

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151547	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/01/2012
NAME OF PROVIDER OR SUPPLIER HANCOCK MEMORIAL HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560B STATE ST GREENFIELD, IN 46140		
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S0000	<p>This visit was a hospice state licensure survey.</p> <p>Dates: January 31 and February 1, 2012</p> <p>Facility #: 9173</p> <p>Medicaid #: 200192200A</p> <p>Hancock Memorial Hospice was found to be out of compliance with IC 16-25-3 and the Condition of Participation 42 CFR 418.54 Initial and Comprehensive Assessment of the patient and 418.58 Quality Assessment and Performance Improvement.</p> <p>Surveyors: Bridget Boston, RN Public Health Nurse Surveyor Susan E. Sparks, RN Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 6, 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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S0509	<p>[The hospice must: (ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures;</p> <p>Based on patient rights document and clinical record review and interview, the hospice failed to ensure patients were informed that the hospice would immediately investigate all violations involving anyone providing services, take action to prevent future violations, and document the result for 3 of 3 records reviewed (#1-3).</p> <p>Findings:</p> <ol style="list-style-type: none"> The hospice rights document provided to the patients failed to inform the patient that the hospice would immediately investigate all violations involving anyone providing services, take action to prevent future violations, and document the result. Clinical records #1-3 evidenced the patient had received the patient rights document. On 2/1/12 at 10 AM, Employee E, the 	S0509	<p>Correction: On 02/08/2012 Patient Rights and Responsibilities statement was revised to include "The hospice will immediately investigate all violations involving anyone providing services, take action to prevent future violations, and document the result." (Attachment #1) All current patients will be provided an updated Patient Rights and Responsibilities statement. Prevention: All patients admitted on 2/9/12 and later will be provided with the revised Patient Rights and Responsibilities statement. Person Responsible: Crissa Mulkey, RN, Clinical Supervisor</p>	03/02/2012	

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S0512	<p>Clinical Supervisor, indicated the form did not include all the patient rights.</p> <p>The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;</p> <p>Based on patient rights document and clinical record review and interview, the hospice failed to ensure patients were informed of the right to receive effective pain management and symptom control for the conditions related to their terminal illness for 3 of 3 records reviewed (#1-3).</p> <p>Findings:</p> <ol style="list-style-type: none"> The hospice rights document provided to the patients failed to inform the patient of the right to receive effective pain management and symptom control for the conditions related to their terminal illness. Clinical records #1-3 evidenced the patient had received the patient rights document. On 2/1/12 at 10 AM, Employee E, the Clinical Supervisor, indicated the form did not include all the patient rights. 	S0512	<p>Correction: On 02/08/2012 Patient Rights and Responsibilities statement was revised to include "You have the right to effective pain management and symptom control from the hospice for conditions related to the terminal illness." (Attachment #1) All current patients will be provided an updated Patient Rights and Responsibilities statement.</p> <p>Prevention: All patients admitted on 2/9/12 and later will be provided with the revised Patient Rights and Responsibilities statement. Person Responsible: Crissa Mulkey, RN, Clinical Supevisor</p>	03/02/2012			

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S0517	<p>[The patient has a right to the following:] (6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;</p> <p>Based on patient rights document and clinical record review and interview, the hospice failed to ensure patients were informed of the right to be free from mistreatment and sexual abuse including injuries of unknown source and misappropriation of patient property 3 of 3 records reviewed (#1-3).</p> <p>Findings:</p> <ol style="list-style-type: none"> The hospice rights document provided to the patients failed to inform the patient of the right to be free from mistreatment and sexual abuse including injuries of unknown source and misappropriation of patient property. Clinical records #1-3 evidenced the patient had received the patient rights document. On 2/1/12 at 10 AM, Employee E, the Clinical Supervisor, indicated the form did not include all the patient rights. 	S0517	<p>Correction: On 02/08/2012 Patient Rights and Responsibilities statement was revised to include "You have the right to considerate and respectful care free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice." (Attachment #1) All current patients will be provided an updated Patient Rights and Responsibilities statement. Prevention: All patients admitted on 2/9/12 and later will be provided with the revised Patient Rights and Responsibilities statement. Person Responsible: Criss Mulkey, RN, Clinical Supervisor</p>	03/02/2012	

