

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/06/2012
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NAME OF PROVIDER OR SUPPLIER  SERENITY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 103 S GRANT AVE FOWLER, IN 47944
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S0000	<p>This was a hospice state re-licensure survey.</p> <p>Facility provider number: 3308</p> <p>Survey dates: November 28 through December 6, 2012</p> <p>Medicaid vender number: 200378060</p> <p>Surveyor: Bridget Boston, RN, Public Health Nurse Surveyor</p> <p>Unduplicated admissions: 174 Clinical record review: 13 Home Visits: 3</p> <p>Serenity Hospice was found to be out of compliance with IC 16-15-3 and the Conditions of Participation 42 CFR 418.54: Initial and Comprehensive Assessment of the Patient; 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services; and 418.58 Quality Assessment and Performance Improvement.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 14, 2012</p>	S0000		

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

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

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S0520	<p>418.54 INITIAL &amp; COMPREHENSIVE ASSESSMENT OF PATIENT</p> <p>Based on clinical record and policy review and interview, it was determined the hospice failed to ensure comprehensive assessments included a medication review that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring in 13 of 13 records reviewed (See S 530); failed to ensure the comprehensive assessment was updated by all members of the interdisciplinary group and included information on the patient's progress toward desired outcomes in 7 of 7 active records reviewed of patients who received services for more than 15 days (See S 533); failed to ensure measurable data elements, collected in the same manner for all patients, had been incorporated into the comprehensive assessments in 13 of 13 clinical records reviewed (See S 534); and failed to ensure comprehensive assessments included measurable data elements that were documented in a systematic way for each patient, that measurable data elements were used in individual patient care planning, and that data elements were collected for use in</p>	S0520	The policy and procedure has been revised to be in compliance with 418.54. The RN will complete the initial assessment within 48 hours. Each discipline will complete assessments within 5 days. Once comprehensive assessments are completed the Interdisciplinary Team will meet with the primary physician or Hospice Medical Director, patient, staff if in a NF, responsible party, to initiate the plan of care and provide immediate necessary care and services. PCM will facilitate arrangement of care plan meeting. Staff will be in-serviced regarding this new process before January 3rd, 2013. PCM will complete an admission audit within 48 hours of initial plan of care meeting on all admissions. This process will be monitored through a formal PIP in January 2013.	01/03/2013	

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	<p>quality assessment and performance improvement activities in 13 of 13 clinical records reviewed (See S 535).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being out of compliance with IC 16-25-3 and the Condition of Participation 418.54: Initial and Comprehensive Assessment of the Patient with the potential to affect all the patients of the hospice.</p>				

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S0530	<p>418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:</p> <ul style="list-style-type: none"> <li>(i) Effectiveness of drug therapy</li> <li>(ii) Drug side effects</li> <li>(iii) Actual or potential drug interactions</li> <li>(iv) Duplicate drug therapy</li> <li>(v) Drug therapy currently associated with laboratory monitoring.</li> </ul> <p>Based on clinical record review and interview, the hospice failed to ensure comprehensive assessments included a medication review that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring in 13 of 13 records reviewed with the potential to affect all the patients of the hospice. (#s 1 through 13)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #1, start of care (SOC) 4/4/12, failed to evidence a medication review had been completed as part of the comprehensive assessment or any updates</li> </ol>	S0530	<p>All comprehensive assessments will include a medication review which includes consideration of the patient as an individual considering pt history, effectiveness of the drug therapy, side effects, actual or potential drug interactions, duplicate or drug therapy, currently or associated with laboratory monitoring. The policy and procedure was updated to reflect the importance of individualized assessment and intervention. The Hospice Medication Profile will be completed by the assigned Case Manager which is an addendum the Comprehensive Assessment. Upon admission the medication Profile and Medications Effects reference are completed part of the Comprehensive Assessment. Medications are then profiles</p>	01/04/2013	

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	<p>to the comprehensive assessment.</p> <p>2. Clinical record #2, SOC 7/13/12, failed to evidence a medication review had been completed as part of the comprehensive assessment or any updates to the comprehensive assessment.</p> <p>3. Clinical record # 3, SOC 12/28/11, failed to evidence a medication review had been completed as part of the comprehensive assessment or any updates to the comprehensive assessment.</p> <p>4. Clinical record # 4, SOC 11/4/12, failed to evidence a medication review had been completed as part of the comprehensive assessment or any updates to the comprehensive assessment.</p> <p>5. Clinical record # 5, SOC 1/27/12, failed to evidence a medication review had been completed as part of the comprehensive assessment or any updates to the comprehensive assessment.</p> <p>6. Clinical record # 6, SOC 11/16/12, failed to evidence a medication review had been completed as part of the comprehensive assessment.</p> <p>7. Clinical record # 7, SOC 11/20/12, failed to evidence a medication review had been completed as part of the</p>		<p>with our pharmacy for clinical consultation. The medication profile is then updated with any changes. Any updates or noted side effects will be monitored and addressed immediately and or as part of the Comprehensive Assessment. The patient and or responsible party will be included in discussions regarding suggested changes. All pts remaining on caseload will be reviewed, Patients # 1, 2, 3, 5, 6, 8, 9, 11, 12 and 13 have passed. Clinical staff will be educated regarding the change in policy and procedures.</p>		

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	<p>comprehensive assessment.</p> <p>8. Clinical record # 8, SOC 11/14/12, failed to evidence a medication review had been completed as part of the comprehensive assessment.</p> <p>9. Clinical record # 9, SOC 4/19/10, failed to evidence a medication review had been completed as part of the comprehensive assessment or any updates to the comprehensive assessment</p> <p>10. Clinical record # 10, SOC 11/19/12, failed to evidence a medication review had been completed as part of the comprehensive assessment.</p> <p>11. Clinical record # 11, SOC 8/31/12, failed to evidence a medication review had been completed as part of the comprehensive assessment or any updates to the comprehensive assessment.</p> <p>12. Clinical record # 12, SOC 8/22/12, failed to evidence a medication review had been completed as part of the comprehensive assessment or any updates to the comprehensive assessment.</p> <p>13. Clinical record # 13, SOC 10/20/12, failed to evidence a medication review had been completed as part of the comprehensive assessment or any updates</p>						

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	<p>to the comprehensive assessment.</p> <p>14. On 12/6/12 at 12 PM, employee B indicated, prior to each IDG meeting, one of her tasks was to print for each patient, from the hospice pharmacy Enclara Health electronic records, a document for each patients record titled "Completed Drug Profile Review Patient Summary" which contained a list and was titled "Medication Profile Review Date Time." She said the time and date listed was when the list of medications was updated and the name of the registered nurse on the form was populated on the document automatically. She indicated the nurses do not have access to this electronic list of medications to review and document the effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring.</p>				

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S0533	<p>418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>Based on facility policy and clinical record review and interview, the hospice failed to ensure the comprehensive assessment was updated by all members of the interdisciplinary group and included information on the patient's progress toward desired outcomes in 7 of 7 active records reviewed (# 4, 5, 6, 8, 9, 11, and 13) of patients who received services for more than 15 days with the potential to affect all the patients of the hospice.</p> <p>Findings include:</p> <p>1. Clinical record # 4, with an election date and an established plan of care date of 11-4-2012, failed to evidence an update to the comprehensive assessment with outcomes that were documented and</p>	S0533	<p>The Comprehensive Assessment will be reviewed and updated by all members of the IDG for recertification and with significant change. Individualized care plans will be developed for each patient by each discipline utilizing a collaborative approach. patient review and care plan updates will be part of each IDG. Comprehensive Assessments will be updated for recertification and with significant changes. Staff will be educated regarding developing individualized care plans to include but not limited to pt declining care, non pharmacological methods to treat pain/symptoms, pt family education, pain assessment, monitoring medication changes. Comprehensive assessments will be updated by all departments for clinical records #4,5,8,9. Clinical records # 11 and 13 expired.</p>	01/03/2013	

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	<p>measurable.</p> <p>2. Clinical record # 5, with an election date and an established plan of care date of 1-27-2012, failed to evidence an update to the comprehensive assessment with outcomes that were documented and measurable.</p> <p>3. Clinical record # 6, with an election date and an established plan of care date of 11-16-2012, evidenced an updated a document titled "Hospice IDG Meeting / Care Plan Update" dated 11/29/12. The record failed to evidence an update to the comprehensive assessment with outcomes that were documented and measurable.</p> <p>4. Clinical record # 8, with an election date and an established plan of care date of 11-14-2012, evidenced an updated a document titled "Hospice IDG Meeting / Care Plan Update" dated 11/29/12. The record failed to evidence an update to the comprehensive assessment with outcomes that were documented and measurable.</p> <p>5. Clinical record # 9, with an election date and an established plan of care date of 4-16-2010, failed to evidence updates to the comprehensive assessments and progress toward desired outcomes that were documented and measurable.</p>		PCM or ADM will facilitate the IDG meetings to insure the Comprehensive Assessment is updated and individualized.		

