

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0000  Bldg. 00	<p>This was a revisit to the Federal hospice recertification and State re-licensure survey conducted on 6-20-16, 6-21-16, 6-22-16, and 6-23-16</p> <p>Survey Date: 8-5-16</p> <p>Facility #: 009557</p> <p>Medicare Provider # 15-1565</p> <p>Medicaid Vendor #: 200318420</p> <p>Current Census: 5</p> <p>Thirty-one (31) standards and 3 conditions were found to be corrected as a result of this survey. Eighteen (18) standards and 4 conditions remain uncorrected and were re-cited.</p> <p>Medical Services of America Hospice was found to be out of compliance with 42 CFR 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services; 42 CFR 418.72 Physical Therapy, Occupational Therapy, and Speech-Language Pathology; 42 CFR 418.100 Organization and Administration of Services; and 418.112 Hospices That Provide Hospice Care to Residents of a</p>	L 0000	<p>L 000 MSA Hospice was surveyed by SA Surveyor Vicki Hagan June 20-23, 2016. The Statement of Deficiencies (SOD) was anticipated to be received within ten days of the last day of the survey or July 3, 2016. The SOD was posted on the state website on July 15, 2016. Despite the delay in receiving the SOD, the SA Program Director, Kelly Hemmelgarn, indicated the deficiencies were to be corrected within 30 days of the survey exit date or July 23, 2016, which provided the agency 8 days to implement the plan of correction which was less than 10 days after receiving the SOD. During this same period, on July 12, 2016, MSA Hospice received a letter from SA Program Director, Kelly Hemmelgarn informing the Administrator the agency that the licensure requirements for the agency had been met for the license coverage period beginning September 30, 2016 and continuing until August 31, 2017. The surveyor, Vicki Hagan, visited to resurvey the Agency on August 5, 2016. Based on the July 12, 2016, letter indicating all standards were met and the July 14, 2016, receipt of notices of deficiencies, there is and continues to be significant confusion on the part of the hospice agency. In light of the</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2016
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 0503 Bldg. 00	SNF/NF or ICF/MR.  418.52(a)(2) NOTICE OF RIGHTS AND RESPONSIBILITIES (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. Based on record review and interview, the hospice failed to ensure patients had been informed of the hospice's policy	L 0503	confusion, the below deficiencies will be corrected as indicated and the agency will make every effort to comply will all hospice rules and regulations . During the short time between surveys, the agency corrected 33 standards and 3 conditions and will and has continued to correct the remaining standards and conditions by retraining appropriate staff and bringing in additional support from the corporate staff. The Corporate Clinical Liaison has participated in the plan of correction process and has personally directed the process for how each standard and condition will be corrected and implemented on an ongoing basis. Specifically, the Corporate Clinical Liaison will monitor the agency's adherence to all standards and conditions of participation and ensure compliance of the standards and conditions of participation.  L 503 The Administrator will instruct clinical staff to inform the patient and/or patient representative in writing and	09/04/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2016
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 0518	<p>concerning advance directives in 3 (#s 2, 5, and 6) of 3 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical records numbered 2, 5, and 6 failed to evidence the patients had been provided with written information regarding the hospice's policy concerning advance directives.</li> <li>2. The administrator stated, on 8-5-16 at 11:15 AM, "We developed a new form for the provision of this hospice's policy to current and new patients. I think the policy was give to all current patients but I am not sure where it would be documented." No further information and/or documentation was received.</li> <li>3. The hospice's 12/2015 "Advance Directives HC.70" policy states, "The MSA Hospice Nurse or Social Worker 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."</li> </ol> <p>418.52(c)(7) RIGHTS OF THE PATIENT</p>		<p>verbally of the hospice policy concerning advance directives prior to providing care. The hospice policy, "Advance Directives, HC 70" and "Decisions about Life Sustaining Treatments and End of Life Care" booklet will be given to patient and/or patient representative. The form, "MSA Hospice Agencies Hospice Available Services and Costs" will be revised to include Volunteer Services. 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 Advance Directives 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.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2016	
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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
Bldg. 00	<p>[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 3 (#s 2, 5, and 6) of 3 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, signed and dated by the patient's representative on 4-27-16. The form failed to evidence the patient had been informed of the availability of volunteer services.</p> <p>The record failed to evidence any updates to the available services form to include the availability of volunteer services.</p> <p>2. 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>	L 0518	<p>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. The form, "MSA Hospice Agencies Hospice Available Services and Costs" will be revised to include Volunteer Services. 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.</p>	08/23/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The record failed to evidence any updates to the available services form to include the availability of volunteer services.</p> <p>3. Clinical record number 6 included a "MSA Hospice Agencies Hospice Available Services and Costs" form, 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>The record failed to evidence any updates to the available services form to include the availability of volunteer services.</p> <p>4. The intake coordinator, employee L, stated on 8-5-16 at 2:35 PM, "The patients have not been informed yet because we do not have any volunteers yet."</p> <p>5. 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>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

