

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151569		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/30/2013	
NAME OF PROVIDER OR SUPPLIER SPENCER COUNTY HOSPICE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 225 MAIN ST ROCKPORT, IN 47635			
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L000000	<p>This was a hospice federal recertification and state re-licensure survey.</p> <p>Survey Dates: 8-8-28-13, 8-29-13, and 8-30-13</p> <p>Facility #: 010652</p> <p>Medicaid Vendor #: 200257590A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>September 5, 2013</p>	L000000					

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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L000545	<p>418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care addressed needs identified in the comprehensive assessments in 4 (#s 2, 5, 6, & 8) of 11 records reviewed creating the potential to affect all of the hospice's 4 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 included a comprehensive nursing assessment completed by the registered nurse (RN), employee H, on 8-23-13. The assessment states, "This pt [patient] is used to being in control of every aspect of [the patient's] life & is finding it hard to adjust to [the patient's] new reality. [The patient] states, 'I never intended to die a slow lingering death & planned to die like my father, walking out to get the mail & just dropping over. Sometimes I get 	L000545	L 545Patient 5, 6, and 8 are deceased. Clinical record #2 was reviewed and revised by the IDT on 9/27/13 to reflect needs identified in the updated comprehensive assessment. The plan of care has individualized interventions/goals and measurable outcomes to meet patients identified psychosocial needs. Education provided to all applicable staff on 9/27/13. Education included instruction on problems identified in comprehensive assessment flowing into the plan of care. The Client Care Coordinator will be responsible for monitoring that problems identified in the assessment are identified on the plan of care to ensure that this deficiency is corrected and will not occur again.	09/27/2013

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	<p>aggravated & hard to get along with when I think about it."</p> <p>A. The plan of care, established by the interdisciplinary group (IDG) on 8-21-13, failed to evidence interventions to address the patient's identified psychosocial needs.</p> <p>B. An update to the plan of care, dated 8-28-13, states, "Ineffective Coping/Impaired Communication: . . . Pt coping within [the patient's] normal ability - frustrated because 'I can't do what I want to do & because I wanted to take care [the patient's spouse]." The update failed to evidence interventions specific to the identified psychosocial needs.</p> <p>2. Clinical record number 5 included an initial psychosocial assessment completed by the MSW, employee I, on 10-19-12. The assessment states, "The patient, at [the spouse's] urging, agreed for me to explain Hospice care to [the patient]. When assessor used the term 'end of life' patients expression/affect completely changed - [the patient] seemed to go blank. [The spouse] believes this to be a combination of denial and confusion . . . The couple both report . . . that patients death will be very difficult for their 15 yo [year old] [child] . . . [The spouse] also concerned about 1. cost of funeral 2.</p>						

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	<p>respite (some help from neighbors)." The plan of care, established by the IDG on 10-15-12, failed to evidence interventions to address the identified psychosocial needs.</p> <p>3. Clinical record number 6 included an initial psychosocial assessment completed by the MSW, employee D, on 12-16-12. The assessment identifies multiple financial concerns, significant losses of friends and/or family members, communication issues within the family, and past substance abuse issues. The plan of care, established by the IDG on 12-10-12, failed to evidence interventions to address the specific identified psychosocial needs.</p> <p>4. Clinical record number 8 included an initial psychosocial assessment completed by the MSW, employee D, on 2-7-13. The assessment identifies a risk potential related to "death will mean loss of constant companion/emotional support", "excessive or prolonged emotional problems/mental illness" and "lack of community support." The plan of care, established by the IDG on 2-5-13, failed to evidence interventions to monitor the patient's psychosocial status and address any needs that arise.</p> <p>5. The patient care coordinator, employee</p>				

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	<p>B, was unable to provide any additional documentation and/or information when asked on 8-30-13 at 12:40 PM.</p> <p>6. The hospice's undated "Plan of Care - Content" policy number REG.P30 states, "The plan of care reflects patient and family goals and interventions that are based on the problems identified in the initial, comprehensive, and updated assessments."</p>			

