

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L0000	<p>This was a federal recertification and state re-licensure hospice survey.</p> <p>Facility #: 005816</p> <p>Survey Dates: 6-13-12, 6-14-12, 6-15-12, and 6-18-12</p> <p>Medicaid Vendor #: 200845180FW</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Angels of Mercy Hospice was found to be out of compliance with Conditions of Participation 42 CFR 418.54 Initial and Comprehensive Assessment of the Patient; 418.56 Interdisciplinary Group, Care Planning and Coordination of Services; 418.100 Organization and Administration of Services; 418.108 Short-term Inpatient Care; and 418.112 Hospices That Provide Hospice Care to Residents of a SNF/NF or ICF/MR.</p> <p>Quality Review: Linda Dubak, R.N. June 27, 2012</p>	L0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0503	<p>418.52(a)(2) NOTICE OF RIGHTS AND RESPONSIBILITIES</p> <p>(2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure patients had been informed of this hospice's policy regarding advance directives in 11 (#s 1 through 11) of 11 records reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. The hospice's undated "Advance Directives" policy number EBR.A15 states, "Angels of Mercy Hospice complies with all State and Federal laws regarding advance directives and informs and distributes written information to the patient on his or her right to formulate advance directives. The provision of hospice care is not conditioned upon whether or not the individual has executed an advance directive . . . The written information given to the patient and or legal representative includes: the hospice's policies on the implementation of the patient's advance directives</p>	L0503	The Director of Nursing will inservice staff on providing patients with a copy of the agency Advance Directive policy on admission. The Advanced Directive policy will be added to the admission packet.100% of admissions will be reviewed to ensure documentation of patient receipt of agency Advance Directive policy.The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>including any limitation."</p> <p>2. Clinical record number 1 evidenced the patient had been provided with advance directives information on the start of care date of 5-3-12. The record failed to evidence the information provided to the patient included this hospice's policy regarding advance directives.</p> <p>3. Clinical record number 2 evidenced the patient had been provided with advance directives information on the start of care date of 6-7-12. The record failed to evidence the information provided to the patient included this hospice's policy regarding advance directives.</p> <p>4. Clinical record number 3 evidenced the patient had been provided with advance directives information on the start of care date of 6-1-11. The record failed to evidence the information provided to the patient included this hospice's policy regarding advance directives.</p> <p>5. Clinical record number 4 evidenced the patient had been provided with advance directives information on the start of care date of 9-1-11. The record failed to evidence the information</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>provided to the patient included this hospice's policy regarding advance directives.</p> <p>6. Clinical record number 5 evidenced the patient had been provided with advance directives information on the start of care date of 10-5-11. The record failed to evidence the information provided to the patient included this hospice's policy regarding advance directives.</p> <p>7. Clinical record number 6 evidenced the patient had been provided with advance directives information on the start of care date of 1-10-12. The record failed to evidence the information provided to the patient included this hospice's policy regarding advance directives.</p> <p>8. Clinical record number 7 evidenced the patient had been provided with advance directives information on the start of care date of 2-1-12. The record failed to evidence the information provided to the patient included this hospice's policy regarding advance directives.</p> <p>9. Clinical record number 8 evidenced the patient had been provided with advance directives information on the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>start of care date of 1-26-12. The record failed to evidence the information provided to the patient included this hospice's policy regarding advance directives.</p> <p>10. Clinical record number 9 evidenced the patient had been provided with advance directives information on the start of care date of 4-19-12. The record failed to evidence the information provided to the patient included this hospice's policy regarding advance directives.</p> <p>11. Clinical record number 10 evidenced the patient had been provided with advance directives information on the start of care date of 3-6-12. The record failed to evidence the information provided to the patient included this hospice's policy regarding advance directives.</p> <p>12. Clinical record number 11 evidenced the patient had been provided with advance directives information on the start of care date of 3-20-12. The record failed to evidence the information provided to the patient included this hospice's policy regarding advance directives.</p> <p>13. The hospice director, employee B,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	indicated, on 6-14-12 at 10:55 AM Central Time, patients had not been provided with this hospice's policy regarding advance directives.