L 0536  Bldg. 00	<p>Based on record review and interview, it was determined the hospice failed to maintained compliance with this condition by failing to ensure plans of care were specific and reflected needs identified in the comprehensive assessment in 3 of 3 records reviewed (See L 538); by failing to ensure plans of care were individualized in 3 of 3 records reviewed and failed to evidence care and services had been provided in accordance with the plan in 2 of 3 records reviewed (See L 543); by failing to ensure plans of care were individualized in 3 of 3 records reviewed (See L 545); by failing to ensure plans of care included measurable outcomes in 3 of 3 records reviewed (See L 548); and by failing to ensure revisions to the plan of care included progress towards outcomes and goals in 3 of 3 records reviewed (See L 553).</p> <p>The cumulative effect of these systemic problems resulted in the hospice's inability maintain compliance with this condition, 42 CFR 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services.</p>	L 0536	<p>L 536 The Administrator will instruct all clinical staff that plans of care are specific and reflect needs identified in the 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. 10% of all medical charts will be audited monthly to ensure compliance. The Administrator will be responsible for monitoring to ensure this deficiency is corrected and will not recur.</p>	09/04/2016
------------------------	---	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2016	
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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L 0538  Bldg. 00	<p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES</p> <p>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 3 (#s 2, 5, and 6) of 3 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included interdisciplinary group (IDG) meeting minutes dated 7-29-16 that state, "On 07/28/16 [the hospice aide, employee B] notified me [the licensed practical nurse (LPN), employee C] that the patient had emesis at breakfast possibly due to dysphagia, patient denied [the patient] was choking . . . dysphagia [difficulty swallowing]getting worse . . . risk for asp [aspiration] pneumonia has had before."</p> <p>A. The 7-29-16 update to the plan of care failed to evidence specific updates to include interventions to address the increased dysphagia.</p> <p>B. Employee C, the LPN, stated, on</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's 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 is specific and reflects the needs identified in the comprehensive assessment. The Administrator will be responsible for monitoring to ensure this deficiency is corrected and will not recur.	09/04/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>8-5-16 at 11:55 AM, "We added thickened fluids, there is already ground meat and mechanical soft diet. There is still free water at the bedside per the patient and family's request."</p> <p>C. An update to the comprehensive assessment, completed by the registered nurse (RN), employee M on 7-25-16, states, "Physical/Urinary . . . Incontinent: unable to sense need to void. Urinary symptoms: Dribbling."</p> <p>The 7-29-16 update failed to evidence specific interventions to address the urinary problem.</p> <p>2. Clinical record number 5 included skilled nurse (SN) visit notes, dated 7-22-16, 7-25-16, 7-27-16, and 7-29-16, that state, "Physical/Skin/Incision/Wound . . . outer side of left foot . . . pressure ulcer . . . Stage 2 . . . Drainage: Serosanguineous . . . Amount: Small . . . Dressing Changed this Visit: Yes, per orders, see Care Plan."</p> <p>A. The plan of care, established by the IDG on 7-22-16, failed to evidence specific interventions related to the care of the left outer foot pressure ulcer.</p> <p>B. The record evidenced the plan of care had not been updated with specific</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>interventions for the care of the left outer foot pressure ulcer until the 7-29-16 IDG meeting.</p> <p>C. An update to the comprehensive assessment, completed by the RN, employee M, on 7-25-16, identified the patient was "Incontinent: bowel and bladder." The 7-29-16 update to the plan of care failed to evidence interventions specific to the identified bowel and bladder incontinence problem.</p> <p>3. Clinical record number 6 included an update to the comprehensive assessment completed by the RN, employee M, on 7-26-16. The assessment identified bowel and bladder incontinence, sleep disturbances, activity intolerance, and that the patient was hard of hearing and "legally blind."</p> <p>A. The update to the plan of care, dated 7-29-16, failed to evidence specific interventions to address the identified problems.</p> <p>B. Employee M, an RN, stated, on 8-5-16 at 12:45 PM, "The skilled nursing facility (SNF) staff assist with transfers to the toilet, the patient has some dribbling and bowel smears, the patient is on a bowel regimen at the SNF. The patient can hear if you are face-to-face with her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0543  Bldg. 00	<p>but has problems if there is other noise. The patient can see, just not well, the SNF assist the patient to transfer and check on the patient several times throughout the night."</p> <p>4. 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.</p> <p>Based on record review and interview, the hospice failed to ensure plans of care were individualized in 3 (#s 2, 5, and 6) of 3 records reviewed and failed to evidence care and services had been provided in accordance with the plan in 2 (#s 2 and 5) of 3 records reviewed.</p> <p>The findings include:</p>	L 0543	L 543 The Administrator will instruct all clinical staff that plans of care are individualized and care and services provided are in accordance with the plan of care. 10% of all medical records will be audited monthly to ensure 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	09/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2016
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Regarding individualized plans of care:</p> <p>1. Clinical record number 2 included an update to the plan of care dated 7-29-16. The update to the plan of care identifies "Care Plan H120: Medication Management" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p> <p>A. The update to the plan of care identifies "H16 Pain" as a problem to be addressed. The update to the plan failed to be individualized and identify the location or any other characteristics of the patient's pain.</p> <p>B. The update to the plan of care identifies H180: Cardiovascular" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified cardiovascular problem.</p> <p>C. The update to the plan of care identifies "H190: Respiratory" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns</p>		ensure this deficiency is corrected and will not recur.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>associated with the identified respiratory problem.</p> <p>D. The update to the plan of care identifies "H200: Skin-Wound" as a problem to be addressed. The update to the plan of care failed to identify the location or any other characteristics of the wound. The update failed to be individualized and distinguish the specific concerns associated with the identified wound problem.