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S0520	Based on clinical record review and interview, it was determined the hospice failed to ensure the comprehensive assessment took into consideration complications and risk factors that affect care planning for 2 of 2 clinical records reviewed of patients that were direct admits to the inpatient hospice (See S 526), failed to ensure the comprehensive assessment noted imminence of death in 2 of 2 clinical records reviewed of patients that were direct admits to the inpatient hospice (See S 528), failed to ensure the comprehensive assessment noted severity of symptoms in 2 of 2 clinical records reviewed of patients that were direct admits to the inpatient hospice (See S 529), failed to ensure the comprehensive assessment had a bereavement assessment in 2 of 2 clinical records reviewed of patients that were direct admits to the inpatient hospice (See S 531), failed to ensure the comprehensive assessment noted data elements to allow for measurement of outcomes in 2 of 2 clinical records reviewed of patients that were direct admits to the inpatient hospice (See S 534), and failed to ensure the comprehensive assessment had data elements that were an integral part of the comprehensive assessment and could be	S0520	Correction and Prevention: Implemented new policy, Assessment Procedure Policy #2156 (Attachment #2) which indicates that the comprehensive assessment includes consideration of complications and risk factors that impact care planning, to make note of the imminence of death, to note the severity of symptoms, to include a bereavement assessment, to include data elements that allow for measurement of outcomes and that are an integral part of the comprehensive assessment and are documented in a systematic and retrievable way for each patient. Discontinued use of EHR and replaced it with a manual documentation system that includes all required components of the initial assessment, comprehensive assessment, update to the comprehensive assessment, psychosocial assessment, spiritual care assessment, bereavement assessment, and interdisciplinary plan of care; visit notes for nursing, social work, chaplain and aides, aide assignment sheet, and updates to the IDG plan of care. All clinicians will be educated on the new policy and new documentation system, specifically the required elements of the comprehensive assessment and how it is used to develop the plan of care and in	02/16/2012	

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	<p>documented in a systematic and retrievable way for each patient in 2 of 2 clinical records reviewed of patients that were direct admits to the inpatient hospice (See S 525).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to provide safe patient care and being out of compliance with the Condition of Participation 418.54 Initial and Comprehensive Assessment of the patient.</p>		<p>the QAPI program. NP will review all initial and comprehensive assessments for compliance with all required components through 05/02/2012. This review will be added to the quality program. Person Responsible: Crissa Mulkey, RN, Clinical Supervisor</p>		

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S0526	<p>[The comprehensive assessment must take into consideration the following factors:] (2) Complications and risk factors that affect care planning.</p> <p>Based on clinical record review and interview, the hospice failed to ensure the comprehensive assessment took into consideration complications and risk factors that affect care planning for 2 of 2 clinical records reviewed (#1 & 2) of patients that were direct admits to the inpatient hospice.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record #1 included a comprehensive assessment dated 1/25/12 that failed to take into consideration complications and risk factors that affect care planning. 2. Clinical record #2 included a comprehensive assessment dated 1/28/12 that failed to take into consideration complications and risk factors that affect care planning. 3. On February 1, 2012, at 9:20 AM, Employee M, the Clinical Supervisor, indicated the software did not allow for this in the assessment. 	S0526	<p>Correction and Prevention: Implemented new policy, Assessment Procedure Policy #2156 (Attachment #2) which indicates that the comprehensive assessment includes consideration of complications and risk factors that impact care planning. Discontinued use of EHR and replaced it with a manual documentation system that includes all required components of the comprehensive assessment, and specifically consideration of complications and risk factors that impact care planning. Trained all hospice clinical staff on the requirements of documentation of complications and risk factors that directly impact care planning and how they are used to develop the plan of care. NP will review all initial and comprehensive assessments for compliance with all required components through 05/02/2012. This review will be added to the quality program. Person Responsible: Crissa Mulkey, RN, Clinical Supervisor</p>	03/02/2012			

