

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/23/2016
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NAME OF PROVIDER OR SUPPLIER MEDICAL SERVICES OF AMERICA HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 3101 NORTH GREEN RIVER ROAD, SUITE 210 EVANSVILLE, IN 47715
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L 0000 Bldg. 00	<p>This was a Federal hospice recertification and State re-licensure survey.</p> <p>Survey Dates: 6-20-16, 6-21-16, 6-22-16, and 6-23-16</p> <p>Facility #: 009557</p> <p>Medicare Provider # 15-1565</p> <p>Medicaid Vendor #: 200318420</p> <p>Census: 6 active patients</p> <p>Medical Services of America Hospice was found to be out of compliance with Conditions of Participation 42 CFR 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services; 42 CFR 418.58 Quality Assessment and Performance Improvement; 42 CFR 418.72 Physical Therapy, Occupational Therapy, and Speech-Language Pathology; 42 CFR 418.76 Hospice Aide and Homemaker Services; 42 CFR 418.78 Volunteers; 42 CFR 418.100 Organization and Administration of Services; and 418.112 Hospices That Provide Hospice Care to Residents of a SNF/NF or ICF/MR.</p>	L 0000		
L 0503	418.52(a)(2)			

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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Bldg. 00	<p>NOTICE OF RIGHTS AND RESPONSIBILITIES</p> <p>(2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.</p> <p>Based on record review and interview, the hospice failed to ensure patients had been informed of the hospice's policy concerning advance directives in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice's admission packet failed to evidence written information regarding the hospice's policy on the implementation of advance directives. Clinical records numbered 1 through 11 failed to evidence the patients had been provided with written information concerning the hospice's policy on advance directives. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM. The hospice's 12/2015 "Advance Directives HC.70" policy states, "The MSA Hospice Nurse or Social Worker 	L 0503	<p>L 503 The Administrator will instruct clinical staff to inform the patientand/or patient representative in writing and verbally of the hospice policyconcerning advance directives prior to providing care.</p> <p>The Corporate Clinical Liaison willinclude the hospice policy concerning advance directives in the "Decisions aboutLife Sustaining Treatments and End of Life Care" booklet to be given to patientand/or patient representative.</p> <p>10% of all medical records will be auditedmonthly to ensure the patient or patient representative certifies by signatureon the Notice of Election that Advance Directives have been received, reviewedand explained.</p> <p>The Administrator will beresponsible for monitoring these corrections to ensure that this deficiency iscorrected and will not recur</p>	07/22/2016			

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L 0518 Bldg. 00	<p>provides written and verbal information on advance directives to the patient and/or legal health care representative prior to providing care. Written information given to the patient or legal representative includes: hospice policy on implementation of patient's advance directives including any limitations."</p> <p>418.52(c)(7) RIGHTS OF THE PATIENT [The patient has a right to the following:] (7) Receive information about the services covered under the hospice benefit; Based on record review and interview, the hospice failed to ensure patients had been informed of all services covered under the hospice benefit in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, signed and dated by the patient/patient's representative on 9-24-15. The form failed to evidence the patient had been informed of the availability of volunteer services. 2. Clinical record number 2 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, signed and dated by the patient's 	L 0518	L 518 The Administrator will instruct clinical staff to inform patients and/or patient representatives verbally and in writing of all services covered under the hospice benefit including volunteer services in the hospice admissions booklet. 10% of all medical records will be audited monthly to ensure the patient or patient representative certifies by signature on the Notice of Election that available services have been received, reviewed and explained. The Administrator will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.	07/22/2016

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	<p>representative on 4-27-16. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>3. Clinical record number 3 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, signed and dated by the patient on 3-7-16. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>4. Clinical record number 4 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, signed and dated by the patient's representative on 10-12-15. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>5. Clinical record number 5 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, signed and dated by the patient's representative on 2-17-16. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>6. Clinical record number 6 included a "MSA Hospice Agencies Hospice Available Services and Costs" form,</p>			

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	<p>signed and dated by the patient's representative on 5-2-16. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>7. Clinical record number 7 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, signed and dated by the patient on 3-15-16. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>8. Clinical record number 8 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, signed and dated by the patient's representative on 4-24-16. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>9. Clinical record number 9 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, signed and dated by the patient on 7-16-15. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>10. Clinical record number 10 included a "MSA Hospice Agencies Hospice Available Services and Costs" form,</p>				

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	<p>signed and dated by the patient's representative on 8-11-15. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>11. Clinical record number 11 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, signed and dated by the patient's representative on 1-9-16. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>12. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM.</p> <p>13. The hospice's 02/2016 "Patient Rights and Responsibilities HC.69" policy states, "You have the right . . . receive information about the services covered under the hospice benefit; receive information about the scope of services the hospice will provide and specific limitations on those services."</p>			

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L 0523 Bldg. 00	<p>418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT</p> <p>The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.</p> <p>Based on record review and interview, the hospice failed to ensure the attending physicians had been consulted for completion of the comprehensive assessment in 3 (#s 2, 5, 8,) of 7 records reviewed for completion of the initial comprehensive assessment of the 11 total records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 included a comprehensive assessment initiated by the registered nurse (RN) on 4-27-16. The record failed to evidence the attending physician had been consulted to complete the comprehensive assessment. 2. Clinical record number 5 included a comprehensive assessment initiated by the RN on 2-17-16. The record failed to evidence the attending physician had been consulted to complete the 	L 0523	L 523 The Administrator will instruct the clinical staff that the hospice IDG, in consultation with the patient's attending physician, if any, must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care. The Administrator will also review the hospice policy, "Comprehensive Assessment HC28" with clinical staff. 10% of all medical records will be audited monthly to ensure the Medical Director and attending physician, if any, was consulted and completed the comprehensive assessment within 5 days. To ensure this deficiency is corrected and will not recur, the Administrator will be responsible for monitoring.	07/22/2016

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L 0533 Bldg. 00	<p>comprehensive assessment.</p> <p>3. Clinical record number 8 included a comprehensive assessment initiated by the RN on 4-23-16. The record failed to evidence the attending physician had been consulted to complete the comprehensive assessment.</p> <p>4. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM.</p> <p>5. The hospice's 06/2016 "Comprehensive Assessment HC.28" policy states, "The hospice RN consults with the Medical Director or hospice physician and attending physician and coordinates the comprehensive assessment based on the initial assessment to ensure physical, emotional, psychosocial, spiritual, and bereavement needs are assessed to promote the patient's well-being, comfort, and dignity."</p> <p>418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the</p>				

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	<p>initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>Based on record review and interview, the hospice failed to ensure all members of the interdisciplinary group (IDG) had participated in the update of the comprehensive assessment in 11 (#s 1 through 11) of 11 total records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 failed to evidence the medical social worker (MSW), spiritual care counselor (SCC), or the medical director members of the IDG had participated in the updates to the comprehensive assessment initiated by the registered nurse (RN) on 9-27-15. 2. Clinical record number 2 failed to evidence the MSW, SCC, or the medical director members of the IDG had participated in the updates to the comprehensive assessment initiated by the RN on 4-27-16. 3. Clinical record number 3 failed to evidence the MSW, SCC, or the medical director members of the IDG had 	L 0533	L 533 The Administrator will instruct all clinical staff that all members of the IDG are to participate in the update of the comprehensive assessment. The assessment update must be accomplished as the patient's condition changes but no less frequently than every 15 days. 10% of all medical records will be audited monthly to ensure all IDG members participate in the update to the comprehensive assessment at a minimum of every 15 days. To ensure this deficiency is corrected and will not recur, the Administrator will be responsible for monitoring.	07/22/2016

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	<p>participated in the updates to the comprehensive assessment initiated by the RN on 3-7-16.</p> <p>4. Clinical record number 4 failed to evidence the MSW, SCC, or the medical director members of the IDG had participated in the updates to the comprehensive assessment initiated by the RN on 10-12-15.</p> <p>5. Clinical record number 5 failed to evidence the MSW, SCC, or the medical director members of the IDG had participated in the updates to the comprehensive assessment initiated by the RN on 2-17-16.</p> <p>6. Clinical record number 6 failed to evidence the MSW, SCC, or the medical director members of the IDG had participated in the updates to the comprehensive assessment initiated by the RN on 5-2-16.</p> <p>7. Clinical record number 7 failed to evidence the MSW, SCC, or the medical director members of the IDG had participated in the updates to the comprehensive assessment initiated by the RN on 3-15-16.</p> <p>8. Clinical record number 8 failed to evidence the MSW, SCC, or the medical</p>			

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	<p>director members of the IDG had participated in the updates to the comprehensive assessment initiated by the RN on 4-23-16.</p> <p>9. Clinical record number 9 failed to evidence the MSW, SCC, or the medical director members of the IDG had participated in the updates to the comprehensive assessment initiated by the RN on 7-16-15.</p> <p>10. Clinical record number 10 failed to evidence the MSW, SCC, or the medical director members of the IDG had participated in the updates to the comprehensive assessment initiated by the RN on 8-11-15.</p> <p>11. Clinical record number 11 failed to evidence the MSW, SCC, or the medical director members of the IDG had participated in the updates to the comprehensive assessment initiated by the RN on 1-9-16.</p> <p>12. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM.</p> <p>13. The hospice's 06/2016 "Comprehensive Assessment HC.28" policy states, "The comprehensive</p>			

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L 0534 Bldg. 00	<p>assessment is updated at a minimum of every fifteen (15) days or more frequently as needed by the patient."</p> <p>418.54(e)(1) PATIENT OUTCOME MEASURES (1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation. Based on record review and interview, the hospice failed to ensure comprehensive assessments included data elements to allow for the measurement of outcomes in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a comprehensive assessment initiated by the registered nurse (RN) on 9-27-15. The assessment failed to evidence data elements to be used for the measurement of outcomes. 2. Clinical record number 2 included a comprehensive assessment initiated by the RN on 4-27-16. The assessment failed to evidence data elements to be used for the measurement of outcomes. 	L 0534	L 534 The Administrator will instruct all clinical staff that comprehensive assessments include data elements to allow for the measurement of outcomes. 10% of all medical records will be audited monthly to ensure that comprehensive assessments include data elements to allow for the measurement of outcomes. The Administrator will be responsible for monitoring to ensure this deficiency is corrected and will not recur.	07/22/2016

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	<p>3. Clinical record number 3 included a comprehensive assessment initiated by the RN on 3-7-16. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>4. Clinical record number 4 included a comprehensive assessment initiated by the RN on 10-12-15. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>5. Clinical record number 5 included a comprehensive assessment initiated by the RN on 2-17-16. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>6. Clinical record number 6 included a comprehensive assessment initiated by the RN on 5-2-16. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>7. Clinical record number 7 included a comprehensive assessment initiated by the RN on 3-15-16. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>8. Clinical record number 8 included a comprehensive assessment initiated by the RN on 4-23-16. The assessment failed to evidence data elements to be</p>			

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L 0535 Bldg. 00	<p>used for the measurement of outcomes.</p> <p>9. Clinical record number 9 included a comprehensive assessment initiated by the RN on 7-16-15. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>10. Clinical record number 10 included a comprehensive assessment initiated by the RN on 8-11-15. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>11. Clinical record number 11 included a comprehensive assessment initiated by the RN on 1-9-16. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>12. The administrator stated, on 6-23-16 at 3:15 PM, "We just implemented a quality assessment performance improvement program in October of 2015." The administrator was unable to provide a list of data elements used to measure patient outcomes.</p> <p>418.54(e)(2) PATIENT OUTCOME MEASURES (2) The data elements must be an integral part of the comprehensive assessment and</p>			

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	<p>must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.</p> <p>Based on record review and interview, the hospice failed to ensure comprehensive assessments included easily retrievable data elements to be used in the hospice's quality assessment and performance improvement program in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a comprehensive assessment initiated by the registered nurse (RN) on 9-27-15. The assessment failed to evidence data elements to be used for the measurement of outcomes. 2. Clinical record number 2 included a comprehensive assessment initiated by the RN on 4-27-16. The assessment failed to evidence data elements to be used for the measurement of outcomes. 3. Clinical record number 3 included a comprehensive assessment initiated by the RN on 3-7-16. The assessment failed 	L 0535	L535 The Administrator will instruct all clinical staff that data elements must be an integral part of the comprehensive assessment and be easily retrievable to be used for the measurement of outcomes. 10% of all medical records will be audited monthly to ensure that data elements are a part of the comprehensive assessment and used for the measurement of outcomes. The Administrator will be responsible for monitoring to ensure this deficiency is corrected and will not recur.	07/22/2016

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	<p>to evidence data elements to be used for the measurement of outcomes.</p> <p>4. Clinical record number 4 included a comprehensive assessment initiated by the RN on 10-12-15. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>5. Clinical record number 5 included a comprehensive assessment initiated by the RN on 2-17-16. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>6. Clinical record number 6 included a comprehensive assessment initiated by the RN on 5-2-16. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>7. Clinical record number 7 included a comprehensive assessment initiated by the RN on 3-15-16. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>8. Clinical record number 8 included a comprehensive assessment initiated by the RN on 4-23-16. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>9. Clinical record number 9 included a</p>						

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L 0536 Bldg. 00	<p>comprehensive assessment initiated by the RN on 7-16-15. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>10. Clinical record number 10 included a comprehensive assessment initiated by the RN on 8-11-15. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>11. Clinical record number 11 included a comprehensive assessment initiated by the RN on 1-9-16. The assessment failed to evidence data elements to be used for the measurement of outcomes.</p> <p>12. The administrator stated, on 6-23-16 at 3:15 PM, "We just implemented a quality assessment performance improvement program in October of 2015." The administrator was unable to provide a list of data elements used to measure patient outcomes.</p>	L 0536	L 536 The Administrator will instruct all clinical staff that plans of care are specific and reflect needs identified in the	07/22/2016
	Based on record review and interview, it was determined the hospice failed to maintain compliance with this condition			

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	<p>by failing to ensure plans of care were specific and reflected needs identified in the comprehensive assessment in 11 of 11 records reviewed (See L 538); by failing to ensure plans of care were individualized and that care and services provided were in accordance with the plan of care in 11 of 11 records reviewed (See L 543); by failing to ensure plans of care were specific and reflected needs identified in the comprehensive assessment in 11 of 11 records reviewed (See L 545); by failing to ensure ensure plans of care included measurable goals and outcomes in 9 of 11 records reviewed (See L 548) by failing to ensure all members of the interdisciplinary group (IDG) had participated in the reviews and updates of the plan of care in 9 of 11 records reviewed and failed to ensure plans of care had been updated to include all services provided to the patients in 2 of 2 records reviewed of patients that received continuous care services (See L 552); and by failing to ensure updates to plan of care included update information in 10 of 10 records reviewed on service greater than 2 weeks after the establishment of the plan of care of the 11 total records reviewed (See L 553).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this</p>		<p>comprehensive assessment.Plans of care include measurable goals and outcomes and include all services provided to the patients. Plans of care are updated at least every 15 days. The elements of the Plan of Care will be added as a Performance Improvement Project of QAPI, The PIP will be audited monthly and the action plan updated. The QAPI Coordinator will be responsible for monitoring to ensure this deficiency is correct and will not recur.</p>	

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L 0538 Bldg. 00	<p>condition, 42 CFR 418. 56 Interdisciplinary Group, Care Planning, and Coordination of Services.</p> <p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.</p> <p>Based on record review and interview, the hospice failed to ensure plans of care were specific and reflected needs identified in the comprehensive assessment in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included an update to the comprehensive assessment, completed by the registered nurse (RN), on 5-5-16, that identifies the patient has difficulty breathing when walking, uses nebulizer treatments and a positive airway pressure system, oxygen. The plan of care, established by the</p>	L 0538	L 538 The Administrator will instruct all clinical staff that the plan of care must specify the hospice care and services necessary to meet the patient and family specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions. 10% of all medical records will be audited monthly to ensure that the plan of care specifies hospice care and services to meet the specific needs of the patient and family as identified in the comprehensive assessment. The Administrator will be responsible for monitoring to ensure this deficiency is corrected and will not recur.	07/22/2016

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	<p>interdisciplinary group (IDG) on 5-20-16, failed to evidence interventions specific to the identified respiratory needs.</p> <p>A. The update to the comprehensive assessment, completed by the RN on 5-5-16, identifies a "skin tear" on the left upper arm. The assessment states, "Dressing Changed this Visit" Yes, per Orders, see Care Plan." The 5-20-16 plan of care failed to include specific orders/interventions for the dressing change to the left upper arm.</p> <p>B. The 5-5-16 update to the comprehensive assessment identifies occasional urinary incontinence with "urgency, dribbling." The plan of care failed to evidence interventions related to the identified urinary incontinence.</p> <p>C. The 5-5-16 update to the comprehensive assessment identifies "activity intolerance", poor endurance", and increased fatigue and weakness. The plan of care failed to evidence interventions related to the identified activity needs.</p> <p>2. Clinical record number 2 included a comprehensive assessment initiated by the RN on 4-27-6. The assessment identifies the patient is "unable to do most activity." The plan of care,</p>			

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	<p>established by the IDG on 5-6-16, failed to include interventions related to the identified activity need.</p> <p>A. The 4-27-16 assessment identifies a "communication deficit", "aphasia." The 5-6-16 plan of care failed to include interventions specific to the needs related to the aphasia.</p> <p>B. The 4-27-16 assessment identifies "sleep disturbances." The 5-6-16 plan of care failed to include interventions specific related to the identified sleep disturbances need.</p> <p>C. The 4-27-16 assessment identifies a "pressure ulcer" on the right outer ankle "Stage 2". The 5-6-16 plan of care failed to include specific wound care orders/interventions for the treatment of the wound.</p> <p>D. The 4-27-16 assessment identifies an "activity intolerance" with "contractures/deformities . . . post CVA [cardiovascular accident]." The 5-6-16 plan of care failed to evidence interventions related to the identified need.</p> <p>3. Clinical record number 3 included an initial comprehensive assessment initiated by the RN on 3-7-16. The</p>			

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	<p>assessment identifies the patient uses oxygen and nebulizer treatments for respiratory problems. The plan of care, established by the IDG on 3-11-16, failed to evidence interventions related to the oxygen and nebulizer use.</p> <p>4. Clinical record number 4 included an update to the comprehensive assessment completed by the RN on 6-1-16. The assessment identifies "sleep disturbance, difficulty falling asleep, difficulty staying asleep, increased daytime sleep." The plan of care, established by the IDG on 6-3-16, failed to evidence interventions to address the identified sleep problems.</p> <p>A. The 6-1-16 update identifies fatigue and activity intolerance, the patient is bedbound, severe pain limited mobility, has poor endurance, continued weakness, and "contractures/deformities." The 6-3-16 plan of care failed to evidence interventions to address the identifies activity problems.</p> <p>B. The 6-1-16 update identifies the patient "needs reinforcement" regarding increased fluid intake. The 6-3-16 plan of care failed to evidence interventions to address the identified need.</p> <p>5. Clinical record number 5 included an</p>			

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	<p>update to the comprehensive assessment completed by the RN on 5-4-16. The assessment identifies the patient is "confused continuously", identifies a "communication deficit", "aphasia", "non-verbal", "unable to sit upright unsupported", and "must be fed." The plan of care, established by the IDG on 5-6-16, failed to evidence interventions to address the identified problems.</p> <p>A. The 5-4-16 update to the comprehensive assessment identifies a Stage 3 pressure ulcer on the right heel, a Stage 2 pressure ulcer on the outer side of the left foot, a Stage 1 pressure ulcer to the inner side of the left foot, and an unstaged pressure ulcer to the inner left heel. The 5-6-16 plan of care states, "Wound Care: Cleanse with Normal Saline, apply santyl to necrotic area, apply 4 x 4 gauze, abd pad, then wrap with kerlix once a day on day shift (to heel wound)." The plan of care failed to specify which heel.</p> <p>B. The 5-4-16 update identifies "complete" urinary incontinence. The 5-6-16 plan of failed to evidence interventions to address the identified urinary incontinence.</p> <p>C. The 5-4-16 update identifies an "activity intolerance", the patient is</p>			

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	<p>bedbound and "needs assistance of others to transfer", "severe pain limits mobility, poor endurance", "increased weakness", "contractures/deformities." The 5-6-16 plan of care failed to evidence interventions to address the identified activity needs.</p> <p>D. The 5-4-16 update identifies the patient "must be fed with much encouragement, medications crushed or diluted; crushed in applesauce." The 5-6-16 plan of care failed to evidence interventions to address the identified nutritional needs.</p> <p>6. Clinical record number 6 included a comprehensive assessment initiated by the RN on 5-2-16. The assessment identifies the patient is incontinent of both bowel and bladder. The plan of care, established by the IDG on 5-6-16, failed to evidence interventions to address the incontinence problems.</p> <p>A. The 5-2-16 assessment identifies the patient is "fatigued . . . needs assistance of others to transfer . . . continued weakness." The 5-6-16 plan of care failed to evidence interventions to address the identified activity problems.</p> <p>B. The 5-2-16 assessment identifies the patient's appetite is "poor, affected by</p>			

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	<p>depression, early satiety, anorexia . . . hydration poor." The 5-6-16 plan of care failed to evidence interventions to address the identified nutrition problems.</p> <p>7. Clinical record number 7 included a comprehensive assessment initiated by the RN on 3-15-16. The assessment identifies the patient has "increased fatigue, activity intolerance . . . increased weakness." The plan of care, established by the IDG on 3-25-16, failed to evidence interventions to address the identified activity intolerance problems.</p> <p>8. Clinical record number 8 included a comprehensive assessment initiated by the RN on 4-23-16. The assessment identifies the patient had "difficulty staying asleep." The plan of care, established by the IDG on 5-6-16, failed to evidence interventions to address the sleep problem.</p> <p>A. The 4-23-16 assessment identifies the patient had "total" urinary incontinence, "wears adult briefs." The 5-6-16 plan of care failed to evidence interventions to address the urinary incontinence.</p> <p>B. The 4-23-15 assessment identifies the patient had "increased fatigue . . . unable to walk . . . increased weakness."</p>			