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0520	<p>Based on clinical record and hospice policy review and interview, it was determined the hospice failed to ensure comprehensive assessments were completed by the interdisciplinary team and attending physicians and identified and addressed all potential psychosocial and spiritual care needs in 11 of 11 records reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice failed to ensure comprehensive assessments addressed and identified patients' needs or psychosocial, emotional, and spiritual care (See L 521). 2. The hospice failed to ensure the interdisciplinary team (IDT) in consultation with the attending physician had completed the comprehensive assessments in 11 of 11 records reviewed creating the potential to affect both of the hospice's current patients. (See L 523). 3. The hospice failed to ensure comprehensive assessments had been completed that identified patients' psychosocial, emotional, and spiritual 	L0520	<p>The Director of Nursing will inservice staff/required members of Interdisciplinary Group to ensure comprehensive assessments include psychosocial, spiritual, and bereavement needs and documentation is reflective that the comprehensive assessments are being completed by the IDG and attending physician (if applicable). 100% of admissions will be reviewed to ensure comprehensive assessments include psychosocial, spiritual, and bereavement needs and documentation is reflective that the Comprehensive assessments are being completed by the IDG and attending physician (if applicable). The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>care needs in 11 of 11 records reviewed creating the potential to affect both of the hospice's current patients. (See L 524).</p> <p>4. The hospice failed to ensure comprehensive assessments included an assessment of the bereavement needs of the patients' families and other individuals in 11 of 11 records reviewed creating the potential to affect both of the hospice's current patients. (See L 531).</p> <p>5. The hospice failed to ensure comprehensive assessments had been updated with patients' progress towards goals and response to care in 8 (#s 1, 2, 6, 7, 8, 9, 10, and 11) of 11 records reviewed. (See L 533).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.54 Initial and Comprehensive Assessment of the Patient.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0521	<p>418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure comprehensive assessments addressed and identified patients' need for psychosocial, emotional, and spiritual care in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p> <p>1. The hospice's undated "Assessment - Comprehensive Assessment of the Patient" policy number PFC.A45 states, "The hospice interdisciplinary team conducts and documents a patient-specific comprehensive assessment that identifies the patient's need for hospice care, including medical, nursing, psychosocial, emotional and spiritual care . . . Each member of the interdisciplinary team provides input into the comprehensive assessment within the scope of his/her practice. Discipline-specific assessment</p>	L0521	The Director of Nursing will inservice staff/required members of Interdisciplinary Group on the requirment of the completion of the comprehensive assessment to include psychosocial, spiritual care needs and bereavement risk assessments to address and identify patient needs. 100% of admissions will be reviewed to ensure comprehensive assessments include psychosocial, spiritual, and bereavement needs. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>tools obtain accurate and timely information that guide decisions for the development of the patient's plan of care."</p> <p>The hospice's undated "Assessment - Content of the Comprehensive Assessment" policy number PFC.A50 states, "The comprehensive assessment of the patient consists of the following discipline-specific assessment tools: a. the nursing assessment; b. the psychosocial assessment; and c. the spiritual care assessment."</p> <p>2. Clinical record number 1 identified the patient as a resident of a skilled nursing facility (SNF) and included a start of care nursing assessment completed by the registered nurse (RN), employee F, on 5-3-12. The record included an assessment completed by the medical social worker (MSW), employee L, on 5-8-12. The record failed to evidence a spiritual care counseling (SCC) assessment to identify any potential patient and/or family spiritual care needs.</p> <p>3. Clinical record number 2 identified the patient as a resident of a SNF and included a start of care nursing assessment completed by the RN, employee F, on 6-7-12. The record failed to evidence a medical social services (MSS) assessment or a SCC assessment</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>to identify any potential patient and/or family psychosocial and/or spiritual needs.</p> <p>4. Clinical record number 3 included a start of care nursing assessment completed by the RN, employee M, on 6-1-11 and a MSS assessment completed by employee L, the MSW, on 6-2-11. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>5. Clinical record number 4 identified the patient as a SNF resident and included a start of care nursing assessment completed by the RN, employee M, on 9-1-11. The record failed to evidence a MSS or a SCC assessment to identify any potential patient and/or family psychosocial and/or spiritual care needs.</p> <p>6. Clinical record number 5 included a start of care nursing assessment dated 10-5-11 completed by the RN, employee M. The record failed to evidence a MSS or SCC assessment to identify any potential patient and/or family psychosocial and/or spiritual care needs.