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S0528	<p>[The comprehensive assessment must take into consideration the following factors:] (4) Imminence of death.</p> <p>Based on clinical record review and interview, the hospice failed to ensure the comprehensive assessment noted imminence of death 2 of 2 clinical records reviewed (#1 & 2) of patients that were direct admits to the inpatient hospice.</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record #1 included a comprehensive assessment dated 1/25/12 that failed to take into consideration the imminence of death. Clinical record #2 included a comprehensive assessment dated 1/28/12 that failed to take into consideration the imminence of death. On February 1, 2012, at 9:20 AM, Employee M, the Clinical Supervisor, indicated the software did not allow for this in the assessment. 	S0528	<p>Correction and Prevention: Implemented new policy, Assessment Procedure Policy #2156 (Attachment #2) which indicates that the comprehensive assessment includes imminence of death. Discontinued use of EHR and replaced it with a manual documentation system that includes all required components of the comprehensive assessment, and specifically imminence of death. Trained all hospice clinical staff on the requirements of documentation of imminence of death and how it impacts care planning. NP will review all initial and comprehensive assessments for compliance with all required components through 05/02/2012. This review will be added to the quality program. Person Responsible: Crissa Mulkey, RN, Clinical Supervisor</p>	03/02/2012	

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S0529	<p>[The comprehensive assessment must take into consideration the following factors:] (5) Severity of symptoms.</p> <p>Based on clinical record review and interview, the hospice failed to ensure the comprehensive assessment noted severity of symptoms in 2 of 2 clinical records reviewed (#1 & 2) of patients that were direct admits to the inpatient hospice.</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record #1 included a comprehensive assessment dated 1/25/12 that failed to take into consideration severity of symptoms. Clinical record #2 included a comprehensive assessment dated 1/28/12 that failed to take into consideration severity of symptoms. On February 1, 2012, at 9:20 AM, Employee M, the Clinical Supervisor, indicated the software did not allow for this in the assessment. 	S0529	<p>Correction and Prevention: Implemented new policy, Assessment Procedure Policy #2156 (Attachment #2) which indicates that the comprehensive assessment includes severity of symptoms. Discontinued use of EHR and replaced it with a manual documentation system that includes all required components of the comprehensive assessment, and specifically severity of symptoms. Trained all hospice clinical staff on the requirements of documentation of severity of symptoms and how it impacts care planning. NP will review all initial and comprehensive assessments for compliance with all required components through 05/02/2012. This review will be added to the quality program. Person Responsible: Crissa Mulkey, RN, Clinical Supervisor</p>	03/02/2012	

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S0531	<p>[The comprehensive assessment must take into consideration the following factors:]</p> <p>(7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.</p> <p>Based on clinical record review and interview, the hospice failed to ensure the comprehensive assessment included an initial bereavement assessment in 2 of 2 clinical records reviewed (#1 & 2) of patients that were direct admits to the inpatient hospice.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record #1 included a comprehensive assessment dated 1/25/12 that failed to include an initial bereavement assessment. 2. Clinical record #2 included a comprehensive assessment dated 1/28/12 that failed to include an initial bereavement assessment. 3. On February 1, 2012, at 9:20 AM, Employee N, the Social Worker, indicated there was a program but no assessment. 	S0531	<p>Correction and Prevention:</p> <p>Implemented new policy, Assessment Procedure Policy #2156 (Attachment #2) which indicates that the comprehensive assessment includes an initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the death. Information gathered from the initial assessment will be incorporated into the plan of care and considered in the bereavement plan of care. Discontinued use of EHR and replaced it with a manual documentation system that includes all required components of the comprehensive assessment, and specifically an initial bereavement assessment as described in the policy. Trained all hospice clinical staff on the requirements of documentation of an initial bereavement assessment and how it impacts care planning and the bereavement plan of care. NP</p>	03/02/2012
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			will review all initial and comprehensive assessments for compliance with all required components through 05/02/2012. This review will be added to the quality program. Person Responsible: Crissa Mulkey, RN, Clinical Supervisor		

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S0534	<p>(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.</p> <p>Based on clinical record review and interview, the hospice failed to ensure the comprehensive assessment noted data elements to allow for measurement of outcomes in 2 of 2 clinical records reviewed (#1 & 2) of patients that were direct admits to the inpatient hospice.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record #1 included a comprehensive assessment dated 1/25/12 that failed to include data elements to allow for measurement of outcomes. 2. Clinical record #2 included a comprehensive assessment dated 1/28/12 that failed to include data elements to allow for measurement of outcomes. 3. On February 1, 2012, at 9:20 AM, Employee M, the Clinical Supervisor, indicated the software did not allow for this in the assessment. 	S0534	<p>Correction and Prevention: Implemented new policy, Assessment Procedure Policy #2156 (Attachment #2) which indicates that the comprehensive assessment includes data elements to allow for measurement of outcomes. Discontinued use of EHR and replaced it with a manual documentation system that includes all required components of the comprehensive assessment, and specifically data elements to allow for measurement of outcomes. Trained all hospice clinical staff on the requirements of the comprehensive assessment and specifically the measurement of outcomes and how these data elements are part of the QAPI program. NP will review all initial and comprehensive assessments for compliance with all required components through 05/02/2012. This review will be added to the quality program. Person Responsible: Crissa Mulkey, RN, Clinical Supervisor</p>	03/02/2012	