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	<p>6. Clinical record # 11, with an election date and an established plan of care date of 8-31-2012, failed to evidence updates to the comprehensive assessments and progress toward desired outcomes that were documented and measurable.</p> <p>7. Clinical record # 13, with an election date and an established plan of care date of 10-20-2012, failed to evidence updates to the comprehensive assessments and progress toward desired outcomes that were documented and measurable.</p> <p>8. On 11/28/12 at 10 AM, employee F indicated the hospice updated the comprehensive assessment during the IDG meetings where the summary of current status was documented.</p> <p>9. On 11/29/12 at 9 AM, observed the IDG meeting held at the Lafayette Indiana branch location. The IDG members discussed all 16 patients on service from the parent site and all 30 patients on service from the Lafayette branch. During the meeting, members passed to each other documents titled "Hospice IDG Meeting / Care Plan Update" for each current patient and members could document and review the other members notes and then sign the document. The IDG members did not have on hand an updated comprehensive assessment or the</p>				

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	<p>clinical records for reference at the time of the meeting for each patient.</p> <p>10. On 12-5-12 at 10:40 AM, employee B indicated the documents completed during the IDG meetings titled "Hospice IDG Meeting / Care Plan Update" are not completed from an updated assessment.</p> <p>11. The policy titled "Quality Assessment Performance Improvement Program" and dated 12/2/08 stated, "Care Plan Formation and Review at Team Meetings ... Interdisciplinary Team review after the Initial admission discussion will take place as needed, or at least every fifteen days thereafter, with updated comprehensive assessments demonstrating the patient's progress toward outcomes determined."</p>				

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S0534	<p>418.54(e)(1) PATIENT OUTCOME MEASURES (1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation. Based on clinical record and document review and interview, the hospice failed to ensure measurable data elements, collected in the same manner for all patients, had been incorporated into the comprehensive assessments in 13 of 13 clinical records reviewed with the potential to affect all the hospice's patients. (#s 1 through 13)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical records numbered 1 through 13 evidenced the hospice had used the same standardized forms in each record for the completion of the comprehensive assessments and titled, "Hospice Initial / Comprehensive Assessments." The comprehensive assessment form failed to evidence any measurable data elements had been collected.</li> <li>On 11/28/12 at 10:50 AM, employee B indicated she was not aware of the term data elements and was not not aware of the hospice collecting data elements from</li> </ol>	S0534	<p>All measurable Data Elements will be collected in the same manner for all patients and incorporated into the comprehensive assessment. Date Elements will be identified on each comprehensive assessment. Care plans will be individualized to reflect the identified risk indicators with related plans to resolve known risks. Utilizing critical thinking skills, team collaboration and Data Element triggers the plan will be revised with each recertification and with significantly changes. Date Elements we be identified and care planned for clinical records # 4, 5,6,7,8,9. clinical record #1,2,3,10,11,12,13 have expired. PCM will monitor during review of the comprehensive assessment and track risks and outcomes through QAPI.</p>	01/03/2013			

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	<p>the comprehensive assessments completed for all patients.</p> <p>3. On 12/4/12 at 1:40 PM employee L indicated she was not aware of the term data elements and was not not aware of the hospice collecting data elements from comprehensive assessments completed for all patients.</p>				

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S0535	<p>418.54(e)(2) PATIENT OUTCOME MEASURES (2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure comprehensive assessments included measurable data elements that were documented in a systematic way for each patient, that measurable data elements were used in individual patient care planning, and that data elements were collected for use in quality assessment and performance improvement activities in 13 of 13 clinical records reviewed (#s 1 through 13).</p> <p>Findings include:</p> <p>1. Clinical records numbered 1 through 13 evidenced the hospice had used the same standardized forms in each record for the completion of the comprehensive assessments and titled, "Hospice Initial / Comprehensive Assessments." The comprehensive assessment form failed to evidence any measurable data elements</p>	S0535	<p>Comprehensive Assessments will have measurable Data elements documented and include individualized care plans and collected for use in quality assessment and performance improvement activities. Measureable Data Elements are identified on new comprehensive assessments for all disciplines. Data Elements will be care planned and addressed by all disciplines. Care plans are reviewed by all disciplines within seven days of start of care, team collaboration will occur as the individualized plan is established and updated for recertification or with significant changes. Data Elements are tracked for use in QAPI activities. Staff will be educated regarding the integration of Data Elements and the care plan process. Clinical records for #4,5,6,7,8,9 will have individualized care plans with identified Data Elements reviewed by the team. Clinical records # 1,2,3,10,11,12,13 have expired. The PCM will complete</p>	01/03/2013	

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	<p>had been collected.</p> <p>2. On 11/28/12 at 10:50 AM, employee B indicated she was not aware of the term data elements and was not not aware of the hospice collecting data elements from the comprehensive assessments completed for all patients.</p> <p>3. On 12/4/12 at 1:40 PM employee L indicated she was not aware of the term data elements and was not not aware of the hospice collecting data elements from comprehensive assessments completed for all patients.</p> <p>4. The policy titled "Quality Assessment Performance Improvement Program" dated 12/2/08 states, "Care Plan Formulation and Review at Team Meetings. ... This care planning must be data driven, including measurable targeted outcomes ... ."</p>		<p>the admission audit with in 48 hours of completion to insure the program integrity. PCM will facilitate the IDG meeting during recertification or with significant changes. PCM will maintain Data Element tracking logs as part of QAPI and will follow-up to insure the plan of care is adjusted accordingly.</p>		

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S0536	<p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES</p> <p>Based on clinical record and policy review and interview, it was determined the hospice failed to ensure the written plan of care included the interventions based on assessments and included all services necessary for the palliation and management of pain and symptoms and measurable outcomes anticipated from implementing and coordinating the plan of care in 13 of 13 records reviewed (See S 548); failed to ensure the interdisciplinary group revised the plan of care and included information from the patient's updated comprehensive assessment and noted the patient's progress toward desired outcomes and goals specified in the plan of care for 7 of 7 records reviewed of patients on service for more than 15 days (See S 553); and failed to ensure all services provided were in accordance with the written plan of care for 1 of 8 current clinical records reviewed with the potential to affect all hospice patients (See S 555).</p> <p>The cumulative effect of these systemic problems resulted in the hospice's failure to be in compliance with the Condition of Participation 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services with the potential to affect all</p>	S0536	<p>Comprehensive Assessments will have measurable Data Elements which include the assessment and management of pain. Staff will be educated regarding the integration of this Data Element including the assessment of pain regardless of cognition and communication skills. All current patients will be assessed utilizing the same assessment tool. The PCM will complete the admission audit with in 48 hours of completion to insure the program integrity. PCM will facilitate the IDG meeting during recertification or with significant changes. PCM will maintain Data Element tracking logs as part of QAPI and will follow-up to insure the plan of care is adjusted accordingly.</p>	01/03/2013	

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S0548	<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 hospice and nursing facility clinical record and policy review, the hospice failed to ensure the written plan of care included the interventions based on assessments and included all services necessary for the palliation and management of pain and symptoms and measurable outcomes anticipated from implementing and coordinating the plan of care in 13 (#s 1 through 13) of 13 records reviewed with the potential to affect all hospice patient's.</p> <p>The findings include:</p> <p>1. Clinical record # 1, with an election date 4/4/12 and an established plan of care for the certification period 10/1/12 through 11/29/12, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or from an updated comprehensive assessment.</p>	S0548	<p>Individualized care plans will be written by all disciplines including interventions based on assessments and reviewed by the interdisciplinary team through collaborative efforts. Each discipline will develop individualized care plans with specific interventions and measureable outcomes. Individualized care plans will be reviewed within seven days from the start of care, recertification and significant change. All disciplines will document review and update to the plan of care. Staff will be educated regarding the importance of collaboration and individualized interventions. Clinical record #4,5,6,7,8,9 will have individualized care plans developed and reviewed by the IDG. Clinical records #1,2,3,10,11,12,13 have expired. The ADM will provide individual department training regarding capturing Data Element and the development of individualized plans of care.</p>	01/03/2013			

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	<p>2. Clinical record # 2, with an election date 7/13/12 and established plans of care for the certification periods 7/13/12 through 10/10/12 and 10/11/12 through 1/8/13, failed to evidence specific interventions and measurable outcomes for this individual and family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or from an updated comprehensive assessment.</p> <p>3. Clinical record # 3, with an election date 12/28/11 and established plans of care for the certification periods 8/24/12 through 10/22/12 and 10/23/12 through 12/21/12, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or from an updated comprehensive assessment.</p> <p>4. Clinical record # 4, with an election date 11/4/12 and established plan of care for the certification period 11/4/12 through 2/1/13, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or</p>						

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	<p>from an updated comprehensive assessment.</p> <p>5. Clinical record # 5, with an election date 1/27/12 and established plans of care for the certification periods 9/23/12 through 11/21/12 and 11/22/12 through 1/20/13, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or from an updated comprehensive assessment.</p> <p>A. During a home visit observation on 12/3/12 at 12:15 PM, a nurse of the extended care facility indicated she cared for the patient routinely and the patient was administered as needed medications and included ativan 0.5 milligrams and morphine sulfate 1.0 milligrams nearly daily to manage the patient's behaviors. She indicated the patient exhibited excessive yelling and screaming and was routinely administered fentanyl patch at 12 micrograms / hour and geodon at 20 milligrams twice a day which was increased to 40 milligrams twice a day on 11/29/12.</p> <p>B. The patient record in the extended care facility records evidenced the ECF</p>				