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L000547	<p>418.56(c)(2) 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:] (2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care included a specific frequency of visits for medical social services (MSS) and spiritual care counseling (SCC) visits in 11 (#s 1-11) of 11 records reviewed creating the potential to affect the hospice's 4 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 1 included a plan of care established by the interdisciplinary group (IDG) on 8-2-13. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care identifies the MSW and SCC are to visit "prn [as needed]." Clinical record number 2 included a plan of care established by the IDG on 8-21-13. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care identifies the MSW and SCC are to visit "prn." 	L000547	L 547Patient 1 and 3-11 are deceased. Clinical record #2 was reviewed and revised on 9/27/13 by the IDT to reflect needs identified on the updated comprehensive assessment. Education was provided to all clinical staff to address content of plan of care needing to include a specific frequency for visits based on patient/family needs identified in the assessment and the proper use of "PRN"- will use specific time frequency. The Client Care Coordinator will be responsible for monitoring that the plan of care includes specific range of visits for all disciplines as applicable.	09/27/2013			

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	<p>3. Clinical record number 3 included a plan of care established by the IDG on 8-26-13. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care identifies the MSW and SCC are to visit "prn."</p> <p>4. Clinical record number 4 included a plan of care established by the IDG on 2-8-12 and updated on 7-31-13, 8-14-13, and 8-28-13. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care and updates identify the MSW and SCC are to visit "prn."</p> <p>5. Clinical record number 5 included a plan of care established by the IDG on 10-15-12. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care identifies the MSW and SCC are to visit "prn."</p> <p>6. Clinical record number 6 included a plan of care established by the IDG on 12-10-12. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care identifies the MSW and SCC are to visit "prn."</p>			

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	<p>7. Clinical record number 7 included a plan of care established by the IDG on 12-19-12. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care identifies the MSW and SCC are to visit "prn."</p> <p>8. Clinical record number 8 included a plan of care established by the IDG on 2-4-13. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care identifies the MSW and SCC are to visit "prn."</p> <p>9. Clinical record number 9 included a plan of care established by the IDG on 7-12-13. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care identifies the MSW and SCC are to visit "prn."</p> <p>10. Clinical record number 10 included a plan of care established by the IDG on 8-24-13. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care identifies the MSW and SCC are to visit "prn."</p> <p>11. Clinical record number 11 included a plan of care established by the IDG on</p>						

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	<p>12-18-12. The plan of care failed to evidence a specific frequency of visits for MSS and SCC visits. The plan of care identifies the MSW and SCC are to visit "prn."</p> <p>12. The patient care coordinator, employee B, indicated, on 8-30-13 at 12:40 PM, records numbered 1 through 11 did not evidence a specific frequency of visits for MSS and SCC services.</p> <p>13. The hospice's undated "Plan of Care - Content" policy number REG.P30 states, "The plan of care includes, but is not limited to: . . . a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs."</p>			

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L000548	<p>418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care included measurable goals and outcomes in 11 (#s 1 through 11) of 11 records reviewed creating the potential to affect all of the hospice's 4 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical records numbered 1 through 11 included standardized plans of care established by the interdisciplinary group (IDG). The plans of care included the same non-specific goals and outcomes for each identified problem. The plans of care failed to evidence the outcomes were individualized to the patient and were specific enough to be measured. <p>A. Clinical record number 1 included a plan of care established by the interdisciplinary group (IDG) on 8-2-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p>	L000548	<p>L 548Patient 1 and 3-11 are deceased. Plan of care for clinical record #2 was reviewed and revised by the IDT on 9/27/13. Identified problems and expected outcomes 1-6 were revised to reflect individualized interventions/goals and measurable outcomes. The problems on the plan of care are based directly on the assessment of the patient. Education provided to all clinical staff on the use of the plan of care form. Education included instruction on individualizing interventions/goals and utilizing measurable outcomes. The Client Care Coordinator will be responsible for auditing 100% of all plans of care over the next three months and include this information in the QAPI program. Goal is that 100%of the plans of care will be in-compliance with L 548.</p>	09/27/2013	

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	<p>1.) "Impaired elimination R/T [related to] limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p> <p>2.) "Nutrition/hydration changes" with the expected outcomes of "Patients / family / caregivers accept nutritional changes as part of disease process" and "Patient will have adequate nutrition and stable weight per pt's [patient's] desire."</p> <p>3.) "Social isolation" with the expected outcome "Patient will participate in activities as tolerated/desires."</p> <p>4.) "Spiritual comfort: Alteration in needs for spiritual support" with the expected outcome "Improves/maintains communication or relationship with individuals from faith community or within belief system."</p> <p>5.) "Alteration in perceived quality of life from fatigue / progression of terminal illness" with the expected outcome "Patient will remain active and independent within disease process limits."</p>			