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	<p>The 5-6-16 plan of care failed to evidence interventions to address the identified activity problems.</p> <p>C. The 4-23-15 assessment identifies "appetite affected by pain, early satiety, dysphagia, cachexia, special feeding needs: can only drink liquids or very moistened foods." The 5-6-16 plan of care failed to evidence interventions to address the identified nutrition needs.</p> <p>9. Clinical record number 9 included an update to the comprehensive assessment completed by the RN on 12-3-15. The assessment identifies the presence of a suprapubic catheter. The plan of care, established by the IDG on 12-4-15, failed to evidence specific interventions related to the care and maintenance of the catheter. The plan of care failed to evidence how often the catheter was to be flushed and with what solution and how often the catheter was to be changed.</p> <p>The 12-3-15 assessment identifies the patient was "fatigues . . . bed/wheelchair bound . . . continued weakness." The 12-4-15 plan of care failed to evidence interventions to address the identified activity problems.</p> <p>10. Clinical record number 10 included an update to the comprehensive</p>			

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	<p>assessment completed by the RN on 1-13-16. The assessment identifies urinary incontinence and "sometimes stool." The plan of care, established by the IDG on 1-29-16, failed to evidence interventions to address the bowel and bladder incontinence.</p> <p>A. The 1-13-16 assessment identifies "increased fatigue . . . needs assistance of others to transfer . . . ambulate . . . gait unsteady, unsafe . . . increased contractions of adductors of legs . . . no longer walk safely with just one person to ambulate using gait belt." The 1-29-16 plan of care failed to evidence interventions to address the identified activity and safety problems.</p> <p>B. The 1-13-16 assessment identifies "special feeding needs; does not chew meats; has soft diet, medications crushed or diluted . . . [spouse] reports that pt [patient] will cough sometimes while eating." The 1-29-16 plan of care failed to evidence interventions to address the identified nutrition problems.</p> <p>11. Clinical record number 11 included a comprehensive assessment initiated by the RN on 1-9-16. The assessment identifies "increased fatigue" and "continued weakness." The plan of care, established by the IDG on 1-15-16, failed</p>			

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L 0543 Bldg. 00	<p>to evidence interventions to address the identified activity problem.</p> <p>12. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM.</p> <p>13. The hospice's 09/2015 "Plan of Care, HC.31" policy states, "The plan of care specifies interventions, care and services necessary to meet the needs of the patient and/or caregiver identified in the comprehensive assessment and ongoing assessments of the patient."</p> <p>418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. Based on record review and interview, the hospice failed to ensure plans of care</p>	L 0543	L 543 The Administrator will instruct all clinical staff that plans of care are individualized and	07/22/2016

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	<p>were individualized and that care and services provided were in accordance with the plan of care in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p> <p>Regarding individualization of care plans:</p> <p>1. Clinical record number 1 included a plan of care established by the interdisciplinary group (IDG) on 5-20-16. The plan of care identifies "Care Plan H120: Medication Management" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p> <p>A. The plan of care identifies "Care Plan H190 Respiratory" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified respiratory problem.</p> <p>B. The plan of care identifies "Care Plan H290 Diabetic Management" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified diabetic management problem.</p>		<p>care and services provided are in accordance with the plan of care. 10% of all medical records will be audited monthly to ensure that the plan of care is individualized and care and services are in accordance with the plan of care. The Administrator will be responsible for monitoring to ensure this deficiency is corrected and will not recur.</p>	

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	<p>C. The plan of care identifies "Care Plan H320 Altered Mental Status" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified altered mental status problem.</p> <p>D. The plan of care identifies "Care Plan H330 Mobility-Safety" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified mobility-safety problem.</p> <p>2. Clinical record number 2 included a plan of care established by the IDG on 5-6-16. The plan identifies "Care Plan H120: Medication Management" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p> <p>A. The plan identifies "Care Plan H16 Pain as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified pain problem.</p> <p>B. The plan identifies "Care Plan H180 Cardiovascular" as a problem to be</p>			

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	<p>addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified cardiovascular problem.</p> <p>C. The plan identifies "Care Plan H190 Respiratory" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified respiratory problem.</p> <p>D. The plan identifies "Care Plan H200 Skin-Wound" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified skin-wound problem.</p> <p>E. The plan identifies "Care Plan H350 Communication" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified communication problem.</p> <p>3. Clinical record number 3 included a plan of care established by the IDG on 3-11-16. The plan of care identifies "Care Plan H120: Medication Management" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the</p>			

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	<p>identified medication management problem.</p> <p>A. The plan identifies "Care Plan H16 Pain as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified pain problem.</p> <p>B. The plan identifies "Care Plan H190 Respiratory" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified respiratory problem.</p> <p>C. The plan identifies "Care Plan H240 Nausea" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified nausea problem.</p> <p>D. The plan identifies "Care Plan H310 Agitation/Anxiety" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified agitation/anxiety problem.</p> <p>4. Clinical record number 4 included a plan of care established by the IDG on 4-8-16. The plan "Care Plan H120:</p>			

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	<p>Medication Management" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p> <p>A. The plan identifies "Care Plan H16 Pain as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified pain problem.</p> <p>B. The plan identifies "Care Plan H200 Skin-Wound" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified skin-wound problem.</p> <p>C. The plan identifies "Care Plan H220 Nutrition" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem.</p> <p>D. The plan identifies "Care Plan H240 Nausea" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified nausea problem.</p>			

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	<p>E. The plan identifies "Care Plan H280 Urinary" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified urinary problem.</p> <p>F. The plan identifies "Care Plan H300 Neurological" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified neurological problem.</p> <p>5. Clinical record number 5 included a plan of care established by the IDG on 5-6-16. The plan of care identified "Care Plan H16 Pain" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified pain problem.</p> <p>A. The plan of care identified "Care Plan H180 Cardiovascular" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified cardiovascular problem.</p> <p>B. The plan identifies "Care Plan H200 Skin-Wound" as a problem to be addressed. The plan failed to be</p>			

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	<p>individualized and distinguish the specific concerns associated with the identified skin-wound problem.</p> <p>C. The plan identifies "Care Plan H220 Nutrition" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem.</p> <p>D. The plan identifies "Care Plan H310 Agitation/Anxiety" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified agitation/anxiety problem.</p> <p>E. The plan identifies "Care Plan H320 Altered Mental Status" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified altered mental status problem.</p> <p>6. Clinical record number 6 included a plan of care established by the IDG on 5-6-16. The plan identified "Care Plan H120 Medication Management" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p>			

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	<p>A. The plan identifies "Care Plan H300 Neurological" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified neurological problem.</p> <p>B. The plan of care identifies "Care Plan H320 Altered Mental Status" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified altered mental status problem.</p> <p>C. The plan of care identifies "Care Plan H330 Mobility-Safety" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified mobility-safety problem.</p> <p>7. Clinical record number 7 included a plan of care established by the IDG on 3-25-16. The plan identified "Care Plan H120 Medication Management" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p> <p>A. The plan of care identified "Care Plan H16 Pain" as a problem to be</p>			

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	<p>addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified pain problem.</p> <p>B. The plan identifies "Care Plan H220 Nutrition" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem.</p> <p>C. The plan identifies "Care Plan H250 Bowel" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified bowel problem.</p> <p>D. The plan identifies "Care Plan H310 Agitation/Anxiety" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified agitation/anxiety problem.</p> <p>E. The plan of care identifies "Care Plan H330 Mobility-Safety" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified mobility-safety problem.</p> <p>F. The plan of care identifies "Care</p>			

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	<p>Plan H340 Sleep Disorder" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified sleep problem.</p> <p>8. Clinical record number 8 included a plan of care established by the IDG on 5-6-16. The plan of care identified "Care Plan H120 Medication Management" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p> <p>A. The plan of care identified "Care Plan H16 Pain" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified pain problem.</p> <p>B. The plan of care identified "Care Plan H200 Skin-Wound" as a problem to be addressed. The plan failed to be individualized and distinguish specific concerns associated with the identified skin-wound problem.</p> <p>C. The plan identifies "Care Plan H220 Nutrition" as a problem to be addressed. The plan failed to be individualized and distinguish the</p>			

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	<p>specific concerns associated with the identified nutrition problem.</p> <p>D. The plan identifies "Care Plan H240 Nausea" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified nausea problem.</p> <p>E. The plan identifies "Care Plan H310 Agitation/Anxiety" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified agitation/anxiety problem.</p> <p>F. The plan of care identifies "Care Plan H330 Mobility-Safety" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified mobility-safety problem.</p> <p>9. Clinical record number 9 included a plan of care established by the IDG on 10-23-15. The plan of care identified "Care Plan H120 Medication Management" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p>			

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	<p>A. The plan of care identified "Care Plan H16 Pain" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified pain problem.</p> <p>B. The plan of care identified "Care Plan H200 Skin-Wound" as a problem to be addressed. The plan failed to be individualized and distinguish specific concerns associated with the identified skin-wound problem.</p> <p>C. The plan identifies "Care Plan H220 Nutrition" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem.</p> <p>D. The plan identifies "Care Plan H280 Urinary" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified urinary problem.</p> <p>E. The plan identifies "Care Plan H310 Agitation/Anxiety" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the</p>			

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	<p>identified agitation/anxiety problem.</p> <p>10. Clinical record number 10 included a plan of care established by the IDG on 1-29-16. The plan of care identified "Care Plan H120 Medication Management" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p> <p>A. The plan of care identified "Care Plan H16 Pain" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified pain problem.</p> <p>B. The plan identifies "Care Plan H220 Nutrition" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem.</p> <p>C. The plan identifies "Care Plan H250 Bowel" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified bowel problem.</p>			

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	<p>D. The plan identifies "Care Plan H300 Neurological" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified neurological problem.</p> <p>E. The plan of care identifies "Care Plan H330 Mobility-Safety" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified mobility-safety problem.</p> <p>11. Clinical record number 11 included a plan of care established by the IDG on 3-11-16. The plan of care identified "Care Plan H120 Medication Management" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p> <p>A. The plan of care identified "Care Plan H16 Pain" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified pain problem.</p> <p>B. The plan of care identified "Care Plan H180 Cardiovascular" as a problem</p>			

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	<p>to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified cardiovascular problem.</p> <p>C. The plan identifies "Care Plan H200 Skin-Wound" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified skin-wound problem.</p> <p>D. The plan identifies "Care Plan H220 Nutrition" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem.</p> <p>12. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM and 6-23-16 at 3:15 PM.</p> <p>13. The hospice's 09/2015 "Plan of Care, HC.31" states, "MSA Hospice Agencies provide care and services to patient and their caregivers in accordance to an individualized plan of care developed by the IDG in collaboration with the attending physician, if any, and, when appropriate, the patient and/or caregiver."</p>			

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	<p>Regarding care provided in accordance with plan of care:</p> <p>1. Clinical record number 1 included a plan of care established by the interdisciplinary group (IDG) on 5-20-16. The plan identified home health aide services were to be provided 3 times per week for 9 weeks. The record evidenced only 2 home health aide visits had been provided the week of 5-29-16 (week 2).</p> <p>A. The record included a skilled nurse visit note dated 6-7-16 that evidenced the skilled nurse (SN) had collected a urine specimen for a urinalysis. The record failed to evidence an order for the collection of the urine specimen for a urinalysis.</p> <p>B. The record included a SN visit note dated 5-5-16 that evidenced the SN had performed a dressing change to a skin tear on the patient's left upper arm. The record failed to evidence an order for the dressing change.</p> <p>2. Clinical record number 2 evidenced an initial comprehensive assessment completed by the RN on 4-27-16 and a start of care date of 4-27-16. The initial physician orders for hospice care and services were not signed by the attending physician until 5-5-16 and the plan of</p>			

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	<p>care was not established by the IDG until 5-6-16. The record evidenced additional SN visits had been provided on 4-28-16, 4-29-16, 5-2-16, and 5-4-16.</p> <p>A. The record evidenced the spiritual care counselor (SCC) had completed an assessment on 5-25-16. The record included a SCC visit note dated 6-13-16. The record failed to evidence the plan of care, established by the IDG on 5-6-16, had been updated to include the SCC services.</p> <p>B. The plan of care, established by the IDG on 5-6-16, evidenced home health aide services were to be provided 2 times per week for the first week and 3 times per week for the next 11 weeks.</p> <p>1.) The record evidenced only 1 home health aide visit had been completed the first week.</p> <p>2.) The record evidenced only 2 home health aide visits per week had been provided from 5-9-16 to 6-16-16.</p> <p>3. Clinical record number 3 evidenced an initial comprehensive assessment by the RN on 3-7-16. The record evidenced the initial physician orders for hospice care and services were not signed by the attending physician (also the hospice</p>			

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	<p>medical director) until 3-11-16 and the plan of care was not established by the IDG until 3-11-16.</p> <p>4. Clinical record number 4 included a plan of care reviewed by the IDG on 6-3-16 that states, "Initiate care of suprapubic catheter change every week." The record failed to evidence the catheter had been changed the week of 6-12-16.</p> <p>5. Clinical record number 5 evidenced SN visits had been provided 3 times per week the weeks of 5-22-16, 5-29-16, 6-5-16, and 6-12-16. The record failed to evidence the plan of care had been updated to include the SN visits 3 times per week.</p> <p>A. "Physician Orders/Plan of Care from 05-17-16 to 07-15-16" states "SN 05=17=16 2 x week x 1 week."</p> <p>B. An IDG update to the plan of care dated 5-20-16 states, "SN 05-15-16 1 x week x 1 week."</p> <p>C. An IDG update to the plan of care dated 6-3-16 states, "SN 05-17-2016 2 x week x 1 week ended on 05-21-2016."</p> <p>D. An IDG update to the plan of care dated 6-17-16 states, "SN 05-17-2016 2 x week x 1 week ended on 05-21-2016."</p>			

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	<p>6. Clinical record number 6 included IDG updates to the plan of care, dated 5-20-16, 6-3-16, and 6-17-16, that state "Aid 05-08-16 3 x week x 12 weeks."</p> <p>The record evidenced hospice aide visits had been provided only 2 times per week the weeks of 5-22-16 and 5-29-16 and only 1 time per week the week of 6-5-16.</p> <p>7. Clinical record number 7 evidenced a hospice aide visit had been provided on 3-23-16. The plan of care failed to evidence an update to include an order for the aide visit.</p> <p>8. Clinical record number 8 included an initial comprehensive assessment initiated by the RN on 4-23-16 and a start of care date of 4-23-16. The record evidenced the initial physician orders for hospice care and services were not signed by the attending physician until 5-9-16 and the plan of care was not established by the IDG until 5-6-16.</p> <p>A. The record evidenced SN visits had been provided on 4-24-16, 4-26-16, 4-28-16, 5-2-16, 5-3-16, and 5-5-16.</p> <p>B. The record evidenced hospice aide services had been provided on 4-27-16,</p>			

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	<p>4-29-16, 5-2-16, and 5-4-16.</p> <p>9. Clinical record number 9 included a SN visit note dated 11-19-15 that identified the SN had performed a dressing change to a pressure ulcer on the bottom of the patient's left foot. The note states, "Dressing changed as described: cleaned with normal saline, medipore dressing applied."</p> <p>A. The record failed to evidence the plan of care, established by the IDG on 10-23-15, had been updated to include an order for a dressing change to left foot.</p> <p>B. The administrator indicated, on 6-23-16 at 9:40 AM, the record did not include an order for the dressing change to the left foot.</p> <p>C. The record included "Physician Orders/Plan of Care from 10-14-15 to 01-11-16" and IDG updates dated 11-20-16, 12-18-16, and 12-30-16, that evidenced hospice aide services were to be provided 3 times per week.</p> <p>1.) The record evidenced hospice aide services had been provided only 2 times per week the weeks of 12-6-15, 12-20-15, 12-27-15, and 1-3-16.</p> <p>2.) The administrator was unable</p>			

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	<p>to provide any additional documentation and/or information when asked on 6-23-16 at 8:55 AM.</p> <p>10. Clinical record number 10 included IDG reviews of the plan of care dated 2-26-16 and 3-11-16 that identified medical social services (MSS) and SCC services were to be provided 1 time per month for 3 months with 8 as needed visits each.</p> <p>The record failed to evidence any SCC services had been provided from 2-26-16 till the time of discharge on 3-17-16.</p> <p>11. Clinical record number 11 included IDG reviews of the plan of care dated 1-29-16 and 2-12-16 that identified hospice aide services were to be provided 3 times per week. The record evidenced aide services had been provided only 2 times per week the weeks of 1-31-16, 2-7-16, and 2-14-16.</p> <p>The record included an IDG review of the plan of care dated 2-26-16 that identified hospice aide services had been increased to 5 times per week. The record evidenced hospice aide services had been provided only 1 time per week the week of 2-28-16 and only 2 times per week the weeks of 3-6-16 and 3-13-16. The record evidenced the patient expired</p>			

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L 0545 Bldg. 00	<p>on 3-22-16.</p> <p>12. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM and 6-23-16 at 3:15 PM.</p> <p>13. The hospice's 09/2015 "Plan of Care, HC.31" policy states, "Hospice services are delivered in accordance to the plan of care."</p> <p>418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Based on record review and interview, the hospice failed to ensure plans of care were specific and reflected needs identified in the comprehensive assessment in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p>	L 0545	L 545 The Administrator will instruct the individual plan of care must reflect the patient and family goals and interventions based on problems identified in he initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related	07/22/2016			

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	<p>1. Clinical record number 1 included an update to the comprehensive assessment, completed by the registered nurse (RN), on 5-5-16, that identifies the patient has difficulty breathing when walking, uses nebulizer treatments and a positive airway pressure system, oxygen. The plan of care, established by the interdisciplinary group (IDG) on 5-20-16, failed to evidence interventions specific to the identified respiratory needs.</p> <p>A. The update to the comprehensive assessment, completed by the RN on 5-5-16, identifies a "skin tear" on the left upper arm. The assessment states, "Dressing Changed this Visit" Yes, per Orders, see Care Plan." The 5-20-16 plan of care failed to include specific orders/interventions for the dressing change to the left upper arm.</p> <p>B. The 5-5-16 update to the comprehensive assessment identifies occasional urinary incontinence with "urgency, dribbling." The plan of care failed to evidence interventions related to the identified urinary incontinence.</p> <p>C. The 5-5-16 update to the comprehensive assessment identifies "activity intolerance", poor endurance", and increased fatigue and weakness. The plan of care failed to evidence</p>		<p>conditions. The elements of the Plan of Care will be added as a Performance Improvement Project of QAPI, The PIP will be audited monthly and the action plan updated. The QAPI Coordinator will be responsible for monitoring to ensure this deficiency is correct and will not recur.</p>	

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	<p>interventions related to the identified activity needs.</p> <p>2. Clinical record number 2 included a comprehensive assessment initiated by the RN on 4-27-6. The assessment identifies the patient is "unable to do most activity." The plan of care, established by the IDG on 5-6-16, failed to include interventions related to the identified activity need.</p> <p>A. The 4-27-16 assessment identifies a "communication deficit", "aphasia." The 5-6-16 plan of care failed to include interventions specific to the needs related to the aphasia.</p> <p>B. The 4-27-16 assessment identifies "sleep disturbances." The 5-6-16 plan of care failed to include interventions specific related to the identified sleep disturbances need.</p> <p>C. The 4-27-16 assessment identifies a "pressure ulcer" on the right outer ankle "Stage 2". The 5-6-16 plan of care failed to include specific wound care orders/interventions for the treatment of the wound.</p> <p>D. The 4-27-16 assessment identifies an "activity intolerance" with "contractures/deformities . . . post CVA</p>			

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	<p>[cardiovascular accident]." The 5-6-16 plan of care failed to evidence interventions related to the identified need.</p> <p>3. Clinical record number 3 included an initial comprehensive assessment initiated by the RN on 3-7-16. The assessment identifies the patient uses oxygen and nebulizer treatments for respiratory problems. The plan of care, established by the IDG on 3-11-16, failed to evidence interventions related to the oxygen and nebulizer use.</p> <p>4. Clinical record number 4 included an update to the comprehensive assessment completed by the RN on 6-1-16. The assessment identifies "sleep disturbance, difficulty falling asleep, difficulty staying asleep, increased daytime sleep." The plan of care, established by the IDG on 6-3-16, failed to evidence interventions to address the identified sleep problems.</p> <p>A. The 6-1-16 update identifies fatigue and activity intolerance, the patient is bedbound, severe pain limited mobility, has poor endurance, continued weakness, and "contractures/deformities." The 6-3-16 plan of care failed to evidence interventions to address the identifies activity problems.</p>			

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	<p>B. The 6-1-16 update identifies the patient "needs reinforcement" regarding increased fluid intake. The 6-3-16 plan of care failed to evidence interventions to address the identified need.</p> <p>5. Clinical record number 5 included an update to the comprehensive assessment completed by the RN on 5-4-16. The assessment identifies the patient is "confused continuously", identifies a "communication deficit", "aphasia", "non-verbal", "unable to sit upright unsupported", and "must be fed." The plan of care, established by the IDG on 5-6-16, failed to evidence interventions to address the identified problems.</p> <p>A. The 5-4-16 update to the comprehensive assessment identifies a Stage 3 pressure ulcer on the right heel, a Stage 2 pressure ulcer on the outer side of the left foot, a Stage 1 pressure ulcer to the inner side of the left foot, and an unstaged pressure ulcer to the inner left heel. The 5-6-16 plan of care states, "Wound Care: Cleanse with Normal Saline, apply santyl to necrotic area, apply 4 x 4 gauze, abd pad, then wrap with kerlix once a day on day shift (to heel wound)." The plan of care failed to specify which heel.</p>			

