cascade Park Vista	Lincoln Strand	242 St Helens Ave S	Tacoma	WA	98402	(253)627-3833	(253)680-1960	117	ASL	Pierce
Cedar Ridge Retirement & Assisted Living	Travis McDaniel	9515 198th Ave E	Bonney Lake	WA	98391	(253)299-6461		70	ASL	Pierce
Charlton Place	James Severa	9723 S Steele St	Tacoma	WA	98444	(253)589-1834	(253)581-8540	105	ASL	Pierce
Cottages at Edgewood, The	Robert Chapman	2510 Meridian Ave E	Edgewood	WA	98371	(253)881-1435		60	ASL	Pierce
Country Cottage	Robert Judd	12109 Kapowsin Hwy E	Graham	WA	98338	(253)847-2004		15	ASL	Pierce
Emerald Care Center	Lydia Waweru	23809 46th Ave E	Spanaway	WA	98387	(253)847-9452		14	ASL	Pierce
Gibraltar Senior Living	Maria Salas	10816 18th Ave E	Tacoma	WA	98445	(253)537-5395		46	ASL	Pierce
Gig Harbor Court	Marykay Duran	3213 45th St Ct NW	Gig Harbor	WA	98335	(253)858-5300	(253)858-5323	55	ASL	Pierce
Harbor Place at Cottesmore	Administrator	1016 29th St NW	Gig Harbor	WA	98335	(253)853-3354		90	ASL	Pierce
Hearthside Manor	Kimberlee Fry	3615 Drexler Dr W	University Place	WA	98466	(253)460-3330		36	ASL	Pierce
Heritage House Buckley	Peggy Jensen	28833 Highway 410 E	Buckley	WA	98321	(360)829-5292		85	ASL	Pierce
Hope Guest Home	Paula Wetterlind	915 S 7th St	Tacoma	WA	98405	(253)627-3620		18	ASL	Pierce
Kats Care Center	Kenosha Turner	321 S 116th St	Tacoma	WA	98444	(253)537-3022		23	ASL	Pierce
King's Manor Senior Living Community	Nichol Coit	8609 Portland Ave	Tacoma	WA	98445	(253)538-7222	(253)531-4228	76	ASL	Pierce
Living Hope Care Center	Fetene Fasika	402 North J St	Tacoma	WA	98403	(253)572-7977		56	ASL	Pierce
Lodge At Mallard's Landing, The	Steve Brudnick	7083 Wagner Way NW	Gig Harbor	WA	98335	(253)858-4990		136	ASL	Pierce
Maple Creek Of Lakewood	David Langdon	10420 Gravelly Lake Dr SW	Lakewood	WA	98499	(253)588-0227		60	ASL	Pierce
McGee Guest Home	Toni Anderson	21520 82nd Ave E	Spanaway	WA	98387	(253)847-2292		64	ASL	Pierce
Meridian Hills Assisted Living	Robert Chapman	1813 S Meridian St	Puyallup	WA	98371	(253)841-4909	(253)841-2523	97	ASL	Pierce
Mill Ridge Village	Jennifer Reich	607 28th Ave	Milton	WA	98354	(253)925-9200		55	ASL	Pierce
Northwest Retirement Center	Thomas Gallucci	610 N Fife St	Tacoma	WA	98406	(253)272-8600		110	ASL	Pierce
Olympic Alzheimer's Residence	Angela Connery	3025 14th Ave NW	Gig Harbor	WA	98335	(253)851-5306		60	ASL	Pierce
Pacific Avenue Residential Care	Gerilyn Arenas	5621 Pacific Ave	Tacoma	WA	98408	(253)473-3577		16	ASL	Pierce
Peoples Retirement Community	Sindrella Brown	1720 E 67th St	Tacoma	WA	98404	(253)474-1741		110	ASL	Pierce
Pioneer Place Alzheimer's Residence	Peggy O'Donnell	11519 24th Ave E	Tacoma	WA	98445	(253)539-3410		65	ASL	Pierce
Puyallup Valley Enhanced Residential	Gerald Pratt	723 2nd St NW	Puyallup	WA	98371	(253)845-5398		51	ASL	Pierce
Silver Creek Retirement & Assisted Livin	Michael Ball	17607 91st Ave E	Puyallup	WA	98375	(253)875-8644		104	ASL	Pierce
Sound Vista Village	Kristi Knox	6633 McDonald Ave	Gig Harbor	WA	98335	(253)851-9929		36	ASL	Pierce
Spring Ridge Retirement Community	Tonya Hamilton	6856 Portland Ave	Tacoma	WA	98404	(253)474-1093	(253)474-0662	75	ASL	Pierce
Tacoma Lutheran Home Retirement Comm	Janice Dion	1301 N Highlands Pkwy	Tacoma	WA	98406	(253)752-7112	(253)752-7265	59	ASL	Pierce
Village Retirement & Assisted Living	Tamala Morris	4707 S Orchard St	Tacoma	WA	98466	(253)475-4707		110	ASL	Pierce
Waller Road Home	Gerilyn Arenas	4710 Waller Rd E	Tacoma	WA	98443	(253)922-2550		9	ASL	Pierce