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	<p>6.) "Grief associated with anticipatory life changes and losses for patient. Family Grief related to anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding losses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p> <p>B. Clinical record number 2 included a plan of care established by the IDG on 8-21-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) "Impaired elimination R/T limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p> <p>2.) "Nutrition / hydration changes" with the expected outcomes of "Patient / family / caregivers accept nutritional changes as part of disease process" and "Patient will have adequate nutrition and stable weight."</p> <p>3.) "Impaired skin integrity, actual</p>			

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	<p>or potential, secondary to immobility and nutritional deficits" with the expected outcome "Skin will be maintained at optimum integrity in the presence of advanced disease process" and "Patient will report comfort."</p> <p>4.) "Spiritual comfort: Alteration in needs for spiritual support" with the expected outcome "Improves / maintains communication or relationship with individuals from faith community or within belief system."</p> <p>5.) "Alteration in perceived quality of life from fatigue / progression of terminal illness" with the expected outcome "Patient will remain active and independent within disease process limits."</p> <p>6.) "Grief associated with anticipatory life changes and losses for patient. Family Grief related to anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding losses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p> <p>C. Clinical record number 3 included a plan of care established by the IDG on</p>			

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	<p>8-26-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) "Cognition: Impaired cognition and decision making ability" with the expected outcome "Patient's safety and comfort will be maintained" and "Patient's wishes for care will be respected and followed."</p> <p>2.) "Adjustment in coping with health status changes: impaired/ineffective" with the expected outcome "Patient / family / caregiver acknowledge changing relationships and improve / maintain system of support within family", "Patient / family / caregiver accepts help needed to maximize control and meet adjustment / coping goals", and "Patient's financial resources will be maximized."</p> <p>3.) "Impaired elimination R/T limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p> <p>4.) "Neurological deficits" with the expected outcome "Patient will be safe</p>			

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	<p>and needs will be met as neurological status declines."</p> <p>5.) "Impaired sensory function and communication" with the expected outcome "Patient will function at optimal levels, for disease process, despite sensory losses."</p> <p>6.) "Impaired skin integrity, actual or potential, secondary to immobility and nutritional deficits" with the expected outcome "Skin will be maintained at optimum integrity in the presence of advanced disease process" and "Patient will report comfort."</p> <p>7.) "Spiritual comfort: Alteration in needs for spiritual support" with the expected outcome "Improves/maintains communication or relationship with individuals from faith community or within belief system."</p> <p>8.) "Alteration in perceived quality of life from fatigue / progression of terminal illness" with the expected outcome "Patient will remain active and independent within disease process limits."</p> <p>9.) "Grief associated with anticipatory life changes and losses for patient. Family Grief related to</p>			

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	<p>anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding looses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p> <p>D. Clinical record number 4 included a plan of care established by the IDG on 2-8-12 and updated on 7-31-13, 8-14-13, and 8-28-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) "Behavior/Psych: Presence of behavioral symptoms that may be harmful to self or others or interfering with function or care" with the expected outcomes "Patient will be safe and free from injury to self and others", "Psychotropic side effects will be minimized", and "Medications will be effective."</p> <p>2.) "Cognition: Impaired cognition and decision making ability" with the expected outcome "patient's safety and comfort will be maintained" and "patient's wishes for care will be respected and followed."</p>						

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	<p>3.) "Adjustment in coping with health status changes: impaired/ineffective" with the expected outcome "Patient / family / caregiver acknowledge changing relationships and improve/maintain system of support within family", "Patient / family / caregiver accepts help needed to maximize control and meet adjustment / coping goals", and "Patient's financial resources will be maximized."</p> <p>4.) "Impaired elimination R/T limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p> <p>5.) "Neurological deficits" with the expected outcome " Patient will be safe and needs will be met as neurological status declines."</p> <p>6.) "Nutrition / hydration changes" with the expected outcomes of "Patient/family/caregivers accept nutritional changes as part of disease process" and "Patient will have adequate nutrition and stable weight."</p> <p>7.) "Impaired sensory function and communication" with the expected outcome "Patient will function at optimal</p>			