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	<p>B. The 5-4-16 update identifies "complete" urinary incontinence. The 5-6-16 plan of failed to evidence interventions to address the identified urinary incontinence.</p> <p>C. The 5-4-16 update identifies an "activity intolerance", the patient is bedbound and "needs assistance of others to transfer", "severe pain limits mobility, poor endurance", "increased weakness", "contractures/deformities." The 5-6-16 plan of care failed to evidence interventions to address the identified activity needs.</p> <p>D. The 5-4-16 update identifies the patient "must be fed with much encouragement, medications crushed or diluted; crushed in applesauce." The 5-6-16 plan of care failed to evidence interventions to address the identified nutritional needs.</p> <p>6. Clinical record number 6 included a comprehensive assessment initiated by the RN on 5-2-16. The assessment identifies the patient is incontinent of both bowel and bladder. The plan of care, established by the IDG on 5-6-16, failed to evidence interventions to address the incontinence problems.</p> <p>A. The 5-2-16 assessment identifies</p>			

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	<p>the patient is "fatigued . . . needs assistance of others to transfer . . . continued weakness." The 5-6-16 plan of care failed to evidence interventions to address the identified activity problems.</p> <p>B. The 5-2-16 assessment identifies the patient's appetite is "poor, affected by depression, early satiety, anorexia . . . hydration poor." The 5-6-16 plan of care failed to evidence interventions to address the identified nutrition problems.</p> <p>7. Clinical record number 7 included a comprehensive assessment initiated by the RN on 3-15-16. The assessment identifies the patient has "increased fatigue, activity intolerance . . . increased weakness." The plan of care, established by the IDG on 3-25-16, failed to evidence interventions to address the identified activity intolerance problems.</p> <p>8. Clinical record number 8 included a comprehensive assessment initiated by the RN on 4-23-16. The assessment identifies the patient had "difficulty staying asleep." The plan of care, established by the IDG on 5-6-16, failed to evidence interventions to address the sleep problem.</p> <p>A. The 4-23-16 assessment identifies the patient had "total" urinary</p>			

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	<p>incontinence, "wears adult briefs." The 5-6-16 plan of care failed to evidence interventions to address the urinary incontinence.</p> <p>B. The 4-23-15 assessment identifies the patient had "increased fatigue . . . unable to walk . . . increased weakness." The 5-6-16 plan of care failed to evidence interventions to address the identified activity problems.</p> <p>C. The 4-23-15 assessment identifies "appetite affected by pain, early satiety, dysphagia, cachexia, special feeding needs: can only drink liquids or very moistened foods." The 5-6-16 plan of care failed to evidence interventions to address the identified nutrition needs.</p> <p>9. Clinical record number 9 included an update to the comprehensive assessment completed by the RN on 12-3-15. The assessment identifies the presence of a suprapubic catheter. The plan of care, established by the IDG on 12-4-15, failed to evidence specific interventions related to the care and maintenance of the catheter. The plan of care failed to evidence how often the catheter was to be flushed and with what solution and how often the catheter was to be changed.</p> <p>The 12-3-15 assessment identifies the</p>			

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	<p>patient was "fatigues . . . bed/wheelchair bound . . . continued weakness." The 12-4-15 plan of care failed to evidence interventions to address the identified activity problems.</p> <p>10. Clinical record number 10 included an update to the comprehensive assessment completed by the RN on 1-13-16. The assessment identifies urinary incontinence and "sometimes stool." The plan of care, established by the IDG on 1-29-16, failed to evidence interventions to address the bowel and bladder incontinence.</p> <p>A. The 1-13-16 assessment identifies "increased fatigue . . . needs assistance of others to transfer . . . ambulate . . . gait unsteady, unsafe . . . increased contractions of adductors of legs . . . no longer walk safely with just one person to ambulate using gait belt." The 1-29-16 plan of care failed to evidence interventions to address the identified activity and safety problems.</p> <p>B. The 1-13-16 assessment identifies "special feeding needs; does not chew meats; has soft diet, medications crushed or diluted . . . [spouse] reports that pt [patient] will cough sometimes while eating." The 1-29-16 plan of care failed to evidence interventions to address the</p>			

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L 0548 Bldg. 00	<p>identified nutrition problems.</p> <p>11. Clinical record number 11 included a comprehensive assessment initiated by the RN on 1-9-16. The assessment identifies "increased fatigue" and "continued weakness." The plan of care, established by the IDG on 1-15-16, failed to evidence interventions to address the identified activity problem.</p> <p>12. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM.</p> <p>13. The hospice's 09/2015 "Plan of Care, HC.31" policy states, "The plan of care specifies interventions, care and services necessary to meet the needs of the patient and/or caregiver identified in the comprehensive assessment and ongoing assessments of the patient."</p> <p>418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of</p>				

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	<p>care.</p> <p>Based on record review and interview, the hospice failed to ensure plans of care included measurable goals and outcomes in 9 (#s 1, 2, 3, 5, 7, 8, 9, 10, & 11) of 11 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the interdisciplinary group (IDG) on 5-20-16. The plan of care failed to evidence measurable outcomes expected from the implementation of interventions to address identified problems.</p> <p>A. The plan of care identified "chronic low back pain and intermittent pain in right lower lung area." The plan failed to evidence a measurable goal for the management of the patient's pain.</p> <p>B. The plan of care identified the patient "had episode of fast, irregular heartbeat upon assessment. Has prior history while in hospice of A Fib. Is on oral antiarrhythmic." The plan failed to evidence a measurable goal for the management of the identified cardiovascular problem.</p> <p>C. The plan of care identified a "respiratory" problem. The plan of care</p>	L 0548	L 548 The Administrator will instruct the IDG members on the process for development and documentation of the individualized plan of care with documentation of the goals and outcomes of care. An audit tool will be developed to monitor 10% of all patient records each month to insure compliance. The Administrator will be responsible for monitoring to ensure this deficiency is corrected and will not recur.	07/22/2016

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	<p>failed to evidence a detailed description of the respiratory problem and failed to include a measurable outcome related to the management of the respiratory problem.</p> <p>D. The plan of care identified a "Diabetic Management" problem of a "new diagnosis of diabetes". The plan failed to evidence a measurable outcome for the management of the diabetes problem.</p> <p>E. The plan of care identified an "Agitation/Anxiety" problem. The plan failed to include a detailed description of the problem and failed to evidence a measurable outcome related to the management of the agitation and anxiety.</p> <p>2. Clinical record number 2 included a plan of care established by the IDG on IDG on 5-6-16. The plan failed to evidence measurable outcomes expected from the implementation of interventions to address identified problems.</p> <p>A. The plan of care identified pain as a problem. The plan failed to evidence a measurable outcome for the management of the pain.</p> <p>B. The plan of care identified a "cardiovascular" problem. The plan</p>			

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	<p>failed to evidence a description of the cardiovascular problem and failed to evidence measurable outcomes related to the identified problem.</p> <p>C. The plan of care identified a "respiratory" problem. The plan failed to evidence a description of the respiratory problem and failed to evidence measurable outcomes related to the identified respiratory problem.</p> <p>3. Clinical record number 3 included a plan of care established by the IDG on 3-11-16. The plan of care failed to evidence measurable outcomes expected from the implementation of interventions to address identified problems.</p> <p>A. The plan of care identified "pain" as a problem. The plan failed to evidence a measurable outcome for the management of the identified problem with pain.</p> <p>B. The plan of care identified a "respiratory" problem. The plan failed to evidence a detailed description of the respiratory problem and failed to evidence a measurable outcome related to the identified problem.</p> <p>C. The plan of care identified "nausea" as a problem. The plan failed to</p>			

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	<p>evidence a measurable outcome related to the identified nausea problem.</p> <p>D. The plan of care identified "agitation/anxiety" as a problem. The plan failed to evidence a measurable outcome related to the identified agitation/anxiety problem.</p> <p>4. Clinical record number 5 included a plan of care established by the IDG on 5-6-16. The plan failed to evidence measurable outcomes expected from the implementation of interventions to address identified problems.</p> <p>A. The plan of care identified "pain" as a problem. The plan failed to evidence a measurable goal for the management of the identified pain problem.</p> <p>B. The plan of care identified "cardiovascular" as a problem. The plan failed to include a detailed description of the cardiovascular problem and failed to evidence a measurable outcome for the management of the identified cardiovascular problem</p> <p>C. The plan of care identified "agitation/anxiety" as a problem. The plan failed to evidence a measurable outcome for the management of the identified agitation/anxiety problem.</p>			

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	<p>5. Clinical record number 7 included a plan of care established by the IDG on 3-25-16. The plan failed to evidence measurable outcomes expected from the implementation of interventions to address identified problems.</p> <p>A. The plan of care identified "pain" as a problem. The plan failed to evidence a measurable outcome related to the management of the identified problem with pain.</p> <p>B. The plan of care identified "bowel" as a problem. The plan failed to include a detailed description of the bowel problem and failed to evidence a measurable outcome for the management of the identified bowel problem.</p> <p>C. The plan of care identified "agitation/anxiety" as a problem. The plan failed to evidence a measurable outcome for the management of the identified agitation/anxiety problem.</p> <p>D. The plan of care identified "sleep disorder" as a problem. The plan failed to evidence a measurable outcome for the management of the identified sleep problem.</p> <p>6. Clinical record number 8 included a</p>			

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	<p>plan of care established by the IDG on 5-6-16. The plan of care failed to evidence measurable outcomes expected from the implementation of interventions to address identified problems.</p> <p>A. The plan of care identified "pain" as a problem. The plan failed to evidence a measurable outcome for the management of the identified pain problem.</p> <p>B. The plan identified "nutrition" as a problem. The plan failed to evidence a measurable outcome for the management of the identified nutrition problem.</p> <p>C. The plan identified "agitation/anxiety" as a problem The plan failed to evidence a measurable outcome for the management of the identified agitation/anxiety problem.</p> <p>D. The plan identified "mobility-safety" as a problem. The plan failed to evidence a measurable outcome for the management of the identified mobility-safety problem.</p> <p>7. Clinical record number 9 included a plan of care established by the IDG on 10-23-15. The plan failed to evidence measurable outcomes expected from the implementation of interventions to</p>			

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	<p>address identified problems.</p> <p>A. The plan identified "pain" as a problem. The plan failed to evidence measurable outcomes for the management of the identified pain problem.</p> <p>B. The plan identified "nutrition" as a problem. The plan failed to evidence a measurable outcome for the management of the identified nutrition problem.</p> <p>C. The plan identified "agitation/anxiety" as a problem. The plan failed to evidence a measurable outcome for the management of the identified agitation/anxiety problem.</p> <p>8. Clinical record number 10 included a plan of care established by the IDG on 1-29-16. The plan failed to evidence measurable outcomes expected from the implementation of interventions to address identified problems.</p> <p>A. The plan identified "pain" as a problem. The plan failed to evidence a measurable outcome for the management of the identified pain problem.</p> <p>B. The plan identified "bowel" as a problem. The plan failed to evidence a measurable outcome for the management</p>			

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	<p>of the identified bowel problem.</p> <p>9. Clinical record number 11 included a plan of care established by the IDG on 1-15-16. The plan failed to evidence measurable outcomes expected from the implementation of interventions to address identified problems.</p> <p>A. The plan identified "pain" as a problem. The plan failed to evidence a measurable outcome for the management of the identified pain problem.</p> <p>B. The plan identified "cardiovascular" as a problem. The plan failed to evidence a measurable outcome for the management of the identified cardiovascular problem.</p> <p>C. The plan identified "nutrition" as a problem. The plan failed to evidence a measurable outcome for the management of the identified nutrition problem.</p> <p>10. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM.</p> <p>11. The hospice's 09/2015 "Plan of Care, HC.31" policy states, "The plan of care includes, but not limited to: . . . measurable outcomes anticipated from</p>			

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L 0552 Bldg. 00	<p>implementing and coordination the plan of care."</p> <p>418.56(d) REVIEW OF THE PLAN OF CARE The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.</p> <p>Based on record review and interview, the hospice failed to ensure all members of the interdisciplinary group (IDG) had participated in the reviews and updates of the plan of care in 9 (#s 2, 3, 4, 5, 6, 7, 9, 10, and 11) of 11 records reviewed and failed to ensure plans of care had been updated to include all services provided to the patients in 2 (#s 8 and 10) of 2 records reviewed of patients that received continuous care services.</p> <p>The findings include:</p> <p>Regarding all members of IDG participate in review and update of plan of care:</p>	L 0552	L 552 The Administrator will instruct IDG members that in collaboration with the attending physician, if any, they must review, revise and document the individualized plan of care as frequently as the patient's condition requires, but no less frequently than every 15 days. All members of the IDG must participate. The Administrator will recruit, hire and orient a prn Chaplain to provide spiritual care and attend IDG when the chaplain is unavailable. The Administrator will be responsible for monitoring staffing to ensure this deficiency is corrected and will not recur.	07/22/2016	

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	<p>1. Clinical record number 2 included a plan of care review and update dated 5-6-16. The update failed to evidence the spiritual care counselor (SCC) member of the IDG had participated in the review and update.</p> <p>2. Clinical record number 3 included a plan of care review and update dated 5-6-16. The update failed to evidence the SCC member of the IDG had participated in the review and update.</p> <p>3. Clinical record number 4 included a plan of care review and update dated 5-6-16. The update failed to evidence the SCC member of the IDG had participated in the review and update.</p> <p>4. Clinical record number 5 included a plan of care review and update dated 5-6-16. The update failed to evidence the SCC member of the IDG had participated in the review and update.</p> <p>5. Clinical record number 6 included a plan of care review and update dated 5-6-16. The update failed to evidence the SCC member of the IDG had participated in the review and update.</p> <p>6. Clinical record number 7 included a plan of care review and update dated 4-8-16. The update failed to evidence the</p>			

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	<p>SCC member of the IDG had participated in the review and update.</p> <p>7. Clinical record number 9 included a plan of care review and update dated 12-30-15. The update failed to evidence the SCC member of the IDG had participated in the review and update.</p> <p>8. Clinical record number 10 included plan of care reviews and updates dated 1-15-16 and 2-26-16. The updates failed to evidence the SCC member of the IDG had participated in the reviews and updates.</p> <p>9. Clinical record number 11 included plan of care reviews and updated dated 1-29-16 and 2-26-16. The updates failed to evidence the SCC member of the IDG had participated in the reviews and updates.</p> <p>10. The administrator indicated, on 6-22-16 at 2:55 PM, the hospice did not have a SCC for a period of time. The administrator stated, "The other SCC quit on 4-1-16 and the present one started on 5-16-16.</p> <p>11. The hospice's 06/2016 "Interdisciplinary Group HC.61" policy states, "The MSA Hospice Interdisciplinary Group (IDG) meets at</p>			

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	<p>least every fifteen (15) days to discuss patient and family changes, updates to the plan of care . . . The interdisciplinary group (IDG) includes at a minimum the following disciplines: a. doctor of medicine or osteopathy b. registered nurse c. social worker d. pastoral or other counselor . . . The interdisciplinary group responsibilities may include, but not limited to: . . . reviewing and revising plan of care."</p> <p>Regarding plans of care updated to include all services:</p> <ol style="list-style-type: none"> 1. Clinical record number 8 included a "Clinical Notes" entry dated 5-14-16 that states, "Continuous care initiated at this time due to continued decline in patients condition." The record failed to evidence the plan of care dated 5-6-16 had been updated to include the initiation of the continuous care. 2. Clinical record number 10 included a "Clinical Notes" entry dated 3-7-16 that states, "Continuous care initiated at this time due to continued decline in patients condition." The record failed to evidence the plan of care dated 1-29-16 had been updated to include the initiation of the continuous care. 3. The administrator was unable to 			

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L 0553 Bldg. 00	<p>provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM and 6-23-16 at 3:15 PM.</p> <p>4. The hospice's 09/2015 "Plan of Care, HC.31" policy states, "The hospice interdisciplinary group in collaboration with the individual's attending physician, if any, reviews, revises, and documents the individualized plan as frequently as the patient's condition requires."</p> <p>418.56(d) REVIEW OF THE PLAN OF CARE A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. Based on record review and interview, the hospice failed to ensure updates to plan of care included update information in 10 (#s 1, 2, 3, 4, 5, 6, 7, 9, 10, and 11)</p>	L 0553	L 553 The Administrator will instruct all clinical staff a revised plan of care must include information from the patient's updated comprehensive assessment and must note the	07/22/2016

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	<p>of 10 records reviewed on service greater than 2 weeks after the establishment of the plan of care of the 11 total records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 failed to evidence revisions to the plan of care, established by the interdisciplinary group (IDG) on 5-20-16, included progress towards stated goals and updated information.</p> <p>A. The record included an update to the plan of care dated 6-3-16. The update included medication management goals of "Patient/caregiver verbalizes understanding of medications as evidenced by recall of action, dose & side effects" and "Patient/caregiver demonstrates safe administration of drugs and biologicals." The update failed to evidence progress towards achieving these goals.</p> <p>1.) The update included pain goals of "Patient/caregiver verbalizes/demonstrates understanding of pain management and proper medication administration - as evidenced by questioning caregiver about meds, side effects, and any questions" and "Patient's pain remains at comfortable level during</p>		<p>patient's progress toward outcomes and goals specified in the plan of care. 10% of all medical records will be audited monthly to ensure that the revised plan of care includes information from the updated comprehensive assessment and notes the patient's progress toward outcomes and goals specified in the plan of care. The Administrator will be responsible for monitoring to ensure this deficiency is corrected and will not recur.</p>	

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	<p>care - as evidenced on assessment of condition." The update failed to evidence progress towards achieving these goals.</p> <p>2.) The update included cardiovascular goals of "Patient/caregiver receives optimal teaching and support as cardiac function change." The update failed to evidence progress towards achieving the goal.</p> <p>3.) The update included respiratory goals of "Patient/caregiver anxiety related to symptom exacerbation is minimized" and "Patient maintains adequate airway and respiratory function within limits of disease process." The update failed to evidence progress towards achieving the goals.</p> <p>4.) The update included diabetic management goals of "Patient/caregiver demonstrates knowledge of diabetes disease management at end of life/potential complications/what to report". The update failed to evidence progress towards achieving the goal.</p> <p>5.) The update included agitation/anxiety goals of "Patient/caregiver anxiety is minimized within limits of disease progression" and "Patient/caregiver verbalizes/demonstrates understanding of</p>			

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	<p>anxiety management and proper medication administration." The update failed to evidence progress towards achieving the goals.</p> <p>6.) The update included altered mental status goals of "Patient/caregiver verbalizes understanding of mental and functional changes related to disease process" and "Caregiver demonstrates ability to cope with patient's altered mental status." The update failed to evidence progress towards achieving the goals.</p> <p>7.) The update included mobility-safety goals of "Patient maintains optimal mobility and participation in activities of daily living within disease limitations" and "Maintain safe patient environment throughout Hospice care." The update failed to evidence progress towards achieving the goals.</p> <p>8.) The update include hospice aide careplan goals of "Patient's personal hygiene is maintained" and "Patient stated wishes are respected." The update failed to evidence progress towards achieving the goals.</p> <p>B. The record included an update to the plan of care dated 6-17-16. The</p>			

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	<p>update included medication management goals of "Patient/caregiver verbalizes understanding of medications a evidenced by recall of action, dose & side effects" and "Patient/caregiver demonstrates safe administration of drugs and biologicals." The update failed to evidence progress towards achieving these goals.</p> <p>1.) The update included pain goals of "Patient/caregiver verbalizes/demonstrates understanding of pain management and proper medication administration - as evidenced by questioning caregiver about meds, side effects, and any questions" and "Patient's pain remains at comfortable level during care - as evidenced on assessment of condition." The update failed to evidence progress towards achieving these goals.</p> <p>2.) The update included cardiovascular goals of "Patient/caregiver receives optimal teaching and support as cardiac function change." The update failed to evidence progress towards achieving the goal.</p> <p>3.) The update included respiratory goals of "Patient/caregiver anxiety related to symptom exacerbation is minimized" and "Patient maintains adequate airway and respiratory function</p>			

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	<p>within limits of disease process." The update failed to evidence progress towards achieving the goals.</p> <p>4.) The update included diabetic management goals of "Patient/caregiver demonstrates knowledge of diabetes disease management at end of life/potential complications/what to report". The update failed to evidence progress towards achieving the goal.</p> <p>5.) The update included agitation/anxiety goals of "Patient/caregiver anxiety is minimized within limits of disease progression" and "Patient/caregiver verbalizes/demonstrates understanding of anxiety management and proper medication administration." The update failed to evidence progress towards achieving the goals.</p> <p>6.) The update included altered mental status goals of "Patient/caregiver verbalizes understanding of mental and functional changes related to disease process" and "Caregiver demonstrates ability to cope with patient's altered mental status." The update failed to evidence progress towards achieving the goals.</p> <p>7.) The update included</p>			

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	<p>mobility-safety goals of "Patient maintains optimal mobility and participation in activities of daily living within disease limitations" and "Maintain safe patient environment throughout Hospice care." The update failed to evidence progress towards achieving the goals.</p> <p>8.) The update include hospice aide careplan goals of "Patient's personal hygiene is maintained" and "Patient stated wishes are respected." The update failed to evidence progress towards achieving the goals.</p> <p>2. Clinical record number 2 failed to evidence revisions to the plan of care, established by the interdisciplinary group (IDG) on 5-6-16, included progress towards achieving the stated goals and updated information.</p> <p>A. The record included an update to the plan of care dated 5-20-16. The update included a medication goal of "Patient receives prescribed medications." The update failed to evidence progress towards achieving the stated goal.</p> <p>1.) The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold</p>			