</p> <p>7. Clinical record number 6 included a start of care nursing assessment completed by the RN, employee N, on 1-10-12. The record failed to evidence a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>MSS of SCC assessment to identify any potential patient and/or family psychosocial and/or spiritual care needs.</p> <p>8. Clinical record number 7 included a start of care nursing assessment completed by the RN, employee M, on 2-1-12. The record failed to evidence a MSS or SCC assessment to identify any potential patient and/or family psychosocial and/or spiritual care needs.</p> <p>9. Clinical record number 8 included a start of care nursing assessment completed by the RN, employee M, on 1-26-12. The record failed to evidence a MSS or SCC assessment to identify any potential patient and/or family psychosocial and/or spiritual care needs.</p> <p>10. Clinical record number 9 included a start of care nursing assessment completed by the RN, employee B, on 4-19-12. The record included an initial MSS visit note dated completed by employee L on 4-24-12. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>11. Clinical record number 10 included a start of care nursing assessment completed by the RN, employee N, on 3-6-12 and an initial MSS visit note</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>completed by employee L dated 3-6-12. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>12. Clinical record number 11 included a start of care nursing assessment completed by the RN, employee N, on 3-20-12, and an initial MSS visit note completed by employee L on 4-3-12. The record failed to evidence a SCC assessment to identify any potential patient and/or spiritual care needs.</p> <p>13. The hospice director, employee B, indicated, on 6-15-12 at 11:35 AM Central Time, the records did not include complete comprehensive assessments. The director stated, "I know the SCC needs his own assessment and plan of care tools." The director indicated when a patient "refused" MSS, the nurse only completed the psychosocial portion of the initial nursing assessment and did not complete an entire psychosocial assessment.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L0523	<p>418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT</p> <p>The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure the interdisciplinary team (IDT) in consultation with the attending physician had completed the comprehensive assessments in 11 (#s 1 through 11) of 11 records reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's undated "Assessment - Comprehensive Assessment of the Patient" policy number PFC.A45 states, "The comprehensive assessment of the patient is completed by members of the interdisciplinary team in consultation with the patient's attending physician no later than five (5) calendar days after the patient elects the hospice benefit." 2. Clinical record number 1 identified the patient as a resident of a skilled nursing facility (SNF) and included a start of care nursing assessment completed by the 	L0523	<p>The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) on the requirement of documentation to support the IDG members participation in the completion of the comprehensive assessment within the required 5 days. 100% of admissions will be reviewed to ensure comprehensive assessments include participation of all required IDG members. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>registered nurse (RN), employee F, on 5-3-12. The record included an assessment completed by the medical social worker (MSW), employee L, on 5-8-12. The record failed to evidence participation of the spiritual care counselor (SCC), the hospice medical director, or the patient's attending physician in the completion of the comprehensive assessment.</p> <p>3. Clinical record number 2 identified the patient as a resident of a SNF and included a start of care nursing assessment completed by the RN, employee F, on 6-7-12. The record failed to evidence participation of the MSW, the SCC, the medical director, or the patient's attending physician in the completion of the comprehensive assessment.</p> <p>4. Clinical record number 3 included a start of care nursing assessment completed by the RN, employee M, on 6-1-11 and a MSS assessment completed by employee L, the MSW, on 6-2-11. The record failed to evidence participation of the SCC, the medical director, or the attending physician in the completion of the comprehensive assessment.</p> <p>5. Clinical record number 4 identified the patient as a SNF resident and included a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>start of care nursing assessment completed by the RN, employee M, on 9-1-11. The record failed to evidence participation of the MSW, the SCC, the medical director, or the attending physician in the completion of the comprehensive assessment.</p> <p>6. Clinical record number 5 included a start of care nursing assessment dated 10-5-11 completed by the RN, employee M. The record failed to evidence participation of the MSW, the SCC, the medical director, or the attending physician in the completion of the comprehensive assessment.</p> <p>7. Clinical record number 6 included a start of care nursing assessment completed by the RN, employee N, on 1-10-12. The record failed to evidence participation of the MSW, the SCC, the medical director, or the attending physician in the completion of the comprehensive assessment.</p> <p>8, Clinical record number 7 included a start of care nursing assessment completed by the RN, employee M, on 2-1-12. The record failed to evidence participation of the MSW, the SCC, the medical director, or the attending physician in the completion of the comprehensive assessment.