Facility Name	Number	Provider Type	County Name	Street Address	City	Zip Code	Phone Number	Bed Count
CHI FRANCISCAN REHABILITATION HOSPITAL	503026	01 - HOSPITALS	WASHINGTON - PIERCE	815 S VASSAULT ST	TACOMA	98465	(253) 444-3320	60
MADIGAN GEN HOSP	50005F	01 - HOSPITALS	WASHINGTON - PIERCE		TACOMA	98431	0	560
MARY BRIDGE CHILDREN'S HOSPITAL	503301	01 - HOSPITALS	WASHINGTON - PIERCE	317 MARTIN LUTHER KING JR W BOX 5299	TACOMA	98415	(253) 403-1400	68
MERIDIAN SURGERY CENTER	500155	01 - HOSPITALS	WASHINGTON - PIERCE	208 17TH AVE SE #201	EDGEWOOD	98372	(360) 419-4000	1
MULTICARE GOOD SAMARITAN HOSPITAL	500079	01 - HOSPITALS	WASHINGTON - PIERCE	401 15TH AVENUE SE	PUYALLUP	98372	(253) 697-2102	365
RANIER STATE SCHOOL HOSP	50026E	01 - HOSPITALS	WASHINGTON - PIERCE		BUCKLEY	98321	0	48
ST ANTHONY HOSPITAL	500151	01 - HOSPITALS	WASHINGTON - PIERCE	11567 CANTERWOOD BOULEVARD NW	GIG HARBOR	98332	(253) 530-2050	80
ST CLARE HOSPITAL	500021	01 - HOSPITALS	WASHINGTON - PIERCE	11315 BRIDGEPORT WAY S W	LAKEWOOD	98499	(253) 588-1711	105
ST JOSEPH MEDICAL CENTER	500108	01 - HOSPITALS	WASHINGTON - PIERCE	1717 SOUTH J STREET	TACOMA	98405	(253) 627-4101	340
TACOMA GENERAL ALLENMORE HOSPITAL	500129	01 - HOSPITALS	WASHINGTON - PIERCE	315 S MLK JR WAY	TACOMA	98405	(253) 403-1000	521
US DEPARTMENT OF JUSTICE HOSP	50008F	01 - HOSPITALS	WASHINGTON - PIERCE	MC NEIL ISLAND	STEILACOOM	98388	0	50
VA HOSP	50009F	01 - HOSPITALS	WASHINGTON - PIERCE		AMERICAN LAKE	98493	0	824
WELLFOUND BEHAVIORAL HEALTH HOSPITAL	504016	01 - HOSPITALS	WASHINGTON - PIERCE	3402 S 19TH ST	TACOMA	98405	(253) 403-4565	120
AVAMERE AT PACIFIC RIDGE	505264	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	3625 EAST B STREET	TACOMA	98404	(253) 475-2507	102
AVAMERE HERITAGE REHABILITATION OF TACOMA	505183	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	7411 PACIFIC AVENUE	TACOMA	98408	(253) 474-8456	89
AVAMERE TRANSITIONAL CARE OF PUGET SOUND	505529	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	630 SOUTH PEARL STREET	TACOMA	98465	(253) 671-7300	60
COTTESMORE OF LIFE CARE	505499	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	2909 14TH AVENUE NORTHWEST	GIG HARBOR	98335	(253) 851-5433	108
LIFE CARE CENTER OF PUYALLUP	505324	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	511 10TH AVENUE SOUTHEAST	PUYALLUP	98372	(253) 845-7566	102
LIFE CARE CENTER OF SOUTH HILL	505526	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	2508 7TH ST SOUTHEAST	PUYALLUP	98374	(253) 661-5948	100
LINDEN GROVE HEALTH CARE CENTER	505485	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	400 - 29TH STREET NORTHEAST	PUYALLUP	98373	(253) 840-4400	130
MANOR CARE OF GIG HARBOR WA, LLC	505435	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	3309 45TH STREET COURT NORTHWEST	GIG HARBOR	98335	(253) 858-8688	120
MANOR CARE OF TACOMA WA, LLC	505289	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	5601 S ORCHARD STREET	TACOMA	98409	(253) 474-8421	124