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S0535	<p>(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 review and interview, the hospice failed to ensure the comprehensive assessment had data elements that were an integral part of the comprehensive assessment and could be documented in a systematic and retrievable way in 2 of 2 clinical records reviewed (#1 & 2) of patients that were direct admits to the inpatient hospice.</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record #1 included a comprehensive assessment dated 1/25/12 that failed to ensure data elements were an integral part of the comprehensive assessment and could be documented in a systematic and retrievable way. Clinical record #2 included a comprehensive assessment dated 1/28/12 that failed to ensure data elements were an integral part of the comprehensive assessment and could be documented in a systematic and retrievable way. 	S0535	<p>Correction and Prevention: Implemented new policy, Assessment Procedure Policy #2156 (Attachment #2) which indicates that data elements are an integral part of the comprehensive assessment and are documented in a systematic and retrievable way for each patient, the data elements are used in individual care planning and in coordination of services and are used in the aggregate in the QAPI program. Discontinued use of EHR and replaced it with a manual documentation system that includes all required components of the comprehensive assessment, and specifically patient outcome measures. Incorporated the following patient outcome measures into the QAPI program: dyspnea and pain. Trained all hospice clinical staff on the requirements of documentation of patient outcomes measures and how they should be used in individual care planning and how they are used in the aggregate in the QAPI program. NP will review all initial</p>	03/02/2012			

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	3. On February 1, 2012, at 9:20 AM, Employee M, the Clinical Supervisor, indicated the software did not allow for this in the assessment.		and comprehensive assessments for compliance with all required components through 05/02/2012. This review will be added to the quality program. Person Responsible: Crissa Mulkey, RN, Clinical Supervisor		

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S0559	Based on administrative record 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 for 1 of 1 hospice (See S 560), 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 (See S 561), the hospice failed to ensure a quality assessment/performance improvement program had been implemented that tracked and analyzed adverse patient events in 1 of 1 hospice (See S 562), 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 (See S 563), 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 (See S 564), the hospice failed to ensure the frequency and detail of the data collection	S0559	Correction and Prevention: Implemented a new policy Serious Adverse Events Policy #2025 (Attachment #3) that defines adverse event. Revised QAPI program to track and analyze adverse events. Revised QAPI program to specifically address quality measures pertinent to inpatient hospice care. The QAPI program will use patient care and other relevant quality indicators, monitor the safety and effectiveness of patient care activities and identified opportunities and priorities for improvement, will focus on high-risk, high-volume or problem prone areas and include activities that consider the incidence, prevalence, and severity of problem. The frequency and detail of the data collection will be approved by the governing body and the performance improvement activities will affect palliative outcomes, patient safety and quality of care. This will ensure the hospice maintains an effective, on-going, hospice-wide, data-driven QAPI program and the governing body will ensure that a QAPI program is defined and implemented, maintained and evaluated annually. All staff will be inserviced on the QAPI program and their role in it. Person Responsible: Valerie Wender, RN, Performance	02/16/2012			

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	<p>was approved by the hospice's governing body in 1 of 1 hospice (See S 565), 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 (See S 566), 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 (See S 567), 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 (See S 568), the hospice failed to ensure it had implemented performance improvement activities that tracked and analyzed adverse events in 1 of 1 hospice (See S 569), the hospice failed to ensure it had developed, implemented, and evaluated a performance improvement project in 1 of 1 hospice (See S 570), the hospice failed to ensure it had documented any performance improvement projects in 1 of 1 hospice (See S 572), the hospice failed to ensure it had documented any performance improvement projects in 1 of 1 hospice (See S 573), the governing body failed to ensure that a quality assessment/performance improvement program had been defined and implemented in 1 of 1 hospice (See S</p>		Improvement Coordinator	
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	574). The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with the requirements of this condition, 42 CFR 418.58 Quality Assessment and Performance Improvement.			
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S0560	<p>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 record 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.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide evidence of a quality assessment / performance improvement program that addressed program objectives, included all patient care disciplines and the scope of all hospice services; described how the program would be administered and coordinated, included a methodology for</p>	S0560	<p>Correction and Prevention: Revised QAPI Plan (Attachment #4) to evidence a QAPI program that addresses program objectives, includes all patient care disciplines and the scope of all hospice services; describes how the program will be administered and coordinated, includes a methodology for monitoring and evaluating care provided (PDCA); includes criteria to prioritize the resolution of any identified problems; addresses how monitoring of the effectiveness of the program will be accomplished; and how review of the program will be documented. Inpatient hospice care indicators as indicated on the QAPI Schedule (Attachment #5) that are part of the QAPI program include palliative care outcomes for dyspnea, pain, and falls. The pain indicator was</p>	03/02/2012			