</p> <p>E. The update to the plan of care identifies "H350 Communication" as a problem to be addressed. The update failed to be individualized and distinguish the specific concerns associated with the identified communication problem.</p> <p>F. The update to the plan of care identifies "H550: Hospice Aide Care Plan" as a problem. The update failed to be individualized and distinguish the specific concerns associated with the need for a hospice aide.</p> <p>2. Clinical record number 5 included an update to the plan of care dated 7-29-16. The update identified "H150: Infection/Isolation" as a problem to be addressed. The update failed to be individualized and distinguish the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>specific concerns associated with the identified infection/isolation problem.</p> <p>A. An update to the plan of care identifies "H16 Pain" as a problem to be addressed. The update to the plan failed to be individualized and identify the location or any other characteristics of the patient's pain.</p> <p>B. The update to the plan of care identifies "H180: Cardiovascular" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified cardiovascular problem.</p> <p>C. The update to the plan of care identifies "H220: Nutrition" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem.</p> <p>D. The update to the plan identifies "H250 Bowel" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified bowel problem.</p> <p>E. The update to the plan identifies</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2016
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>"H280: Urinary" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified urinary problem.</p> <p>F. The update to the plan identifies "H310: Agitation/Anxiety" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified agitation/anxiety problem.</p> <p>G. The update to the plan identifies "H320 Altered Mental Status" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified altered mental status problem.</p> <p>H. The update to the plan of care identifies "H550: Hospice Aide Care Plan" as a problem. The update failed to be individualized and distinguish the specific concerns associated with the need for a hospice aide.</p> <p>3. Clinical record number 6 included an update to the plan of care dated 7-29-16. T the update to the plan of care identifies "Care Plan H120: Medication</p>				

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  08/05/2016
--	---	---	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Management" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p> <p>A. The update to the plan of care identifies "H220: Nutrition" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem.</p> <p>B. The update to the plan of care identifies "H300 Neurological" as a problem. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified neurological problem.</p> <p>C. The update to the plan of care identifies "H 320: Altered Mental Status" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified altered mental status problem.</p> <p>D. The update to the plan of care identifies "H330 Mobility-Safety" as a problem to be addressed. The update to the plan failed to be individualized and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2016
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>distinguish the specific concerns associated with the identified mobility-safety management problem.</p> <p>E. The update to the plan of care identifies "H550 Hospice Aide Careplan" as a problem to be addressed. The update failed to be individualized and distinguish the specific concerns associated with the need for a hospice aide.</p> <p>4. The administrator was unable to provide any additional information and/or documentation when asked on 8-5-16 at 1:00 PM.</p> <p>5. 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> <p>Regarding care and services in accordance with the plan:</p> <p>1. Clinical record number 2 included an update to the plan of care dated 7-15-16 that identified hospice aide services were to be provided 3 times per week.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A. The record evidenced only 2 hospice aide visits had been provided the week of 7-24-16.</p> <p>B. The Office Coordinator was unable to provide any additional documentation and/or information when asked on 8-5-16 at 12:00 PM.</p> <p>2. Clinical record number 5 included skilled nurse (SN) visit notes, dated 7-22-16, 7-25-16, 7-27-16, and 7-29-16, that state, "Physical/Skin/Incision/Wound . . . outer side of left foot . . . pressure ulcer . . . Stage 2 . . . Drainage: Serosanguineous . . . Amount: Small . . . Dressing Changed this Visit: Yes, per orders, see Care Plan."</p> <p>A. The plan of care, established by the IDG on 7-22-16, failed to evidence specific interventions related to the care of the left outer foot pressure ulcer.</p> <p>B. The record evidenced the plan of care had not been updated with specific interventions for the care of the left outer foot pressure ulcer until the 7-29-16 IDG meeting.</p> <p>C. The administrator was unable to provide any additional information and/or documentation when asked on 8-5-16 at 1:35 PM.</p>			

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  08/05/2016
--	---	---	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0545  Bldg. 00	<p>3. 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 individualized in 3 (#s 2, 5, and 6) of 3 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included an update to the plan of care dated 7-29-16. The update to the plan of care identifies "Care Plan H120: Medication Management" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the</p>	L 0545	L 545 The Administrator will instruct all clinical staff the individual plan of care must reflect the patient and family goals and interventions based on 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. The elements of the Plan of Care, including individualized plans of care, will be added as a Performance Improvement Project of QAPI.	09/04/2016

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  08/05/2016