ORCHARD PARK HEALTH CARE & REHAB CENTER	505093	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	4755 SOUTH 48TH	TACOMA	98409	(253) 475-4611	147
PARK ROSE CARE CENTER	505239	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	3919 SOUTH 19TH STREET	TACOMA	98405	(253) 752-5677	139
PUYALLUP NURSING AND REHABILITATION CENTER	505211	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	516 23RD AVE SE	PUYALLUP	98372	(253) 845-6631	96
RAINIER REHABILITATION	505304	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	920 12TH AVENUE SOUTHEAST	PUYALLUP	98372	(253) 841-3422	117
TACOMA LUTHERAN RETIREMENT COMMUNITY	505435	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	1301 N HIGHLANDS PARKWAY	TACOMA	98406	(253) 752-7112	189
TACOMA NURSING AND REHABILITATION CENTER	505154	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	2102 SOUTH 96TH STREET	TACOMA	98444	(253) 581-2514	150
WASHINGTON SOLDIERS HOME	505516	02 - SNF/NF (DUALLY CERTIFIED)	WASHINGTON - PIERCE	1301 ORTING-KAPOWSIN HWY E	ORTING	98360	(360) 893-4515	97
ALASKA GARDENS HEALTH AND REHABILITATION	505483	03 - SNF/NF (DISTINCT PART)	WASHINGTON - PIERCE	6220 SOUTH ALASKA STREET	TACOMA	98408	(253) 476-5300	123
ARCADIA HEALTHCARE - UNIVERSITY PLACE	505473	03 - SNF/NF (DISTINCT PART)	WASHINGTON - PIERCE	5520 BRIDGEPORT WAY WEST	UNIVERSITY PLACE	98467	(253) 566-7166	120
HEARTWOOD EXTENDED HEALTHCARE	505326	03 - SNF/NF (DISTINCT PART)	WASHINGTON - PIERCE	1649 EAST 72ND	TACOMA	98404	(253) 472-9027	120
THE OAKS AT LAKEWOOD	505347	03 - SNF/NF (DISTINCT PART)	WASHINGTON - PIERCE	11411 BRIDGEPORT WAY	TACOMA	98499	(253) 581-9002	80
HERON'S KEY	505531	04 - SKILLED NURSING FACILITIES	WASHINGTON - PIERCE	4340 BORGEN BLVD NW	GIG HARBOR	98332	(253) 313-0800	45
CAREAGE HOME HEALTH	507129	05 - HOME HEALTH AGENCIES	WASHINGTON - PIERCE	4924 109TH ST SW	LAKEWOOD	98499	(253) 853-4457	0
CHI FRANCISCAN HEALTH AT HOME	507124	05 - HOME HEALTH AGENCIES	WASHINGTON - PIERCE	2901 BRIDGEPORT W WAY	UNIVERSITY PLACE	98466	(253) 543-7026	0
ENVISION HOME HEALTH	507125	05 - HOME HEALTH AGENCIES	WASHINGTON - PIERCE	1818 S UNION AVE STE 1A	TACOMA	98405	(206) 452-0058	0
KINDRED AT HOME	507031	05 - HOME HEALTH AGENCIES	WASHINGTON - PIERCE	4020 S 56TH ST, STE 101	TACOMA	98409	(253) 475-6862	0
MULTICARE GOOD SAMARITAN HOME HEALTH	507046	05 - HOME HEALTH AGENCIES	WASHINGTON - PIERCE	3901 SOUTH FIFE STREET	TACOMA	98409	(253) 301-6400	0
PUGET SOUND HOME HEALTH	507101	05 - HOME HEALTH AGENCIES	WASHINGTON - PIERCE	4002 TACOMA MALL BLVD STE 204	TACOMA	98409	(253) 581-9410	0
PUGET SOUND HOME HEALTH OF KING COUNTY	507122	05 - HOME HEALTH AGENCIES	WASHINGTON - PIERCE	4002 TACOMA MALL BLVD, STE 204A	TACOMA	98409	(253) 735-4282	0
QUALITY MEDICAL IMAGING OF WASHINGTON, INC	50X0009833	07 - PORTABLE X-RAY SUPPLIERS	WASHINGTON - PIERCE	5720 144TH ST NW #100	GIG HARBOR	98332	(206) 362-3080	0
SOUND BONE AND HEALTH	50X0009823	07 - PORTABLE X-RAY SUPPLIERS	WASHINGTON - PIERCE	P O BOX 88998	STEILACOOM	98388	(253) 964-3579	0