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	<p>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 February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for hospice, and 4) documentation by the hospice registered nurse that the patient was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the</p>		<p>revised to include patients not able to rate their pain. Written interventions were developed and implemented to reach the benchmarks for the indicators. Revised the UTI data gathering purpose to tracking only to be sure no problems develop in this area. Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>				

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	<p>documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used, were not included in the pain data gathered.</p> <p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months</p>						

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	<p>the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>			
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S0561	<p>(1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.</p> <p>Based on administrative record 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.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice was unable to provide evidence a quality assessment / performance improvement program that addressed the measurement of indicators related to improved palliative outcomes and hospice services had been implemented. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the 	S0561	<p>Correction and Prevention: Inpatient hospice care indicators as indicated on the QAPI Schedule (Attachment #5) that are part of the QAPI program include palliative care outcomes for dyspnea, pain, and falls. The pain indicator was revised to include patients not able to rate their pain. Written interventions were developed and implemented to reach the benchmarks for the indicators. Other hospice services are included in the program as indicated on the QAPI Schedule (Attachment #5). Measurable improvement will be noted through quarterly monitoring and reporting by the Performance Improvement Coordinator to the IDG. Reports will be provided annually to the governing body. Monitoring and Reporting Completion Date: 2/28/2012 and quarterly beginning 7/2012. Reports to Governing Body: 2/2013 Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>	03/02/2012	

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	<p>electronic medical records used for hospice, and 4) documentation by the hospice registered nurse that the patient was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals,</p>						

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	<p>where a non verbal pain scale was used, were not included in the pain data gathered.</p> <p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>				

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S0562	<p>(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.</p> <p>Based on administrative record review and interview, the hospice failed to ensure a quality assessment / performance improvement program had been implemented that tracked and analyzed adverse patient events in 1 of 1 hospice reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice was unable to provide evidence a quality assessment / performance improvement program had been implemented that tracked and analyzed adverse patient events. 2. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the 	S0562	<p>Correction and Prevention: Implemented a new policy Serious Adverse Events Policy #2025 (Attachment #3) that defines adverse event. Revised QAPI program to track and analyze adverse events. Adverse events will be monitored on occurrence and reported to the IDG monthly by Performance Improvement Coordinator. Reporting will be provided quarterly to the governing body. Monitoring and Reporting Completion Date: 2/28/2012 Reports to Governing Body: 4/2012 Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>	03/02/2012

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	<p>electronic medical records used for hospice, and 4) documentation by the hospice registered nurse that the patient was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals,</p>						

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	<p>where a non verbal pain scale was used, were not included in the pain data gathered.</p> <p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p> <p>5. On February 1, 2012, at 4 PM, employee M indicated the hospice did not define an adverse patient event.</p>			
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S0563	<p>(1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.</p> <p>Based on administrative record 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.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice was unable to provide evidence of a quality assessment / performance improvement program that evaluated all patient services and activities. 2. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for hospice, and 4) documentation by the hospice registered nurse that the patient was educated on oxygen precautions if the 	S0563	<p>Correction and Prevention: Revised QAPI program to include all patient services and activities as indicated on the QAPI Schedule (Attachment #5). QAPI Schedule indicates frequency and detail of data collection and reporting for all indicators. Person Responsible: Valerie Wender, RN, Performance Improvement</p>	03/02/2012			