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	<p>nursing staff administered a total of 77 as needed doses of ativan and / or morphine sulfate to treat the patient's anxiety and pain between November 1 through 30, 2012. Fifty - five of these 77 doses were morphine sulfate. The hospice plan of care failed to evidence specific interventions and a measurable goal related to the patients anxiety, behaviors, and pain.</p> <p>6. Clinical record # 6, with an election date 11/16/12 and established plan of care for the certification period beginning 11/16/12, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or an updated comprehensive assessment.</p> <p>7. Clinical record # 7, with an election date 11/20/12 and established plan of care for the certification period beginning 11/20/12, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or from an updated comprehensive assessment.</p>				

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	<p>8. Clinical record # 8, with an election date 11/14/12 and established plan of care for the certification period beginning 11/14/12, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or from an updated comprehensive assessment.</p> <p>9. Clinical record # 9, with an election date 4/16/10 and established plan of care for the certification period 10/5/12 through 12/3/12, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or from an updated comprehensive assessment.</p> <p>10. Clinical record # 10, with an election date 11/19/12 and established plans of care for the certification period beginning 11/19/12, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment.</p>				

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	<p>11. Clinical record # 11, with an election date 8/31/12 and established plans of care for the certification periods 8/31/12 through 11/28/12 and 11/29/12 through 2/26/13, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or from an updated comprehensive assessment.</p> <p>12. Clinical record # 12, with an election date 8/22/12 and an established plan of care date of 8/22/12 through 11/19/12, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or from an updated comprehensive assessment.</p> <p>13. Clinical record # 13, with an election date and an established plan of care date of 10/20/12, failed to evidence specific interventions and measurable outcomes for this individual and the family / caregivers, based on the comprehensive assessment and any changes identified since the comprehensive assessment or from an updated comprehensive assessment.</p>				

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	14. The policy titled "Quality Assessment Performance Improvement Program" and dated 12/2/08 stated, "Care Plan Formation and Review at Team Meetings ... Current and prospective problems of patients and families being served by hospice will be discussed at Interdisciplinary Team meetings, and recorded on the hospice Interdisciplinary Care Plan as part of an individualized plan of care at the time of admission Interdisciplinary Team review after the Initial admission discussion will take place as needed, or at least every fifteen days thereafter, with updated comprehensive assessments demonstrating the patient's progress toward outcomes determined. Summaries of updates will be written and documented on the hospice IDG Meeting / Care Plan."				

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S0553	<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 clinical record and policy review, the hospice failed to ensure the interdisciplinary group revised the plan of care and included information from the patient's updated comprehensive assessment and noted the patient's progress toward desired outcomes and goals specified in the plan of care for 7 of 7 records reviewed of patients on service for more than 15 days with the potential to affect all the hospice patients. (# 4, 5, 6, 8, 9, 11, and 13)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record # 4, with an election date and an established plan of care date of 11/4/12, evidenced a document titled "Hospice IDG Meeting / Care Plan Update" dated 11/15/12 and 11/29/12. The record failed to evidence an update to the comprehensive assessment that documented progress toward desired outcomes and was the basis for the revised plan of care. The revised plans of care failed to evidence patient specific interventions and measurable outcomes.</li> </ol>	S0553	The interdisciplinary team through collaborative efforts, will review and revise individualized care plans during recertification and with significant changes. Patients progress toward specific goals will and desired outcomes. Care plans will be set at start of care, recertification and significant change.	01/03/2013			

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	<p>2. Clinical record # 5, with an election date and an established plan of care dated 1/27/12, evidenced a document titled "Hospice IDG Meeting / Care Plan Update" dated 11/15/12 and 11/29/12. The record failed to evidence an update to the comprehensive assessment that documented progress toward desired outcomes and was the basis for the revised plan of care. The revised plans of care failed to evidence patient specific interventions and measurable outcomes.</p> <p>3. Clinical record # 6, with an election date and an established plan of care date of 11/16/12, evidenced an updated a document titled "Hospice IDG Meeting / Care Plan Update" dated 11/29/12. The record failed to evidence the revised care plan was based on an update to the comprehensive assessment with outcomes that were documented and measurable.</p> <p>4. Clinical record # 8, with an election date and an established plan of care date of 11-14-2012, evidenced an updated a document titled "Hospice IDG Meeting / Care Plan Update" dated 11/29/12. The record failed to evidence the revised care plan was based on an update to the comprehensive assessment with outcomes that were documented and measurable.</p> <p>5. Clinical record # 9, with an election</p>				

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	<p>date and an established plan of care date of 4/16/10, evidenced a document titled "Hospice IDG Meeting / Care Plan Update" dated 11/15/12 and 11/29/12. The record failed to evidence updated assessments to the comprehensive assessment that documented progress toward desired outcomes and was the basis for the revised plans of care. The revised plans of care failed to evidence patient specific interventions and measurable outcomes.</p> <p>6. Clinical record # 11, with an election date and an established plan of care date of 8/31/12, evidenced a document titled "Hospice IDG Meeting / Care Plan Update" dated 11/15/12 and 11/29/12 that failed to evidence the revised plan of care was based on an update to the comprehensive assessment and documented progress toward desired immeasurable outcomes.</p> <p>7. Clinical record # 13, with an election date and an established plan of care date of 10/20/12, evidenced a document titled "Hospice IDG Meeting / Care Plan Update" dated 11/15/12 and 11/29/12 failed to evidence the revised plan of care was based on an update to the comprehensive assessment and documented progress toward desired immeasurable outcomes.</p>				

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	<p>8. On 12-5-12 at 10:40 AM, employee B indicated the documents completed during the IDG meetings titled "Hospice IDG Meeting / Care Plan Update" were not completed from an updated comprehensive assessment. She indicated all visits to the patients included an assessment.</p> <p>9. The policy titled "Quality Assessment Performance Improvement Program" and dated 12/2/08 states, "Care Plan Formation and Review at Team Meetings ... Interdisciplinary Team review after the Initial admission discussion will take place as needed, or at least every fifteen days thereafter, with updated comprehensive assessments demonstrating the patient's progress toward outcomes determined. Summaries of updates will be written and documented on the hospice IDG Meeting / Care Plan."</p>				

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S0555	<p>418.56(e)(2) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (2) Ensure that the care and services are provided in accordance with the plan of care. Based on clinical record and personnel file review and interview, the facility failed to ensure all services provided were in accordance with the written plan of care for 1 of 8 current clinical records reviewed with the potential to affect all hospice patients. (9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. During a home visit observation on 12/4/12 at 10 AM, patient 9 indicated to have voiced concern over employee J coming to the home. The patient indicated employee J arrived several times on the weekend with little or no notice and was not sure why the employee was required to see the patient. The patient indicated he / she continued to see physicians in the physician office setting.</li> <li>2. Personnel file J, a nurse practitioner and direct hire of the hospice, failed to evidence employee J had an collaborative agreement with the medical director of the hospice or the attending physician for patient 9.</li> </ol>	S0555	All services provided will be accordance with the written plan of care. Each patient has the right to accept or deny visits-staff will track method of notifying patient of need for face to face visit. The patient will be offered the choice to see their own physician or receive a visit from a NP who is authorized to see the patient on behalf of their physician. If a NP visit is approved by the patient a physicians order will be secure for the NP to visit on behalf of the physician. The NP has been informed of the refined process. PCM will monitor the process. Patient, family and staff concerns will be monitored and resolved through the QAPI process.	01/03/2013	

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	<p>3. On 12/5/12 at 9:40 AM, during a telephone interview with employee J, he indicated he was hired by the hospice to visit the hospice patients for the purpose of completing a face to face medicare encounter requirement. He indicated he was given a list of hospice patient's names and a time frame to complete these visits. He indicated once he received the patient name, he reviewed the patient record in the hospice office, and then made a home visit to assess the hospice patient. He indicated he only documented his assessment on the face to face encounter note and did not complete any other documentation in the hospice record. He indicated he did not communicate with the patient's attending physician in the completion of this task on behalf of the hospice.</p> <p>4. On 12/5/12 at 10:40, employee B indicated employee J was a nurse practitioner directly hired by the hospice to complete face to face encounters on behalf of the hospice. She indicated a staff member maintained a list of all hospice patients and when they were due and then employee J is given the list of hospice patients which are due. She indicated this encounter was required beginning with the 3rd certification period and made every 60 days before the new</p>			

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	<p>recertification period began. She indicated this procedure was completed for all patients to ensure their face to face encounters were completed.</p> <p>5. Clinical record 9 evidenced the patient's attending physician was physician P 7. The record evidenced employee J made a home visit at the request of and on behalf of the hospice on 9/29/12. The clinical record failed to evidence an order for the nurse practitioner to visit the patient.</p>			