TACOMA RADIOLOGICAL ASSOCIATES, PS	50X0009819	07 - PORTABLE X-RAY SUPPLIERS	WASHINGTON - PIERCE	3402 SOUTH 18TH	TACOMA	98405	(206) 659-3052	0
SELECT PHYSICAL THERAPY	506569	08 - OUTPATIENT PHYSICAL/SPEECH T	WASHINGTON - PIERCE	11212 SUNRISE BOULEVARD, SUITE #202	PUYALLUP	98374	(253) 435-0360	0
FRESENIUS KIDNEY CARE - BONNEY LAKE	502602	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	19663 SR 410 E	BONNEY LAKE	98391	(253) 987-4534	0
FRESENIUS KIDNEY CARE GIG HARBOR	502588	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	4700 PT FOSDICK DRIVE NW #101	GIG HARBOR	98335	(253) 853-2965	0
FRESENIUS KIDNEY CARE MT RAINIER	502591	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	1717 SOUTH J ST	TACOMA	98401	(253) 627-4101	0
FRESENIUS KIDNEY CARE PUYALLUP	502587	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	702 SOUTH HILL PARK	PUYALLUP	98373	(253) 445-7520	0
FRESENIUS KIDNEY CARE SOUTH TACOMA	502590	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	5825 TACOMA MALL BLVD SUITE 103	TACOMA	98409	(253) 476-5110	0
FRESENIUS KIDNEY CARE TACOMA EAST	502589	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	1415 EAST 72ND ST	TACOMA	98404	(253) 476-5110	0
GRAHAM DIALYSIS CENTER	502554	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	10219 196TH STREET COURT EAST, SUITE C	GRAHAM	98338	(615) 341-5847	0
LAKEWOOD COMMUNITY DIALYSIS CENTER	502519	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	5919 LAKEWOOD TOWNE CENTER BLVD, SUITE A	LAKEWOOD	98499	(253) 512-2400	0
NKC FIFE KIDNEY CENTER	502597	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	6021 12TH ST E STE 100	FIFE	98424	(253) 943-6335	0
PARKLAND DIALYSIS CENTER	502566	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	311 140TH ST SOUTH	PARKLAND	98444	(253) 536-7597	0
PUGET SOUND KIDNEY CENTER-LAKEWOOD	502600	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	11950 47TH AVE SW	LAKEWOOD	98499	(253) 393-6444	0
PUYALLUP DIALYSIS	502534	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	802 30TH AVE SW	PUYALLUP	98373	(253) 272-1916	0
RAINIER VIEW DIALYSIS	502579	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	1822 - 112 STREET EAST SUITE A	TACOMA	98445	(253) 539-5659	0
TACOMA DIALYSIS CENTER	502551	09 - END STAGE RENAL DISEASE FACIL	WASHINGTON - PIERCE	3401 S 19TH STREET	TACOMA	98405	(253) 573-1600	0
RAINIER SCHOOL PAT C	50G047	11 - INTERMEDIATE CARE-MENTAL HA	WASHINGTON - PIERCE	RYAN ROAD	BUCKLEY	98321	(360) 829-1111	112
RAINIER SCHOOL PAT E	50G046	11 - INTERMEDIATE CARE-MENTAL HA	WASHINGTON - PIERCE	320 RYAN ROAD	BUCKLEY	98321	(360) 829-1111	150
CASCADE LASER & SURGERY CTR	50C0001134	15 - AMBULATORY SURGICAL CENTER	WASHINGTON - PIERCE	1703 SOUTH MERIDIAN, SUITE 201	PUYALLUP	98371	(253) 845-4666	0
CEDAR LASER & SURGERY CENTER	50C0001206	15 - AMBULATORY SURGICAL CENTER	WASHINGTON - PIERCE	2202 SOUTH CEDAR STREET, SUITE 150	TACOMA	98405	(253) 830-5432	0
EVERGREEN EYE CENTER	50C0001328	15 - AMBULATORY SURGICAL CENTER	WASHINGTON - PIERCE	502 S M ST	TACOMA	98405	(206) 212-2100	0