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	<p>(SIT) as verbalized by the patient/caregiver" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the goals.</p> <p>2.) The update failed to evidence any cardiovascular goals.</p> <p>3.) The update included respiratory goals of "Patient/caregiver verbalizes knowledge of dyspnea management", "Patient maintains adequate airway and respiratory function within limits of disease process", "Patient/caregiver demonstrates proper use of respiratory equipment/medications", and "Patient/caregiver demonstrates proper and safe use of oxygen." The update failed to evidence progress towards achieving the goals.</p> <p>4.) The update included skin-wound goals of "Patient's wound improves within limits of disease process" and "Patient's skin remains intact within limits of disease process." The update failed to evidence progress towards achieving the goals.</p> <p>A skilled nurse (SN) visit note dated 5-18-16 identifies the stage 2 pressure ulcer on the patient's right outer</p>			

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	<p>ankle is "healed."</p> <p>5.) The update included communication goals of "Patient/caregiver communicates effectively with Hospice team." The update failed to evidence progress towards achieving the goals.</p> <p>6.) The update included hospice aide care plan goals of "Patient's personal hygiene is maintained", "Patient/caregiver receives assistance with ADLs [activities of daily living]", and "Patient's stated wishes are respected." The update failed to evidence progress towards achieving the goals.</p> <p>B. The record included an update to the plan of care dated 6-3-16. The update included The update included a medication goal of "Patient receives prescribed medications." The update failed to evidence progress towards achieving the stated goal.</p> <p>1.) The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalized by the patient/caregiver" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the goals.</p>			

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	<p>2.) The update failed to evidence any cardiovascular goals.</p> <p>3.) The update included respiratory goals of "Patient/caregiver verbalizes knowledge of dyspnea management", "Patient maintains adequate airway and respiratory function within limits of disease process", "Patient/caregiver demonstrates proper use of respiratory equipment/medications", and "Patient/caregiver demonstrates proper and safe use of oxygen." The update failed to evidence progress towards achieving the goals.</p> <p>4.) The update included skin-wound goals of "Patient's wound improves within limits of disease process" and "Patient's skin remains intact within limits of disease process." The update failed to evidence progress towards achieving the goals.</p> <p>5.) The update included communication goals of "Patient/caregiver communicates effectively with Hospice team." The update failed to evidence progress towards achieving the goals.</p> <p>6.) The update included hospice</p>			

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	<p>aide care plan goals of "Patient's personal hygiene is maintained", "Patient/caregiver receives assistance with ADLs [activities of daily living]", and "Patient's stated wishes are respected." The update failed to evidence progress towards achieving the goals.</p> <p>C. The record included an update to the plan of care dated 6-17-16. The update included a medication management goal of "Patient receives prescribed medications." The update failed to evidence progress towards achieving the stated goal.</p> <p>1.) The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalized by the patient/caregiver" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the goals.</p> <p>2.) The update failed to evidence any cardiovascular goals.</p> <p>3.) The update included respiratory goals of "Patient/caregiver verbalizes knowledge of dyspnea management", "Patient maintains adequate airway and respiratory function within limits of disease process",</p>						

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	<p>"Patient/caregiver demonstrates proper use of respiratory equipment/medications", and "Patient/caregiver demonstrates proper and safe use of oxygen." The update failed to evidence progress towards achieving the goals.</p> <p>4.) The update included skin-wound goals of "Patient's wound improves within limits of disease process" and "Patient's skin remains intact within limits of disease process." The update failed to evidence progress towards achieving the goals.</p> <p>SN visit notes, dated 6-13-16, 6-15-16, and 6-17-16 identified a stage 1 pressure ulcer on the patient's dorsal right shoulder.</p> <p>5.) The update included communication goals of "Patient/caregiver communicates effectively with Hospice team." The update failed to evidence progress towards achieving the goals.</p> <p>6.) The update included hospice aide care plan goals of "Patient's personal hygiene is maintained", "Patient/caregiver receives assistance with ADLs [activities of daily living]", and "Patient's stated wishes are</p>			

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	<p>respected." The update failed to evidence progress towards achieving the goals.</p> <p>3. Clinical record number 3 failed to evidence revisions to the plan of care, established by the interdisciplinary group (IDG) on 6-3-16, included progress towards achieving the stated goals and updated information.</p> <p>The record included an update to the plan of care dated 6-17-16. The update included medication management goals of "Patient/caregiver verbalizes understanding of medications as evidenced by recall of action, dose & side effects" and "Patient/caregiver demonstrates safe administration of drugs and biologicals". The update failed to evidence progress towards achieving the stated goals.</p> <p>1.) The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalized by patient/caregiver" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated goals.</p> <p>2.) The update included respiratory goals of "Patient/caregiver verbalizes knowledge of dyspnea</p>			

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	<p>management", "Patient/caregiver anxiety related to symptom exacerbation is minimized", "Patient/caregiver verbalizes factors that may precipitate exacerbation of dyspnea", and "Patient/caregiver receives optimal teaching and support as respiratory function changes." The update failed to evidence progress towards achieving the stated goals.</p> <p>3.) The update included a nausea goal of "Patient/caregiver verbalizes understanding of methods to manage symptoms of nausea/vomiting." The update failed to evidence progress towards achieving the stated goal.</p> <p>4.) The update included bowel goals of "Patient maintains bowel function within limits of disease process/progression" and "Patient/caregiver verbalizes understanding and demonstrates ability to manage bowel regimen." The update failed to evidence progress towards achieving the stated goals.</p> <p>5.) The update included agitation/anxiety goals of "Patient/caregiver agitation is controlled within limits of disease progression" and "Patient/caregiver verbalizes/demonstrates understanding of anxiety management and proper</p>			

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	<p>medication administration". The update failed to evidence progress towards achieving the stated goals.</p> <p>6.) The update included a sleep disorder goal of "Patient's sleep pattern as optimized within limits of disease process". The update failed to evidence progress towards achieving the state goal.</p> <p>4. Clinical record number 4 failed to evidence revisions to the plan of care, established by the interdisciplinary group (IDG) on 6-3-16, included progress towards achieving the stated goals and updated information.</p> <p>The record included an update to the plan of care dated 6-17-16. The update included a medication management goal of "Patient/caregiver verbalizes understanding of medications as evidenced by recall of action, dose & side effects - patient will be able to state what medications [the patient] takes and what the medication is for." The update failed to evidence progress towards achieving the stated goal.</p> <p>1.) The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalized by the patient/caregiver - Goal is for pain to be</p>			

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	<p>less than 5" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated goals.</p> <p>2.) The update included a skin-wound goal of "Patient's skin remains intact within limits of disease process." The update failed to evidence progress towards achieving the stated goal.</p> <p>3.) The update included a nutrition goal of "Patient/caregiver verbalizes understanding of methods to decrease choking and prevent aspiration." The update failed to evidence progress towards achieving the stated goal.</p> <p>4.) The update included a nausea goal of "Patient/caregiver verbalizes understanding of methods to manage symptoms of nausea/vomiting - Patient will verbalize understanding of methods to manage symptoms of nausea/vomiting by avoiding food that cause [the patient] nausea and to ask for nausea medication to decrease symptoms." The update failed to evidence progress towards achieving the stated goal.</p> <p>5.) The update included urinary goals of "Patient maintains urinary function without complications within</p>			

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	<p>limitations of disease process/progression" and "Patient's catheter remains patent". The update failed to evidence progress towards achieving the stated goal.</p> <p>6.) The update included a neurological goal of "Patient seizure activity is controlled within limits of disease process - Keppra will be given as ordered and Ativan will be administered per [name of physician] orders for active seizure management." The update failed to evidence progress towards achieving the stated goal.</p> <p>7.) The update included a hospice aide care plan goal of "Patient's stated wishes are respected." The update failed to evidence progress towards the stated goal.</p> <p>5. Clinical record number 5 failed to evidence revisions to the plan of care, established by the interdisciplinary group (IDG) on 5-6-16, included progress towards achieving the stated goals and updated information.</p> <p>A. The record included an update to the plan of care dated 5-20-16. The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as</p>			

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	<p>verbalized by patient/caregiver" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated goals.</p> <p>1.) The update included cardiovascular goals of "Patient/caregiver demonstrates understanding/management of heart disease" and "Patient/caregiver receives optimal teaching and support as cardiac functions change." The update failed to evidence progress towards achieving the stated goals.</p> <p>2.) The update included skin-wound goals of "Patient's wound improves within limits of disease process" and "Patient/caregiver verbalizes knowledge of wound treatment plan." The update failed to evidence progress towards achieving the stated goals.</p> <p>3.) The update included nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life" and "Patient/caregiver verbalizes understanding methods to decrease choking and prevent aspiration." The update failed to evidence progress towards achieving the stated goals.</p>			

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	<p>4.) The update included agitation/anxiety goals of "Patient/caregiver anxiety is minimized within limits of disease progression", "Patient/caregiver agitation is controlled within limits of disease progression", "Patient has reduction in terminal agitation", and "Patient/caregiver verbalizes/demonstrates understanding of anxiety management and proper medication administration." The update failed to evidence progress towards achieving the stated goals.</p> <p>5.) The update included altered mental status of "Patient/caregiver verbalizes understanding of mental and functional changes related to disease process", "Caregiver utilizes appropriate interventions for patient with altered mental status", and "Caregiver demonstrates ability to cope with patient's altered mental status." The update failed to evidence progress towards achieving the stated goals.</p> <p>6.) The update included hospice aide care plan goals of "Patient's personal hygiene is maintained", "Patient/caregiver receives assistance with ADLs", and "Patient's stated wishes are respected." The update failed to evidence progress towards achieving the stated goals.</p>				

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	<p>B. The record included an update to the plan of care dated 6-3-16. The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalized by patient/caregiver" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated goals.</p> <p>1.) The update included cardiovascular goals of "Patient/caregiver demonstrates understanding/management of heart disease" and "Patient/caregiver receives optimal teaching and support as cardiac functions change." The update failed to evidence progress towards achieving the stated goals.</p> <p>2.) The update included skin-wound goals of "Patient's wound improves within limits of disease process" and "Patient/caregiver verbalizes knowledge of wound treatment plan." The update failed to evidence progress towards achieving the stated goals.</p> <p>3.) The update included nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life" and</p>			

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	<p>"Patient/caregiver verbalizes understanding methods to decrease choking and prevent aspiration." The update failed to evidence progress towards achieving the stated goals.</p> <p>4.) The update included agitation/anxiety goals of "Patient/caregiver anxiety is minimized within limits of disease progression", "Patient/caregiver agitation is controlled within limits of disease progression", "Patient has reduction in terminal agitation", and "Patient/caregiver verbalizes/demonstrates understanding of anxiety management and proper medication administration." The update failed to evidence progress towards achieving the stated goals.</p> <p>5.) The update included altered mental status of "Patient/caregiver verbalizes understanding of mental and functional changes related to disease process", "Caregiver utilizes appropriate interventions for patient with altered mental status", and "Caregiver demonstrates ability to cope with patient's altered mental status." The update failed to evidence progress towards achieving the stated goals.</p> <p>6.) The update included hospice aide care plan goals of "Patient's personal</p>			

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	<p>hygiene is maintained", "Patient/caregiver receives assistance with ADLs", and "Patient's stated wishes are respected." The update failed to evidence progress towards achieving the stated goals.</p> <p>C. The record included an update to the plan of care dated 6-17-16. The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalized by patient/caregiver" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated goals.</p> <p>1.) The update included cardiovascular goals of "Patient/caregiver demonstrates understanding/management of heart disease" and "Patient/caregiver receives optimal teaching and support as cardiac functions change." The update failed to evidence progress towards achieving the stated goals.</p> <p>2.) The update included skin-wound goals of "Patient's wound improves within limits of disease process" and "Patient/caregiver verbalizes knowledge of wound treatment plan." The update failed to evidence progress towards achieving the stated</p>				

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	<p>goals.</p> <p>3.) The update included nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life" and "Patient/caregiver verbalizes understanding methods to decrease choking and prevent aspiration." The update failed to evidence progress towards achieving the stated goals.</p> <p>4.) The update included agitation/anxiety goals of "Patient/caregiver anxiety is minimized within limits of disease progression", "Patient/caregiver agitation is controlled within limits of disease progression", "Patient has reduction in terminal agitation", and "Patient/caregiver verbalizes/demonstrates understanding of anxiety management and proper medication administration." The update failed to evidence progress towards achieving the stated goals.</p> <p>5.) The update included altered mental status of "Patient/caregiver verbalizes understanding of mental and functional changes related to disease process", "Caregiver utilizes appropriate interventions for patient with altered mental status", and "Caregiver demonstrates ability to cope with</p>			

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	<p>patient's altered mental status." The update failed to evidence progress towards achieving the stated goals.</p> <p>6.) The update included hospice aide care plan goals of "Patient's personal hygiene is maintained", "Patient/caregiver receives assistance with ADLs", and "Patient's stated wishes are respected." The update failed to evidence progress towards achieving the stated goals.</p> <p>6. Clinical record number 6 failed to evidence revisions to the plan of care, established by the interdisciplinary group (IDG) on 5-6-16, included progress towards achieving the stated goals and updated information.</p> <p>A. The record included an update to the plan of care dated 5-20-16. The update included medication management goals of "Patient receives prescribed medications" and "Patient/caregiver demonstrates safe administration of drugs and biologicals." The update failed to evidence progress towards achieving the stated goals.</p> <p>1.) The update included nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life" and</p>			

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	<p>"Patient/caregiver verbalizes understanding of methods to decrease choking and prevent aspiration." The update failed to evidence progress towards achieving the stated goals.</p> <p>2.) The update included neurological goals of "Patient/caregiver verbalizes understanding of neurological changes related to disease process" and "Patient remains safe from injury related to neurological disease." The update failed to evidence progress towards achieving the stated neurological goals.</p> <p>3.) The update included altered mental status goals of "Patient/caregiver verbalizes understanding of mental and functional changes related to disease process" and "Maintain safe environment." The update failed to evidence progress towards achieving the stated altered mental status goals.</p> <p>4.) The update included mobility-safety goals of "Patient maintains optimal mobility and participation in activities of daily living within disease limitations", "Patient/caregiver demonstrates safe, effective use of equipment", and "Maintain safe patient environment throughout Hospice care." The update failed to evidence progress towards</p>			

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	<p>achieving the stated mobility-safety goals.</p> <p>5.) The update included hospice aide care plan goals of "Patient's personal hygiene is maintained" and "Patient/caregiver receives assistance with ADLs." The update failed to evidence progress towards achieving the stated hospice aide goals.</p> <p>B. The record included an update to the plan of care dated 6-3-16. The update included medication management goals of "Patient receives prescribed medications" and "Patient/caregiver demonstrates safe administration of drugs and biologicals." The update failed to evidence progress towards achieving the stated goals.</p> <p>1.) The update included nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life" and "Patient/caregiver verbalizes understanding of methods to decrease choking and prevent aspiration." The update failed to evidence progress towards achieving the stated goals.</p> <p>2.) The update included neurological goals of "Patient/caregiver verbalizes understanding of neurological</p>			

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	<p>changes related to disease process" and "Patient remains safe from injury related to neurological disease." The update failed to evidence progress towards achieving the stated neurological goals.</p> <p>3.) The update included altered mental status goals of "Patient/caregiver verbalizes understanding of mental and functional changes related to disease process" and "Maintain safe environment." The update failed to evidence progress towards achieving the stated altered mental status goals.</p> <p>4.) The update included mobility-safety goals of "Patient maintains optimal mobility and participation in activities of daily living within disease limitations", "Patient/caregiver demonstrates safe, effective use of equipment", and "Maintain safe patient environment throughout Hospice care." The update failed to evidence progress towards achieving the stated mobility-safety goals.</p> <p>5.) The update included hospice aide care plan goals of "Patient's personal hygiene is maintained" and "Patient/caregiver receives assistance with ADLs." The update failed to evidence progress towards achieving the</p>			

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	<p>stated hospice aide goals.</p> <p>C. The record included an update to the plan of care dated 6-17-16. The update included medication management goals of "Patient receives prescribed medications" and "Patient/caregiver demonstrates safe administration of drugs and biologicals." The update failed to evidence progress towards achieving the stated goals.</p> <p>1.) The update included nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life" and "Patient/caregiver verbalizes understanding of methods to decrease choking and prevent aspiration." The update failed to evidence progress towards achieving the stated goals.</p> <p>2.) The update included neurological goals of "Patient/caregiver verbalizes understanding of neurological changes related to disease process" and "Patient remains safe from injury related to neurological disease." The update failed to evidence progress towards achieving the stated neurological goals.</p> <p>3.) The update included altered mental status goals of "Patient/caregiver verbalizes understanding of mental and</p>			
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	<p>functional changes related to disease process" and "Maintain safe environment." The update failed to evidence progress towards achieving the stated altered mental status goals.</p> <p>4.) The update included mobility-safety goals of "Patient maintains optimal mobility and participation in activities of daily living within disease limitations", "Patient/caregiver demonstrates safe, effective use of equipment", and "Maintain safe patient environment throughout Hospice care." The update failed to evidence progress towards achieving the stated mobility-safety goals.</p> <p>5.) The update included hospice aide care plan goals of "Patient's personal hygiene is maintained" and "Patient/caregiver receives assistance with ADLs." The update failed to evidence progress towards achieving the stated hospice aide goals.</p> <p>7. Clinical record number 7 failed to evidence revisions to the plan of care, established by the interdisciplinary group (IDG) on 3-25-16, included progress towards achieving the stated goals and updated information.</p>			

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	<p>The record included an update to the plan of care dated 4-8-16. The update included medication management goals of "Patient/caregiver verbalizes understanding of medications as evidenced by recall of action, dose & side effects", "Patient receives prescribed medications", and "Patient/caregiver verbalizes understanding of adverse events related to anticoagulant therapy and what to report." The update failed to evidence progress towards achieving the stated medication management goals.</p> <p>1.) The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalized by the patient/caregiver", "Patient/caregiver verbalizes/demonstrates understanding of pain management and proper medication administration", and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated pain goals.</p> <p>2.) The update included respiratory goals of "Patient/caregiver verbalizes knowledge of dyspnea management as evidenced by demonstrating what was taught", and "Patient/caregiver receives optimal teaching and support as respiratory function changes as evidenced</p>						

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	<p>by spouse verbalizing knowledge." The update failed to evidence progress towards achieving the stated respiratory goals.</p> <p>3.) The update included nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life", "Patient/caregiver verbalizes understanding of methods to decrease choking and prevent aspiration", and "Promote optimal nutrition/hydration at end of life." The update failed to evidence progress towards achieving the stated nutrition goals.</p> <p>4.) The update included bowel goals of "Patient maintains bowel function within limits of disease process/progression", "Patient/caregiver verbalizes understanding and demonstrates ability to manage bowel regimen", and "Patient/caregiver reports progressive decrease in loose stools." The update failed to evidence progress towards achieving the stated bowel goals.</p> <p>5.) The update included agitation/anxiety goals of "Patient/caregiver anxiety is minimized within limits of disease progression", "Patient/caregiver agitation is controlled within limits of disease progress",</p>			

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	<p>"Patient has reduction in terminal agitation", and "Patient/caregiver verbalizes/demonstrates understanding of anxiety management and proper medication administration." The update failed to evidence progress towards achieving the stated agitation/anxiety goals.</p> <p>6.) The update included mobility-safety goals of "Patient maintains optimal mobility and participation in activities of daily living within disease limitations", "Patient/caregiver demonstrates safe, effective use of equipment", "Patient/caregiver demonstrates safe mobility and transfer techniques", and "Maintain safe patient environment throughout Hospice care." The update failed to evidence progress towards achieving the stated mobility-safety goals.</p> <p>7.) The update included sleep disorder goals of "Patient's sleep pattern as optimized within limits of disease process", "Patient/caregiver verbalize understanding of measures to aid sleep", and "Patient/caregiver verbalize understanding of disease process on sleep pattern." The update failed to evidence progress towards achieving the stated sleep disorder goals.</p>			

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	<p>8.) The update included "Imminently Dying" goals of "Caregiver reports confidence in what to expect when patient is dying" and "Caregiver capable of providing ongoing care during imminent death." The update failed to evidence progress towards achieving the stated imminently dying goals.</p> <p>9.) The update included hospice aide careplan goals of "Patient's personal hygiene is maintained", "Patient/caregiver receives assistance with ADLs", and "Patient's stated wishes are respected." The update failed to evidence progress towards achieving the stated hospice aide careplan goals.</p> <p>8. Clinical record number 9 failed to evidence revisions to the plan of care, established by the IDG on 10-23-15, included progress towards achieving the stated goals and updated information.</p> <p>A. The record included an update to the plan of care dated 11-20-15. The update included a medication management goal of "Patient receives prescribed medications as evidenced by facility MAR [medication administration record]." The update failed to evidence progress towards achieving the stated medication management goal.</p>			

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	<p>1.) The update included pain goals of "Patient's pain remains at comfortable level during care as evidenced by patient/caregiver report that pain is managed to their comfort level" and "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalized by patient/caregiver within this certification period." The update failed to evidence progress towards achieving the stated pain goal.</p> <p>2.) The update included skin-wound goals of "Patient/caregiver verbalizes knowledge of wound treatment plan as evidenced by facility compliance with wound care orders" and "Patient/caregiver verbalize understanding of measures to prevent skin breakdown as evidenced by turning and positioning patient every 2 hours." The update failed to evidence progress towards achieving the stated skin-wound goals.</p> <p>3.) The update include a nutrition goal of "Patient/caregiver verbalizes understanding methods to decrease choking and prevent aspiration as evidenced by recall of aspirations precautions." The update failed to evidence progress towards achieving the stated nutrition goal.</p>			

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	<p>4.) The update dated included bowel goals of "Patient maintains bowel function within limits of disease process/progression" and "Patient/caregiver verbalizes understanding and demonstrates ability to manage bowel regimen." The update failed to evidence progress towards achieving the stated bowel goals.</p> <p>5.) The update included urinary goals of "Patient's catheter remains patent as evidenced no obstructions in flow of urine" and "Patient/caregiver verbalizes understanding of renal function changes at end of life as evidenced by recall of symptoms of renal failure and decreased uring [sic] output." The update failed to evidence progress towards achieving the stated urinary goals.</p> <p>6.) The update included an agitation/anxiety goal of "Patient/caregiver anxiety is minimized within limits of disease progression as evidenced by no PRN [as needed] visits for anxiety." The update failed to evidence progress towards achieving the stated agitation/anxiety goals.</p> <p>7.) The update included hospice aide care plan goals of "Patient's personal hygiene is maintained as evidenced by</p>			