--	---	---	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>specific concerns associated with the identified medication management problem.</p> <p>A. The update to the plan of care identifies "H16 Pain" as a problem to be addressed. The update to the plan failed to be individualized and identify the location or any other characteristics of the patient's pain.</p> <p>B. The update to the plan of care identifies H180: Cardiovascular" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified cardiovascular problem.</p> <p>C. The update to the plan of care identifies "H190: Respiratory" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified respiratory problem.</p> <p>D. The update to the plan of care identifies "H200: Skin-Wound" as a problem to be addressed. The update to the plan of care failed to identify the location or any other characteristics of the wound. The update failed to be individualized and distinguish the</p>		The PIP will be audited monthly and the action plan updated. The Administrator will be responsible for monitoring to ensure this deficiency is corrected and will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>specific concerns associated with the identified wound problem.</p> <p>E. The update to the plan of care identifies "H350 Communication" as a problem to be addressed. The update failed to be individualized and distinguish the specific concerns associated with the identified communication problem.</p> <p>F. The update to the plan of care identifies "H550: Hospice Aide Care Plan" as a problem. The update failed to be individualized and distinguish the specific concerns associated with the need for a hospice aide.</p> <p>2. Clinical record number 5 included an update to the plan of care dated 7-29-16. The update identified "H150: Infection/Isolation" as a problem to be addressed. The update failed to be individualized and distinguish the specific concerns associated with the identified infection/isolation problem.</p> <p>A. An update to the plan of care identifies "H16 Pain" as a problem to be addressed. The update to the plan failed to be individualized and identify the location or any other characteristics of the patient's pain.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>B. The update to the plan of care identifies "H180: Cardiovascular" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified cardiovascular problem.</p> <p>C. The update to the plan of care identifies "H220: Nutrition" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem.</p> <p>D. The update to the plan identifies "H250 Bowel" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified bowel problem.</p> <p>E. The update to the plan identifies "H280: Urinary" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified urinary problem.</p> <p>F. The update to the plan identifies "H310: Agitation/Anxiety" as a problem to be addressed. The update to the plan failed to be individualized and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>distinguish the specific concerns associated with the identified agitation/anxiety problem.</p> <p>G. The update to the plan identifies "H320 Altered Mental Status" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified altered mental status problem.</p> <p>H. The update to the plan of care identifies "H550: Hospice Aide Care Plan" as a problem. The update failed to be individualized and distinguish the specific concerns associated with the need for a hospice aide.</p> <p>3. Clinical record number 6 included an update to the plan of care dated 7-29-16. T the update to the plan of care identifies "Care Plan H120: Medication Management" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified medication management problem.</p> <p>A. The update to the plan of care identifies "H220: Nutrition" as a problem to be addressed. The update to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem.</p> <p>B. The update to the plan of care identifies "H300 Neurological" as a problem. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified neurological problem.</p> <p>C. The update to the plan of care identifies "H 320: Altered Mental Status" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified altered mental status problem.</p> <p>D. The update to the plan of care identifies "H330 Mobility-Safety" as a problem to be addressed. The update to the plan failed to be individualized and distinguish the specific concerns associated with the identified mobility-safety problem.</p> <p>E. The update to the plan of care identifies "H550 Hospice Aide Careplan" as a problem to be addressed. The update failed to be individualized and distinguish the specific concerns associated with the need for a hospice</p>			

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  08/05/2016
--	---	---	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0548 Bldg. 00	<p>aide.</p> <p>4. The administrator was unable to provide any additional information and/or documentation when asked on 8-5-16 at 1:00 PM.</p> <p>5. 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> <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 care.</p> <p>Based on record review and interview, the hospice failed to ensure plans of care included measurable outcomes in 3 (#s 2, 5, and 6) of 3 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included an update to the plan of care dated 7-29-16. The plan of care failed to evidence measurable outcomes expected from the</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 measurable 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.	09/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>implementation of interventions to address identified problems.</p> <p>A. The update to the plan of care identifies "Care Plan H120: Medication Management" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified medication management problem.</p> <p>B. The update to the plan of care identifies "H16 Pain" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the patient's pain.</p> <p>C. The update to the plan of care identifies "H180: Cardiovascular" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified cardiovascular problem.</p> <p>D. The update to the plan of care identifies "H190: Respiratory" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified respiratory problem.</p> <p>E. The update to the plan of care</p>			

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  08/05/2016
--	---	---	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>identifies "H200: Skin-Wound" as a problem to be addressed. The update to the plan of care failed to evidence measurable goals and outcomes for the management of the identified wound problem.</p> <p>E. The update to the plan of care identifies "H350 Communication" as a problem to be addressed. The update failed to evidence measurable goals and outcomes for the management of the identified communication problem.</p> <p>F. The update to the plan of care identifies "H550: Hospice Aide Care Plan" as a problem. The update failed to evidence measurable goals and outcomes for the management of the identified need for hospice aide services.</p> <p>2. Clinical record number 5 included an update to the plan of care dated 7-29-16. The update identified "H150: Infection/Isolation" as a problem to be addressed. The update failed to evidence measurable goals and outcomes for the management of the identified infection/isolation problem.</p> <p>A. An update to the plan of care identifies "H16 Pain" as a problem to be addressed. The update to the plan failed to evidence measurable goals and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>outcomes for the management of the identified pain problem.