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S0559	<p>418.58 QUALITY ASSESSMENT &amp; PERFORMANCE IMPROVEMENT</p> <p>Based on administrative document and policy review and interview, it was determined the hospice failed to ensure it had developed, implemented, and maintained an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program in 1 of 1 hospice reviewed (See S 560); failed to ensure a quality assessment / performance improvement program had been implemented that was capable of showing improvement in palliative outcomes in 1 of 1 hospice reviewed (See S 561); failed to ensure it had implemented a quality assessment / performance improvement program that tracked and analyzed adverse patient events in 1 of 1 hospice reviewed (See S 562); failed to ensure it had a quality assessment / performance improvement program in place that used patient care and other relevant quality indicators in 1 of 1 hospice reviewed (See S 563); failed to ensure it had a quality assessment / performance improvement program in place that monitored the safety and effectiveness of patient care activities and identified opportunities and priorities for improvement in 1 of 1 hospice reviewed (See S 564); failed to ensure it had developed, implemented, and</p>	S0559	<p>A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially Impact the patients quality of life, quality of care, pt /family, employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly, review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends.</p>	01/03/2013	

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	maintained an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program approved by the hospice's governing body in 1 of 1 hospice reviewed (See S 565); failed to ensure it had a performance improvement program in place that focused on high risk, high volume, or problem-prone areas in 1 of 1 hospice reviewed (See S 566); failed to ensure it had in place performance improvement activities that considered incidence, prevalence, and severity of problems in 1 of 1 hospice reviewed (See S 567); failed to ensure it had implemented performance improvement activities that affected palliative outcomes, patient safety, and quality of care in 1 of 1 hospice reviewed (See S 568); failed to ensure it had implemented performance improvement activities that tracked and analyzed adverse events in 1 of 1 hospice reviewed (See S 569); failed to ensure it had developed, implemented, and evaluated performance improvement projects in 1 of 1 hospice reviewed (See S 570 and S 571); failed to ensure a quality assessment / performance improvement program had been defined and implemented in 1 of 1 hospice reviewed (See S 574); failed to ensure the governing body had established hospice-wide quality assessment and performance						

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	<p>improvement efforts that addressed priorities for improved quality of care and patient safety and all improvement actions are evaluated for effectiveness in 1 of 1 hospice reviewed (See S 575); and failed to ensure the governing body appointed individuals who would operate a hospice wide quality assessment/ performance improvement program in 1 of 1 hospice reviewed with the potential to affect all the hospice's patients (See S 576).</p> <p>The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with IC 16-25-3 and the Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement with the potential to affect all the patients of the hospice.</p>				

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S0560	<p>418.58 QUALITY ASSESSMENT &amp; PERFORMANCE IMPROVEMENT The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.</p> <p>Based on administrative document and policy review and interview, the hospice failed to ensure it had developed, implemented, and maintained an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentation of a quality assessment / performance improvement program that identified and addressed program objectives, included all patient care disciplines, described how the program</p>	S0560	A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship. with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Monthly report will be submitted to the Governing Body With review,	01/03/2013	

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	<p>would be administered and coordinated, included a methodology for monitoring and evaluating care provided, included criteria to prioritize the resolution of any identified problems, addressed how monitoring of the effectiveness of the program would be accomplished, and how review of the program would be documented.</p> <p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or a part of the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08 states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement</p>		suggestions and response from the Governing Body will tracked.				

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	<p>Project will include acceptable limits for findings. Specifying the outcome indicator requires a determination of the specific observable immeasurable characteristics or changes that will represent performance improvement. ...</p> <p>d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."</p> <p>5. The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice was closing their PIP related to admissions. 4) A folder titled " Admissions QAPI - PIP " and contained a ' transfer, discharge, &amp; revoke, protocol not dated. 5) An administrative document titled " Quality Committee Agenda, " dated 12/29/11 contained random and undated potential policies. 6) A folder</p>				

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	<p>titled " Bowel Regimen PIP, " contained loose paper, Tri-Star policies with some handwriting. No conclusion and no indication as to what the folder was to represent. Contained a meeting note dated 9/18/12 " Management Meeting Note " that failed to evidence how it related to QA/ PI. 7) A folder titled " Comfortable Dying " with loose paper and on top a document titled " Fact Sheet " and a ' comfortable dying audit ' dated Nov 2012 which listed a patient name, identification, start of care date and date of death, length of hospice service, place of residence, county, town, diagnosis ICD 9 code, and the name of their attending physician. It is not clear what this information provided to the hospice or what conclusion the hospice made based on this information. 8) A policy draft titled " Guidelines for Pain Assessment and Management " and undated. No indication this was part of any ongoing plan or prior plan, no indication if or when data was to be or was collected, if the plan was implemented, and a timeframe for to review the initial implementation, and any goals.</p>			

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S0561	<p>418.58(a)(1) PROGRAM SCOPE (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services. Based on administrative document and policy review and interview, the hospice failed to ensure a quality assessment/performance improvement program had been implemented that was capable of showing improvement in palliative outcomes in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentation of a quality assessment / performance improvement program that addressed the measurement of indicators to improve palliative outcomes and hospice services had been implemented.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice</p>	S0561	<p>A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship with contracted providers. The ADM will serve as the OAPI chairman with the PCM serving as co-chair. The QAPI program will monitor Service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly, review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trend. Staff will be educated regarding findings and systems adjusted as needed. Monthly report will be submitted to the Governing Body with review, suggestions and response from the Governing Body will tracked.</p>	01/03/2013	

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	<p>was closing their PIP related to admissions. 4) A folder titled " Admissions QAPI - PIP " and contained a ' transfer, discharge, &amp; revoke, protocol not dated. 5) An administrative document titled " Quality Committee Agenda, " dated 12/29/11 contained random and undated potential policies. 6) A folder titled " Bowel Regimen PIP, " contained loose paper, Tri-Star policies with some handwriting. No conclusion and no indication as to what the folder was to represent. Contained a meeting note dated 9/18/12 " Management Meeting Note " that failed to evidence how it related to QA/ PI. 7) A folder titled " Comfortable Dying " with loose paper and on top a document titled " Fact Sheet " and a ' comfortable dying audit ' dated Nov 2012 which listed a patient name, identification, start of care date and date of death, length of hospice service, place of residence, county, town, diagnosis ICD 9 code, and the name of their attending physician. It is not clear what this information provided to the hospice or what conclusion the hospice made based on this information. 8) A policy draft titled " Guidelines for Pain Assessment and Management " and undated. No indication this was part of any ongoing plan or prior plan, no indication if or when data was to be or was collected, if the plan was</p>			

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	<p>implemented, and a timeframe for to review the initial implementation, and any goals.</p> <p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or a part of the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08 states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome indicator requires a determination of the specific observable immeasurable characteristics or changes that will represent performance improvement. ...</p>						

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	d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."				

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S0562	<p>418.58(a)(2) PROGRAM SCOPE (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.</p> <p>Based on administrative document and policy review and interview, the hospice failed to ensure a quality assessment/performance improvement program had been implemented that tracked and analyzed adverse patient events had been implemented in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentation of a quality assessment / performance improvement program that tracked and analyzed adverse patient events had been implemented.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and</p>	S0562	<p>A program will be Implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family /employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Staff will be educated regarding findings and systems adjusted as needed. Monthly report will be submitted to the Governing Body with review, suggestions and response from the Governing Body will tracked.</p>	01/03/2013	

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	medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice was closing their PIP related to admissions. 4) A folder titled " Admissions QAPI - PIP " and contained a ' transfer, discharge, & revoke, protocol not dated. 5) An administrative document titled " Quality Committee Agenda, " dated 12/29/11 contained random and undated potential policies. 6) A folder titled " Bowel Regimen PIP, " contained loose paper, Tri-Star policies with some handwriting. No conclusion and no indication as to what the folder was to represent. Contained a meeting note dated 9/18/12 " Management Meeting Note " that failed to evidence how it related to QA/ PI. 7) A folder titled " Comfortable Dying " with loose paper and on top a document titled " Fact Sheet " and a ' comfortable dying audit ' dated Nov 2012 which listed a patient name, identification, start of care date and date of death, length of hospice service, place of residence, county, town, diagnosis ICD 9 code, and the name of their attending physician. It is not clear what this information provided to the hospice or what conclusion the hospice made based on this information. 8) A policy draft titled " Guidelines for Pain Assessment and Management " and undated. No indication this was part of any ongoing plan or prior plan, no				

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	<p>indication if or when data was to be or was collected, if the plan was implemented, and a timeframe for to review the initial implementation, and any goals.</p> <p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or a part of the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08 states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome</p>			

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	indicator requires a determination of the specific observable immeasurable characteristics or changes that will represent performance improvement. ... d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."				