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	<p>levels, for disease process, despite sensory losses."</p> <p>8.) "Impaired skin integrity, actual or potential, secondary to immobility and nutritional deficits" with the expected outcome "Skin will be maintained at optimum integrity in the presence of advanced disease process" and "Patient will report comfort."</p> <p>9.) "Spiritual comfort: Alteration in needs for spiritual support" with the expected outcome "Improves / maintains communication or relationship with individuals from faith community or within belief system."</p> <p>10.) "Grief associated with anticipatory life changes and losses for patient. Family Grief related to anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding losses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p> <p>E. Clinical record number 5 included a plan of care established by the IDG on 10-15-12. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and</p>			

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	<p>expected outcomes included the following:</p> <p>1.) "Cognition: Impaired cognition and decision making ability" with the expected outcome "patient's safety and comfort will be maintained" and "Patient's wishes for care will be respected and followed."</p> <p>2.) "Adjustment in coping with health status changes: impaired/ineffective" with the expected outcome "Patient/family/caregiver acknowledge changing relationships and improve/maintain system of support within family", "Patient/family/caregiver accepts help needed to maximize control and meet adjustment/coping goals", and "Patient's financial resources will be maximized."</p> <p>3.) "Impaired elimination R/T limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p> <p>4.) "Nutrition / hydration changes" with the expected outcomes of "Patient / family / caregivers accept nutritional changes as part of disease process" and "Patient will have adequate nutrition and</p>			

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	<p>stable weight."</p> <p>5.) "Impaired skin integrity, actual or potential, secondary to immobility and nutritional deficits" with the expected outcome "Skin will be maintained at optimum integrity in the presence of advanced disease process" and "Patient will report comfort."</p> <p>6.) "Spiritual comfort: Alteration in needs for spiritual support" with the expected outcome "Improves/maintains communication or relationship with individuals from faith community or within belief system."</p> <p>7.) "Grief associated with anticipatory life changes and losses for patient. Family Grief related to anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding losses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p> <p>F. Clinical record number 6 included a plan of care established by the IDG on 12-10-12. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the</p>						

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	<p>following:</p> <p>1.) "Cognition: Impaired cognition and decision making ability" with the expected outcome "Patient's safety and comfort will be maintained" and "Patient's wishes for care will be respected and followed."</p> <p>2.) "Adjustment in coping with health status changes: impaired/ineffective" with the expected outcome "Patient / family / caregiver acknowledge changing relationships and improve/maintain system of support within family", "Patient / family / caregiver accepts help needed to maximize control and meet adjustment/coping goals", and "Patient's financial resources will be maximized."</p> <p>3.) "Impaired elimination R/T limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p> <p>4.) "Nutrition / hydration changes" with the expected outcomes of "Patient / family / caregivers accept nutritional changes as part of disease process" and "Patient will have adequate nutrition and stable weight."</p>			
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	<p>5.) "Impaired skin integrity, actual or potential, secondary to immobility and nutritional deficits" with the expected outcome "Skin will be maintained at optimum integrity in the presence of advanced disease process" and "Patient will report comfort."</p> <p>6.) "Spiritual comfort: Alteration in needs for spiritual support" with the expected outcome "Improves / maintains communication or relationship with individuals from faith community or within belief system."</p> <p>7.) "Alteration in perceived quality of life from fatigue/progression of terminal illness" with the expected outcome "Patient will remain active and independent within disease process limits."</p> <p>8.) "Grief associated with anticipatory life changes and losses for patient. Family Grief related to anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding losses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p>			

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	<p>G. Clinical record number 7 included a plan of care established by the IDG on 12-19-12. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) "Cognition: Impaired cognition and decision making ability" with the expected outcome "Patient's safety and comfort will be maintained" and "Patient's wishes for care will be respected and followed."</p> <p>2.) "Adjustment in coping with health status changes: impaired/ineffective" with the expected outcome "Patient / family / caregiver acknowledge changing relationships and improve/maintain system of support within family", "Patient / family / caregiver accepts help needed to maximize control and meet adjustment/coping goals", and "Patient's financial resources will be maximized."</p> <p>3.) "Impaired elimination R/T limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p>						