</p> <p>B. The update to the plan of care identifies "H180: Cardiovascular" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified cardiovascular problem.</p> <p>C. The update to the plan of care identifies "H220: Nutrition" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified nutrition problem.</p> <p>D. The update to the plan identifies "H250 Bowel" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified bowel problem.</p> <p>E. The update to the plan identifies "H280: Urinary" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified urinary problem.</p> <p>F. The update to the plan identifies "H310: Agitation/Anxiety" as a problem to be addressed. The update to the plan</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>failed to evidence measurable goals and outcomes for the management of the identified agitation/anxiety problem.</p> <p>G. The update to the plan identifies "H320 Altered Mental Status" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified altered mental status problem.</p> <p>H. The update to the plan of care identifies "H550: Hospice Aide Care Plan" as a problem. The update failed to evidence measurable goals and outcomes for the management of the identified need for hospice aide services.</p> <p>3. Clinical record number 6 included an update to the plan of care dated 7-29-16.</p> <p>T the update to the plan of care identifies "Care Plan H120: Medication Management" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified medication management problem.</p> <p>A. The update to the plan of care identifies "H220: Nutrition" as a problem to be addressed. The update to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the plan failed to evidence measurable goals and outcomes for the management of the identified nutrition problem.</p> <p>B. The update to the plan of care identifies "H300 Neurological" as a problem. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified neurological problem.</p> <p>C. The update to the plan of care identifies "H 320: Altered Mental Status" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified altered mental status problem.</p> <p>D. The update to the plan of care identifies "H330 Mobility-Safety" as a problem to be addressed. The update to the plan failed to evidence measurable goals and outcomes for the management of the identified mobility-safety problem.</p> <p>E. The update to the plan of care identifies "H550 Hospice Aide Careplan" as a problem to be addressed. The update failed to evidence measurable goals and outcomes for the management of the identified need for a hospice aide problem.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0553 Bldg. 00	<p>4. The administrator was unable to provide any additional information and/or documentation when asked on 8-5-16 at 1:00 PM.</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 revisions to the plan of care included progress towards outcomes and goals in 3 (#s 2, 5, and 6) of 3 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included an update to the plan of care dated 7-29-16. 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>A. The 7-29-16 update include respiratory goals of "Patient/caregiver</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 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.	09/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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 stated goals.</p> <p>B. The 7-29-16 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 stated goals.</p> <p>C. The 7-29-16 update included a communication goal of "Patient/caregiver communicates effectively with Hospice team." The update failed to evidence progress towards achieving the stated goal.</p> <p>D. The 7-29-16 update included "Hospice Aide Careplan" 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>progress towards achieving the stated goals.</p> <p>2. Clinical record number 5 included an update to the plan of care dated 7-29-16. The update included "Infection/Isolation" goals of "Minimize symptoms of infections", "Patient/caregiver verbalizes understanding of infection control measures", and "Patient/caregiver verbalizes understanding of quality of life issues related to continuing antibiotic therapy at end of life." The update failed to evidence progress towards achieving the stated goals.</p> <p>A. The 7-29-16 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 stated goals.</p> <p>B. The 7-29-16 update included cardiovascular goals of "Patient/caregiver demonstrates understanding/management of heart disease" and "Patient/caregiver receives optimal teaching and support as cardiac function change." The update failed to evidence progress towards achieving the stated goals.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>C. The 7-29-16 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>D. The 7-29-16 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>E. The 7-29-16 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", "Patient/caregiver demonstrates compliance with bowel regimen", and "Patient/caregiver reports progressive decrease in loose bowels." The update failed to evidence progress towards achieving the stated goals.</p> <p>F. The 7-29-16 update included</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"Urinary" goals of "Patient maintains urinary function without complications within limitations of disease process/progression", "Patient/caregiver verbalizes understanding of renal function changes at end of life", "Patient/caregiver verbalizes understanding of cleansing after each episode of incontinence", "Patient perineal area remains free from breakdown, irritation", and "Patient/caregiver verbalizes understanding of sign/symptoms and prevention of infection." The update failed to evidence progress towards achieving the stated goals.</p> <p>G. The 7-29-16 update included "Altered Mental Status" goals 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>H. The 7-29-16 update included "Hospice Aide Careplan" goals of "Patient's personal hygiene is maintained:", "Patient/caregiver receives</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>assistance with ADLs", and "Patient's stated wishes are respected." The update failed to evidence progress towards achieving the stated goals.</p> <p>3. Clinical record number 6 included an update to the plan of care dated 7-29-16. The update included a medication management goal of "Patient/caregiver demonstrates safe administration of drugs and biologicals." The update failed to evidence progress towards achieving the stated goal.</p> <p>A. The 7-29-16 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>B. The 7-29-16 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 goals.</p> <p>C. The 7-29-16 update included</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"Altered mental status" goals of "Patient/caregiver verbalizes understanding of mental and functional changes related to disease process" and "Maintain a safe environment". The update failed to evidence progress towards achieving the stated goals.