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	<p>patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used, were not included in the pain data gathered.</p>			
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	<p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151547	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/01/2012
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S0564	<p>(2) The hospice must use the data collected to do the following:</p> <p>(i) Monitor the effectiveness and safety of services and quality of care.</p> <p>(ii) Identify opportunities and priorities for improvement.</p> <p>Based on administrative record 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.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentary evidence of a quality assessment / performance improvement program that monitored the effectiveness and safety of services provided and identified opportunities and priorities for improvement.</p> <p>2. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's</p>	S0564	<p>Correction: Revised QAPI Plan (Attachment #4) to indicate monitoring of safety and effectiveness of patient care activities. Developed and implemented QAPI Schedule (Attachment #5) based on identified opportunities and priorities for improvement. Opportunities and priorities for improvement were identified by the IDG as indicated in the meeting minutes of 02/14/2012 (Attachment #6). Prevention: Routine monitoring and reporting will occur as identified in the QAPI Schedule (Attachment #5). Monitoring and Reporting Completion Date: Quarterly: 4/2012; Semi-Annual: 7/2012; Annual: 2/2013 Reports to Governing Body: 2/2013 Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>	03/02/2012	

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	<p>report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for hospice, and 4) documentation by the hospice registered nurse that the patient was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable</p>			
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	<p>pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used, were not included in the pain data gathered.</p> <p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>				

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S0566	<p>(1) The hospice's performance improvement activities must:</p> <p>(i) Focus on high risk, high volume, or problem-prone areas.</p> <p>Based on administrative record 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.</p> <p>The findings include:</p> <p>1. The hospice was unable to provide documentary evidence of a quality assessment / performance improvement program that focused on high risk, high volume, or problem -prone areas.</p> <p>2. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for hospice, and 4) documentation by the hospice registered nurse that the patient</p>	S0566	<p>Correction: The IDG selected and governing body approved a performance improvement project (PIP) for 2012 for inpatients based on high-risk, high-volume, or problem-prone areas and in consideration of incidence, prevalence, and severity. The project chosen is: falls on the inpatient unit. Patient care indicators for the inpatient hospice were chosen for the QAPI program based on high-risk, high-volume, or problem-prone areas and in consideration of incidence, prevalence, and severity. See attached QAPI Schedule (Attachment #5). Prevention: The IDG and governing body will ensure that at least one PIP is completed annually. This will be part of the annual review of the program. The QAPI indicator selection and prioritization process will include the criteria: high-risk, high-volume, and problem-prone as well as severity, incidence, and prevalence. See Process Improvement Project (PIP) form (Attachment #7). Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>	03/02/2012			

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	<p>was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used, were not included in the pain data gathered.</p>			
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	<p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>			
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S0567	<p>[The hospice's performance improvement activities must:] (ii) Consider incidence, prevalence, and severity of problems in those areas.</p> <p>Based on administrative record 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.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice was unable to provide documentary evidence the hospice had implemented performance improvement activities that considered incidence, prevalence, and severity of problems in the chosen areas. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for hospice, and 4) documentation by the 	S0567	<p>Correction: The IDG selected and governing body approved a performance improvement project (PIP) for 2012 for inpatients based on high-risk, high-volume, or problem-prone areas and in consideration of incidence, prevalence, and severity. The project chosen is: falls on the inpatient unit. Patient care indicators for the inpatient hospice were chosen for the QAPI program based on high-risk, high-volume, or problem-prone areas and in consideration of incidence, prevalence, and severity. See attached QAPI Schedule (Attachment #5). Prevention: The IDG and governing body will ensure that at least one PIP is completed annually. This will be part of the annual review of the program. The QAPI indicator selection and prioritization process will include the criteria: high-risk, high-volume, and problem-prone as well as severity, incidence, and prevalence. See Process Improvement Performance (PIP) form (Attachment #7) and Performance Improvement Project (PIP) Selection and Reporting Document (Attachment #8). Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>	03/02/2012			

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	<p>hospice registered nurse that the patient was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used, were not included in the pain data</p>						

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	<p>gathered.</p> <p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>				

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S0568	<p>[The hospice's performance improvement activities must:] (iii) Affect palliative outcomes, patient safety, and quality of care.</p> <p>Based on administrative record and hospice 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.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice was unable to provide evidence of a quality assessment / performance improvement program that included activities that affected palliative outcomes, patient safety, and quality of care. 2. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for 	S0568	<p>Correction: Inpatient hospice care indicators as indicated on the QAPI Schedule (Attachment #5) that are part of the QAPI program include activities that affect palliative care outcomes (dyspnea, pain, and falls), patient safety (falls), and quality of care (dyspnea, pain, and falls). The pain indicator was revised to include patients not able to rate their pain. Written interventions were developed and implemented to reach the benchmarks for the indicators. Revised the UTI data gathering purpose to tracking only to be sure no problems develop in this area. A PIP on falls was developed and implemented to affect palliative care outcomes, patient safety, and quality of care. Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>	03/02/2012			