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	<p>4.) "Neurological deficits" with the expected outcomes of "Patient will be safe and needs will be met as neurological status declines" and "Patient will verbalize understanding of anticipated decline in neurological status and functional progresses."</p> <p>5.) "Nutrition / hydration changes" with the expected outcomes of "Patient / family / caregivers accept nutritional changes as part of disease process" and "Patient will have adequate nutrition and stable weight."</p> <p>6.) "Impaired skin integrity, actual or potential, secondary to immobility and nutritional deficits" with the expected outcome "Skin will be maintained at optimum integrity in the presence of advanced disease process" and "Patient will report comfort."</p> <p>7.) "Spiritual comfort: Alteration in needs for spiritual support" with the expected outcome "Improves / maintains communication or relationship with individuals from faith community or within belief system."</p> <p>8.) "Alteration in perceived quality of life from fatigue/progression of terminal illness" with the expected outcome "Patient will remain active and</p>				

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	<p>independent within disease process limits."</p> <p>9.) "Grief associated with anticipatory life changes and losses for patient. Family Grief related to anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding losses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p> <p>H. Clinical record number 8 included a plan of care established by the IDG on 2-4-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) "Cognition: Impaired cognition and decision making ability" with the expected outcome "Patient's safety and comfort will be maintained" and "Patient's wishes for care will be respected and followed."</p> <p>2.) "Adjustment in coping with health status changes: impaired/ineffective" with the expected outcome "Patient / family / caregiver acknowledge changing relationships and</p>			

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	<p>improve/maintain system of support within family", "Patient / family / caregiver accepts help needed to maximize control and meet adjustment/coping goals", and "Patient's financial resources will be maximized."</p> <p>3.) "Impaired elimination R/T limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p> <p>4.) "Nutrition / hydration changes" with the expected outcomes of "Patients / family / caregivers accept nutritional changes as part of disease process" and "Patient will have adequate nutrition and stable weight."</p> <p>5.) "Impaired skin integrity, actual or potential, secondary to immobility and nutritional deficits" with the expected outcome "Skin will be maintained at optimum integrity in the presence of advanced disease process" and "Patient will report comfort."</p> <p>6.) "Spiritual comfort: Alteration in needs for spiritual support" with the expected outcome "Improves / maintains communication or relationship with individuals from faith community or</p>			

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	<p>within belief system."</p> <p>7.) "Alteration in perceived quality of life from fatigue/progression of terminal illness" with the expected outcome "Patient will remain active and independent within disease process limits."</p> <p>8.) "Grief associated with anticipatory life changes and losses for patient. Family Grief related to anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding losses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p> <p>I. Clinical record number 9 included a plan of care established by the IDG on 7-12-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) "Adjustment in coping with health status changes: impaired/ineffective" with the expected outcome "Patient / family / caregiver acknowledge changing relationships and improve/maintain system of support</p>						

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	<p>within family", "Patient / family / caregiver accepts help needed to maximize control and meet adjustment/coping goals", and "Patient's financial resources will be maximized."</p> <p>2.) "Impaired elimination R/T limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p> <p>3.) "Nutrition / hydration changes" with the expected outcomes of "Patient / family / caregivers accept nutritional changes as part of disease process" and "Patient will have adequate nutrition and stable weight."</p> <p>4.) "Impaired skin integrity, actual or potential, secondary to immobility and nutritional deficits" with the expected outcome "Skin will be maintained at optimum integrity in the presence of advanced disease process" and "Patient will report comfort."</p> <p>5.) "Alteration in perceived quality of life from fatigue / progression of terminal illness" with the expected outcome "Patient will remain active and independent within disease process limits."</p>			

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	<p>6.) "Grief associated with anticipatory life changes and losses for patient. Family Grief related to anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding losses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p> <p>J. Clinical record number 10 included a plan of care established by the IDG on 8-24-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) "Cognition: Impaired cognition and decision making ability" with the expected outcome "patient's safety and comfort will be maintained" and "patient's wishes for care will be respected and followed."</p> <p>2.) "Adjustment in coping with health status changes: impaired/ineffective" with the expected outcome "Patient / family / caregiver acknowledge changing relationships and improve/maintain system of support within family", "Patient / family /</p>						

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	<p>caregiver accepts help needed to maximize control and meet adjustment / coping goals", and "Patient's financial resources will be maximized."</p> <p>3.) "Impaired elimination R/T limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p> <p>4.) "Neurological deficits" with the expected outcomes of "Patient will be safe and needs will be met as neurological status declines" and "Patient will verbalize understanding of anticipated decline in neurological status and functional progresses."</p> <p>5.) "Nutrition / hydration changes" with the expected outcomes of "Patient / family / caregivers accept nutritional changes as part of disease process" and "Patient will have adequate nutrition and stable weight."</p> <p>6.) "Spiritual comfort: Alteration in needs for spiritual support" with the expected outcome "Improves / maintains communication or relationship with individuals from faith community or within belief system."</p>			

