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 01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY HOSPICE	103 S GRANT AVE FOWLER, IN 47944

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L0000	This was a revisit for a hospice federal and state complaint investigation. Facility number: 003308 Survey date: January 17, 2013 Medicaid vender number: 200378060 Surveyor: Bridget Boston, RN, Public Health Nurse Surveyor During this survey, three condition level and twenty - three standard level deficiencies were corrected, six standard level deficiencies were recited, and one new standard level deficiency was cited. Quality Review: Joyce Elder, MSN, BSN, RN January 23, 2013	L0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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L0522	418.54(a) INITIAL ASSESSMENT The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with §418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.) Based on clinical record review and interview, the hospice failed to ensure the registered nurse completed an initial assessment within 48 hours of the election of hospice care for 1 of 2 records reviewed with date of election after 1/3/13 with the potential to affect all new patients of the hospice. (# 15) Findings include: 1. Clinical record #15, election of hospice care dated 1/14/13, failed to evidence the registered nurse completed an initial or comprehensive assessment. 2. On 1/17/13 at 4:05 PM, employee B indicated the patient was assessed on 1/14/13 by employee H, a registered nurse, who made the initial nurse visit and had not yet documented the visit on an initial or comprehensive document.	L0522	**L522** The hospice registered nurse will complete an initial assessment within 48 hours after the election of the hospice benefit. Through the Initial Assessment, critical information necessary to meet the patients needs will be gathered through the assessment process. In addition, the support system will also be evaluated. The clinical record will reflect the assessment is clearly documented on the appropriate clinical form and met the required time frame. The Patient Care Manager or delegate will review the Initial Assessment for all future admissions within 24 hours of the admission to ensure documentation is complete. Chart #15 was completed (RN notes transferred to the Initial Assessment form reflecting late entry) Pt expired on 1/17/2013. The process was refined and fully implemented on 1/28/2013.	01/28/2013

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L0530	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: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. 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 2 of 2 records reviewed of patients who received hospice services for more than 5 days with the potential to affect all new patients of the hospice. (#s 14 and 16) Findings include: 1. Clinical record #14, start of care (SOC) 1/11/13, failed to evidence a medication review had been completed as	L0530	**L530** All Comprehensive Assessments will include a medication review which evaluates the patient as an individual. This includes assessment of the patients history, effectiveness of the drug therapy, side effects, actual or potential drug interactions, duplicate drug therapy, current or associated lab monitoring. The hospice policy and procedure was updated in Dec 2012 to reflect the importance of individualized assessment and interventions. The Hospice system was further refined in January 2013. The hospice Medication Profile will be completed by the assigned Case Manager which is an addendum to the Comprehensive Assessment. Upon admission, the Medication Profile and Medication Side Effects Reference are completed as part of	02/01/2013

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	part of the comprehensive assessment. 2. Clinical record # 16, SOC 11/28/12, failed to evidence a medication review had been completed as part of any updates to the comprehensive assessment. 3. On 1/17/13 at 12 PM, employee B indicated clinical record 14 did not evidence completion of the medication review as part of the comprehensive assessment. At 4:56 PM, employee B indicated there was no documentation of a medication review for clinical record 16.		the Comprehensive Assessment. The Hospice Medication Profile will be completed in it's entirety which includes the Extended Care Facility / Home Hospice Medication Policy and Procedure Review portion of the assessment. A copy of the policy and procedure will be provided to the patient / responsible party upon admission. Education will be provided regarding safe use, misuse, disposal and the management of controlled drugs. The assessment will determine if the patient or responsible party can safely administer medications. An individualized plan of care will be developed to reflect known risk indicators related to medications, over the counter, supplements and method of medication management for all current and future patients. Record #14 and #16 were audited and the Medication Policy and Procedure Review portion of the Medication profile was completed.	

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L0533	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. Based on clinical record and policy 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 1 of 1 active record reviewed of patients who received services for more than 15 days with the potential to affect all the patients of the hospice. (16) Findings include: 1. Clinical record # 16, with an election date and an established plan of care date of 11-28-2012, failed to evidence an update to the comprehensive assessment with outcomes that were documented and measurable.	L0533	**L533** The Comprehensive Assessment will be reviewed and updated by all members of the IDG for recertification and with significant change. Individualized plans of care will be developed for each patient by each discipline utilizing a collaborative approach. Patient review and care plan updates will be part of the IDG. Comprehensive Assessments will be updated for recertification and with significant changes. All disciplines were reeducated regarding developing individualized care plans to include but not limited to decline in patient care, non pharmacological methods to treat pain / symptoms, patient family education, pain assessment and monitoring medication changes. Data Elements are clearly outlined and additional assessments were implemented for	02/01/2013

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	2. On 1/17/13 at 4:56 PM, employee B indicated there was no further documentation when asked. 3. 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."		pain, falls, wounds, and bowel protocols. Additional Data Elements will be identified through future assessments. Comprehensive Assessments were updated for pt #16 and process was refined for all current and future patients.	