</p> <p>D. The 7-29-16 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 goals.</p> <p>E. The 7-29-16 update included a "Hospice Aide Careplan" goal of "Patient's personal hygiene is maintained." The update failed to evidence progress towards achieving the stated goal.</p> <p>4. The administrator was unable to provide any additional information and/or documentation when asked on 8-5-16 at 1:00 PM.</p> <p>5. The hospice's 09/2015 "Plan of Care, HC.31" states, "The hospice</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0565 Bldg. 00	<p>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> <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 the governing body had approved the data collection frequency and details of the quality assessment and performance improvement program.</p> <p>The findings include:</p> <p>1. The hospice's administrative records evidenced the hospice had instituted a hospice-wide, data driven quality assessment and performance improvement program effective 7-22-16. The records failed to evidence the program had been approved by the governing body.</p>	L 0565	L 565 The QAPI committee will be instructed by the Administrator that the data collection frequency and details of the QAPI must be approved by the governing body. Approval by the governing body was obtained. The Administrator will ensure the QAPI program data collection methods are approved by the Board of Directors and will not recur.	08/08/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0575 Bldg. 00	<p>The hospice's administrative records included a "MSA Hospice MSA Board Resolution to Improve and Ensure Quality through Hospice" form. The form identified governing body approval of the hospice's quality assessment and performance improvement program. The form was un-signed and undated.</p> <p>2. The Intake Coordinator, employee L, stated, on 8-5-16 at 2:35 PM, "The governing body has not signed off on this. [Corporate name] took to be signed, we have not received anything back yet."</p> <p>3. 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 hospice failed to ensure the governing</p>	L 0575	L 575 The Administrator will provide documentation that the hospice's Board is responsible for	08/08/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>body had approved the hospice's quality assessment and performance improvement program.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The hospice's administrative records evidenced the hospice had instituted a hospice-wide, data driven quality assessment and performance improvement program effective 7-22-16. The records failed to evidence the program had been approved by the governing body.</li> <li>The hospice's administrative records included a "MSA Hospice MSA Board Resolution to Improve and Ensure Quality through Hospice" form. The form identified governing body approval of the hospice's quality assessment and performance improvement program. The form was un-signed and undated.</li> <li>The Intake Coordinator, employee L, stated, on 8-5-16 at 2:35 PM, "The governing body has not signed off on this. [Corporate name] took to be signed, we have not received anything back yet."</li> <li>The hospice's 05/2016 "Quality Assessment Performance Improvement HC.59" policy states, "MSA Board of Directors ensures the QAPI Program is</li> </ol>		<p>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.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0603 Bldg. 00	<p>developed, implemented and maintained and delegates management of the program to the Administrator."</p> <p>418.72 PHYS, OCCUPNL THERAPY &amp; 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 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>	L 0603	L 603 The Administrator will ensure physical therapy services, occupational therapy services and speech language pathology services are available by obtaining a hospice agreement with a skilled nursing facility for PT, OT and ST services. The Administrator will ensure deficiency is corrected and will not recur.	08/23/2016
L 0604 Bldg. 00	<p>418.72 PHYS, OCCUPNL THERAPY &amp; SPEECH-LANG PATHOLOGY</p> <p>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</p>	L 0604	L 604 The Administrator will secure a hospice agreement with a skilled nursing facility to provide	08/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2016
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>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"> <li>1. The hospice's employee roster, provided on 8-5-16, failed to evidence a physical therapist, an occupational therapist, or a speech language pathologist was employed by the hospice.</li> <li>2. The hospice's administrative records failed to evidence a valid contract for the provision of PT, OT, or SLP services. <ul style="list-style-type: none"> <li>A. The hospice administrative records included a contract dated 7-18-16, for the provision of PT, OT, and SLP services between the hospice and a therapy provider. The contract referenced the provision of therapy services to home health patients. The contract states, "Whereas, Company, through its affiliated entities, operates Medicare certified home health agencies and at times requires additional appropriately licensed or trained staff to perform certain home health therapy services in accordance with the orders of a patient's attending physician;"</li> <li>B. The contract included a "Therapy Services and Rates" attachment that</li> </ul> </li> </ol>		<p>physical therapy services, occupational therapy services and speech language pathology services to hospice patients. An employee roster will include the physical therapist, occupational therapist and speech language pathology therapist. The Administrator will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0646 Bldg. 00	<p>referenced reimbursement for therapists conducting home health OASIS start of care, recertification, resumption of care, and discharge comprehensive assessments.</p> <p>3. The administrator stated, on 8-5-16 at 3:05 PM, "That contract is signed by [a corporate person]. I did not know it said home health. They know we are a hospice."</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. (2) The work time spent by volunteers occupying those positions. (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 a system was in place to track and document cost savings achieved through the use of volunteers.</p> <p>The findings include:</p>	L 0646	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	08/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0647 Bldg. 00	<p>1. The hospice's administrative records included an "MSA Hospice Volunteer Department Evansville, Indiana 2016 Strategic Plan" dated 7-29-16. The plan failed to evidence a system for tracking and documenting cost savings achieved through the use of volunteers.