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	<p>hospice, and 4) documentation by the hospice registered nurse that the patient was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used,</p>			
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	<p>were not included in the pain data gathered.</p> <p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>				

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S0569	<p>(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 record 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.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice was unable to provide evidence of a quality assessment / performance improvement program that tracked and analyzed adverse events and implemented preventive actions and mechanisms. 2. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for 	S0569	Correction and Prevention: Implemented a new policy Serious Adverse Event Policy #2025 (Attachment #3) that defines adverse event. Revised QAPI program to track and analyze adverse events. All staff will be inserviced on the QAPI program and their role in it. Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator	03/02/2012			

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	<p>hospice, and 4) documentation by the hospice registered nurse that the patient was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used,</p>				

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	<p>were not included in the pain data gathered.</p> <p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p> <p>5. On February 1, 2012, at 4 PM, employee M indicated the hospice did not define an adverse patient event.</p>			
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S0570	<p>(3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.</p> <p>Based on administrative record and interview, the hospice failed to ensure it had developed, implemented, and evaluated a performance improvement project in 1 of 1 hospice reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice was unable to provide evidence any performance improvement projects had been developed and implemented. 2. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for hospice, and 4) documentation by the hospice registered nurse that the patient 	S0570	<p>Correction: The IDG selected and governing body approved a performance improvement project (PIP) for 2012 for inpatients based on high-risk, high-volume, or problem-prone areas and in consideration of incidence, prevalence, and severity. The project chosen is: falls on the inpatient unit. The PIP was implemented and will be documented on Performance Improvement Project (PIP) Selection and Reporting document (Attachment #8) and evaluated through reporting quarterly, at minimum.</p> <p>Prevention: The IDG and governing body will ensure that at least one PIP is completed annually. This will be part of the annual review of the program. PIP Evaluation Completion Date: 2nd Quarter Calendar Year 2012 Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>	03/02/2012	

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	<p>was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used, were not included in the pain data gathered.</p>						

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	<p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>			
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S0572	<p>(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.</p> <p>Based on administrative record review and interview, the hospice failed to ensure it had documented any performance improvement projects in 1 of 1 hospice reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice was unable to provide evidence any performance improvement projects had been implemented. 2. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for hospice, and 4) documentation by the 	S0572	<p>Correction: The IDG selected and governing body approved a performance improvement project (PIP) for 2012 for inpatients based on high-risk, high-volume, or problem-prone areas and in consideration of incidence, prevalence, and severity. The project chosen is: falls on the inpatient unit. The PIP was implemented and will be documented on Performance Improvement Project (PIP) Selection and Reporting Document (Attachment #8) and evaluated through reporting quarterly, at minimum.</p> <p>Prevention: The IDG and governing body will ensure that at least one PIP is completed annually. This will be part of the annual review of the program. PIP Evaluation Completion Date: 2nd Quarter Calendar Year 2012 Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>	03/02/2012	

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	<p>hospice registered nurse that the patient was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used, were not included in the pain data</p>						

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	<p>gathered.</p> <p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>				

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S0573	<p>(2)The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.</p> <p>Based on administrative record review and interview, the hospice failed to ensure it had documented any performance improvement projects in 1 of 1 hospice reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice was unable to provide documentary evidence any performance improvement projects had been implemented. 2. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for hospice, and 4) documentation by the hospice registered nurse that the patient was educated on oxygen precautions if the 	S0573	<p>Correction: The IDG selected and governing body approved a performance improvement project (PIP) for 2012 for inpatients based on high-risk, high-volume, or problem-prone areas and in consideration of incidence, prevalence, and severity. The project chosen is: falls on the inpatient unit. The PIP was implemented and will be documented on Performance Improvement Project (PIP) Selection and Reporting Document (Attachment #8) and evaluated through reporting quarterly, at minimum.</p> <p>Prevention: The IDG and governing body will ensure that at least one PIP is completed annually. This will be part of the annual review of the program.PIP Evaluation Completion Date: 2nd Quarter Calendar Year 2012Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>	03/02/2012	