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	<p>satisfactory reports from patient and staff on supervisory visits", "Patient/caregiver receives assistance with ADLs as evidenced by no refusal of aid visits", and "Patient's stated wishes are respected as evidenced by patient/caregiver positive feedback." The updated failed to evidence progress towards achieving the stated hospice aide careplan goals.</p> <p>B. The record included an IDG update dated 12-18-15. The update included a medication management goal of "Patient receives prescribed medications as evidenced by facility MAR [medication administration record]." The update failed to evidence progress towards achieving the stated medication management goal.</p> <p>1.) The update included infection/isolation goals of "Minimize symptoms of infection as evidenced by decreased drainage from wound, no fevers" and "Patient/caregiver verbalizes understanding of quality of life issues related to continuing antibiotic therapy at end of life as evidenced by verbalization of illness and results of using or not using antibiotics." The update failed to evidence progress towards achieving the stated infection/isolation goals.</p> <p>2.) The update included pain goals</p>			

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	<p>of "Patient's pain remains at comfortable level during care as evidenced by patient/caregiver report that pain is managed to their comfort level" and "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalized by patient/caregiver within this certification period." The update failed to evidence progress towards achieving the stated pain goal.</p> <p>3.) The update included skin-wound goals of "Patient/caregiver verbalizes knowledge of wound treatment plan as evidenced by facility compliance with wound care orders" and "Patient/caregiver verbalize understanding of measures to prevent skin breakdown as evidenced by turning and positioning patient every 2 hours." The update failed to evidence progress towards achieving the stated skin-wound goals.</p> <p>4.) The update dated included bowel goals of "Patient maintains bowel function within limits of disease process/progression" and "Patient/caregiver verbalizes understanding and demonstrates ability to manage bowel regimen." The update failed to evidence progress towards achieving the stated bowel goals.</p>			

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	<p>5.) The update included urinary goals of "Patient's catheter remains patent as evidenced no obstructions in flow of urine" and "Patient/caregiver verbalizes understanding of renal function changes at end of life as evidenced by recall of symptoms of renal failure and decreased uring [sic] output." The update failed to evidence progress towards achieving the stated urinary goals.</p> <p>6.) The update included an agitation/anxiety goal of "Patient/caregiver anxiety is minimized within limits of disease progression as evidenced by no PRN [as needed] visits for anxiety." The update failed to evidence progress towards achieving the stated agitation/anxiety goals.</p> <p>7.) The update included hospice aide care plan goals of "Patient's personal hygiene is maintained as evidenced by satisfactory reports from patient and staff on supervisory visits", "Patient/caregiver receives assistance with ADLs as evidenced by no refusal of aid visits", and "Patient's stated wishes are respected as evidenced by patient/caregiver positive feedback." The updated failed to evidence progress towards achieving the stated hospice aide careplan goals.</p> <p>C. The record included an IDG update</p>			

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	<p>to the plan of care dated 12-30-15. The update included a medication management goal of "Patient receives prescribed medications as evidenced by facility MAR [medication administration record]." The update failed to evidence progress towards achieving the stated medication management goal.</p> <p>1.) The update included infection/isolation goals of "Minimize symptoms of infection as evidenced by decreased drainage from wound, no fevers" and "Patient/caregiver verbalizes understanding of quality of life issues related to continuing antibiotic therapy at end of life as evidenced by verbalization of illness and results of using or not using antibiotics." The update failed to evidence progress towards achieving the stated infection/isolation goals.</p> <p>2.) The update included pain goals of "Patient's pain remains at comfortable level during care as evidenced by patient/caregiver report that pain is managed to their comfort level" and "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalized by patient/caregiver within this certification period." The update failed to evidence progress towards achieving the stated pain goal.</p>						

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	<p>3.) The update included skin-wound goals of "Patient/caregiver verbalizes knowledge of wound treatment plan as evidenced by facility compliance with wound care orders" and "Patient/caregiver verbalize understanding of measures to prevent skin breakdown as evidenced by turning and positioning patient every 2 hours." The update failed to evidence progress towards achieving the stated skin-wound goals.</p> <p>4.) The update dated included bowel goals of "Patient maintains bowel function within limits of disease process/progression" and "Patient/caregiver verbalizes understanding and demonstrates ability to manage bowel regimen." The update failed to evidence progress towards achieving the stated bowel goals.</p> <p>5.) The update included urinary goals of "Patient's catheter remains patent as evidenced no obstructions in flow of urine" and "Patient/caregiver verbalizes understanding of renal function changes at end of life as evidenced by recall of symptoms of renal failure and decreased uring [sic] output." The update failed to evidence progress towards achieving the stated urinary goals.</p>			

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	<p>6.) The update included an agitation/anxiety goal of "Patient/caregiver anxiety is minimized within limits of disease progression as evidenced by no PRN [as needed] visits for anxiety." The update failed to evidence progress towards achieving the stated agitation/anxiety goals.</p> <p>7.) The update included hospice aide care plan goals of "Patient's personal hygiene is maintained as evidenced by satisfactory reports from patient and staff on supervisory visits", "Patient/caregiver receives assistance with ADLs as evidenced by no refusal of aid visits", and "Patient's stated wishes are respected as evidenced by patient/caregiver positive feedback." The updated failed to evidence progress towards achieving the stated hospice aide careplan goals.</p> <p>9. Clinical record number 10 failed to evidence revisions to the plan of care, established by the IDG on 1-29-16, included progress towards achieving the stated goals and updated information.</p> <p>A. The record included an IDG update to the plan of care dated 2-12-16. The update included a medication management goal of "Patient receives prescribed medications." The update failed to evidence progress towards</p>			

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	<p>achieving the stated medication management goal.</p> <p>1.) The update included pain goals of "Patient/caregiver verbalizes/demonstrates understanding of pain management and proper medication administration" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated pain goals.</p> <p>2.) The update included nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life. Caregiver will provide appropriate nutritional intake for patient and understand to adjust nutritional consistencies when needed and to notify the nurse with changes", "Patient/caregiver verbalizes understanding of methods to decrease choking and prevent aspiration. Caregiver understands s/s [signs and symptoms] of aspiration and the need to notify the SN [skilled nurse] when dysphasia begins", and "Promote optimal nutrition/hydration status will be monitored every visit for the need for changes." The update failed to evidence progress towards achieving the stated nutrition goals.</p> <p>3.) The update included a bowel</p>			

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	<p>goal of "Patient maintains bowel function within limits of disease process/progression. Monitor bowel function every visit." The update failed to evidence progress towards achieving the stated bowel goal.</p> <p>4.) The update included a neurological goal of "Patient remains safe from injury related to neurological disease. Patient will have no falls this cert period." The update failed to evidence progress towards achieving the stated neurological goal.</p> <p>5.) The update included a mobility-safety goal of "Maintain safe patient environment throughout Hospice care. No loose rugs, no falls, gait belt used upon ambulation." The update failed to evidence progress towards the stated mobility-safety goals.</p> <p>6.) The update included a hospice aide careplan goal of "Patient's stated wishes are respected. Aide follows the wishes of the caregiver and patient." The update failed to evidence progress towards achieving the stated hospice aide careplan goal.</p> <p>B. The record included an IDG update to the plan of care dated 2-26-16. The update included a medication</p>			

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	<p>management goal of "Patient receives prescribed medications." The update failed to evidence progress towards achieving the stated medication management goal.</p> <p>1.) The update included pain goals of "Patient/caregiver verbalizes/demonstrates understanding of pain management and proper medication administration" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated pain goals.</p> <p>2.) The update included nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life. Caregiver will provide appropriate nutritional intake for patient and understand to adjust nutritional consistencies when needed and to notify the nurse with changes", "Patient/caregiver verbalizes understanding of methods to decrease choking and prevent aspiration. Caregiver understands s/s [signs and symptoms] of aspiration and the need to notify the SN [skilled nurse] when dysphagia begins", and "Promote optimal nutrition/hydration status will be monitored every visit for the need for changes." The update failed to evidence progress towards achieving the stated</p>			

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	<p>nutrition goals.</p> <p>3.) The update included a bowel goal of "Patient maintains bowel function within limits of disease process/progression. Monitor bowel function every visit." The update failed to evidence progress towards achieving the stated bowel goal.</p> <p>4.) The update included a neurological goal of "Patient remains safe from injury related to neurological disease. Patient will have no falls this cert period." The update failed to evidence progress towards achieving the stated neurological goal.</p> <p>5.) The update included a mobility-safety goal of "Maintain safe patient environment throughout Hospice care. No loose rugs, no falls, gait belt used upon ambulation." The update failed to evidence progress towards the stated mobility-safety goals.</p> <p>6.) The update included a hospice aide careplan goal of "Patient's stated wishes are respected. Aide follows the wishes of the caregiver and patient." The update failed to evidence progress towards achieving the stated hospice aide careplan goal.</p>			

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	<p>C. The record included an IDG update to the plan of care dated 3-11-16. The update included a medication management goal of "Patient receives prescribed medications." The update failed to evidence progress towards achieving the stated medication management goal.</p> <p>1.) The update included pain goals of "Patient/caregiver verbalizes/demonstrates understanding of pain management and proper medication administration" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated pain goals.</p> <p>2.) The update included nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life. Caregiver will provide appropriate nutritional intake for patient and understand to adjust nutritional consistencies when needed and to notify the nurse with changes", "Patient/caregiver verbalizes understanding of methods to decrease choking and prevent aspiration. Caregiver understands s/s [signs and symptoms] of aspiration and the need to notify the SN [skilled nurse] when dysphagia begins", and "Promote optimal nutrition/hydration status will be</p>			

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	<p>monitored every visit for the need for changes." The update failed to evidence progress towards achieving the stated nutrition goals.</p> <p>3.) The update included a bowel goal of "Patient maintains bowel function within limits of disease process/progression. Monitor bowel function every visit." The update failed to evidence progress towards achieving the stated bowel goal.</p> <p>4.) The update included a neurological goal of "Patient remains safe from injury related to neurological disease. Patient will have no falls this cert period." The update failed to evidence progress towards achieving the stated neurological goal.</p> <p>5.) The update included a mobility-safety goal of "Maintain safe patient environment throughout Hospice care. No loose rugs, no falls, gait belt used upon ambulation." The update failed to evidence progress towards the stated mobility-safety goals.</p> <p>6.) The update included a hospice aide careplan goal of "Patient's stated wishes are respected. Aide follows the wishes of the caregiver and patient." The update failed to evidence progress</p>			

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	<p>towards achieving the stated hospice aide careplan goal.</p> <p>10. Clinical record number 11 failed to evidence revisions to the plan of care, established by the IDG on 1-15-16, included progress towards achieving the stated goals and updated information.</p> <p>A. The record included an IDG update to the plan of care dated 1-29-16. The update included medication management goals of "Patient/caregiver verbalizes understanding of medications as evidenced by recall of action, dose & side effects", "Patient receives prescribed medications", and "Patient/caregiver verbalizes understanding of adverse events related to anticoagulant therapy and what to report." The update failed to evidence progress towards achieving the stated medication management goals.</p> <p>1.) The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalizes by patient/caregiver" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated pain goals.</p> <p>2.) The update included cardiovascular goals of "Patient</p>				

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	<p>verbalizes ways to manage edema" and "Patient/caregiver receives optimal teaching and support as cardiac functions change." The update failed to evidence progress towards achieving the stated cardiac goals.</p> <p>3.) The update include nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life" and "Promote optimal nutrition/hydration at end of life." The update failed to evidence progress towards achieving the stated nutrition goals.</p> <p>4.) The update included mobility-safety goals of "Patient maintains optimal mobility and participation in activities of daily living within disease limitations", "Patient/caregiver demonstrates safe, effective use of equipment", "Patient/caregiver demonstrates safe mobility and transfer techniques", and "Maintain safe patient environment throughout Hospice care." The update failed to evidence progress towards achieving the stated mobility-safety goals.</p> <p>5.) The update included hospice aide careplan goals of "Patient's personal hygiene is maintained as patient will</p>			

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	<p>allow; can be stubborn", "Patient/caregiver receives assistance with ADLs very independent; will inform aide what [the patient] prefers [the patient] wants done", and "Patient's stated wishes are respected a private person; respect dignity." The update failed to evidence progress towards achieving the stated hospice aide careplan goals.</p> <p>B. The record included an IDG update to the plan of care dated 2-12-16. The update included medication management goals of "Patient/caregiver verbalizes understanding of medications as evidenced by recall of action, dose & side effects", "Patient receives prescribed medications", and "Patient/caregiver verbalizes understanding of adverse events related to anticoagulant therapy and what to report." The update failed to evidence progress towards achieving the stated medication management goals.</p> <p>1.) The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalizes by patient/caregiver" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated pain goals.</p> <p>2.) The update included</p>			

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	<p>cardiovascular goals of "Patient verbalizes ways to manage edema" and "Patient/caregiver receives optimal teaching and support as cardiac functions change." The update failed to evidence progress towards achieving the stated cardiac goals.</p> <p>3.) The update include nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life" and "Promote optimal nutrition/hydration at end of life." The update failed to evidence progress towards achieving the stated nutrition goals.</p> <p>4.) The update included mobility-safety goals of "Patient maintains optimal mobility and participation in activities of daily living within disease limitations", "Patient/caregiver demonstrates safe, effective use of equipment", "Patient/caregiver demonstrates safe mobility and transfer techniques", and "Maintain safe patient environment throughout Hospice care." The update failed to evidence progress towards achieving the stated mobility-safety goals.</p> <p>5.) The update included hospice aide careplan goals of "Patient's personal</p>			

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	<p>hygiene is maintained as patient will allow; can be stubborn", "Patient/caregiver receives assistance with ADLs very independent; will inform aide what [the patient] prefers [the patient] wants done", and "Patient's stated wishes are respected a private person; respect dignity." The update failed to evidence progress towards achieving the stated hospice aide careplan goals.</p> <p>C. The record included an IDG update to the plan of care dated 2-26-16. The update included medication management goals of "Patient/caregiver verbalizes understanding of medications as evidenced by recall of action, dose & side effects", "Patient receives prescribed medications", and "Patient/caregiver verbalizes understanding of adverse events related to anticoagulant therapy and what to report." The update failed to evidence progress towards achieving the stated medication management goals.</p> <p>1.) The update included pain goals of "Patient's pain controlled and managed at the patient's self-identified threshold (SIT) as verbalizes by patient/caregiver" and "Patient's pain remains at comfortable level during care." The update failed to evidence progress towards achieving the stated pain goals.</p>			

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	<p>2.) The update included cardiovascular goals of "Patient verbalizes ways to manage edema" and "Patient/caregiver receives optimal teaching and support as cardiac functions change." The update failed to evidence progress towards achieving the stated cardiac goals.</p> <p>3.) The update include nutrition goals of "Patient/caregiver verbalizes understanding of nutritional changes/needs at end of life" and "Promote optimal nutrition/hydration at end of life." The update failed to evidence progress towards achieving the stated nutrition goals.</p> <p>4.) The update included mobility-safety goals of "Patient maintains optimal mobility and participation in activities of daily living within disease limitations", "Patient/caregiver demonstrates safe, effective use of equipment", "Patient/caregiver demonstrates safe mobility and transfer techniques", and "Maintain safe patient environment throughout Hospice care." The update failed to evidence progress towards achieving the stated mobility-safety goals.</p> <p>5.) The update included hospice</p>						

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	<p>aide careplan goals of "Patient's personal hygiene is maintained as patient will allow; can be stubborn", "Patient/caregiver receives assistance with ADLs very independent; will inform aide what [the patient] prefers [the patient] wants done", and "Patient's stated wishes are respected a private person; respect dignity." The update failed to evidence progress towards achieving the stated hospice aide careplan goals.</p> <p>11. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM and 6-23-16 at 3:15 PM. The administrator indicated, on 6-23-16 at 3:15 PM, progress towards achieving goals are discussed at the IDG meetings but, the progress is not documented on the IDG updates.</p> <p>12. The hospice's 09/2015 "Plan of Care, HC.31" states, "The hospice interdisciplinary group in collaboration with the individual's attending physician, if any, reviews, revises and documents the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days."</p>			

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L 0559 Bldg. 00	418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT Based on record review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure a quality assessment performance improvement (QAPI) program was in place that identified improvements in indicators related to palliative outcomes in 7 of 7 months reviewed (See L 561); by failing to ensure quality indicators, including adverse events, had been tracked, analyzed, and trended to assess hospice care and services in 7 of 7 months reviewed (See L 562); by failing to ensure the hospice had implemented a QAPI program that used quality data to include patient care and other areas, in the design of the program (See L 563); by	L 0559	L 559 The Administrator will instruct clinical staff/QAPI committee on the regulations regarding Quality Assessment and Performance Improvement (QAPI). The Administrator and QAPI Committee will revise the QAPI program to reflect an effective, ongoing, hospice wide data driven program. The Administrator will ensure QAPI implementation that provides for the collection and analysis of data and the monitoring of performance improvement projects to ensure improvement in hospice performance per hospice policy, HC 59. Once the deficiency is corrected, the Administrator will ensure the deficiency will not recur.	07/22/2016

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	<p>failing to ensure the hospice had implemented a QAPI program that used quality data, to include patient care and other areas, to monitor the effectiveness and services and identify opportunities for improvement (See L 564); by failing to ensure its QAPI program data collection methods had been approved by the governing body (See L 565); by failing to ensure performance improvement activities included review and tracking of adverse events in 7 of 7 months reviewed (See L 569); by failing to ensure performance improvement activities had been tracked to measure improvement in 7 of 7 months reviewed (See L 570); by failing to ensure reasons for performance improvement activities had been documented, and progress tracked to measure improvement in 7 of 7 months reviewed (See L 573); by failing to ensure the governing body had defined, implemented, and maintained a QAPI program (See L 574); and by failing to ensure the governing body had ensured reasons for performance improvement activities had been documented, and progress tracked to measure improvement in 7 of 7 months reviewed (See L 575).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this</p>			

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L 0560 Bldg. 00	<p>condition, 42 CFR 418.58 Quality Assessment and Performance Improvement.</p> <p>418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS. Based on record review and interview, the hospice failed to ensure a quality assessment and performance improvement (QAPI) program had been implemented that provided for the collection and analysis of data and the</p>	L 0560	L 560 The Administrator will ensure and in collaboration with the QAPI Committee develop, implement and maintain an effective, ongoing, hospice-wide data driven quality assessment and performance program. The Board will ensure the program	07/22/2016

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	<p>monitoring of performance improvement projects failed to ensure performance improvement projects were monitored for improvements in hospice performance in 7 (October 2015 through May 2016) of 7 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice's administrative records included a "Process Improvement Project", undated, that identified the hospice's need for a QAPI program. The QAPI program improvement project failed to evidence a program had been implemented with defined purposes and goals a description of how the program would be administered and coordinated, a methodology for monitoring and evaluating the quality of care, and monitoring to determine the effectiveness of the program. The administrator indicated, on 6-23-16 at 3:15 PM, the hospice had identified a need for a QAPI program in September 2015. The administrator indicated the program had been implemented and include a review of "documentation, quality of care, cost per patient day, patient falls, hospice aide supervision, and infection control." <p>The administrator indicated, on</p>		<p>reflects the complexity of its organization and services, involves all hospice services, focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The Administrator will maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. The Administrator will be responsible for monitoring and ensuring this deficiency s corrected and will not recur.</p>	

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L 0561 Bldg. 00	<p>6-23-16 at 3:30 PM, the hospice had implemented performance improvement plans addressing visit frequency, plans of care, bereavement, the volunteer program, and infection control in September 2015. The administrator was unable to provide documentation of any monitoring of the performance improvement plans for effectiveness or any changes implemented to address the need to adjust the plans.</p> <p>3. The hospice's administrative records included "Quality Focus Areas" for 2014-2015. The records failed to evidence quality focus areas for 2015-2016 or 2016-2017.</p> <p>4. The hospice's 05/2016 "Quality Assessment Performance Improvement, HC.59" policy states, "MSA Hospices develop, implement and maintain an effective, ongoing, hospice-wide and data drive quality assessment performance improvement program that reflects the complexity of the hospice's organization and services . . . Actions are taken aimed at performance improvement and, after implementing those actions, the hops</p> <p>418.58(a)(1) PROGRAM SCOPE (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative</p>			

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L 0561	<p>outcomes and hospice services. Based on record review and interview, the hospice failed to ensure a quality assessment performance improvement (QAPI) program was in place that identified improvements in indicators related to palliative outcomes in 7 (September 2015 through May 2016) of 7 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice failed to ensure data elements for the measurement of outcomes had been incorporated into comprehensive assessments for collection, measurement, and analysis of outcomes related to palliative care. 2. The administrator indicated, on 6-23-16 at 3:30 PM, the hospice had implemented performance improvement plans addressing visit frequency, plans of care, bereavement, the volunteer program, and infection control in September 2015. The administrator was unable to provide documentation of any monitoring of the performance improvement plans for effectiveness or any changes implemented to address the need to adjust the plans. 	L 0561	L 561 The Administrator will instruct the clinical staff/QAPI Committee that the QAPI program must include identified improvements in indicators related to palliative outcomes. The Administrator and QAPI Committee will ensure the QAPI program includes improvements in indicators related to palliative outcomes.	07/22/2016
L 0562	418.58(a)(2) PROGRAM SCOPE			