</p> <p>2. The Intake Coordinator, employee L, stated, on 8-5-16 at 2:35 PM, "I am not sure a cost savings process has been implemented." The Coordinator indicated she was unsure how the cost savings would be tracked.</p> <p>3. 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,</p>	L 0647	<p>be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p> <p>L 647 The Administrator will instruct the Volunteer Coordinator</p>	09/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the hospice failed to ensure a process had been implemented to track volunteer hours to ensure at least 5% of total patient care hours were provided by volunteers.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The hospice's administrative records included an "MSA Hospice Volunteer Department Evansville, Indiana 2016 Strategic Plan" dated 7-29-16. The plan failed to evidence a system for tracking and documenting cost savings achieved through the use of volunteers and to ensure that at least 5% of patient care hours were provided by volunteers.</li> <li>2. The Intake Coordinator, employee L, stated, on 8-5-16 at 2:35 PM, "I am not sure a cost savings process has been implemented." The Coordinator indicated she was unsure how the cost savings would be tracked.</li> <li>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 exceeds five (5) percent of total patient care hours of all hospice employees and contract staff."</li> </ol>		<p>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 of volunteer hours to document percentage of total patient care hours of all paid employees and contracted staff will be provided to the Administrator to monitor compliance. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2016	
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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
L 0648  Bldg. 00	<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 (PT), occupational therapy (OT), and speech language pathology (SLP) services were available to patients (See L 652).</p> <p>The cumulative of this systemic problem resulted in the hospice's inability to maintain compliance with this condition, 42 CFR 418.100 Organization and Administration of Services.</p>			L 0648	<p>L 648 The Administrator will ensure the organizational chart is in place to delineate the hospice's organization and lines of 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. An agreement for contracted therapy services is in place for therapy services. The Administrator will be responsible for monitoring and ensuring this deficiency is corrected and will not recur.</p>		09/04/2016
L 0652  Bldg. 00	<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</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>services.</p> <p>(vi) Physical therapy, occupational therapy, and speech-language pathology services.</p> <p>(vii) Short-term inpatient care.</p> <p>(viii) Medical supplies (including drugs and biologicals) and medical appliances.</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"> <li>The hospice's employee roster, provided on 8-5-16, failed to evidence a physical therapist, an occupational therapist, or a speech language pathologist was employed by the hospice.</li> <li>The hospice's administrative records failed to evidence a valid contract for the provision of PT, OT, or SLP services. <ul style="list-style-type: none"> <li>A. The hospice administrative records included a contract dated 7-18-16, for the provision of PT, OT, and SLP services between the hospice and a therapy provider. The contract referenced the provision of therapy services to home health patients. The contract states, "Whereas, Company, through its affiliated entities, operates Medicare certified home health agencies and at times requires additional appropriately</li> </ul> </li> </ol>	L 0652	<p>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 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>	09/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0759  Bldg. 00	<p>licensed or trained staff to perform certain home health therapy services in accordance with the orders of a patient's attending physician;"</p> <p>B. The contract included a "Therapy Services and Rates" attachment that referenced reimbursement for therapists conducting home health OASIS start of care, recertification, resumption of care, and discharge comprehensive assessments.</p> <p>3. The administrator stated, on 8-5-16 at 3:05 PM, "That contract is signed by [a corporate person]. I did not know it said home health. They know we are a hospice."</p>	L 0759	L 759 The Administrator will ensure the only facility agreement used is the most recent revision of the MSA Hospice Facility Agreement, currently ver. 1.6 2015. The Account Executive 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	09/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0773  Bldg. 00	<p>care specified all services needed by the patient and identified the responsible provider in 3 of 3 records reviewed of patients that were residents of SNFs of the 3 total records reviewed (See L 774); by failing to ensure updates to the plan of care demonstrated participation by skilled nursing facility (SNF) staff in 3 of 3 records reviewed of patients that were residents of skilled nursing facilities of the 3 total records reviewed (See L 775); and by failing to ensure appropriate orientation regarding hospice philosophy and policies had been provided to skilled nursing facility (SNF) staff in 4 of 4 SNF contracts reviewed (See L 782).</p> <p>The cumulative effect of these systemic problems resulted in the hospice's inability to maintain 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(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.</p>		<p>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>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<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 3 (#s 2, 5, &amp; 6) of 3 records reviewed of patients that were residents of SNFs of the 3 total records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>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 7-29-16. The IDG review failed to evidence consultation with SNF staff.</li> <li>2. 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 7-29-16. The IDG review failed to evidence consultation with SNF staff.</li> <li>3. 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</li> </ol>	L 0773	L 773 The Administrator will instruct Clinical staff that a written plan of care must be established and maintained in consultation 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.	09/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0774 Bldg. 00	<p>reviewed by the IDG on 7-29-16. The IDG review failed to evidence consultation with SNF staff.</p> <p>4. The administrator was unable to provide any additional information and/or documentation when asked on 8-5-16 at 1:35 PM.</p> <p>5. 