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	<p>patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used, were not included in the pain data gathered.</p>			
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	<p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>			
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S0574	<p>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.</p> <p>Based on administrative record 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.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice was unable to provide evidence the governing body had defined and implemented a quality assessment / performance improvement program. 2. On February 1, 2012, at 1:50 PM, employee M indicated the hospice's quality assessment/performance improvement (QA/PI) program focus in 2011 and continuing into 2012 was 1) patients admitted with reported constipation; 2) for patients that report pain at admission and are able to rate and set their own pain goal, these patient's report if they met their set pain goal within 2 days of admission; 3) staff training on the software change for the electronic medical records used for hospice, and 4) documentation by the 	S0574	<p>Correction and Prevention: Implemented a new policy Serious Adverse Event Policy #2025 (Attachment #3) that defines adverse event. Revised QAPI program to track and analyze adverse events. Revised QAPI program to specifically address quality measures pertinent to inpatient hospice care. The QAPI program will use patient care and other relevant quality indicators, monitor the safety and effectiveness of patient care activities and identified opportunities and priorities for improvement, will focus on high-risk, high-volume or problem prone areas and include activities that consider the incidence, prevalence, and severity of problem. The frequency and detail of the data collection will be approved by the governing body and the performance improvement activities will affect palliative outcomes, patient safety and quality of care. This will ensure the hospice maintains an effective, on-going, hospice-wide, data-driven QAPI program and the governing body will ensure that a QAPI program is defined and implemented, maintained and evaluated annually. All staff</p>	03/02/2012			

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	<p>hospice registered nurse that the patient was educated on oxygen precautions if the patient was ordered oxygen at admission. Employee M indicated that because the hospice employs few registered nurses, that when the benchmarks are not met, the individual nurse is counseled; she indicated there was not written interventions developed and implemented to reach the set benchmarks. She further indicated the home health associate that tabulates the data, reviews the documentation from the comprehensive assessment and skilled nurse visit notes. If a patient was ordered a narcotic for pain at admission, then the patient's record is included in the data collection under "constipation" and is considered to have met this indicator of "on a bowel program" if at admission a stool softener or other stimulant was ordered with the ordered narcotic. She confirmed that if the patient was admitted with constipation and not ordered a narcotic at admission, then that patient would not be included in the data collection. In regards to the collection of pain data, she indicated that only those patients that could verbalize and set an individualized and acceptable pain level goal were included in the pain data collection. Those patients that could not rate their pain or set individual goals, where a non verbal pain scale was used, were not included in the pain data</p>		<p>will be inserviced on the QAPI program and their role in it. Annual Evaluation Completion Date: 1st Quarter 2013 for Performance in Calendar Year 2012 Person Responsible: Valerie Wender, RN, Performance Improvement Coordinator</p>				

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	<p>gathered.</p> <p>3. The administrative documents indicated the hospice had collected information on 1) urinary tract device related urinary tract infections per 1000 Foley catheter days, 2) urinary tract device related urinary tract infections per 1000 supra pubic catheter days, and 3) infusion device - related infections per 1000 device days for the previous 15 months and for each of the last 15 months the result was zero each month. On February 1, 2012, at 5:20 PM, employee M indicated documentation was not available to support why the hospice was collecting this data and indicated these were not problems that were identified for their hospice patients.</p> <p>4. On February 1, 2012, at 5:20 PM, the acting administrator, employee M, indicated she was not able to gain access to the meeting minutes of the QA/PI program as the employee that gathers the information, a home health care employee, was out of the office.</p>				

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S0733	<p>The hospice must maintain an infection control program that protects patients, staff and others by preventing and controlling infections and communicable disease as stipulated in §418.60.</p> <p>Based on document review and interview, the hospice failed to ensure the inpatient hospice unit had a infection control program in 1 of 1 in-centers reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence an infection control program for the inpatient unit. 2. On February 1, 2012, at 4 PM, employee M indicated the hospice did not have an infection control program for the inpatient hospice. 	S0733	<p>Correction and Prevention: Implemented Inpatient Hospice Infection Control Program supported by a written Inpatient Hospice Infection Control Plan (Attachment # 9). The program is designed to protect patient, families, associates, and others from infections and communicable diseases. The Plan takes into account prevention, early detection, control, education, and investigation of communicable diseases. The Infection Control Program will be evaluated on an annual basis and corrective actions taken when necessary. Person Responsible: Crissa Mulkey, RN, Clinical Supervisor</p>	03/02/2012	