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>9. Clinical record number 8 included a start of care nursing assessment completed by the RN, employee M, on 1-26-12. The record failed to evidence participation of the MSW, the SCC, the medical director, or the attending physician in the completion of the comprehensive assessment.</p> <p>10. Clinical record number 9 included a start of care nursing assessment completed by the RN, employee B, on 4-19-12. The record included an initial MSS visit note dated completed by employee L on 4-24-12. The record failed to evidence participation of the SCC, the medical director, or the attending physician in the completion of the comprehensive assessment.</p> <p>11. Clinical record number 10 included a start of care nursing assessment completed by the RN, employee N, on 3-6-12 and an initial MSS visit note completed by employee L dated 3-6-12. The record failed to evidence participation of the SCC, the medical director, or the attending physician in the completion of the comprehensive assessment.</p> <p>12. Clinical record number 11 included a start of care nursing assessment</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>completed by the RN, employee N, on 3-20-12, and an initial MSS visit note completed by employee L on 4-3-12. The record failed to evidence participation of the SCC, the medical director, or the attending physician in the completion of the comprehensive assessment.</p> <p>13. The hospice director, employee B, indicated, on 6-15-12 at 11:35 AM Central Time, the records did not include complete comprehensive assessments. The director stated, "I know the SCC needs his own assessment and plan of care tools." The director indicated when a patient "refused" MSS, the nurse only completed the psychosocial portion of the initial nursing assessment and did not complete an entire psychosocial assessment. The director indicated the hospice medical director and the patients' attending physicians were contacted per telephone call when the patient was admitted but that the content and findings of the telephone calls were not documented and incorporated into the comprehensive assessment.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0524	<p>418.54(c) CONTENT OF COMPREHENSIVE ASSESSMENT The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure comprehensive assessments had been completed that identified patients' psychosocial, emotional, and spiritual care needs in 11 (#s 1 through 11) of 11 records reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. The hospice's undated "Assessment - Comprehensive Assessment of the Patient" policy number PFC.A45 states, "The hospice interdisciplinary team conducts and documents a patient-specific comprehensive assessment that identifies the patient's need for hospice care, including medical, nursing, psychosocial, emotional and spiritual care . . . Each member of the interdisciplinary team provides input into the comprehensive assessment within the scope of his/her practice. Discipline-specific assessment tools obtain accurate and timely</p>	L0524	The Director of Nursing will inservice staff/required members of Interdisciplinary Group on the requirement of documentation to support the completion of the comprehensive assessment includes psychosocial, emotional and spiritual care needs. 100% of admissions will be reviewed to ensure comprehensive assessments include psychosocial, emotional and spiritual care. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>information that guide decisions for the development of the patient's plan of care."</p> <p>The hospice's undated "Assessment - Content of the Comprehensive Assessment" policy number PFC.A50 states, "The comprehensive assessment of the patient consists of the following discipline-specific assessment tools: a. the nursing assessment; b. the psychosocial assessment; and c. the spiritual care assessment."</p> <p>2. Clinical record number 1 identified the patient as a resident of a skilled nursing facility (SNF) and included a start of care nursing assessment completed by the registered nurse (RN), employee F, on 5-3-12. The record included an assessment completed by the medical social worker (MSW), employee L, on 5-8-12. The record failed to evidence a spiritual care counseling (SCC) assessment to identify any potential patient and/or family spiritual care needs.</p> <p>3. Clinical record number 2 identified the patient as a resident of a SNF and included a start of care nursing assessment completed by the RN, employee F, on 6-7-12. The record failed to evidence a medical social services (MSS) assessment or a SCC assessment to identify any potential patient and/or</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>family psychosocial and/or spiritual needs.</p> <p>4. Clinical record number 3 included a start of care nursing assessment completed by the RN, employee M, on 6-1-11 and a MSS assessment completed by employee L, the MSW, on 6-2-11. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>5. Clinical record number 4 identified the patient as a SNF resident and included a start of care nursing assessment completed by the RN, employee M, on 9-1-11. The record failed to evidence a MSS or a SCC assessment to identify any potential patient and/or family psychosocial and/or spiritual care needs.</p> <p>6. Clinical record number 5 included a start of care nursing assessment dated 10-5-11 completed by the RN, employee M. The record failed to evidence a MSS or SCC assessment to identify any potential patient and/or family psychosocial and/or spiritual care needs.