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	<p>7.) "Grief associated with anticipatory life changes and losses for patient. Family Grief related to anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding losses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p> <p>K. Clinical record number 11 included a plan of care established by the IDG on 12-18-12. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) "Cognition: Impaired cognition and decision making ability" with the expected outcome "Patient's safety and comfort will be maintained" and "Patient's wishes for care will be respected and followed."</p> <p>2.) "Adjustment in coping with health status changes: impaired/ineffective" with the expected outcome "Patient / family / caregiver acknowledge changing relationships and improve/maintain system of support within family", "Patient / family / caregiver accepts help needed to</p>						

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	<p>maximize control and meet adjustment / coping goals", and "Patient's financial resources will be maximized."</p> <p>3.) "Impaired elimination R/T limited mobility, weakness, poor nutrition and end stage disease process" with the expected outcomes of "Improved management of bowel and bladder" and "Regular bowel and bladder routines."</p> <p>4.) "Neurological deficits" with the expected outcomes of "Patient will be safe and needs will be met as neurological status declines" and "Patient will verbalize understanding of anticipated decline in neurological status and functional progresses."</p> <p>5.) "Nutrition / hydration changes" with the expected outcomes of "Patient / family / caregivers accept nutritional changes as part of disease process" and "Patient will have adequate nutrition and stable weight."</p> <p>6.) "Spiritual comfort: Alteration in needs for spiritual support" with the expected outcome "Improves / maintains communication or relationship with individuals from faith community or within belief system."</p> <p>7.) "Grief associated with</p>						

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	<p>anticipatory life changes and losses for patient. Family Grief related to anticipatory loss of loved one" with the expected outcome "Patient expresses feeling surrounding losses and communicate expressions of hope within limitations of disease process" and "Family adaptations support the mourning process."</p> <p>12. The patient care coordinator, employee B, indicated, on 8-30-13 at 12:40 PM, records numbered 1 through 11 did not evidence measurable goals and outcomes.</p> <p>13. The hospice's undated "Plan of Care - Content" policy number REG.P30 states, "The plan of care includes, but is not limited to: . . . measurable outcomes anticipated from implementing and coordinating the plan of care."</p>			

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L000579	<p>418.60(a) PREVENTION</p> <p>The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. Based on hospice policy review, observation, interview, and the Centers for Disease Control document review, the hospice failed to ensure staff provided services in accordance with the Centers for Disease Control Standard Precautions and the hospice's own infection control policies in 1 (# 1) of 2 nursing home visits creating the potential to affect all of the hospice's 4 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's undated "Infection Control - Standard and Transmission-Based Precautions" policy number REG.I30 states, "The hospice follows accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard and transmission-based precautions." 2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient 	L000579	L 579Spencer County Hospice will provide an in service on Standard Precautions, infection control policy, and hand washing annually. All clinical staff will be checked of as competent or non-competent(needs remediation). The Client Care Coordinator will be responsible for monitoring the corrective actions to ensure that the deficiency is corrected and will not occur again.	09/25/2013

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

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	<p>3. Employee C, a registered nurse (RN), was observed to provide care to patient number 1 during a home visit on 8-28-13 at 10 AM. The RN washed her hands upon entering the home and completed an assessment of the patient. The RN measured the patient's blood pressure, temperature, pulse, and respirations and performed a pulse oximetry check. Without cleansing her hands, the RN cleaned the pulse oximeter and placed it back into her nursing bag.</p> <p>A. The RN then touched the patient's feet and ankles. The RN touched the container that held the blood pressure cuff and replaced it into her bag. The RN donned clean gloves without cleansing her hands. The RN examined a dressing on the patient's mid-chest area for any drainage, listened to the patient's lungs, and then cleaned the blood pressure cuff with the dirty gloves on. The RN replaced her stethoscope into her bag after cleansing it, still wearing the same gloves.</p> <p>B. The RN checked a dressing on the patient's sacrum and removed her gloves. Without cleaning her hands, the RN gathered her paperwork and nursing bag and then cleaned her hands.</p> <p>4. The patient care coordinator, employee</p>						

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	B, indicated, on 8-30-13 at 12:40 PM, employee C had not followed standard precautions or the hospice's infection control policy.			