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S0563	<p>418.58(b)(1) PROGRAM DATA (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program. Based on administrative document and policy review and interview, the hospice failed to ensure it had a quality assessment/performance improvement program in place that used patient care and other relevant quality indicators in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentation of a quality assessment / performance improvement program that used patient care and other relevant quality indicators had been implemented.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice was closing their PIP related to admissions. 4) A folder titled " Admissions QAPI - PIP " and contained</p>	S0563	<p>All staff were educated regarding their role in a successful QAPI program and potential assignment to PIPs during the 12/2012 All Staff meeting. Additional follow-up will occur. A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement opportunities which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Staff will be educated regarding findings and systems adjusted as needed. Monthly report will be submitted to the Governing Body with review, suggestions and response from the Governing Body will tracked.</p>	01/03/2013	

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	a ' transfer, discharge, & revoke, protocol not dated. 5) An administrative document titled " Quality Committee Agenda, " dated 12/29/11 contained random and undated potential policies. 6) A folder titled " Bowel Regimen PIP, " contained loose paper, Tri-Star policies with some handwriting. No conclusion and no indication as to what the folder was to represent. Contained a meeting note dated 9/18/12 " Management Meeting Note " that failed to evidence how it related to QA/ PI. 7) A folder titled " Comfortable Dying " with loose paper and on top a document titled " Fact Sheet " and a ' comfortable dying audit ' dated Nov 2012 which listed a patient name, identification, start of care date and date of death, length of hospice service, place of residence, county, town, diagnosis ICD 9 code, and the name of their attending physician. It is not clear what this information provided to the hospice or what conclusion the hospice made based on this information. 8) A policy draft titled " Guidelines for Pain Assessment and Management " and undated. No indication this was part of any ongoing plan or prior plan, no indication if or when data was to be or was collected, if the plan was implemented, and a timeframe for to review the initial implementation, and any goals.				

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	<p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or a part of the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08 states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome indicator requires a determination of the specific observable immeasurable characteristics or changes that will represent performance improvement. ...</p>						

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	d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."				

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S0564	<p>418.58(b)(2) PROGRAM DATA (2) The hospice must use the data collected to do the following: (i) Monitor the effectiveness and safety of services and quality of care. (ii) Identify opportunities and priorities for improvement.</p> <p>Based on administrative document and policy review and interview, the hospice failed to ensure it had a quality assessment/performance improvement program in place that monitored the safety and effectiveness of patient care activities and identified opportunities and priorities for improvement in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. Review of hospice documents failed to evidence a quality assessment / performance improvement program that monitored the effectiveness and safety of services provided and identified opportunities and priorities for improvement.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event</p>	S0564	<p>All staff were educated regarding their role in a successful QAPI program and potential assignment to PIPs during the 12/2012 All Staff meeting. Additional follow-up will occur. A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Staff will be educated regarding findings and systems adjusted as needed. Monthly report will be submitted to the Governing Body with review, suggestions and response from the Governing Body will tracked.</p>	01/03/2013			

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	<p>any ongoing plan or prior plan, no indication if or when data was to be or was collected, if the plan was implemented, and a timeframe for to review the initial implementation, and any goals.</p> <p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or a part of the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08 states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for</p>				

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	findings. Specifying the outcome indicator requires a determination of the specific observable immeasurable characteristics or changes that will represent performance improvement. ... d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."				

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S0565	<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.</p> <p>Based on administrative document and policy review and interview, the hospice failed to ensure it had developed, implemented, and maintained an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program approved by the hospice's governing body in 1 of 1 hospice reviewed with the potential to affect all the hospice patients.</p> <p>The findings include:</p> <p>1. A review of hospice documents failed to evidence documentation the hospice had a quality assessment / performance improvement program that had been approved by the governing body.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice was closing their PIP related to</p>	S0565	<p>All staff were educated regarding their role in a successful QAPI program and potential assignment to PIPs during the 12/2012 All Staff meeting.</p> <p>Additional follow-up will occur. A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Staff will be educated regarding findings and systems adjusted as needed. Monthly report will be submitted to the Governing Body with review, suggestions and response from the Governing Body will tracked.</p>	01/03/2013	

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	<p>admissions. 4) A folder titled " Admissions QAPI - PIP " and contained a ' transfer, discharge, &amp; revoke, protocol not dated. 5) An administrative document titled " Quality Committee Agenda, " dated 12/29/11 contained random and undated potential policies. 6) A folder titled " Bowel Regimen PIP, " contained loose paper, Tri-Star policies with some handwriting. No conclusion and no indication as to what the folder was to represent. Contained a meeting note dated 9/18/12 " Management Meeting Note " that failed to evidence how it related to QA/ PI. 7) A folder titled " Comfortable Dying " with loose paper and on top a document titled " Fact Sheet " and a ' comfortable dying audit ' dated Nov 2012 which listed a patient name, identification, start of care date and date of death, length of hospice service, place of residence, county, town, diagnosis ICD 9 code, and the name of their attending physician. It is not clear what this information provided to the hospice or what conclusion the hospice made based on this information. 8) A policy draft titled " Guidelines for Pain Assessment and Management " and undated. No indication this was part of any ongoing plan or prior plan, no indication if or when data was to be or was collected, if the plan was implemented, and a timeframe for to</p>			

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	<p>review the initial implementation, and any goals.</p> <p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or played a role in the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program. She indicated she was not aware of exactly who the members of the governing body were and there were not any governing body minutes available for review pertaining to the QAPI program.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08, states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome indicator requires a determination of the</p>						

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S0566	<p>418.58(c)(1)(i) PROGRAM ACTIVITIES (1) The hospice's performance improvement activities must: (i) Focus on high risk, high volume, or problem-prone areas. Based on administrative document and policy review and interview, the hospice failed to ensure it had a performance improvement program in place that focused on high risk, high volume, or problem-prone areas in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentation of a quality assessment / performance improvement program that focused on high risk, high volume, or problem-prone areas.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice was closing their PIP related to admissions. 4) A folder titled "</p>	S0566	<p>All staff were educated regarding their role in a successful QAPI program and potential assignment to PIPs during the 12/2012 All Staff meeting. Additional follow-up will occur. A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Staff will be educated regarding findings and systems adjusted as needed. Monthly report will be submitted to the Governing Body with review, suggestions and response from the Governing Body will tracked.</p>	01/03/2013			

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S0567	<p>418.58(c)(1)(ii) PROGRAM ACTIVITIES [The hospice's performance improvement activities must:] (ii) Consider incidence, prevalence, and severity of problems in those areas. Based on administrative document and policy review and interview, the hospice failed to ensure it had in place performance improvement activities that considered incidence, prevalence, and severity of problems in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentation the hospice had implemented performance improvement activities that considered incidence, prevalence, and severity of problems in the chosen areas.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice was closing their PIP related to</p>	S0567	<p>All staff were educated regarding their role in a successful QAPI program and potential assignment to PIPs during the 12/2012 All Staff meeting. Additional follow-up will occur. A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Staff will be educated regarding findings and systems adjusted as needed. Monthly report will be submitted to the Governing Body with review, suggestions and response from the Governing Body will tracked.</p>	01/03/2013	

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	<p>admissions. 4) A folder titled " Admissions QAPI - PIP " and contained a ' transfer, discharge, &amp; revoke, protocol not dated. 5) An administrative document titled " Quality Committee Agenda, " dated 12/29/11 contained random and undated potential policies. 6) A folder titled " Bowel Regimen PIP, " contained loose paper, Tri-Star policies with some handwriting. No conclusion and no indication as to what the folder was to represent. Contained a meeting note dated 9/18/12 " Management Meeting Note " that failed to evidence how it related to QA/ PI. 7) A folder titled " Comfortable Dying " with loose paper and on top a document titled " Fact Sheet " and a ' comfortable dying audit ' dated Nov 2012 which listed a patient name, identification, start of care date and date of death, length of hospice service, place of residence, county, town, diagnosis ICD 9 code, and the name of their attending physician. It is not clear what this information provided to the hospice or what conclusion the hospice made based on this information. 8) A policy draft titled " Guidelines for Pain Assessment and Management " and undated. No indication this was part of any ongoing plan or prior plan, no indication if or when data was to be or was collected, if the plan was implemented, and a timeframe for to</p>			

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	<p>review the initial implementation, and any goals.</p> <p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or played a role in the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08, states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome indicator requires a determination of the specific observable immeasurable</p>				

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	<p>characteristics or changes that will represent performance improvement. ...</p> <p>d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."</p>				

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S0568	<p>418.58(c)(1)(iii) PROGRAM ACTIVITIES [The hospice's performance improvement activities must:] (iii) Affect palliative outcomes, patient safety, and quality of care.</p> <p>Based on administrative document and policy review and interview, the hospice failed to ensure it had implemented performance improvement activities that affected palliative outcomes, patient safety, and quality of care in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentation of a quality assessment / performance improvement program that included activities that affected palliative outcomes, patient safety, and quality of care.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice was closing their PIP related to</p>	S0568	<p>PIPs will be established as outlined to reflect short-term studies with anticipated long-term resolution. Multiple PIPs will be identified throughout the year and resolved as rapidly as positive outcomes can occur. All staff were educated regarding their role in a successful QAPI program and potential assignment to PIPs during the 12/2012 All staff meeting. Additional follow-up will occur. A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, Pt / employee / contracted provider satisfaction through daily, weekly, monthly review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Staff will be educated regarding findings and systems adjusted as needed. Monthly report will be submitted</p>	01/03/2013	