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Bldg. 00	<p>(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.</p> <p>Based on record review and interview, the hospice failed to ensure quality indicators, including adverse events, had been tracked, analyzed, and trended to assess hospice care and services in 7 (September 2015 through May 2016) of 7 months reviewed.</p> <p>1. The hospice's administrative records included a "Process Improvement Project", undated, that identified the hospice's need for a QAPI program. The QAPI program improvement project failed to evidence a program had been implemented with defined quality indicators and a methodology for monitoring and evaluating the quality of care.</p> <p>2. The administrator indicated, on 6-23-16 at 3:15 PM, the hospice had identified a need for a QAPI program in September 2015. The administrator indicated the program had been implemented and include a review of "documentation, quality of care, cost per patient day, patient falls, hospice aide supervision, and infection control."</p>	L 0562	L 562 The Administrator will instruct the clinical staff/QAPI committee that quality indicators, including adverse events, must be tracked, analyzed and trended to assess hospice care and services. The Administrator will monitor QAPI activities to ensure quality indicators are tracked, analyzed and trended to assess hospice care and services. . Once the deficiency is corrected, the Administrator will ensure the deficiency will not recur.	07/22/2016			

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L 0563 Bldg. 00	<p>3. The hospice failed to ensure data elements for the measurement of outcomes had been incorporated into comprehensive assessments for collection, measurement, and analysis of outcomes related to palliative care.</p> <p>4. The hospice's administrative records included an "Adverse Event Summary" with a list of adverse events, the number of events, the rate of occurrence, the number of patients involved in the events, and the percentage of patients involved in the events for the months of January 2016 through May 2016. The records failed to evidence adverse events had been tracked since May 2016.</p> <p>5. The hospice's 05/2016 "Quality Assessment Performance Improvement HC.59" policy states, "Performance improvement activities tracks adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice."</p> <p>418.58(b)(1) PROGRAM DATA (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program. Based on record review and interview, the hospice failed to ensure the hospice</p>	L 0563	L 563 The Administrator will instruct the clinical staff/QAPI committee that quality indicator	07/22/2016			

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	<p>had implemented a quality assessment performance improvement (QAPI) program that used quality data to include patient care and other areas, in the design of the program.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records included a "Process Improvement Project", undated, that identified the hospice's need for a QAPI program. The QAPI program improvement project failed to evidence a program had been implemented with defined quality indicators and a methodology for monitoring and evaluating the quality of care and all facets of the hospice program. 2. The administrator indicated, on 6-23-16 at 3:15 PM, the hospice had identified a need for a QAPI program in September 2015. The administrator indicated the program had been implemented and include a review of "documentation, quality of care, cost per patient day, patient falls, hospice aide supervision, and infection control." 3. The hospice failed to ensure data elements for the measurement of outcomes had been incorporated into comprehensive assessments for 		<p>data, including patient care, and other relevant data is in the design of its program. The Administrator will monitor and ensure the QAPI program deficiency is corrected and will not recur.</p>		

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L 0564 Bldg. 00	<p>collection, measurement, and analysis of outcomes related to palliative care.</p> <p>4. The hospice's administrative records included an "Adverse Event Summary" with a list of adverse events, the number of events, the rate of occurrence, the number of patients involved in the events, and the percentage of patients involved in the events for the months of January 2016 through May 2016. The records failed to evidence adverse events had been tracked since May 2016.</p> <p>5. The hospice's 05/2016 "Quality Assessment Performance Improvement, HC.59" policy states, "Data is collected to examine all facets of the hospice operations and used to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement."</p> <p>418.58(b)(2) PROGRAM DATA (2) The hospice must use the data collected to do the following: (i) Monitor the effectiveness and safety of services and quality of care. (ii) Identify opportunities and priorities for improvement. Based on record review and interview, the hospice failed to ensure the hospice had implemented a quality assessment performance improvement (QAPI)</p>	L 0564	L 564 The Administrator will instruct the QAPI Committee and ensure the program data is collected to monitor the effectiveness and safety of	07/22/2016	

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	<p>program that used quality data, to include patient care and other areas, to monitor the effectiveness and services and identify opportunities for improvement.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records included a "Process Improvement Project", undated, that identified the hospice's need for a QAPI program. The QAPI program improvement project failed to evidence a program had been implemented with defined quality indicators and a methodology for monitoring and evaluating the quality of care and all facets of the hospice program. 2. The administrator indicated, on 6-23-16 at 3:15 PM, the hospice had identified a need for a QAPI program in September 2015. The administrator indicated the program had been implemented and include a review of "documentation, quality of care, cost per patient day, patient falls, hospice aide supervision, and infection control." 3. The hospice failed to ensure data elements for the measurement of outcomes had been incorporated into comprehensive assessments for collection, measurement, and analysis of 		<p>services and quality of care and identify opportunities and priorities for improvement. The Administrator will monitor and ensure the QAPI program deficiency is corrected and will not recur.</p>	

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L 0565 Bldg. 00	<p>outcomes related to palliative care.</p> <p>4. The hospice's administrative records included an "Adverse Event Summary" with a list of adverse events, the number of events, the rate of occurrence, the number of patients involved in the events, and the percentage of patients involved in the events for the months of January 2016 through May 2016. The records failed to evidence adverse events had been tracked since May 2016.</p> <p>5. The hospice's 05/2016 "Quality Assessment Performance Improvement, HC.59" policy states, "Data is collected to examine all facets of the hospice operations and used to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement."</p> <p>418.58(b)(3) PROGRAM DATA (3) The frequency and detail of the data collection must be approved by the hospice's governing body. Based on record review and interview, the hospice failed to ensure its quality assessment performance improvement (QAPI) program data collection methods had been approved by the governing body.</p>	L 0565	L 565 The Administrator will ensure the QAPI program data collection methods is approved by the Board of Directors and will not recur.	07/22/2016

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	<p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records included a "Process Improvement Project", undated, that identified the hospice's need for a QAPI program. The QAPI program improvement project failed to evidence a program had been implemented with defined quality indicators and a methodology for monitoring and evaluating the quality of care. 2. The administrator indicated, on 6-23-16 at 3:15 PM, the hospice had identified a need for a QAPI program in September 2015. The administrator indicated the program had been implemented and include a review of "documentation, quality of care, cost per patient day, patient falls, hospice aide supervision, and infection control." 3. The administrator was unable to provide documentation the hospice's QAPI program had been approved by the governing body when asked on 6-23-16 at 3:30 PM. 4. The hospice's 05/2016 "Quality Assessment Performance Improvement HC.59" policy states, "MSA Board of Directors ensures the QAPI Program is 			
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L 0569 Bldg. 00	<p>developed, implemented and maintained and delegates management of the program to the Administrator."</p> <p>418.58(c)(2) PROGRAM ACTIVITIES (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.</p> <p>Based on record review and interview, the hospice failed to ensure performance improvement activities included review and tracking of adverse events in 7 (September 2015 through May 2016) of 7 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records included an "Adverse Event Summary" with a list of adverse events, the number of events, the rate of occurrence, the number of patients involved in the events, and the percentage of patients involved in the events for the months of January 2016 through May 2016. The records failed to evidence adverse events had been tracked since May 2016. 2. The hospice's administrative records included undated "Process Improvement 	L 0569	L 569 The Administrator will instruct the clinical staff/QAPI Committee that the PI activities must track adverse events, analyze their causes and implement preventive actions and mechanisms that include feedback and learning throughout the hospice. The Administrator will monitor the QAPI program and ensure deficiency is corrected and will not recur.	07/22/2016

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	<p>Projects" for a QAPI Program, visit frequencies, plan of care, bereavement services, volunteer program, and infection control program. The documentation failed to evidence a project to track, trend, and analyze adverse events.</p> <p>3. The administrator indicated, on 6-23-16 at 3:30 PM, the hospice had implemented performance improvement plans addressing visit frequency, plans of care, bereavement, the volunteer program, and infection control in September 2015. The administrator was unable to provide documentation of any monitoring of the performance improvement plans for effectiveness or any changes implemented to address the need to adjust the plans.</p> <p>4. The hospice's 05/2016 "Quality Assessment Performance Improvement HC.59" policy states, "Performance improvement activities tracks adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice . . . Performance improvement projects are documented with measurable progress achieved."</p>			

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L 0570 Bldg. 00	<p>418.58(c)(3) PROGRAM ACTIVITIES</p> <p>(3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.</p> <p>Based on record review and interview, the hospice failed to ensure performance improvement activities had been tracked to measure improvement in 7 (September 2015 through May 2016) of 7 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice's administrative records included undated "Process Improvement Projects" for a QAPI Program, visit frequencies, plan of care, bereavement services, volunteer program, and infection control program. The documentation failed to evidence a project to track, trend, and analyze adverse events. <p>The performance improvement project documentation failed to evidence the performance improvement activities had been implemented, tracked, and analyzed for effectiveness.</p> <ol style="list-style-type: none"> The administrator indicated, on 	L 0570	L 570 The Administrator will instruct the clinical staff/QAPI Committee that they must take actions aimed at PI and after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained, The Administrator will monitor the QAPI program and ensure deficiency is corrected and will not recur	07/22/2016

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L 0573 Bldg. 00	<p>6-23-16 at 3:30 PM, the hospice had implemented performance improvement plans addressing visit frequency, plans of care, bereavement, the volunteer program, and infection control in September 2015. The administrator was unable to provide documentation of any monitoring of the performance improvement plans for effectiveness or any changes implemented to address the need to adjust the plans.</p> <p>4. The hospice's 05/2016 "Quality Assessment Performance Improvement HC.59" policy states, "Performance improvement activities tracks adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice . . . Performance improvement projects are documented with measurable progress achieved."</p> <p>418.58(d)(2) PERFORMANCE IMPROVEMENT PROJECTS (2)The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview,</p>	L 0573	L 573 The Administrator will	07/22/2016			

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	<p>the hospice failed to ensure reasons for performance improvement activities had been documented, and progress tracked to measure improvement in 7 (September 2015 through May 2016) of 7 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records included undated "Process Improvement Projects" for a QAPI Program, visit frequencies, plan of care, bereavement services, volunteer program, and infection control program. The documentation failed to evidence a project to track, trend, and analyze adverse events. The performance improvement project documentation failed to evidence the performance improvement activities had been implemented, tracked, and analyzed for effectiveness. 3. The administrator indicated, on 6-23-16 at 3:30 PM, the hospice had implemented performance improvement plans addressing visit frequency, plans of care, bereavement, the volunteer program, and infection control in September 2015. The administrator was unable to provide documentation of any monitoring of the performance 		<p>instruct the clinical staff/QAPI Committee that they will document the PI projects are being conducted, the reasons for conducting these projects and the measurable progress achieved on these projects. The Administrator will monitor the PI project and ensure deficiency is corrected and will not recur.</p>	

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L 0574 Bldg. 00	<p>improvement plans for effectiveness or any changes implemented to address the need to adjust the plans.</p> <p>4. The hospice's 05/2016 "Quality Assessment Performance Improvement HC.59" policy states, "Performance improvement activities tracks adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice . . . Performance improvement projects are documented with measurable progress achieved."</p> <p>418.58(e)(1) EXECUTIVE RESPONSIBILITIES The hospice's governing body is responsible for ensuring the following: (1)That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually. Based on record review and interview, the governing body failed to ensure a quality assessment performance improvement (QAPI) program had been defined and implemented and maintained.</p> <p>The findings include:</p>	L 0574	L 574 The Administrator will obtain the Board's signature that they are responsible for ensuring that an ongoing program for quality improvement and patient safety is defined, implemented and maintained and is evaluated annually. The Administrator will monitor and ensure deficiency is corrected and will not recur.	07/22/2016

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	<p>1. The hospice's administrative records included a "Process Improvement Project", undated, that identified the hospice's need for a QAPI program. The governing body failed to ensure the QAPI program improvement project had implemented a program that included defined quality indicators and a methodology for monitoring and evaluating the quality of care.</p> <p>2. The administrator indicated, on 6-23-16 at 3:15 PM, the hospice had identified a need for a QAPI program in September 2015. The administrator indicated the program had been implemented and include a review of "documentation, quality of care, cost per patient day, patient falls, hospice aide supervision, and infection control."</p> <p>3. The governing body failed to ensure data elements for the measurement of outcomes had been incorporated into comprehensive assessments for collection, measurement, and analysis of outcomes related to palliative care.</p> <p>4. The hospice's administrative records included an "Adverse Event Summary" with a list of adverse events, the number of events, the rate of occurrence, the number of patients involved in the</p>			

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L 0575 Bldg. 00	<p>events, and the percentage of patients involved in the events for the months of January 2016 through May 2016. The governing body failed to ensure the QAPI program had tracked adverse events since May 2016.</p> <p>5. The hospice's 05/2016 "Quality Assessment Performance Improvement, HC.59" policy states, "MSA Board of Directors ensures the QAPI program is developed, implemented and maintained and delegates management of the program to the Administrator."</p> <p>418.58(e)(2) EXECUTIVE RESPONSIBILITIES [The hospice's governing body is responsible for ensuring the following:] (2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.</p> <p>Based on record review and interview, the governing body failed to ensure reasons for performance improvement activities had been documented, and progress tracked to measure improvement in 7 (September 2015 through May 2016) of 7 months reviewed.</p> <p>The findings include:</p>	L 0575	L 575 The Administrator will provide documentation that the hospice's Board is responsible for ensuring the hospice wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and all improvement actions are evaluated for effectiveness. The Administrator will monitor and ensure deficiency is corrected and will not recur.	07/22/2016

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	<p>1. The hospice's administrative records included undated "Process Improvement Projects" for a QAPI Program, visit frequencies, plan of care, bereavement services, volunteer program, and infection control program. The documentation failed to evidence a project to track, trend, and analyze adverse events.</p> <p>The performance improvement project documentation failed to evidence the performance improvement activities had been implemented, tracked, and analyzed for effectiveness.</p> <p>3. The administrator indicated, on 6-23-16 at 3:30 PM, the hospice had implemented performance improvement plans addressing visit frequency, plans of care, bereavement, the volunteer program, and infection control in September 2015. The administrator was unable to provide documentation of any monitoring of the performance improvement plans for effectiveness or any changes implemented to address the need to adjust the plans.</p> <p>4. The hospice's 05/2016 "Quality Assessment Performance Improvement HC.59" policy states, "Performance improvement activities tracks adverse patient events, analyze their causes, and</p>			

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L 0579 Bldg. 00	<p>implement preventive actions and mechanisms that include feedback and learning throughout the hospice . . . Performance improvement projects are documented with measurable progress achieved."</p> <p>418.60(a) PREVENTION</p> <p>The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. Based on record review, observation, and interview, the hospice failed to ensure staff had provided services in accordance with the hospice's own infection control policies and procedures in 3 (#s 1, 2, and 3) of 3 home visit observations completed.</p> <p>The findings include:</p> <p>1. The hospice's 12/2015 "Infection Control Program HC.55" policy states, "Hospice staff follows accepted standards of practice to prevent transmission of infections and communicable diseases, including use of standard precautions in the care of all hospice patients, which includes, but is not limited to: . . .</p>	L 0579	L 579 The Administrator will reeducate clinical staff on following accepted standards of practice to prevent the transmission of infections and communicable diseases, including standard precautions. The hospice policy HC 55 will be reviewed as well as The Centers for Disease Control Standards Precautions. The Administrator will provide a written test to clinical staff on infection control, hand washing and bag technique. The Administrator will monitor and ensure deficiency is corrected and will not recur.	07/22/2016			

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	<p>washing hands immediately after gloves are removed, between patient contact and as indicated to avoid transfer of microorganisms to other people or environments . . . reusable patient care equipment is cleaned and reprocessed before being used on another patient . . . Hospice staff use standard precautions in the care of all hospice patients, regardless of diagnosis or presumed infection status . . . The following standard precautions are used to protect staff, patients and families: Handwashing . . . after gloves are removed, between patient contact and when indicated to avoid transfer or microorganisms to other patients or environments; and between tasks and procedures on the same patient to prevent cross contamination . . . change gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another patient, and wash hands immediately to avoid transfer of microorganisms to other patients or environments."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean</p>			

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	<p>hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p>			

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	<p>3. On 6-22-16 at 8:55 AM, employee C, a licensed practical nurse (LPN), was observed to provide care to patient number 2 (observation # 1). The LPN was observed to retrieve his stethoscope, blood pressure cuff, pulse oximeter, and thermometer from his nursing bag. The LPN listened to the patient's heart and lungs and replaced the stethoscope into his bag without cleaning it. The LPN used the pulse oximeter on the patient and then replaced it into his bag without cleaning it. The LPN took the patient's blood pressure and replaced the cuff back into the bag without cleaning it. The LPN took the patient's temperature using a disposable sheath on the thermometer. When the task was completed, the LPN removed the sheath from the thermometer without donning gloves.</p> <p>4. On 6-22-16 at 9:55 AM, employee G, a registered nurse (RN), was observed to provide care to patient number 4 (observation # 2). The RN completed the patient's meal menu for the week and donned clean gloves without cleansing her hands. The RN took the patient's blood pressure, removed her gloves, and cleansed her hands. The RN took the patient' temperature using a sheath on the thermometer. The RN failed to cleanse her hands prior to donning clean gloves</p>			

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L 0603 Bldg. 00	<p>after retrieving the thermometer from her nursing bag. The RN was observed to use her stethoscope, clean it, and then place it around her neck touching her hair 3 times.</p> <p>5. On 6-22-16 at 12:55 PM, employee H, an RN, was observed to provide care to patient number 3 (observation # 3). The RN was observed to apply lotion to the patient's left arm with a gloved hand. The RN removed the glove upon completion of the task and failed to cleanse her hands.</p> <p>6. The administrator indicated, on 6-22-16 at 2:55 PM, employees C, G, and H had not provided services in accordance with the hospice's infection control policies and procedures.</p> <p>418.72 PHYS, OCCUPNL THERAPY & SPEECH-LANG PATHOLOGY</p> <p>Based on record review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure physical therapy, occupational therapy, and speech language pathology services were</p>	L 0603	L 603 The Administrator will ensure physical therapy services, occupational therapy services and speech language pathology services are available by obtaining an agreement with a skilled nursing facility for PT, OT and ST services. The Administrator	07/22/2016

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L 0604 Bldg. 00	<p>available to patients (See L 604).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being unable to maintain compliance with this condition, 42 CFR 418.72 Physical Therapy, Occupational Therapy, and Speech Language Pathology.</p> <p>418.72 PHYS, OCCUPNL THERAPY & SPEECH-LANG PATHOLOGY Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.</p> <p>Based on record review and interview, the hospice failed to ensure physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services were available to patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's employee roster, provided on 6-20-16, failed to evidence a physical therapist, an occupational therapist, or a speech language pathologist was employed by the hospice. 2. The hospice's administrative records failed to evidence a valid contract for the provision of PT, OT, or SLP services. 	L 0604	<p>will ensure deficiency is corrected and will not recur</p> <p>L 604 The Administrator will secure an agreement with a skilled nursing facility to provide physical therapy services, occupational therapy services and speech language pathology services to hospice patients. The Administrator will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.</p>	07/22/2016

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L 0607 Bldg. 00	<p>A. The hospice administrative records included a contract, dated 4-19-13, for the provision of PT, OT, and SLP services between the previous owners of the hospice and a therapy provider.</p> <p>B. The account executive, employee I, contacted the therapy provider by telephone on 6-22-16 at 3:10 PM. The account executive stated, "They said they no longer provide services in a home." The account executive indicated the contract was no longer valid and was unable to provide any other contract for the provision of PT, OT, or SLP services.</p> <p>418.76 HOSPICE AIDE AND HOMEMAKER SERVICES</p> <p>Based on record review and interview, it was determined the hospice failed to maintain compliance with condition by failing to ensure an individual that had provided hospice aide services on behalf of the hospice had successfully completed a training and/or competency evaluation program in 1 of 1 hospice aide file reviewed (See L 608); by failing to ensure an individual that had provided hospice aide services on behalf of the hospice had successfully completed a training and/or competency evaluation program in 1 of 1 hospice aide file</p>	L 0607	L 607 The Administrator will ensure hospice aides will successfully complete training and competency evaluation programs. Documentation will be ensured and maintained to demonstrate successful completion. The Administrator will ensure the hospice aide is supervised by a registered nurse no less frequently than every 14 days. The Administrator will audit personnel files for documentation of training and competency and 10% of medical records for hospice aide supervision. The Administrator will be responsible for monitoring these corrections	07/22/2016

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	<p>the hospice failed to ensure an individual that had provided hospice aide services on behalf of the hospice had successfully completed a training and/or competency evaluation program in 1 (file B) of 1 hospice aide file reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file B evidenced the individual had been hired on 9-28-15 to provide aide services to patients on behalf of the hospice. The file failed to evidence the individual had completed a training and/or competency evaluation program. 2. The administrator indicated, on 6-22-16 at 2:10 PM, a competency evaluation had been administered to the individual upon hire, but was unable to locate the documentation. The administrator indicated the individual's first patient contact date was 10-6-15. 3. The hospice personnel roster provided on 6-20-16 included only one hospice aide, employee B. 4. The hospice's 12/2015 "Staff Competency Assessment HR308.2" policy states, "A Competency Assessment will be conducted for direct patient care and service personnel under 		<p>ensure hospice aides will successfully complete training and competency evaluations. Documentation will be ensured and maintained to demonstrate successful completion and placed in the personnel file. The Administrator will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.</p>		