Exhibit 18

Leadership Team

Hyrum Kirton
President and CEO, Bristol Hospice, LLC

Hyrum Kirton serves as the Chief Executive Officer for Bristol Hospice, L.L.C. Hyrum has worked in the Healthcare Industry for the past 11+ years and started as the Chief Executive Officer for Bristol Hospice, L.L.C. in 2016.

Hyrum is a Business Healthcare Executive who thrives growth of the company sound decision making, risk management, strategic and critical thinking, general management and broad-based leadership expertise. Responsibly have included multiple business line strategy, and tactical execution to provide earnings growth. Desire and passion to leverage leadership skills and experience at the senior level to bring additional business value.

Hyrum's career began in 2007 with Avalon Health Care Inc. as their Buyer where he later became the CEO of Brighton Healthcare Services and the VP of Procurement. During this time he was responsible for all procurement related activities. This included total oversight of every aspect of; Sourcing, Contracting, Vendor management, and Procurement Governance.

Hyrum Holds a Masters Degree in Business Administration, Health Care Management, and a Bachelors of Science in Information Technology Management.

Gerry Christensen
Executive Vice President and CFO, Bristol Hospice, LLC

Gerry N. Christensen serves as the Executive Vice President of Finance for Bristol Hospice, L.L.C. Gerry is a CPA with over 38 years of total experience in both public accounting and private industry. For the last eleven years, Gerry has served as the Chief Financial Officer of Bristol Hospice.

Gerry's career began in 1982 with Deloitte in Salt Lake City where he worked as an Accounting/Auditing Manager through approximately 2000. While at Deloitte, Gerry served as the audit manager on many of Deloitte's high-profile healthcare engagements and developed special expertise in healthcare. After leaving Deloitte, Gerry worked in private consulting through 2008 at which time, Gerry joined on with Bristol Hospice. As the CFO, Gerry oversees Bristol's finance department including billing, payroll, accounts payable, accounting, auditing and regulatory reporting.

Gerry graduated from the University of Utah in 1981 and received his CPA certificate in 1983.

Sonnie Linebarger, RN
Executive Vice President, Chief Operating Officer

Sonnie Linebarger serves as the Chief Operating Officer and Executive Vice President for Bristol Hospice, L.L.C. Sonnie is a Registered Nurse and has worked in the hospice community for 11+ years. Sonnie is an innovative healthcare leader experienced in clinical, sales and multi-site operations/financial management for hospice and palliative care. She has strong leadership skills and promotes a focus on radical responsibility, mentorship, development, and transformation.

Sonnie has served in leadership roles for major hospice organizations with locations across the country. She began her career as a Pediatric ICU nurse in the Phoenix Children's Hospital and has a passion for patient care.

Sonnie is a part of the National Hospice and Palliative Care Organizations National Quality & Standards Committee and was previously on the Board of Directors for the Arizona Hospice and Palliative Care Organization.