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. Based on record review and interview, the hospice failed to ensure updates to plans of care specified all services needed by the patient and identified the</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	09/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>responsible provider in 3 (#s 2, 5, &amp; 6) of 3 records reviewed of patients that were residents of SNFs of the 3 total records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 evidenced the patient was a resident of a SNF. The record included an update to the plan of care established by the interdisciplinary group (IDG) on 5-6-16. The update to the plan of care, dated 7-29-16, identified "General" hospice problems, "Medication Management", "Pain", "Cardiovascular", "Respiratory", "Skin-Wound", "Communication", and "Hospice Aide Care Plan" as issues to be addressed. The update to 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.</li> <li>2. Clinical record number 5 evidenced the patient was a resident of a SNF. The record included an update to the plan of care established by the IDG on 5-6-16. The update to the plan of care, dated 7-29-16, identified "General" hospice problems, "Infection/Isolation", "Pain", "Cardiovascular", "Skin-Wound", "Nutrition", "Bowel", "Urinary", "Agitation/Anxiety" "Altered Mental</li> </ol>		<p>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.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Status", and "Hospice Aide Care Plan" as issues to be addressed. The update to 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 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 update to the plan of care, dated 7-29-16, identified "General" hospice problems, "Medication Management", "Nutrition", "Neurological", "Altered Mental Status", "Mobility-Safety", and "Hospice Aide Care Plan" as issues to be addressed. The update to 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. The administrator was unable to provide any additional information and/or documentation when asked on 8-5-16 at 1:35 PM.</p> <p>5. 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0775 Bldg. 00	<p>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 extent possible. Based on record review and interview, the hospice failed to ensure updates to the plan of care demonstrated participation by skilled nursing facility (SNF) staff in 3 (#s 2, 5, and 6) of 3 records reviewed of patients that were residents of skilled nursing facilities of the 3 total records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included an update to the plan of care dated 7-29-16. The update failed to evidence participation by SNF staff in the review and update.</li> <li>2. Clinical record number 5 included an update to the plan of care dated 7-29-16. The update failed to evidence participation by SNF staff in the review and update.</li> </ol>	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.	09/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0782 Bldg. 00	<p>3. Clinical record number 6 included an update to the plan of care dated 7-29-16. The update failed to evidence participation by SNF staff in the review and update.</p> <p>4. The administrator was unable to provide any additional information and/or documentation when asked on 8-5-16 at 1:35 PM.</p> <p>5. 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,</p>	L 0782	L 782 The Administrator will instruct clinical staff that hospice	09/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the hospice failed to ensure appropriate orientation regarding hospice philosophy and policies had been provided to skilled nursing facility (SNF) staff in 4 (#s 1, 2, 3, and 4) of 4 SNF contracts reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The hospice's administrative records failed to evidence appropriate hospice training regarding hospice philosophy and this hospice's policies had been provided to the staff at the SNFs named in contracts 1, 2, 3, and 4.</li> <li>Clinical record number 2 evidenced the patient was a resident of the SNF named in contract number 2.               <ol style="list-style-type: none"> <li>Clinical record number 5 evidenced the patient was a resident of the SNF named in contract number 4.</li> <li>Clinical record number 6 evidenced the patient was a resident of the SNF named in contract number 1.</li> </ol> </li> <li>The administrator stated, on 8-5-16 at 1:15 PM, information regarding hospice philosophy and policies had been provided to the administrators of the facilities named in contracts numbered 1, 2, 3, and 4. The administrator stated, "We have not heard back from them. We</li> </ol>		<p>staff must ensure orientation of SNF staff furnishing care to hospice patients in the hospice philosophy, including P&amp;P regarding methods of comfort, pain control, symptom management, as well as principles about death, patient rights, appropriate forms, and record keeping requirements. The Hospice Case Manager will provide orientation materials to SNF staff furnishing care to hospice patients regarding hospice philosophy and care including P&amp;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>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2016
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 9999  Bldg. 00	cannot get them to return the paperwork."  IC 16-25-7 Disclosure Requirements  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. Sec. 2 The disclosure document required under section 1 of this chapter must contain at least the following: (1) A description of all hospice services provided by the hospice program, including the (A) types of nursing services; (B) other service; (C) specific services available during the progressive stages of the terminal illness and thereafter; and (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. (2) An explanation of the hospice's program's internal complaint resolution process. (3) A statement that the hospice program	L 9999	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 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.	09/04/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2016
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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  (A) hospice program patient; or  (B) hospice program patient's family;  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 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 3 (#s 2, 5, and 6) of 11 records reviewed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2016
---	--	--	--

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical records numbered 2, 5, and 6 failed to evidence the hospice patients and/or their family had been provided with the Indiana disclosure document.</li> <li>2. The administrator indicated, on 8-5-16 at 1:00 PM, records numbered 2, 5, and 6 did not evidence patients had been provided with the Indiana disclosure document. The administrator stated, "We have been working on it."</li> </ol>			