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L 0609 Bldg. 00	<p>the following conditions: Upon hire."</p> <p>418.76(a)(1) HOSPICE AIDE QUALIFICATIONS (1) A qualified hospice aide is a person who has successfully completed one of the following: (i) A training program and competency evaluation as specified in paragraphs (b) and (c) of this section respectively. (ii) A competency evaluation program that meets the requirements of paragraph (c) of this section. (iii) A nurse aide training and competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry. (iv) A State licensure program that meets the requirements of paragraphs (b) and (c) of this section.</p> <p>Based on record review and interview, the hospice failed to ensure an individual that had provided hospice aide services on behalf of the hospice had successfully completed a training and/or competency evaluation program in 1 (file B) of 1 hospice aide file reviewed.</p> <p>The findings include:</p> <p>1. Personnel file B evidenced the individual had been hired on 9-28-15 to provide aide services to patients on behalf of the hospice. The file failed to evidence the individual had completed a</p>	L 0609	L 609 The Administrator will ensure documentation in the personnel file that all hospice aides providing hospice aide services on behalf of hospice has successfully completed a training program, competency evaluation and is in good standing with the State nurse aide registry. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.	07/22/2016
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L 0615 Bldg. 00	<p>training and/or competency evaluation program.</p> <p>2. The administrator indicated, on 6-22-16 at 2:10 PM, a competency evaluation had been administered to the individual upon hire, but was unable to locate the documentation. The administrator indicated the individual's first patient contact date was 10-6-15.</p> <p>3. The hospice personnel roster provided on 6-20-16 included only one hospice aide, employee B.</p> <p>4. The hospice's 12/2015 "Staff Competency Assessment HR308.2" policy states, "A Competency Assessment will be conducted for direct patient care and service personnel under the following conditions: Upon hire."</p> <p>418.76(c)(1) COMPETENCY EVALUATION An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may</p>			

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	<p>be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient.</p> <p>Based on record review and interview, the hospice failed to ensure an individual that had provided hospice aide services on behalf of the hospice had successfully completed a competency evaluation program in 1 (file B) of 1 hospice aide file reviewed.</p> <p>The findings include:</p> <p>1. Personnel file B evidenced the individual had been hired on 9-28-15 to provide aide services to patients on behalf of the hospice. The file failed to evidence the individual had completed a competency evaluation program.</p> <p>A. Clinical record number 1 evidenced employee B had provided hospice aide services to the patient 2 to 3 times per week during the benefit period 5-21-16 to 7-19-16.</p> <p>B. Clinical record number 2 evidenced employee B had provided hospice aide services to the patient 2 times per week during the benefit period 4-27-16 to 7-25-16.</p> <p>C. Clinical record number 4 evidenced employee B had provided</p>	L 0615	<p>L 615 The Administrator will ensure the hospice aides have successfully completed a competency evaluation that includes subjects listed in the Federal regulation 418.76 (b) (3) i-xiii and that it is documented in the employee's personnel file. The Administrator will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.</p>	07/22/2016

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	<p>hospice aide services to the patient 3 times per week during the benefit period 4-9-16 to 6-7-16.</p> <p>D. Clinical record number 5 evidenced employee B had provided hospice aide services to the patient 2 to 3 times per week during the benefit period 5-16-16 to 7-15-16.</p> <p>E. Clinical record number 6 evidenced employee B had provided hospice aide services to the patient 3 times per week during the benefit period 5-2-16 to 7-30-16.</p> <p>F. Clinical record number 7 evidenced employee B had provided hospice aide services to the patient 1 to 3 times per week during the benefit period 3-15-16 to 6-12-16.</p> <p>G. Clinical record number 8 evidenced employee B had provided hospice aide services to the patient 2 to 3 times per week during the benefit period 4-27-16 to 5-23-16.</p> <p>H. Clinical record number 10 evidenced employee B had provided hospice aide services to the patient 3 times per week during the benefit period 2-17-16 to 4-6-16.</p>			

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L 0619 Bldg. 00	<p>I. Clinical record number 11 evidenced employee B had provided hospice aide services to the patient 2 times per week during the benefit period 1-9-16 to 4-7-16.</p> <p>2. The administrator indicated, on 6-22-16 at 2:10 PM, a competency evaluation had been administered to the individual upon hire, but was unable to locate the documentation. The administrator indicated the individual's first patient contact date was 10-6-15.</p> <p>3. The hospice personnel roster provided on 6-20-16 included only one hospice aide, employee B.</p> <p>4. The hospice's 12/2015 "Staff Competency Assessment HR308.2" policy states, "A Competency Assessment will be conducted for direct patient care and service personnel under the following conditions: Upon hire."</p> <p>418.76(c)(5) COMPETENCY EVALUATION (5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met. Based on record review and interview, the hospice failed to ensure documentation had been maintained to demonstrate the hospice aide had</p>	L 0619	L 619 The Administrator will ensure documentation is maintained that demonstrates the requirements of a competency evaluation and training upon hire	07/22/2016

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	<p>completed a competency evaluation program in 1 (file B) of 1 hospice aide file reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file B evidenced the individual had been hired on 9-28-15 to provide aide services to patients on behalf of the hospice. The file failed to evidence the individual had completed a training and/or competency evaluation program. 2. The administrator indicated, on 6-22-16 at 2:10 PM, a competency evaluation had been administered to the individual upon hire, but was unable to locate the documentation. The administrator indicated the individual's first patient contact date was 10-6-15. 3. The hospice personnel roster provided on 6-20-16 included only one hospice aide, employee B. 4. The hospice's 12/2015 "Staff Competency Assessment HR308.2" policy states, "A Competency Assessment will be conducted for direct patient care and service personnel under the following conditions: Upon hire." 		<p>nd annually. The Administrator will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.</p>	

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L 0629 Bldg. 00	<p>418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES (l) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit. Based on record review and interview, the hospice failed to ensure the registered nurse (RN) had completed a supervisory visit to the patient's home no less frequently than every 14 days in 2 (#s 2 and 5) of 9 records reviewed of patients that received hospice aide services of the 11 total records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 evidenced hospice aide services had been provided 2 times per week during the benefit period 4-27-16 to 7-24-16. The record evidenced the RN had completed a supervisory visit on 5-25-16. The record failed to evidence any further hospice aide supervisory visits had been completed by the RN. 2. Clinical record number 5 evidenced hospice aide services had been provided 2 to times per week during the benefit period 2-17-16 to 5-16-16. The record 			L 0629	<p>L 629 The Administrator will instruct all R.N.'s that is must be documented that a registered nurse supervises the hospice aide by making an on-site visit to the patient's home no less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure thatservices ordered by the hospice IDG meet the patient's needs. The hospice aide does not have to be present during this visit. The Administrator will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.</p>		07/22/2016

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L 0641 Bldg. 00	<p>evidenced the RN had completed a supervisory visit on 5-11-16. The record failed to evidence any further hospice aide supervisory visits had been completed by the RN.</p> <p>3. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM.</p> <p>Based on record review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure volunteers were available and had been utilized in direct patient care roles in 6 of 6 months reviewed (See L 642); by failing to ensure volunteers were available and had been utilized in direct patient care roles in 6 of 6 months reviewed (See L 644); by failing to ensure ongoing efforts to recruit and retain volunteers had been implemented in 6 of 6 months reviewed (See L 645); by failing to ensure cost savings achieved through the use of volunteers had been calculated and documented for January 2016 through June 2016 (See L 646); and by failing to maintain records of volunteer hours used</p>	L 0641	L 641 The Administrator will instruct and obtain data from the Volunteer Coordinator on recruitment and retention efforts to ensure volunteers are available in direct care and administrative roles, provide cost savings documentation, and volunteer hours that equal 5% of total patient care hours. A monthly report will be submitted to the Administrator to monitor compliance. The Administrator will continue monitoring quarterly for outcomes of recruitment, retention, cost savings and volunteer percentage of total patient care hours. The Administrator will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.	07/22/2016

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L 0642 Bldg. 00	<p>compared to paid hospice employees hours to ensure the amount was equal to at least 5 percent of total patient care hours in 1 of 1 year reviewed (See L 647).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.78 Volunteers.</p> <p>418.78 VOLUNTEERS</p> <p>The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.</p> <p>Based on record review and interview, the hospice failed to ensure volunteers were available and had been utilized in direct patient care roles in 6 (January through June 2016) of 6 months reviewed.</p> <p>The findings include:</p> <p>1. The hospice's volunteer roster, provided on 6-20-16, included only 1 volunteer, employee F. The roster evidenced the individual had started with the hospice on 1-21-16.</p>	L 0642	L 642 The Administrator will instruct and ensure the Volunteer Coordinator recruits for the roles of direct patient care and administrative volunteers. The Administrator will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.	07/22/2016	

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	<p>2. The hospice's administrative records evidenced the volunteer, employee F, had completed administrative volunteer activities in January, February, March, and April 2016. The records failed to evidence any direct patient care volunteer services had been provided from January 2016 to June 2016.</p> <p>3. The volunteer coordinator, employee E, stated, on 6-23-16, "I started with the hospice on 6-1-16. I have not received any orientation and/or training for the volunteer program yet. We have 1 volunteer on staff right now."</p> <p>4. The administrator stated, on 6-23-16 at 11:55 AM, "I don't know if the volunteer would be available to us or not. She may have gone back to school."</p> <p>5. During a home visit to patient number 3, on 6-22-16 at 12:55 PM, the patient could not recall being informed that volunteer services are provided by the hospice. The RN providing care to the patient, employee H, stated, "We really don't have that program up and and running right now."</p> <p>6. A telephone call was placed to the volunteer, employee F, on 6-23-16 at 11:35 AM. There was no answer.</p>			

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L 0644 Bldg. 00	<p>7. The hospice's 12/2015 "Volunteer Services HC.13" policy states, "MSA Hospices ensure qualified volunteers are available to assist with the provision of hospice services to patients and their caregivers."</p> <p>418.78(b) ROLE Volunteers must be used in day-to-day administrative and/or direct patient care roles.</p> <p>Based on record review and interview, the hospice failed to ensure volunteers were available and had been utilized in direct patient care roles in 6 (January through June 2016) of 6 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's volunteer roster, provided on 6-20-16, included only 1 volunteer, employee F. The roster evidenced the individual had started with the hospice on 1-21-16. 2. The hospice's administrative records evidenced the volunteer, employee F, had completed administrative volunteer activities in January, February, March, and April 2016. The records failed to evidence any direct patient care volunteer services had been provided from January 2016 to June 2016. 	L 0644	L 644 The Administrator will instruct the Volunteer Coordinator and ensure volunteers are recruited and available for direct patient care roles and day to day administrative roles. The Administrator will be responsible for monitoring the recruitment of volunteers to ensure availability to patients to ensure that this deficiency is corrected and will not recur.	07/22/2016

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NAME OF PROVIDER OR SUPPLIER MEDICAL SERVICES OF AMERICA HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 3101 NORTH GREEN RIVER ROAD, SUITE 210 EVANSVILLE, IN 47715
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	<p>3. The volunteer coordinator, employee E, stated, on 6-23-16, "I started with the hospice on 6-1-16. I have not received any orientation and/or training for the volunteer program yet. We have 1 volunteer on staff right now."</p> <p>4. The administrator stated, on 6-23-16 at 11:55 AM, "I don't know if the volunteer would be available to us or not. She may have gone back to school."</p> <p>5. A telephone call was placed to the volunteer, employee F, on 6-23-16 at 11:35 AM. There was no answer.</p> <p>6. During a home visit to patient number 3, on 6-22-16 at 12:55 PM, the patient could not recall being informed that volunteer services are provided by the hospice. The RN providing care to the patient, employee H, stated, "We really don't have that program up and and running right now."</p> <p>7. The hospice's 12/2015 "Volunteer Services HC.13" policy states, "MSA Hospices ensure qualified volunteers are available to assist with the provision of hospice services to patients and their caregivers."</p>			

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L 0645 Bldg. 00	<p>418.78(c) RECRUITING AND RETAINING</p> <p>The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers.</p> <p>Based on record review and interview, the hospice failed to ensure ongoing efforts to recruit and retain volunteers had been implemented in 6 (January 2016 to June 2016) of 6 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's volunteer roster, provided on 6-20-16, included only 1 volunteer, employee F. The roster evidenced the individual had started with the hospice on 1-21-16. 2. The hospice's administrative records failed to evidence viable and ongoing efforts to recruit and retain volunteers. 3. The administrator stated, on 6-23-16 at 11:50 AM, "It's not there." The administrator indicated the previous volunteer coordinator might have removed the records upon her departure from the hospice. 4. The hospice's 12/2015 "Volunteer Services HC.13" policy states, "There are active and ongoing efforts to recruit, train and retain volunteers to provide defined services to support ancillary, 	L 0645	L 645 The Administrator will instruct the Volunteer Coordinator to document viable and ongoing efforts to recruit and retain volunteers. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.	07/22/2016

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L 0646 Bldg. 00	<p>administrative, and/or patient care services."</p> <p>418.78(d) COST SAVING</p> <p>The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following:</p> <p>(1) The identification of each position that is occupied by a volunteer.</p> <p>(2) The work time spent by volunteers occupying those positions.</p> <p>(3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section.</p> <p>Based on record review and interview, the hospice failed to ensure cost savings achieved through the use of volunteers had been calculated and documented for January 2016 through June 2016.</p> <p>The findings include:</p> <p>1. The hospice's volunteer roster, provided on 6-20-16, included only 1 volunteer, employee F. The roster evidenced the individual had started with the hospice on 1-21-16.</p> <p>2. The hospice's administrative records failed to evidence cost savings achieved through the use of volunteers had been</p>			L 0646	<p>L 646 The Administrator will instruct and ensure the Volunteer Coordinator documents the cost savings achieved through the use of volunteers. The Administrator will monitor the outcome of monthly reports for cost savings provided by the Volunteer Coordinator. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p>		07/22/2016

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L 0647 Bldg. 00	<p>calculated and documented for January 2016 through June 2016.</p> <p>3. The administrator stated, on 6-23-16 at 11:50 AM, "It's not there." The administrator indicated the previous volunteer coordinator might have removed the records upon her departure from the hospice.</p> <p>4. The hospice's 12/2015 "Volunteer Services HC.13" policy states, "The Volunteer Coordinator summarizes the volunteer activity and estimates the cost savings by using volunteer services on a monthly basis."</p> <p>418.78(e) LEVEL OF ACTIVITY Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked. Based on record review and interview, the hospice failed to maintain records of volunteer hours used compared to paid hospice employees hours to ensure the amount was equal to at least 5 percent of total patient care hours in 1 (2015) of 1 year reviewed.</p>	L 0647	L 647 The Administrator will instruct the Volunteer Coordinator and ensure volunteers provide day to day administrative and/or direct patient care in an amount that at minimum equals 5% of the total patient care of all paid employees and contract staff. A monthly report will be provided to	07/22/2016			

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L 0648 Bldg. 00	<p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records failed to evidence records had been maintained to ensure volunteers had provided administrative and/or direct patient care services in an amount that was at least 5 percent of total patient care hours provided by hospice employees. 2. The hospice administrator was unable to provide documentation of volunteer hours used compared to paid hospice employees when asked on 6-23-16 at 11:55 AM. The administrator indicated the previous volunteer coordinator might have removed the records upon her departure from the hospice. 3. The hospice's 12/2015 "Volunteer Services HC.13" policy states, "Annual compilation of the Volunteer Coordinator monthly data shows volunteer services meets or exceed five (5) percent of total patient care hours of all hospice employees and contract staff." <p>Based on record review and interview, it was determined the hospice failed to maintain compliance with this condition</p>	L 0648	<p>the Administrator to monitor compliance. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p> <p>L 648 The Administrator will ensure the organizational chart is in place to delineate the hospice's organization and lines of</p>	07/22/2016	

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L 0649 Bldg. 00	<p>by failing to ensure an organizational chart was in place to clearly delineate the hospice's organization and lines of authority (See L 649); by failing to ensure volunteer and therapy services were available in 6 of 6 months reviewed (See L 652); by failing to ensure all employees and contracted staff had orientation about the hospice philosophy in 4 of 5 personnel files reviewed and in 2 of 2 skilled nursing facility staff interviewed (See L 661); by failing to ensure all employees received initial orientation that addressed their job duties in 1 of 5 personnel files reviewed (See L 662); and by failing to ensure the skills and competency of the hospice aide had been assessed in 1 of 1 hospice aide file reviewed (See L 663).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.100 Organization and Administration of Services.</p> <p>418.100 ORGANIZATION AND ADMINISTRATION OF SERVICES The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients,</p>		<p>authority, volunteer and therapy services are available, all staff have documented orientation to the hospice philosophy, all employees receive initial orientation that address their job duties and hospice aides have skills and competency documented as successfully completed. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p>		

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	<p>caregivers and families necessary for the palliation and management of the terminal illness and related conditions.</p> <p>Based on record review and interview, the hospice failed to ensure an organizational chart was in place to clearly delineate the hospice's organization and lines of authority.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records failed to evidence an organizational chart that clearly delineated the lines of authority and accountability for the management and administration of the hospice care and services provided to patients. 2. The administrator was unable to provide an organizational chart for the hospice when asked on 6-23-16 at 2:00 PM. The administrator stated, "I looked for one when I first came and could not find it." 3. The hospice's 06/2016 "Organization and Administration of Services HC.04" policy states, "MSA Hospices organize, manage, and administers its resources to provide hospice care and services to patients, caregivers, and families necessary for the palliation and management of the terminal illness and 	L 0649	L 659 The Administrator will ensure the hospice organizes, manages, and administers its resources to provide the hospice care and services to patients, caregivers, and families necessary for the palliation and management of the terminal illness and related conditions. The Administrator will review with all employees, the hospice policy, "Organization and Administration of Services HC04. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.	07/22/2016

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L 0652 Bldg. 00	<p>related conditions . . . Organization of MSA Hospices is clearly delineated in an organizational chart and is communicated in a manner that is understood by all hospice employees. The organizational chart delineates lines of authority and accountability of hospice employees . . . Hospice employees will have access to the organizational chart and understands the organizational structure. The organizational chart summarizes relationships between the hospice's governing body, management and staff."</p> <p>418.100(c)(1) SERVICES (1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice: (i) Nursing services. (ii) Medical social services. (iii) Physician services. (iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling. (v) Hospice aide, volunteer, and homemaker services. (vi) Physical therapy, occupational therapy, and speech-language pathology services. (vii) Short-term inpatient care. (viii) Medical supplies (including drugs and biologicals) and medical appliances. Based on record review and interview, the hospice failed to ensure volunteer and therapy services were available in 6 (January 2016 through June 2016) of 6</p>	L 0652	L 652 The Administrator will instruct all clinical staff and ensure the following services and care is provided in a manner that is consistent with accepted	07/22/2016

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	<p>months reviewed.</p> <p>The findings include:</p> <p>1. The hospice's volunteer roster, provided on 6-20-16, included only 1 volunteer, employee F. The roster evidenced the individual had started with the hospice on 1-21-16.</p> <p>A. The hospice's administrative records evidenced the volunteer, employee F, had completed administrative volunteer activities in January, February, March, and April 2016. The records failed to evidence any direct patient care volunteer services had been provided from January 2016 to June 2016.</p> <p>B. The volunteer coordinator, employee E, stated, on 6-23-16, "I started with the hospice on 6-1-16. I have not received any orientation and/or training for the volunteer program yet. We have 1 volunteer on staff right now."</p> <p>C. The administrator stated, on 6-23-16 at 11:55 AM, "I don't know if the volunteer would be available to us or not. She may have gone back to school."</p> <p>D. During a home visit to patient number 3, on 6-22-16 at 12:55 PM, the</p>		<p>standards of practice: nursing services, social services, physician services, counseling services, including spiritual counseling, dietary counseling and bereavement counseling, hospice aide and volunteer services, PT,OT and speech language pathology services, short term in-patient care, medical supplies and medical appliances. The Administrator will recruit, retain and monitor for all disciplines to provide and ensure care and services are consistent with accepted standards of practice. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p>		

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	<p>patient could not recall being informed that volunteer services are provided by the hospice. The RN providing care to the patient, employee H, stated, "We really don't have that program up and and running right now."</p> <p>E. A telephone call was placed to the volunteer, employee F, on 6-23-16 at 11:35 AM. There was no answer.</p> <p>F. The hospice's 12/2015 "Volunteer Services HC.13" policy states, "MSA Hospices ensure qualified volunteers are available to assist with the provision of hospice services to patients and their caregivers."</p> <p>2. The hospice's employee roster, provided on 6-20-16, failed to evidence a physical therapist, an occupational therapist, or a speech language pathologist was employed by the hospice.</p> <p>A. The hospice's administrative records failed to evidence a valid contract for the provision of PT, OT, or SLP services.</p> <p>B. The hospice administrative records included a contract, dated 4-19-13, for the provision of PT, OT, and SLP services between the previous owners of the hospice and a therapy provider.</p>			

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L 0661 Bldg. 00	<p>C. The account executive, employee I, contacted the therapy provider by telephone on 6-22-16 at 3:10 PM. The account executive stated, "They said they no longer provide services in a home." The account executive indicated the contract was no longer valid and was unable to provide any other contract for the provision of PT, OT, or SLP services.</p> <p>418.100(g)(1) TRAINING (1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact.</p> <p>Based on record review and interview, the hospice failed to ensure all employees and contracted staff had orientation about the hospice philosophy in 4 (files A, B, C, and E) of 5 personnel files reviewed.</p> <p>The findings include:</p> <p>1. Personnel file A evidenced the individual had been hired as the hospice administrator on 5-11-15. The file failed to evidence orientation about the hospice philosophy had been provided to the employee.</p> <p>2. Personnel file B evidenced the individual had been hired on 9-28-15 to</p>	L 0661	<p>L 661 The Administrator will provide and ensure orientation to the hospice philosophy to all employees and contracted staff. The administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p>	07/22/2016

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L 0662 Bldg. 00	<p>provide hospice aide services to patients on behalf of the hospice. The file failed to evidence orientation about the hospice philosophy had been provided to the employee.</p> <p>3. Personnel file C evidenced the individual had been hired on 3-7-16 to provide licensed practical nursing services to patients on behalf of the hospice. The file failed to evidence orientation about the hospice philosophy had been provided to the employee.</p> <p>4. Personnel file E evidenced the individual had been hired on 5-31-16 to provide medical social services to patients on behalf of the hospice. The file failed to evidence orientation about the hospice philosophy had been provided to the employee.</p> <p>5. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:30 PM.</p> <p>418.100(g)(2) TRAINING (2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties. Based on record review and interview, the hospice failed to ensure all employees</p>	L 0662	L 662 The Administrator will ensure provision of an initial orientation foreach employee that addresses the	07/22/2016	