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	<p>review the initial implementation, and any goals.</p> <p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or played a role in the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08, states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome indicator requires a determination of the specific observable immeasurable</p>				

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	<p>characteristics or changes that will represent performance improvement. ...</p> <p>d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."</p>				

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S0569	<p>418.58(c)(2) PROGRAM ACTIVITIES (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.</p> <p>Based on administrative document and hospice policy review and interview, the hospice failed to ensure it had implemented performance improvement activities that tracked and analyzed adverse events in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentation of a quality assessment / performance improvement program that tracked and analyzed adverse events and implemented preventive actions and mechanisms.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting</p>	S0569	<p>Adverse events will be clearly outlined and tracked with interventions adjusted accordingly. All staff were educated regarding their role in a successful QAPI program and potential assignment to PIPs during the 12/2012 All Staff meeting. Additional follow-up will occur. A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Staff will be educated regarding findings and systems adjusted as needed. Monthly report will be submitted to the Governing Body with</p>	01/03/2013	

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	from 4/4/12 that evidenced the hospice was closing their PIP related to admissions. 4) A folder titled " Admissions QAPI - PIP " and contained a ' transfer, discharge, & revoke, protocol not dated. 5) An administrative document titled " Quality Committee Agenda, " dated 12/29/11 contained random and undated potential policies. 6) A folder titled " Bowel Regimen PIP, " contained loose paper, Tri-Star policies with some handwriting. No conclusion and no indication as to what the folder was to represent. Contained a meeting note dated 9/18/12 " Management Meeting Note " that failed to evidence how it related to QA/ PI. 7) A folder titled " Comfortable Dying " with loose paper and on top a document titled " Fact Sheet " and a ' comfortable dying audit ' dated Nov 2012 which listed a patient name, identification, start of care date and date of death, length of hospice service, place of residence, county, town, diagnosis ICD 9 code, and the name of their attending physician. It is not clear what this information provided to the hospice or what conclusion the hospice made based on this information. 8) A policy draft titled " Guidelines for Pain Assessment and Management " and undated. No indication this was part of any ongoing plan or prior plan, no indication if or when data was to be or		review, suggestions and response from the Governing Body will tracked.				

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	<p>was collected, if the plan was implemented, and a timeframe for to review the initial implementation, and any goals.</p> <p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or played a role in the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08, states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome</p>						

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S0570	<p>418.58(c)(3) PROGRAM ACTIVITIES (3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.</p> <p>Based on administrative documents and hospice policy review and interview, the hospice failed to ensure it had developed, implemented, and evaluated any performance improvement projects in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentation any performance improvement projects had been developed and implemented.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice was closing their PIP related to admissions. 4) A folder titled "</p>	S0570	<p>PIPs will be established as outlined to reflect short-term studies with anticipated long-term resolution. Multiple PIPs will be identified throughout the year and resolved as rapidly as positive outcomes can occur. All staff were educated regarding their role in a successful QAPI program and potential assignment to PIPs during the 12/2012 All Staff meeting. Additional follow-up will occur. A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly review. Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Staff will be educated regarding findings and</p>	01/03/2013	

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	represent performance improvement. ... d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."				

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NAME OF PROVIDER OR SUPPLIER  SERENITY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 103 S GRANT AVE FOWLER, IN 47944
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S0571	<p>418.58(d) PERFORMANCE IMPROVEMENT PROJECTS Beginning February 2, 2009, hospices must develop, implement and evaluate performance improvement projects. Based on administrative document and policy review and interview, the hospice failed to ensure it had developed, implemented, and evaluated any performance improvement projects in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentation any performance improvement projects had been developed and implemented.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice was closing their PIP related to admissions. 4) A folder titled " Admissions QAPI - PIP " and contained a ' transfer, discharge, &amp; revoke, protocol</p>	S0571	<p>PIPs will be established as outlined to reflect short-term studies with anticipated long-term resolution. Multiple PIPs will be identified throughout the year and resolved as rapidly as positive outcomes can occur. All staff were educated regarding their role in a successful QAPI program and potential assignment to PIPs during the 12/2012 All Staff meeting. Additional follow-up will occur. A program will be implemented and maintained which is effective, ongoing and hospice wide driven by established Data Elements and Performance Improvement Plans which potentially impact the patients quality of life, quality of care, pt /family/employee satisfaction and relationship with contracted providers. The ADM will serve as the QAPI chairman with the PCM serving as co-chair. The QAPI program will monitor service delivery, pt / employee / contracted provider satisfaction through daily, weekly, monthly, review Data Elements will be monitored, tracked and addressed accordingly to resolve and prevent trends. Staff will be educated regarding findings and systems adjusted as needed. Monthly report will be submitted</p>	01/03/2013

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	not dated. 5) An administrative document titled " Quality Committee Agenda, " dated 12/29/11 contained random and undated potential policies. 6) A folder titled " Bowel Regimen PIP, " contained loose paper, Tri-Star policies with some handwriting. No conclusion and no indication as to what the folder was to represent. Contained a meeting note dated 9/18/12 " Management Meeting Note " that failed to evidence how it related to QA/ PI. 7) A folder titled " Comfortable Dying " with loose paper and on top a document titled " Fact Sheet " and a ' comfortable dying audit ' dated Nov 2012 which listed a patient name, identification, start of care date and date of death, length of hospice service, place of residence, county, town, diagnosis ICD 9 code, and the name of their attending physician. It is not clear what this information provided to the hospice or what conclusion the hospice made based on this information. 8) A policy draft titled " Guidelines for Pain Assessment and Management " and undated. No indication this was part of any ongoing plan or prior plan, no indication if or when data was to be or was collected, if the plan was implemented, and a timeframe for to review the initial implementation, and any goals.		to the Governing Body with review, suggestions and response from the Governing Body will tracked.		

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	<p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or played a role in the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08, states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome indicator requires a determination of the specific observable immeasurable characteristics or changes that will represent performance improvement. ... d. The committee will analyze problem</p>				

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	patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."				

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S0574	<p>418.58(e)(1) EXECUTIVE RESPONSIBILITIES The hospice's governing body is responsible for ensuring the following: (1)That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually. Based on administrative document and policy review and interview, the governing body failed to ensure that a quality assessment / performance improvement program had been defined and implemented in 1 of 1 hospice reviewed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The hospice was unable to provide documentation the governing body had defined and implemented a quality assessment / performance improvement program.</li> <li>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or played a role in the hospice's quality assessment/performance improvement (QA/PI) program.</li> <li>3. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program and she that she had not</li> </ol>	S0574	A monthly report will be submitted to the Governing Body will be submitted by the ADM which will include but not limited to QAPI summary, PIP overview and any policy and procedure changes. The Governing Body will review, make suggestions, and or approve content. Response from the Governing Body will tracked.	01/03/2013	

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	<p>worked with the governing body regarding the QA/ PI program. She was not sure who made up the governing body.</p> <p>4. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08, states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome indicator requires a determination of the specific observable immeasurable characteristics or changes that will represent performance improvement. ... d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."</p>				

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S0575	<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 administrative record and policy review and interview, the hospice failed to ensure the governing body had established a hospice-wide quality assessment and performance improvement program that addressed priorities for improved quality of care and patient safety and all improvement actions were evaluated for effectiveness in 1 of 1 hospice reviewed with the potential to affect all the hospice's patients.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide evidence the governing body had defined and implemented a quality assessment / performance improvement program that addressed priorities for improved quality of care and patient safety and all improvement actions were evaluated for effectiveness.</p> <p>The quality assessment and improvement program documents provided included: 1) Complaint log for</p>	S0575	A monthly report will be submitted to the Governing Body will be submitted by the ADM which will include but not limited to QAPI summary, PIP overview and any policy and procedure changes. The Governing Body will review, make suggestions, and or approve content. Response from the Governing Body will tracked.	01/03/2013			

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	current calendar year. The log was brief, contained no staff signatures or the resolution and any changes made because of the investigation. 2) An adverse event log that included patient falls and medication errors. 3) A QAPI meeting from 4/4/12 that evidenced the hospice was closing their PIP related to admissions. 4) A folder titled " Admissions QAPI - PIP " and contained a ' transfer, discharge, & revoke, protocol not dated. 5) An administrative document titled " Quality Committee Agenda, " dated 12/29/11 contained random and undated potential policies. 6) A folder titled " Bowel Regimen PIP, " contained loose paper, Tri-Star policies with some handwriting. No conclusion and no indication as to what the folder was to represent. Contained a meeting note dated 9/18/12 " Management Meeting Note " that failed to evidence how it related to QA/ PI. 7) A folder titled " Comfortable Dying " with loose paper and on top a document titled " Fact Sheet " and a ' comfortable dying audit ' dated Nov 2012 which listed a patient name, identification, start of care date and date of death, length of hospice service, place of residence, county, town, diagnosis ICD 9 code, and the name of their attending physician. It is not clear what this information provided to the hospice or what conclusion the hospice				

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	<p>made based on this information. 8) A policy draft titled " Guidelines for Pain Assessment and Management " and undated. No indication this was part of any ongoing plan or prior plan, no indication if or when data was to be or was collected, if the plan was implemented, and a timeframe for to review the initial implementation, and any goals.</p> <p>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or played a role in the hospice's quality assessment/performance improvement (QA/PI) program.</p> <p>3. On 11/29/12 at 10:50 AM, the administrator indicated the hospice did not have minutes of the governing body meetings. The minutes were at the corporate office and would not be available for review because the governing body did not want to release other corporate information contained in the same documents.</p> <p>4. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>5. The hospice failed to follow its own policy by failing to ensure a hospice-wide</p>				

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	QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08, states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome indicator requires a determination of the specific observable immeasurable characteristics or changes that will represent performance improvement. ... d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."				