Jeanette Dove, MA, RN, CHPN
Executive Vice President, Chief Quality Officer

Jeanette Dove is a registered nurse and holds a Master's Degree in Human Sciences. Jeanette has worked in the hospice community for 20+ years and now serves as the Executive Vice President, Chief Quality Officer for Bristol Hospice. Jeanette's career focus includes advocacy in delivery of quality hospice delivery, pain and symptom management, advancing education, and healthcare management

Jeanette has served in leadership roles for major hospice organizations within the profit and not for profit setting. She began her career as a critical care nurse and witnessed the need for quality care at end of life in the patient's setting of choice. This fueled the desire to advocate for the patient and led her to a hospice career path.

Jeanette has presented at national and state hospice conferences and lead webinars on a variety of topics to include performance improvement, symptom management and data-driven strategic management. Jeanette serves on the NHPCO Quality and Standards Committee and has co-authored and contributed to publications at a state and national level.

Brian D. Jackson
Executive Vice President of Human Resources, Bristol Hospice LLC

Brian serves as Bristol Hospice's Executive Vice President of Human Resources and has oversight of all aspects of the human resource department. Brian has over 25 years of human resources experience from multiple industries manufacturing, food manufacturing, transportation, retail, distribution as well as health care.

Brian has served in multiple human resources leadership positions before joining Bristol; most recently he was the Regional Vice President of Human Resources for Encompass Health and prior to that was in a consulting leadership position for 8 years. Prior to consulting, Brian held leadership positions within human resources at multiple industries and brings an innovative way of bringing human resources solutions to the business.

Brian holds a bachelor's degree in Sociology from DePaul University and a master's degree in industrial Relations, Human Resources from the University of Minnesota – Minneapolis.

Mary A. Nester, RN, JD, CHC
Bristol Hospice Corporate Compliance Officer

Mary serves as Bristol Hospice's Corporate Compliance Officer and provides oversight of all aspects of the Bristol compliance program both at corporate office and throughout the Bristol program locations. She also serves as Bristol's HIPAA Privacy Officer.

Mary started her career as a registered nurse primarily specializing in oncology, oncology research and pain management. She received her oncology nurse specialist certification through Yale and has had a deep and lasting interest in the area of palliative care and hospice. While continuing in her nursing career, she returned to law school, graduated and was admitted to the bar in Oregon and Washington where she continues to be a licensed attorney.

It was during her years of law practice that she started to specialize in development and implementation of compliance and privacy programs for her various healthcare clients. Then in 2007 she started at Avalon Healthcare Group as its first corporate compliance officer. After completing a long stint with Avalon, she transitioned to exclusively providing compliance oversight and services to Avalon's subsidiary, Bristol Hospice, LLC.

Mary holds a certification in healthcare compliance since 2010. She has had experience in implementing and overseeing a number of compliance programs both as the designated compliance officer and as a compliance consultant or member of various organizations compliance councils. She has received additional education and experience through advanced compliance academies including the FBI Compliance Academy. She has been a regular speaker at various compliance organizations including a national organization for healthcare compliance (HCCA).

Troy Backus, RN
Executive Vice President/Community Relations

Troy Backus, RN serves as the Executive Vice President of Community Relations for Bristol Hospice. Troy has been with Bristol Hospice since 2007 and is responsible for program development in hospice and home health locations across the country.

He leads a talented group of Regional Vice Presidents of Development, who oversee Community development efforts in hospice advocacy and establishing referral relationships with Hospitals, Health Plans, and Discharge Planners.

He is an expert in implementing strategic marketing plans and leading development teams through mentorship and personal development.

Troy's background in healthcare began when he received a Nursing Degree from Utah Valley State College in August, 1997.

Prior to his role with Bristol, Troy worked for 5 years as Vice President of Development over the Skilled Nursing Division of Avalon Health Care, Inc. In this role he was responsible for community development and marketing thirty-six Skilled Nursing Facilities.

Troy began his work as a registered nurse in the Coronary and Surgical Intensive Care Units at Utah Valley Regional Medical Center in 1997 and continues that work today 22 years later in addition to his responsibilities with Bristol Hospice.