</p> <p>7. Clinical record number 6 included a start of care nursing assessment completed by the RN, employee N, on 1-10-12. The record failed to evidence a MSS of SCC assessment to identify any</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>potential patient and/or family psychosocial and/or spiritual care needs.</p> <p>8. Clinical record number 7 included a start of care nursing assessment completed by the RN, employee M, on 2-1-12. The record failed to evidence a MSS or SCC assessment to identify any potential patient and/or family psychosocial and/or spiritual care needs.</p> <p>9. Clinical record number 8 included a start of care nursing assessment completed by the RN, employee M, on 1-26-12. The record failed to evidence a MSS or SCC assessment to identify any potential patient and/or family psychosocial and/or spiritual care needs.</p> <p>10. Clinical record number 9 included a start of care nursing assessment completed by the RN, employee B, on 4-19-12. The record included an initial MSS visit note dated completed by employee L on 4-24-12. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>11. Clinical record number 10 included a start of care nursing assessment completed by the RN, employee N, on 3-6-12 and an initial MSS visit note completed by employee L dated 3-6-12.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>12. Clinical record number 11 included a start of care nursing assessment completed by the RN, employee N, on 3-20-12, and an initial MSS visit note completed by employee L on 4-3-12. The record failed to evidence a SCC assessment to identify any potential patient and/or spiritual care needs.</p> <p>13. The hospice director, employee B, indicated, on 6-15-12 at 11:35 AM Central Time, the records did not include complete comprehensive assessments. The director stated, "I know the SCC needs his own assessment and plan of care tools." The director indicated when a patient "refused" MSS, the nurse only completed the psychosocial portion of the initial nursing assessment and did not complete an entire psychosocial assessment.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0531	<p>418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (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 and hospice policy review and interview, the hospice failed to ensure comprehensive assessments included an assessment of the bereavement needs of the patients' families and other individuals in 11 (#s 1 through 11) of 11 records reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's undated "Bereavement - Care Planning" policy number PFC.B10 states, "At the time of the patient's admission to hospice . . . A bereavement risk assessment is completed for each caregiver/significant other and updated during interdisciplinary team meetings." 2. Clinical record number 1 identified the patient as a resident of a skilled nursing 	L0531	The Director of Nursing will inservice staff/required members of Interdisciplinary Group on the requirement of documentation to support the completion of the initial bereavement assessment to identify needs of the patients' families and other individuals in the comprehensive assessment. 100% of admissions will be reviewed to ensure comprehensive assessments include an initial bereavement assessment and identified needs are included in the patient's Plan of Care. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>facility (SNF) and included a start of care nursing assessment completed by the registered nurse (RN), employee F, on 5-3-12. The record included an assessment completed by the medical social worker (MSW), employee L, on 5-8-12. The record failed to evidence an initial bereavement assessment of the needs of the patient's family and other individuals.</p> <p>3. Clinical record number 2 identified the patient as a resident of a SNF and included a start of care nursing assessment completed by the RN, employee F, on 6-7-12. The record failed to evidence an initial bereavement assessment of the needs of the patient's family and other individuals.</p> <p>4. Clinical record number 3 included a start of care nursing assessment completed by the RN, employee M, on 6-1-11 and a MSS assessment completed by employee L, the MSW, on 6-2-11. The record failed to evidence an initial bereavement assessment of the needs of the patient's family and other individuals.</p> <p>5. Clinical record number 4 identified the patient as a SNF resident and included a start of care nursing assessment completed by the RN, employee M, on 9-1-11. The record failed to evidence an</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>initial bereavement assessment of the needs of the patient's family and other individuals.</p> <p>6. Clinical record number 5 included a start of care nursing assessment dated 10-5-11 completed by the RN, employee M. The record failed to evidence an initial bereavement assessment of the needs of the patient's family and other individuals.</p> <p>7. Clinical record number 6 included a start of care nursing assessment completed by the RN, employee N, on 1-10-12. The record failed to evidence an initial bereavement assessment of the needs of the patient's family and other individuals.</p> <p>8. Clinical record number 7 included a start of care nursing assessment completed by the RN, employee M, on 2-1-12. The record failed to evidence an initial bereavement assessment of the needs of the patient's family and other individuals.</p> <p>9. Clinical record number 8 included a start of care nursing assessment completed by the RN, employee M, on 1-26-12. The record failed to evidence an initial bereavement assessment of the needs of the patient's family and other</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>individuals.