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S0576	<p>418.58(e)(3) EXECUTIVE RESPONSIBILITIES [The hospice's governing body is responsible for ensuring the following:] (3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated. Based on administrative record and policy review and interview, the hospice failed to ensure the governing body appointed individuals who would operate a hospice wide quality assessment / performance improvement program in 1 of 1 hospice reviewed with the potential to affect all the hospice's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The hospice was unable to provide evidence the governing body had appointed individual(s) that would operate the hospice wide quality assessment / performance improvement program.</li> <li>2. On November 28, 2012, at 10:50 AM, employee B indicated she was not in charge or played a role in the hospice's quality assessment/performance improvement (QA/PI) program.</li> <li>3. On 11/29/12 at 10:50 AM, the administrator indicated the hospice did not have minutes of the governing body</li> </ol>	S0576	A monthly report will be submitted to the Governing Body will be submitted by the ADM which will include but not limited to QAPI summary, PIP overview and any policy and procedure changes. The Governing Body will review, make suggestions, and or approve content. Response from the Governing Body will tracked.	01/03/2013			

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	<p>meetings. The minutes were at the corporate office and would not be available for review because the governing body did not want to release other corporate information contained in the same documents.</p> <p>4. On 12/4/12 at 1:40 PM, employee L indicated there was no further information to provide on behalf of the hospice QA/PI program.</p> <p>5. The hospice failed to follow its own policy by failing to ensure a hospice-wide QA/PI program was in place. The hospice's policy titled "Quality Assessment Performance Improvement Program" effective 12/2/08, states, "Conduct a systematic evaluation of the agency's programs through the following mechanisms: a. Receiving written reports on all opportunities for improvement that were identified in the time period preceding the meeting. ... b. Each QAPI performance Improvement Project will include acceptable limits for findings. Specifying the outcome indicator requires a determination of the specific observable immeasurable characteristics or changes that will represent performance improvement. ...</p>				

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	d. The committee will analyze problem patterns that have been identified using the data analysis to identify opportunities for improvement. Performance improvement projects will be recommended to the governing body."				

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S0578	<p>418.60 INFECTION CONTROL</p> <p>The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.</p> <p>Based on interview and review of administrative documents, the hospice failed to ensure an infection control program was in place to protect patients, visitors, and hospice personnel by preventing and controlling infections and communicable diseases for 1 of 1 agency with the potential to affect all patients, visitors, and hospice personnel.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of hospice documents failed to evidence an infection control program had been developed and implemented.</li> <li>2. On 12/4/12 at 1:40 PM, employee L indicated the hospice logged infections and treatment of staff and patients once identified and indicated there was no further documentation available.</li> </ol>	S0578	<p>An Infection Control policy was revised to include completion of an Opportunity For Improvement form. Pt Care Manager will review, track and guide the team accordingly regarding interventions. Plan of care will be updated to reflect status and interventions, treatment will be discussed at IDG, follow-up and reassessment will occur, staff will be further educated as needed. PCM will review clinical visit notes and on call messages ad monitor completion of the related form. Infection events will be logged in the QAPI program. Findings will be reviewed at the QAPI meeting to establish next steps, related trends, required staff education and necessary adjustments of procedures and interventions.</p>	01/03/2013	

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S0580	<p>418.60(b)(1) CONTROL</p> <p>The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that-</p> <p>(1) Is an integral part of the hospice's quality assessment and performance improvement program; and</p> <p>Based on interview and review of documents, the hospice failed to ensure it had developed, implemented, and maintained a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that was an integral part of the hospice's quality assessment and performance improvement program in 1 of 1 hospice reviewed with the potential to affect all patients, visitors, and hospice personnel.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of hospice documents failed to evidence an infection control program had been developed and implemented.</li> <li>2. On 12/4/12 at 1:40 PM, employee L indicated the hospice logged infections and treatment of staff and patients once identified and indicated there was no further documentation available.</li> </ol>	S0580	An Infection Control policy was revised to include completion of an Opportunity For Improvement form. Pt Care Manager will review, track and guide the team accordingly regarding interventions. Plan of care will be updated to reflect status and interventions, treatment will be discussed at IDG, follow-up and reassessment will occur, staff will be further educated as needed. PCM will review clinical visit notes and on call messages ad monitor completion of the related form. Infection events will be logged in the QAPI program. Findings will be reviewed at the QAPI meeting to establish next steps, related trends, required staff education and necessary adjustments of procedures and interventions.	01/03/2013	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151575		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/06/2012	
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S0581	<p>418.60(b)(2) CONTROL</p> <p>[The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that-]</p> <p>(2) Includes the following:</p> <p>(i) A method of identifying infectious and communicable disease problems; and</p> <p>(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.</p> <p>Based on interview and review of documents, the hospice failed to ensure an infection control program was in place that included a method of identifying infectious and communicable disease problems and a plan for implementing appropriate actions that are expected to result in improvement and disease prevention for 1 of 1 hospice with the potential to affect all patients, visitors, and hospice personnel.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of hospice documents failed to evidence an infection control program had been developed and implemented.</li> <li>2. On 12/4/12 at 1:40 PM, employee L indicated the hospice logged infections and treatment of staff and patients once identified and indicated there was no further documentation available.</li> </ol>	S0581	<p>An Infection Control policy was revised to include completion of an Opportunity For Improvement form. Pt Care Manager will review, track and guide the team accordingly regarding interventions. Plan of care will be updated to reflect status and interventions, treatment will be discussed at IDG, follow-up and reassessment will occur, staff will be further educated as needed. PCM will review clinical visit notes and on call messages ad monitor completion of the related form. Infection events will be logged in the QAPI program. Findings will be reviewed at the QAPI meeting to establish next steps, related trends, required staff education and necessary adjustments of procedures and interventions.</p>	01/03/2013			

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S0609	<p>418.76(a)(1) HOSPICE AIDE QUALIFICATIONS (1) A qualified hospice aide is a person who has successfully completed one of the following: (i) A training program and competency evaluation as specified in paragraphs (b) and (c) of this section respectively. (ii) A competency evaluation program that meets the requirements of paragraph (c) of this section. (iii) A nurse aide training and competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry. (iv) A State licensure program that meets the requirements of paragraphs (b) and (c) of this section.</p> <p>Based on personnel file and document review and interview, the hospice failed to ensure the individuals furnishing hospice aide services had successfully completed a competency evaluation program in 2 of 3 active hospice aide personnel files reviewed (G and I) and were in good standing on the state aide registry for 1 of 3 (G) files reviewed with the potential to affect all the patients who received hospice aide services.</p> <p>Findings include:</p> <p>1. Personnel filed I and G, hospice aides, failed to evidence a competency evaluation program had been completed.</p>	S0609	All individuals will have successful completion of a competency before rendering services. The system was revisited and refined-related department leader will be responsible to complete the checklist, HR will monitor for completion.	01/03/2013			

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	<p>Personnel file G also failed to evidence the aide was on and in good standing on the state aide registry.</p> <p>2. On 11/28/12 at 3:10 PM, employee B provided a schedule for employee I for the dates of service between November 25, 2012 through December 1, 2012 and indicated employee I was scheduled to provide aide services to 10 hospice patients who resided in a long term care facility Waterford Place in Kokomo Indiana, patients 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23, and employee G was scheduled to provide hospice aide services for patient 24.</p> <p>3. On 12/4/12 at 4:33 PM, employee O indicated she did not have documentation of training, orientation, and the competency of the skills for employee G and I available for review and indicated the patient care coordinator may have the documents at the branch office. She also indicated there was no evidence employee G was on the state registry. The hospice only looks to see if the individuals are a certified nurse assistant.</p> <p>4. On 12/6/12 at 10:40 AM, employee B indicated she met employee I at the residence of patient 14 on 11/21/12 for the purpose of observation of employee I during the visit and to evaluate her</p>						

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	<p>competency of skills during this visit. She indicated during this observation, employee I provided care for patient 14. She indicated employee I then shadowed employee G to another patient from 1:15 PM to 2:50 PM on the same day. Employee B indicated she did not have a competency of skills for employee G and was not aware of the requirement that the hospice aide be in good standing on the state aide registry.</p> <p>Employee B presented a 3 page untitled document for review. The document included the name of employee I at the top of page 1 and a list of skills to be evaluated. The document was not complete and failed to evidence employee I was evaluated for the following skills which were listed and left blank: 1) Follow standard precautions according to the Centers for Disease Control and Prevention - gown and mask, 2) Mobility - gait belt, cane, and walker, 3) Assist with fracture and bed pan, bedside commode and urinal, 4) A complete bed bath and shower, 5) Emptying of a urinary drainage bag, 6) Providing perineal care with a catheter, 7) Apply anti embolism stockings, 8) Provide mouth care for a comatose patient and gum care, 9) Measure and Record: weight, input, output, and pain.</p>						

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	5. The hospice job description dated 12/23/11 states, "Job Title: Hospice Aide ... Qualifications: 1. Possession of certification to practice as home health aide in the State of Indiana."				