Advisory Board – Bristol Hospice, LLC

Bristol is a closely-held organization whose shareholders feel a moral imperative to make the highest quality hospice programs available in communities throughout the United States. To that end, Bristol's organizational structure provides for a Board of Managers. Bristol has chosen to have such a Board to provide an additional level of healthcare expertise and strategic and compliance guidance. As a closely-held company, it has elected to draw from community expertise. The Advisory Board is composed of nationally recognized experts in their fields including a former OIG Investigator and three highly credentialed Palliative Care Physicians. While it is highly unusual for a closely held company or a for-profit hospice to add the oversight of a Advisory Board, Bristol's leadership voluntarily added this resource to ensure that Bristol is serving its mission to provide high quality compliant care. The Bristol Advisory Board meets on a quarterly basis to review development and quality and to consider any necessary strategies that may be needed to continue to improve the services provided in all Bristol locations. In addition, it is very engaged in all aspects of the programs that Bristol operates and has a dedication to quality hospice outcomes.

Industry updates are a topic of discussion in quarterly board meetings to ensure that Bristol maintains the highest standards and is consistently compliant with current and pending CMS regulations. In 2015 CMS implemented 15 new regulations. Due to the diligence of Bristol leadership, each additional regulation was successfully implemented in all locations and met all requirements and deadlines. Bristol continues to meet full compliance with timely submissions of NOE and HIS documentation. Additionally, Bristol has also put a Compliance Council in place that meets annually. The Council utilizes the expertise of retired OIG Investigator, Dr. Steven Lack and Compliance Officer, Mary Nester to provide various points of analysis ensuring Bristol's compliance in all regulated areas.

The Advisory board members and their bios follow below.

Christie Franklin, Chairman, Advisory Board

Christie Franklin, retired President/CEO of Bristol Hospice, L.L.C. and current Chairman of the Board is responsible for the start-up and development of Bristol Hospice, L.L.C. which includes hospice locations in Salt Lake City, Utah; Sacramento, Stockton and Merced, California; Honolulu, Hawaii; Atlanta, Georgia; The Woodlands and Waxahachie, Texas; Clackamas, and Oregon.

Ms. Franklin has more than 25 years of management experience in the homecare/hospice industry. In addition, her experience includes operations, quality, clinical, and development. Ms. Franklin currently serves on the National Hospice and Palliative Care Organization Hospice Action Network Board of Directors, is Chair of the NHPCO Quality and Standards, Quality Partners and Outcome Task Force, is co-chair of the Research Committee of the National Association of Homecare and Hospice Medicaid Council for Homecare, and is a member of that council, as well as the HCAP Board, the Hospice Association of America and the Home Care LINK Advisory Board.

Ms. Franklin was a member of the NHPCO Quality and Standards Committee from 2008 to 2013 and Vice-Chair of the NHPCO Quality Partners from 2010 to 2013. She also served as a past member of the NPHCO Governance Committee. Ms. Franklin was appointed to the National Quality Forum for Home Health Quality Measures 2004 and the National Quality Forum for Hospice and Palliative Care Framework Review Committee 2005. She is a member of Who's Who in Executives and Professionals 2002 to 2007, and is a member of the HCAP Advisory Board 2009 thru 2014. She also served on the National Association for Home Care and Hospice Strategic Planning Congress and Nominating Committee.

Ms. Franklin has presented over the years at National Conferences of the National Association of Homecare and Hospice, the National Hospice and Palliative Care Organization, the National Quality Forum, and HCAPS.

Christie Franklin has a Bachelor of Arts in Health Care Management, has been a Registered Nurse for over 26 years and has received Certification for Home/Hospice Care Executives.

David Casarett, MD MA – Director

Dr. Casarett is a Professor in the Division of Geriatrics at the University of Pennsylvania and Director of Hospice and Palliative Care for the University of Pennsylvania. Dr. Casarett completed his medical training at Case Western Reserve University. His additional training included a Master's degree in medical anthropology at Case Western Reserve University, and fellowships in ethics at the University of Chicago and in Palliative Medicine at the University of Pennsylvania.