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L0534	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 review and interview, the hospice failed to ensure measurable data elements were identified by the hospice, incorporated into the comprehensive assessment, and collected in the same manner for all patients for 1 of 1 current clinical record reviewed of patients admitted after 1/3/13 which contained an initial or comprehensive assessment with the potential to affect all the hospice's patients. (# 14) Findings include: 1. Clinical record number 14 evidenced an election of hospice dated 1/11/13 and a comprehensive assessment dated 1/12/13 titled, "Hospice Initial / Comprehensive Nursing Assessment." The record failed to evidence any measurable data elements were collected from an initial or comprehensive assessment. 2. On 1/17/13 at 10 AM, employee B indicated the hospice had not yet	L0534	**L534** All measurable Data Elements will be collected and tracked in the same manner for all patients and incorporated into the Comprehensive Assessment. Data Elements will be identified on each Comprehensive Assessment. When the following areas are triggered during the assessment expanded assessments will be completed for pain, falls, wounds and bowels. Care plans will be individualized to reflect the identified risk indicators with related interventions developed to resolve and/or manage known risks. Utilizing critical thinking skills, team collaboration and Data Element triggers, the plan of care will be revised with each recertification and with significant changes. Data Elements will be identified and care planned for patient #14. Patient Care Manager will monitor during review of the comprehensive assessment and track risks and outcomes through QAPI.	02/01/2013

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	identified the specific data elements to be collected and the specific time points for data collection.			

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L0535	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. Based on clinical record review and interview, the hospice failed to ensure comprehensive assessment included measurable data elements that were documented in a systematic way for each patient, were used in individual patient care planning, and were collected for use in quality assessment and performance improvement activities in 1 of 1 clinical record reviewed of patients that were admitted after 1/3/13 and evidenced a comprehensive assessment. (# 14) Findings include: 1. Clinical record number 14 evidenced a signed election of the medicare benefit dated 1/11/13 and a comprehensive assessment dated 1/12/13 titled, "Hospice Initial / Comprehensive Nursing Assessment." The record failed to evidence any measurable data elements were collected from an initial or comprehensive assessment.	L0535	**L535** All measurable Data Elements will be collected and tracked in the same manner for all patients and incorporated into the Comprehensive Assessment. Data Elements will be identified on each Comprehensive Assessment. When the following areas are triggered during the assessment expanded assessments will be completed for pain, falls, wounds and bowels. Care plans will be individualized to reflect the identified risk indicators with related interventions developed to resolve and/or manage known risks. Utilizing critical thinking skills, team collaboration and Data Element triggers, the plan of care will be revised with each recertification and with significant changes. Data Elements will be identified and care planned for patient #14. PCM will monitor during review of the comprehensive assessment and track risks and outcomes through QAPI.	02/01/2013

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	2. On 1/17/13 at 10 AM, employee B indicated the hospice had not yet identified the specific data elements to be collected and the specific time points for data collection.			

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L0548	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. Based on clinical record and policy review, the hospice failed to ensure the written plan of care included interventions based on assessments and included measurable outcomes anticipated from implementing and coordinating the plan of care in 2 (#s 14 and 16) of 2 records reviewed of patients on service for more than 5 days with the potential to affect all hospice patient's. The findings include: 1. Clinical record # 14, with an election date 1/11/13 and an established plan of care for the certification period 1/11/13 through 4/11/13, failed to evidence measurable outcomes for the patient and family / caregivers based on the comprehensive assessment and any changes identified since the comprehensive assessment. 2. Clinical record # 16, with an election date 11/28/12 and an established plan of care for the certification period 11/28/12 through 2/25/13, failed to evidence	L0548	**L548** 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 measurable outcomes by utilizing the SMART approach to care plan development (Specific-Measurable-Attainable-Realistic-Timelined) All disciplines will be provided an in-service with return demonstration regarding the development of SMART goals. Individualized care plans will be reviewed within five days from the start of care, recertification and significant change. All disciplines will document review and update to the plan of care. All disciplines will be reeducated regarding the importance of collaboration and individualized interventions. Individualized care plans were created for patients #14 and #16. Concepts will be implemented for all current and future patients.	02/01/2013

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	specific interventions and measurable outcomes for the patient and family / caregivers based on the comprehensive assessment and any changes identified since the comprehensive assessment and from updated comprehensive assessments. 3. 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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L0553	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 and interview, 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 1 of 1 record reviewed of patients on service for more than 15 days with the potential to affect all the hospice patients. (# 16) The findings include: 1. Clinical record # 16, with an election date and an established plan of care date of 11/28/12, evidenced a document titled "Hospice IDG Meeting / Care Plan Update" dated 12/27/12. The record failed to evidence an update to the comprehensive assessment. 2. On 1/17/13 at 4:56 PM, employee B indicated the patient was currently on service and the last IDG meeting was held on 1/10/13. Employee B indicated there was no further documentation to	L0553	**L553** Through a collaborative effort, the interdisciplinary team will review and revise individualized care plans during recertification and with significant changes. Care plans will be initiated at the start of care, during recertification and with a significant change. Patient progress toward specific goals and desired outcomes will be monitored and adjusted accordingly. The hospice changed the process to include a signature form indicating the collaborative care plan review occurred and an individualized care plan was created and/or revised. This concept will be implemented for all current and future patients. The plan of care for pt #16 was developed and implemented.	02/01/2013

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	evidence. 3. 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."			