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S0615	<p>418.76(c)(1) COMPETENCY EVALUATION An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section.</p> <p>(1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient.</p> <p>Based on personnel file and document review and interview, the hospice failed to ensure the individuals furnishing hospice aide services had successfully completed a competency evaluation program before providing services in 2 of 3 active hospice aide personnel files reviewed (G and I) with the potential to affect all the agency's patients who received hospice aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel filed I and G, hospice aides, failed to evidence a competency evaluation program had been completed.</li> <li>2. On 11/28/12 at 3:10 PM, employee B provided a schedule for employee I for the</li> </ol>	S0615	All individuals will have successful completion of a competency before rendering services. The system was revisited and refined-related department leader will be responsible to complete the checklist, HR will monitor for completion.	01/03/2013	

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	<p>dates of service between November 25, 2012 through December 1, 2012 and indicated employee I was scheduled to provide aide services to 10 hospice patients who resided in a long term care facility Waterford Place in Kokomo Indiana, patients 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23, and employee G was scheduled to provide hospice aide services for patient 24.</p> <p>3. On 12/4/12 at 4:33 PM, employee O indicated she did not have documentation of training, orientation, and the competency of the skills for employee G and I available for review and indicated the patient care coordinator may have the documents at the branch office. She also indicated there was no evidence employee G was on the state registry. The hospice only looks to see if the individuals are a certified nurse assistant.</p> <p>4. On 12/6/12 at 10:40 AM, employee B indicated she met employee I at the residence of patient 14 on 11/21/12 for the purpose of observation of employee I during the visit and to evaluate her competency of skills during this visit. She indicated during this observation, employee I provided care for patient 14. She indicated employee I then shadowed employee G to another patient from 1:15 PM to 2:50 PM on the same day.</p>						

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	<p>Employee B indicated she did not have a competency of skills for employee G and was not aware of the requirement that the hospice aide be in good standing on the state aide registry.</p> <p>Employee B presented a 3 page untitled document for review. The document included the name of employee I at the top of page 1 and a list of skills to be evaluated. The document was not complete and failed to evidence employee I was evaluated for the following skills which were listed and left blank: 1) Follow standard precautions according to the Centers for Disease Control and Prevention - gown and mask, 2) Mobility - gait belt, cane, and walker, 3) Assist with fracture and bed pan, bedside commode and urinal, 4) A complete bed bath and shower, 5) Emptying of a urinary drainage bag, 6) Providing perineal care with a catheter, 7) Apply anti embolism stockings, 8) Provide mouth care for a comatose patient and gum care, 9) Measure and Record: weight, input, output, and pain.</p>				

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S0645	<p>418.78(c) RECRUITING AND RETAINING The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers. Based on document review and interview, the hospice failed to demonstrate documentation of ongoing efforts by the hospice to recruit and retain volunteers for 1 of 1 hospice with the potential to affect all the hospice's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Hospice documents failed to evidence the hospice was actively seeking and retaining volunteers to serve the patients in all locations served by the hospice.</li> <li>On 11/30/12 at 10:15 AM, the volunteer coordinator indicated he did not have evidence that the hospice was actively seeking volunteers. He indicated he participated in numerous community activities, but did not have documentation of these activities. He indicated there were no volunteers willing to travel to see the 11 patients that resided in Kokomo.</li> </ol>	S0645	The current system has been revised. The Volunteer Coordinator is now tracking all efforts to recruit, retain and recognize volunteers. As of Oct 1 the ADM and coordinator meet to discuss monthly goals and objectives. Outreach plan is in place.	01/03/2013			

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S0647	<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.</p> <p>Based on administrative document review and interview, the hospice failed to ensure volunteers were providing a minimum of 5 percent of the total patient care hours of all paid hospice employees and contract staff for 1 of 1 hospice surveyed with the potential to affect all the patients of the hospice.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. A administrative hospice document titled "Serenity Volunteer Hours Percentage Calculations" Calendar Year 2012 failed to evidence the hospice maintained a volunteer staff sufficient to provide a minimum of 5% of the total patient care hours of all paid hospice employees and contract staff in 10 of the 10 months listed, January through October 2012.</li> <li>2. On 11/30/12 at 10:15 AM, employee N indicated he was not aware of the minimum requirement until March or</li> </ol>	S0647	The current system has been revised. The Volunteer Coordinator is now tracking all efforts to recruit, retain and recognize volunteers. As of Oct 1 the ADM and coordinator meet to discuss monthly goals and objectives. Outreach plan is in place.	01/03/2013			

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	April of 2012 during a hospice educational conference. There was no documentation to evidence efforts of the hospice to recruit and retain volunteers. There were no volunteers willing to drive to and provide services to the 11 hospice patients whom reside in Kokomo.				

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S9996	<p>IC 16-25-7 Disclosure Requirements</p> <p>Sec. 1. Each hospice program licensed or approved under this article shall prepare and update as necessary a disclosure document to be presented to each potential patient of the hospice program.</p> <p>Sec. 2. The disclosure document required under section 1 of this chapter must contain at least the following:</p> <p>(1) A description of all hospice services provided by the hospice program, including the</p> <ul style="list-style-type: none"> <li>(A) types of nursing services;</li> <li>(B) other service;</li> <li>(C) specific services available during the progressive stages of the terminal illness and thereafter; and</li> <li>(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.</li> </ul> <p>(2) An explanation of the hospice program's internal complaint resolution process.</p> <p>(3) A statement that the hospice program patient has the right to participate in the planning of the patient's care.</p> <p>(4) A statement that a hospice program patient may refuse any component of hospice services offered by the hospice program.</p> <p>(5) A statement that a hospice employee may provide supplies to a:</p> <ul style="list-style-type: none"> <li>(A) hospice program patient; or</li> <li>(B) hospice program patient's family;</li> </ul> <p>in addition to the supplies provided by the hospice program, but the employee may only be reimbursed for the supplies by providing a written receipt to the hospice program patient or the hospice program</p>			

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	<p>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 16-25-5-4 to receive complaints from hospice program patients and the family members of hospice program patients regarding the hospice program.</p> <p>Based on admission document and clinical record review and interview, the hospice failed to ensure each potential patient of the hospice program received a disclosure document which included a statement that the hospice 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 for 13 of 13 hospice patients admitted with the potential to affect all the hospice's patients. (#'s 1 through 13)</p> <p>Findings include:</p> <p>1. Review of the admission documents failed to evidence 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>	S9996	The Hospice Disclosure Statement will be updated to reflect items outlined including a monthly itemized statement .	01/03/2013	

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	<p>2. Clinical records #1 - 13 evidenced the patient received the admission documents.</p> <p>3. On December 6, 2012, at 10:30 AM, the administrator and patient care coordinator indicated the requirement was not in the admission documents or disclosure statement and confirmed that none of the patients admitted for hospice services had received a disclosure statement with this required information.</p>			

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S9997	<p>IC 16-28-13-4 Aide Registry Sec. 4(a) Except as provided in subsection (b), a person who:</p> <p>1) operates or administers a health care facility; or</p> <p>2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility;</p> <p>shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department...</p> <p>b) A health care facility is not required to apply for the state nurse aide registry report ... required by subsection (a) if the health care facility contracts to use the services of a nurse aide or other unlicensed employee who is employed by an entity in the business of contracting to provide nurse aides or other unlicensed employees to health care facilities.</p> <p>Based on personnel file and document review and interview, the agency failed to ensure application was made within three (3) business days from the date of employment to the state nurse aide registry for a copy of the employee's aide registry report for 1 of 3 (G) hospice aide files reviewed with the potential to affect all the patients who received hospice aide services.</p> <p>Findings include:</p> <p>1. Personnel file G, a hospice aide, failed</p>	S9997	The practice of requesting a copy of the State nurse aide registry will be implemented as outlined in S9997.	01/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/06/2012
NAME OF PROVIDER OR SUPPLIER  SERENITY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 S GRANT AVE FOWLER, IN 47944		
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	<p>to evidence a state nurse aide registry report identifying the aide was on and in good standing on the state aide registry.</p> <p>2. On 12/4/12 at 4:33 PM, employee O indicated the personnel file for employee G failed to evidence the individual was on the state home health registry.</p> <p>3. On 12/6/12 at 10:40 AM, employee B indicated not being aware of the requirement that the hospice aide be in good standing on the state aide registry.</p> <p>4. The job description dated 12/23/11 states, "Job Title: Hospice Aide ... Qualifications: 1. Possession of certification to practice as home health aide in the State of Indiana."</p>				