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L 0663 Bldg. 00	<p>received initial orientation that addressed their job duties in 1 (file A) of 5 personnel files reviewed.</p> <p>The findings include:</p> <p>1. Personnel file A evidenced the individual had been hired as the hospice's administrator on 5-11-15. The file failed to evidence orientation that addressed the administrator job duties.</p> <p>2. Employee A stated, on 6-216 at 2:30 PM, "I did not have any orientation."</p> <p>418.100(g)(3) TRAINING (3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.</p> <p>Based on record review and interview, the hospice failed to ensure the skills and competency of the hospice aide had been assessed in 1 (file B) of 1 hospice aide file reviewed.</p> <p>The findings include:</p> <p>1. Personnel file B evidenced the</p>			L 0663	<p>employee's specific job duties. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p> <p>L 663 The Administrator will ensure provision of skills and competency assessment to all direct care staff including volunteers. Clinical staff will be provided documented in-service training and education programs where required. The Administrator will review Competency Based Orientation Policy HC 57 and Staff Education</p>		07/22/2016

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L 0759 Bldg. 00	<p>individual had been hired on 9-28-15 to provide aide services to patients on behalf of the hospice. The file failed to evidence the individual had completed a competency evaluation program.</p> <p>2. The administrator indicated, on 6-22-16 at 2:10 PM, a competency evaluation had been administered to the individual upon hire, but was unable to locate the documentation. The administrator indicated the individual's first patient contact date was 10-6-15.</p> <p>3. The hospice personnel roster provided on 6-20-16 included only one hospice aide, employee B.</p> <p>4. The hospice's 12/2015 "Staff Competency Assessment HR308.2" policy states, "A Competency Assessment will be conducted for direct patient care and service personnel under the following conditions: Upon hire."</p> <p>Based on record review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure it had maintained professional management of all hospice</p>	L 0759	<p>& Development HC 68 with clinical staff and maintain a manual with documented in-services provided annually. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p> <p>L 759 The Administrator will ensure the only facility agreement used is the most recent revision of the MSA Hospice Facility Agreement, currently ver. 1.62015. The Account Executive</p>	07/22/2016	

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	<p>services provided in 1 of 6 records reviewed of patients that were residents of skilled nursing facilities (SNFs) of the 11 total records reviewed (See L 762); by failing to ensure the written agreement with the skilled nursing facility (SNF) included a provision for the hospice to provide services at the same level and to the same extent as if the patient were in his or her own home in 1 of 2 SNF contracts reviewed (See L 768); by failing to ensure the written agreement with the skilled nursing facility (SNF) included a provision that the hospice may use SNF staff only to the extent that the hospice would routinely use a patient's family member in 1 of 2 SNF contracts reviewed (See L 770); by failing to ensure plans of care had been established and maintained in consultation with skilled nursing facility (SNF) staff in 6 of 6 records reviewed of patients that were residents of SNFs of the 11 total records reviewed (See L 773); by failing to ensure plans of care specified all services needed by the patient and identified the responsible provider in 6 of 6 records reviewed of patients that were residents of SNFs of the 11 total records reviewed (See L 774); by failing to ensure plans of care had been established and maintained in consultation with skilled nursing facility (SNF) staff in 6 of 6 records reviewed of patients that were residents</p>		<p>will review with the facility and have signed the most recent version compliant with regulations. The Administrator will instruct clinical staff that plans of care must specify all services needed by the patient and must identify the responsible provider of care. The plan of care must be established and maintained in consultation with the facility staff. The Administrator will ensure provision of education to facility staff regarding hospice philosophy and hospice policies. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p>	

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L 0762 Bldg. 00	<p>of SNFs of the 11 total records reviewed (See L 775); and by failing to ensure it had provided orientation regarding the hospice philosophy and hospice policies and procedures in 2 of 2 skilled nursing facility staff interviewed.</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.112 Hospices That Provide Hospice Care To Residents of a SNF/NF or ICF/MR.</p> <p>418.112(b) PROFESSIONAL MANAGEMENT The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §418.100 and §418.108. Based on record review and interview, the hospice failed to ensure it had maintained professional management of all hospice services provided in 2 (#s 2 and 4) of 6 records reviewed of patients that were residents of skilled nursing facilities (SNFs) of the 11 total records reviewed.</p> <p>The findings include:</p>	L 0762	L 762 The Administrator will ensure the hospice maintains professional management of all hospice services provided to resident of skilled nursing facilities. 50% of medical records of patients in SNFs will be audited for compliance with professional management of hospice services. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.	07/22/2016

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	<p>1. Clinical record number 2 evidenced the patient was a resident of a SNF. The record included a plan of care established by the interdisciplinary group (IDG) on 4-27-16 that identified the presence of a wound. The plan of care failed to evidence the location or any characteristics of the wound. The plan states, "Measure wound and document the first dressing change of each week by SN [skilled nurse] once a week."</p> <p>A. The record included SN visit notes, dated 6-10-16, 6-13-16, 6-15-16, and 6-17-16, that identified the patient had a "pressure ulcer, Stage I" on the "dorsal right shoulder." The visit notes identified the SN performed dressing changes to the wound "per the care plan."</p> <p>B. During a home visit to patient number 2, on 6-22-16 at 8:55 AM, with the licensed practical nurse (LPN), employee C, the LPN indicated he changed the dressings "1 time per week because I need to measure the wound" and that the SNF staff would do dressing changes, also. The LPN was unable to verbalize how often the SNF staff changed the dressing.</p> <p>C. The record included a "Clinical Note" dated 6-10-16 that indicates the</p>			

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	<p>family had identified an "open area" on the patient's gluteal fold and right bony prominence of the shoulder. The note states, "Red area noted to left shoulder. Dressing covering it at this time, optifoam . . . Skin prep and optifoam reapplied."</p> <p>The update to the plan of care dated 6-3-16 failed to evidence any mention of the open areas to the patient's left gluteal fold, right shoulder, or left shoulder.</p> <p>D. The record included a copy of the SNF care plan. The SNF care plan states, "Apply skin prep to coccyx and cover with foam dressing every day shift every Mon, Wed, Fri for prevention."</p> <p>2. Clinical record number 4 evidenced the patient was a resident of a SNF. The record include an interdisciplinary group update to the plan of care dated 5-6-16 that states, "Initiate care of suprapubic catheter . . . Change every 2 weeks."</p> <p>A. The record included a "Clinical Notes" entry dated 5-25-16 that states, "Facility staff reports that patient's suprapubic catheter was changed already this morning d/t [due to] inability to flush r/t sediment build-up."</p>			

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L 0768 Bldg. 00	<p>B. A "Clinical Notes" entry dated 5-31-16 states, "Facility staff reports changing catheter on 5/30/16 r/t sediment build-up preventing flushing. Contacted medical director [name] et received new order to change catheter once a week. Facility staff notified of new order."</p> <p>3. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM.</p> <p>4. The hospice's 06/2016 "Coordination of Hospice Services HC.20" states, "The patient's plan of care is coordinated and communicated by the RN Case Manager with the contracted facilities, attending physician, vendors, IDG and other healthcare providers who provide services unrelated to the terminal illness."</p> <p>418.112(c)(5) WRITTEN AGREEMENT [The written agreement must include at least the following:] (5) An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/MR resident were in his or her own home. Based on record review and interview, the hospice failed to ensure the written agreement with the skilled nursing facility (SNF) included a provision for</p>	L 0768	L 768 The Administrator will ensure the correct and most recently revised MSA Hospice Facility Agreement is used, currently version 1.6 2015 which	07/22/2016			

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L 0770 Bldg. 00	<p>the hospice to provide services at the same level and to the same extent as if the patient were in his or her own home in 1 (contract 1) of 2 SNF contracts reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice administrative records included a written agreement with Hamilton Pointe Health and Rehab Center dated 4-26-16 (contract # 1). The agreement failed to include a provision that the hospice would provide services to the same level and to the same extent as if the patient were residing in his or her own home. The Account Executive, employee I, was unable to provide any additional documentation and/or information when asked on 6-23-16 at 1:35 PM. <p>418.112(c)(7) WRITTEN AGREEMENT [The written agreement must include at least the following:] (7) A provision that the hospice may use the SNF/NF or ICF/MR nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/MR to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care. Based on record review and interview,</p>	L 0770	is compliant with regulations and includes hospice's responsibility to provide services at the level and to the same extent as those services would be provided if the resident were in his/her own home. The Administrator will instruct and ensure the Account Executive will have the current MSA Hospice Facility Agreement signed by the Facility Administrator. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.	07/22/2016			

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L 0773 Bldg. 00	<p>the hospice failed to ensure the written agreement with the skilled nursing facility (SNF) included a provision that the hospice may use SNF staff only to the extent that the hospice would routinely use a patient's family member in 1 (contract 1) of 2 SNF contracts reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice administrative records included a written agreement with Hamilton Pointe Health and Rehab Center dated 4-26-16 (contract # 1). The agreement failed to include a provision that the hospice may use SNF staff only to the extent that the hospice would routinely use a patient's family member. 2. The Account Executive, employee I, was unable to provide any additional documentation and/or information when asked on 6-23-16 at 1:35 PM. <p>418.112(d) HOSPICE PLAN OF CARE In accordance with §418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care. Based on record review and interview, the hospice failed to ensure plans of care had been established and maintained in</p>	L 0773	<p>ensure the correct and most recently revised MSA Hospice Facility Agreement is signed that includes a provision that the hospice may use the SNF nursing personnel where permitted by the State law and as specified by the SNF to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care. 50% of medical records of SNF hospice patients will be audited to ensure the provision that the hospice may use SNF staff only to the extent that the hospice would routinely use a patient's family member. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p> <p>L 773 The Administrator will instruct Clinical staff that a written plan of care must be established and maintained in consultation</p>	07/22/2016			

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	<p>consultation with skilled nursing facility (SNF) staff in 6 (#s 2, 4, 5, 6, 8, and 9) of 6 records reviewed of patients that were residents of SNFs of the 11 total records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 evidenced the patient was a resident of a SNF. The record included a plan of care established by the interdisciplinary group (IDG) on 5-6-16. The record evidenced the plan of care had been reviewed by the IDG on 5-20-16, 6-3-16, and 6-17-16. The plan of care, and the IDG reviews, failed to evidence consultation with SNF staff. 2. Clinical record number 4 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 4-8-16. The record evidenced the plan of care had been reviewed by the IDG on 5-6-16, 5-20-16, 6-3-16, and 6-17-16. The plan of care, and the IDG reviews, failed to evidence consultation with SNF staff. 3. Clinical record number 5 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 5-6-16. The record evidenced the plan of care had been reviewed by the IDG on 5-20-16, 6-3-16, 		<p>with the SNF representatives. All hospice care is in accordance with this hospice plan of care. 50% of medical records of SNF hospice patients will be audited to ensure the POC was established and maintained in consultation with the SNF representative and care is in accordance with the POC. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p>	

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	<p>and 6-17-16. The plan of care, and the IDG reviews, failed to evidence consultation with SNF staff.</p> <p>4. Clinical record number 6 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 5-6-16. The record evidenced the plan of care had been reviewed by the IDG on 5-20-16, 6-3-16, and 6-17-16. The plan of care, and the IDG reviews, failed to evidence consultation with SNF staff.</p> <p>5. Clinical record number 8 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 5-6-16. The plan of care failed to evidence consultation with SNF staff.</p> <p>6. Clinical record number 9 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 10-23-15. The record evidenced the plan of care had been reviewed by the IDG on 11-20-15, 12-18-15, and 12-30-15. The plan of care, and the IDG reviews, failed to evidence consultation with SNF staff.</p> <p>7. The administrator was unable to provide any additional documentation and/or information when asked on</p>			

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L 0774 Bldg. 00	<p>6-22-16 at 2:55 PM.</p> <p>8. The hospice's 06/2016 "Coordination of Hospice Services HC.20" policy states, "The patient's plan of care is coordinated and communicated by the RN Case Manager with the contracted facilities, attending physician, vendors, IDG and other healthcare providers who provide services unrelated to the terminal illness."</p> <p>418.112(d)(1) HOSPICE PLAN OF CARE The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.</p> <p>Based on record review and interview, the hospice failed to ensure plans of care specified all services needed by the patient and identified the responsible provider in 6 (#s 2, 4, 5, 6, 8, and 9) of 6 records reviewed of patients that were residents of SNFs of the 11 total records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 2 evidenced the patient was a resident of a SNF. The record included a plan of care established by the interdisciplinary group (IDG) on 5-6-16. The plan of care identified "General" hospice problems, "Medication</p>	L 0774	L 774 The Administrator will instruct clinical staff that the hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the functions that have been agreed upon and included in the hospice POC. 50% of the medical records of patients in SNFs will be audited to ensure compliance with this regulation. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.	07/22/2016

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	<p>Management", "Pain", "Cardiovascular", "Respiratory", "Skin-Wound", "Communication", and "Hospice Aide Care Plan" as issues to be addressed. The plan failed to evidence specific services needed related to the identified problems and failed to identify which provider would be responsible for performing the needed interventions.</p> <p>2. Clinical record number 4 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 6-3-16. The plan of care identified "General" hospice problems, "Medication Management", "Pain", "Skin-Wound", "Nutrition", Nausea", "Urinary", "Neurological", and "Hospice Aide Careplan" as issues to be addressed. The plan failed to evidence specific services needed related to the identified problems and failed to identify which provider would be responsible for performing the needed interventions.</p> <p>3. Clinical record number 5 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 5-6-16. The plan of care identified "General" hospice problems, "Pain", "Cardiovascular", "Skin-Wound", "Nutrition", "Agitation/Anxiety", "Altered Mental Status", and "Hospice Aide Care Plan" as issues to be</p>						

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	<p>addressed. The plan failed to evidence specific services needed related to the identified problems and failed to identify which provider would be responsible for performing the needed interventions.</p> <p>4. Clinical record number 6 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 5-6-16. The plan of care identified "General" hospice problems, "Medication Management", "Nutrition", "Neurological", "Mobility-Safety", and "Hospice Aide Care Plan" as issues to be addressed. The plan failed to evidence specific services needed related to the identified problems and failed to identify which provider would be responsible for performing the needed interventions.</p> <p>5. Clinical record number 8 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 5-6-16. The plan of care identified "General" hospice problems, "Medication Management", "Pain", "Skin-Wound", "Nutrition", "Nausea", "Agitation/Anxiety", "Mobility-Safety", and "Hospice Aide Careplan" as issues to be addressed. The plan failed to evidence specific services needed related to identified problems and failed to identify which provider would be responsible for performing the needed interventions.</p>			

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L 0775 Bldg. 00	<p>6. Clinical record number 9 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 10-23-15. The plan of care identified "General" hospice problems, "Medication Management", "Infection/Isolation", "Pain", "Skin-Wound", "Nutrition", "Urinary", "Agitation/Anxiety", and "Hospice Aide Careplan" as issues to be addressed. The plan failed to evidence specific services needed related to identified problems and failed to identify which provider would be responsible for performing the needed interventions.</p> <p>7. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM.</p> <p>8. The hospice's 09/2015 "Plan of Care, HC.31" policy states, "The plan of care specifies interventions, care and services necessary to meet the needs of the patient and/or caregiver identified in the comprehensive assessment and ongoing assessments of the patient."</p> <p>418.112(d)(2) HOSPICE PLAN OF CARE The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the</p>			

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NAME OF PROVIDER OR SUPPLIER MEDICAL SERVICES OF AMERICA HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 3101 NORTH GREEN RIVER ROAD, SUITE 210 EVANSVILLE, IN 47715
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	<p>extent possible.</p> <p>Based on record review and interview, the hospice failed to ensure plans of care had been established and maintained in consultation with skilled nursing facility (SNF) staff in 6 (#s 2, 4, 5, 6, 8, and 9) of 6 records reviewed of patients that were residents of SNFs of the 11 total records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 evidenced the patient was a resident of a SNF. The record included a plan of care established by the interdisciplinary group (IDG) on 5-6-16. The record evidenced the plan of care had been reviewed by the IDG on 5-20-16, 6-3-16, and 6-17-16. The plan of care, and the IDG reviews, failed to evidence consultation with SNF staff. 2. Clinical record number 4 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 4-8-16. The record evidenced the plan of care had been reviewed by the IDG on 5-6-16, 5-20-16, 6-3-16, and 6-17-16. The plan of care, and the IDG reviews, failed to evidence consultation with SNF staff. 3. Clinical record number 5 evidenced the patient was a resident of a SNF. The 	L 0775	L 775 The Administrator will instruct clinical staff that the POC reflects the participation of the hospice, the SNF and the patient and family to the extent possible. 50% of medical records of patients in SNFs will be audited to ensure compliance with this regulation. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.	07/22/2016

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	<p>record included a plan of care established by the IDG on 5-6-16. The record evidenced the plan of care had been reviewed by the IDG on 5-20-16, 6-3-16, and 6-17-16. The plan of care, and the IDG reviews, failed to evidence consultation with SNF staff.</p> <p>4. Clinical record number 6 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 5-6-16. The record evidenced the plan of care had been reviewed by the IDG on 5-20-16, 6-3-16, and 6-17-16. The plan of care, and the IDG reviews, failed to evidence consultation with SNF staff.</p> <p>5. Clinical record number 8 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 5-6-16. The plan of care failed to evidence consultation with SNF staff.</p> <p>6. Clinical record number 9 evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on 10-23-15. The record evidenced the plan of care had been reviewed by the IDG on 11-20-15, 12-18-15, and 12-30-15. The plan of care, and the IDG reviews, failed to evidence consultation with SNF staff.</p>			

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L 0782 Bldg. 00	<p>7. The administrator was unable to provide any additional documentation and/or information when asked on 6-22-16 at 2:55 PM.</p> <p>8. The hospice's 06/2016 "Coordination of Hospice Services HC.20" policy states, "The patient's plan of care is coordinated and communicated by the RN Case Manager with the contracted facilities, attending physician, vendors, IDG and other healthcare providers who provide services unrelated to the terminal illness."</p> <p>418.112(f) ORIENTATION AND TRAINING OF STAFF Hospice staff must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements. Based on record review and interview, the hospice failed to ensure it had provided orientation regarding the hospice philosophy and hospice policies and procedures in 2 (skilled nursing facility staff J and K) of 2 skilled nursing facility staff interviewed.</p> <p>The findings include:</p>	L 0782	L 782 The Administrator will instruct clinical staff that hospice staff must ensure orientation of SNF staff furnishing care to hospice patients in the hospice philosophy, including P&P regarding methods of comfort, pain control, symptom management, as well as principles about death, patient rights, appropriate forms, and record keeping requirements.	07/22/2016

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L 9999 Bldg. 00	<p>1. Skilled nursing facility staff J indicated, on 6-22-16 at 9:15 AM, the hospice had not provided any orientation about the hospice philosophy to her knowledge.</p> <p>2. Skilled nursing facility staff K indicated, on 6-22-16 at 11:15 AM, the hospice had not provided any orientation about the hospice philosophy to her.</p> <p>3. The administrator was unable to provide any additional documentation and/or information when asked on 6-20-16 at 10:00 AM and on 6-22-16 at 2:30 PM.</p> <p>IC 16-25-7 Disclosure Requirements</p> <p>Sec. 1 Each hospice program licensed or approved under this article shall prepare and update as necessary a disclosure document to be presented to each potential patient of the hospice program.</p> <p>Sec. 2 The disclosure document required under section 1 of this chapter must contain at least the following:</p> <p>(1) A description of all hospice services provided by the hospice program, including the</p>	L 9999	<p>The Hospice Case Manager will provide orientation materials to SNF staff furnishing care to hospice patients regarding hospice philosophy and care, including P&P and other items specified in the regulation. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p> <p>L 9999 the Administrator will prepare and update as necessary, a disclosure document as required as a hospice program licensed by the state of Indiana. The disclosure statement will contain the necessary elements listed in IC 16-25-7. The Administrator will instruct the clinical staff to provide and review the disclosure document to each hospice patient and/or patient representative at the time of admission. All currently active patients and/or patient representatives will be</p>	07/22/2016

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	<p>(A) types of nursing services;</p> <p>(B) other service;</p> <p>(C) specific services available during the progressive stages of the terminal illness and thereafter; and</p> <p>(D) a statement that the extent of the hospice services and supplies are dispensed based on the hospice program patient's individual needs as determined by the interdisciplinary team.</p> <p>(2) An explanation of the hospice's program's internal complaint resolution process.</p> <p>(3) A statement that the hospice program patient has the right to participate in the planning of the patient's care.</p> <p>(4) A statement that a hospice program patient may refuse any component of hospice services offered by the hospice program.</p> <p>(5) A statement that a hospice employee may provide supplies to a</p> <p style="padding-left: 20px;">(A) hospice program patient; or</p> <p style="padding-left: 20px;">(B) hospice program patient's family;</p> <p>in addition to the supplies provided by the hospice program, but the employee may only be reimbursed for the supplies by providing a written receipt to the hospice program patient or the hospice program patient's family.</p> <p>(6) A statement that the hospice program patient may request the hospice program to provide, on a monthly basis, an itemized statement of services and</p>		<p>provided this document as well. The clinical staff will be instructed to document that this document was provided and reviewed. 10% of all patient clinical records will be audited for documentation of provision and review of the disclosure document. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p>	

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	<p>supplies delivered to the patient, as submitted to the patient's payer.</p> <p>(7) The toll free number established by the state department under IC 16-25-4 to receive complaints from hospice program patients and the family members of hospice program patients regarding the hospice program.</p> <p>Based on record review and interview, the hospice failed to ensure patient had been provided with a disclosure document in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical records numbered 1 through 11 failed to evidence the hospice patients and/or their family had been provided with the Indiana disclosure document. 2. The administrator indicated, on 6-20-16 at 10:50 AM, she was unaware of the disclosure document requirement. 			