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L000598	<p>418.64(d)(3) COUNSELING SERVICES (3) Spiritual counseling The hospice must:</p> <p>(i) Provide an assessment of the patient's and family's spiritual needs. (ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires. (iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability. (iv) Advise the patient and family of this service.</p> <p>Based on personnel file and hospice job description review and interview, the hospice failed to ensure the individual retained to provide spiritual care counseling on its behalf met the hospice's own qualifications creating the potential to affect all of the hospice's 4 current patients.</p> <p>The findings include:</p> <p>1. The hospice's 11/99 "Job Description: Pastoral Counselor" states, "Qualifications: Education & Training . . . has a degree from an accredited school of theology and has fulfilled appropriate denominational seminary requirements, OR has been approved by the individual's denomination to function in a pastoral</p>	L000598	L 598Employee F provided paperwork from the Bishop of Indiana Conference-The United Methodist Church. The paperwork states that employee F does have clergy credentials and is an ordained Elder of the United Methodist Church.The Client Care Coordinator will be responsible for monitoring employee F personnel record annually for retained documentation of being an ordained elder of the United Methodist Church to ensure that this deficiency is corrected and does not occur again.	08/30/2013	

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	<p>capacity, OR is the spiritual worker of the individual client OR has completed course work in an accredited CPE (Clinical Pastoral Education Unit)."</p> <p>2. Personnel file F evidenced the individual had been retained on 5-16-13 by the hospice as a volunteer chaplain to provide spiritual care counseling to patients of the hospice. The file failed to evidence the individual had any theological training and/or education, had fulfilled any denominational seminary requirements, or had a statement of approval from his denomination to function in a pastoral capacity.</p> <p>3. Employee F was interviewed on 8-29-13 at 1:05 PM. The employee indicated he had degrees in religion, philosophy, and sociology from Indiana Central and had attended seminary in Evanston, Illinois. The employee indicated he had a Masters of Divinity.</p> <p>4. The patient care coordinator, employee B, stated, on 8-30-13 at 8:10 AM, "I've asked him [employee F] for a copy of his degrees and diplomas. He says someone broke into his office and took everything so he doesn't have it. I've asked him twice now. He mentioned getting something from the bishop."</p>			

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L000643	<p>418.78(a) TRAINING</p> <p>The hospice must maintain, document and provide volunteer orientation and training that is consistent with hospice industry standards.</p> <p>Based on personnel file and hospice policy review and interview, the hospice failed to ensure volunteer training included family dynamics and emergency training in 2 (files F and G) of 3 volunteer files reviewed creating the potential to affect the hospice's 4 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file F evidenced the individual had been retained on 5-16-13 as a volunteer chaplain to provide spiritual care counseling services to patients of the hospice. The file failed to evidence the hospice had provided training and orientation that included family dynamics, coping mechanisms and psychological issues surrounding terminal illness, death and bereavement, and procedures to be followed in an emergency or following the death of the patient. 2. Personnel file G evidenced the individual had been retained on 3-21-13 as the volunteer coordinator. The file failed to evidence the hospice had provided training and orientation that 	L000643	<p>L 643Education has been added to the volunteer training program regarding family dynamics around a dying loved one, coping mechanisms that the terminally ill may experience, and psychological issues surrounding terminal illness, death, and bereavement. Volunteers also educated about procedures to be followed should an emergency occur and what to do should a patient death occur while they are present. This is for all current and any new patient care volunteers. All patient care volunteers were trained in these areas. The Client Care Coordinator and the Volunteer Coordinator will be responsible for correcting this deficiency and monitoring volunteer personnel records annually to ensure that it will not occur again.</p>	09/27/2013

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	<p>included family dynamics, coping mechanisms and psychological issues surrounding terminal illness, death and bereavement, and procedures to be followed in an emergency or following the death of the patient.</p> <p>3. The patient care coordinator, employee B, indicated, on 8-30-13 at 9 AM, the files did not evidence the training and orientation provided to employees F and G included family dynamics, coping mechanisms and psychological issues surrounding terminal illness, death and bereavement, and procedures to be followed in an emergency or following the death of the patient.</p> <p>4. The hospice's undated "Volunteers - Services" policy number REG.V15 states, "Volunteers are required to complete an orientation and training program prior to assignment to patients and caregivers."</p>				