Dr. Casarett's major research interest is understanding and improving the way that health systems care for patients near the end of life. His work has included studies of hospice and hospice alternatives, as well as a randomized controlled trial of a decision aid to improve end of life care. Dr. Casarett has been the PI for a nationwide study to develop a valid and reliable technique to assess the quality of end-of-life care that the Veterans' Administration provides, as well as for NIH- and VA-funded projects to understand how end-of-life services can be more patient-focused. Dr. Casarett is the Principal Investigator for CHOICE (Coalition of Hospices Organized to Investigate Comparative Effectiveness), a national research network whose goal is to define safe and effective hospice care. He is also the recipient of a Center for Medicare and Medicaid Innovation grant for a program (CLAIM: Comprehensive Longitudinal Advanced Illness Management) to improve the care of patients with advanced cancer. Dr. Casarett's research has been supported by the VA, NIH, AHRQ, the Paul Beeson Physician Scholars Program, and by grants from the Hartford Foundation, the Aetna Foundation, the Commonwealth Fund, and the Greenwall Foundation. Dr. Casarett is also a recipient of the Presidential Early Career Award for Scientists and Engineers, the highest honor given by the US government to researchers in the early stages of their careers.

Sandra Gomez, MD FAAHPM - Director

Dr. Sandra Gomez accepted appointment to the position on the Bristol Advisory Board in June, 2015, and has been a great support to Bristol Hospice in its mission for many years. Dr. Gomez' extensive knowledge and passion for providing the highest level of care for palliative and hospice patients makes her a very valuable part of the Bristol Advisory Board. She is an instructor, a researcher and is highly regarded in the medical profession.

Steven M. Lack Ph.D., CFE – Director

From 1982 until 2010, Dr. Lack investigated allegations of Medicare fraud for the Department of Health and Human Services, Office of Inspector General. He was a Special Agent and a Supervisory Special Agent for 26 years. Dr. Lack was the case agent on what still are the largest criminal and civil Medicare Fraud cases prosecuted in the Northern

and Eastern Districts of California, with monies recovered in his last 5 years with OIG exceeding $387 million. Dr. Lack retired from the OIG in 2010 and continues to provide consulting services in the area of health care fraud detection and prevention.

Dr. Lack has been on the faculty of the Association of Certified Fraud Examiners, the National Health Care Anti-Fraud Association and for 20 years was the lead instructor for new OI agents on how to conduct Medicare fraud investigations.

The honors Dr. Lack has received include being named the Special Agent of the Year by the Western Regional Inspector General's Council and the OIG Outstanding Employee of the Year and being awarded the President's Council on Integrity and Efficiency Award for Excellence in Investigations. He has authored publications, including When the Candles Cost More than the Cake: Recommendations for Nursing Home Financing in the 21st Century. He also is a recipient of the prestigious Silver Beaver award from the Boy Scouts of America.

Dr. Lack holds a PhD in Public Administration from Golden Gate University and a MPA/BS in Public Administration from the University of Southern California. He earned a certificate in Health Care Administration from USC and is a Certified Fraud Examiner (C.F.E.).

James A Avery, MD, CMD, FACP, FCCP, FAAHM. - Director

Dr. Avery is the newest member to the Bristol Hospice Advisory board joining in February of 2019. Dr. Avery started his medical career in Internal Medicine and Pulmonology in 1986. Since that time he has served as a Senior Medical Director for several hospice agency's and was most recently serving as an Associated Medical Director and Chief Mission Officer.

He is currently the National Medical Director for Diversicare Healthcare Services and Visiting Assistant Professor of Medicine at the University of Virginia Medical School, Division of General Medicine, Geriatrics and Palliative Care.

Dr. Avery is Board Certified on the American Board of Internal Medicine, the American Board of Pulmonary Medicine, the American Board of Hospice and Palliative Medicine, and a Certified Nursing Home Medical Director.

Summary:

Bristol Hospice - Pierce, L.L.C. is ready and able to provide exceptional services to the community of Pierce County. Bristol Hospice has a proven track record of outstanding care, and a constant focus on providing top-quality services that can support patients and families through the end of life. If awarded the certification of need Bristol Hospice - Pierce, L.L.C.will increase the quality of services available and exceed patient and family expectations with quick response times and above average bed-side care. Bristol Hospice is graciously committed to our mission that all patients and families entrusted to our care will be treated with the highest level of compassion, respect and quality of care.