</p> <p>10. Clinical record number 9 included a start of care nursing assessment completed by the RN, employee B, on 4-19-12. The record included an initial MSS visit note dated completed by employee L on 4-24-12. The record failed to evidence an initial bereavement assessment of the needs of the patient's family and other individuals.</p> <p>11. Clinical record number 10 included a start of care nursing assessment completed by the RN, employee N, on 3-6-12 and an initial MSS visit note completed by employee L dated 3-6-12. The record failed to evidence an initial bereavement assessment of the needs of the patient's family and other individuals.</p> <p>12. Clinical record number 11 included a start of care nursing assessment completed by the RN, employee N, on 3-20-12, and an initial MSS visit note completed by employee L on 4-3-12. The record failed to evidence an initial bereavement assessment of the needs of the patient's family and other individuals.</p> <p>13. The hospice director, employee B, indicated, on 6-15-12 at 11:35 AM Central Time, the records did not include complete comprehensive assessments.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0533	<p>418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT</p> <p>The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure comprehensive assessments had been updated with patients' progress towards goals and response to care in 8 (#s 1, 2, 6, 7, 8, 9, 10, and 11) of 11 records reviewed.</p> <p>The findings include:</p> <p>1. The hospice's undated "Assessment - Comprehensive Assessment of the Patient" policy number PFC.A45 states, "The patient's comprehensive assessment is updated at a minimum every 15 days and before the patient is recertified into a new benefit period."</p> <p>The hospice's undated "Assessment - Updates to the Comprehensive Assessment" policy number PFC.A60</p>	L0533	<p>The Director of Nursing will inservice staff/required members of Interdisciplinary Group on the need for the comprehensive assessments to document patients' progress towards goals and response to care. 100% for charts of patients on service at least 15 days will be reviewed to ensure comprehensive assessments include patients' progress towards goals and response to care. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>states, "The hospice's interdisciplinary team updates the comprehensive assessment and reassesses the patient's response to care on a regular basis . . . Documentation of the interdisciplinary team's care planning meeting reflects the ongoing reassessment of the patient/caregiver's status and needs."</p> <p>2. Clinical record number 1 identified the patient as a resident of a skilled nursing facility (SNF) and included a start of care nursing assessment completed by the registered nurse (RN), employee F, on 5-3-12. The record included an assessment completed by the medical social worker (MSW), employee L, on 5-8-12. The record failed to evidence the comprehensive assessment had been updated with the patient's progress towards goals and response to care.</p> <p>3. Clinical record number 2 identified the patient as a resident of a SNF and included a start of care nursing assessment completed by the RN, employee F, on 6-7-12. The record failed to evidence the comprehensive assessment had been updated with the patient's progress towards goals and response to care.</p> <p>4. Clinical record number 6 included a start of care nursing assessment</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>completed by the RN, employee N, on 1-10-12. The record failed to evidence the comprehensive assessment had been updated with the patient's progress towards goals and response to care.</p> <p>5. Clinical record number 7 included a start of care nursing assessment completed by the RN, employee M, on 2-1-12. The record failed to evidence the comprehensive assessment had been updated with the patient's progress towards goals and response to care.</p> <p>6. Clinical record number 8 included a start of care nursing assessment completed by the RN, employee M, on 1-26-12. The record failed to evidence the comprehensive assessment had been updated with the patient's progress towards goals and response to care.</p> <p>7. Clinical record number 9 included a start of care nursing assessment completed by the RN, employee B, on 4-19-12. The record included an initial MSS visit note dated completed by employee L on 4-24-12. The record failed to evidence the comprehensive assessment had been updated with the patient's progress towards goals and response to care.</p> <p>8. Clinical record number 10 included a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>start of care nursing assessment completed by the RN, employee N, on 3-6-12 and an initial MSS visit note completed by employee L dated 3-6-12. The record failed to evidence the comprehensive assessment had been updated with the patient's progress towards goals and response to care.</p> <p>9. Clinical record number 11 included a start of care nursing assessment completed by the RN, employee N, on 3-20-12, and an initial MSS visit note completed by employee L on 4-3-12. The record failed to evidence a the comprehensive assessment had been updated with the patient's progress towards goals and response to care.</p> <p>13. The hospice director, employee B, indicated, on 6-15-12 at 11:35 AM Central Time, the records did not evidence the comprehensive assessments had been updated as required.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0536	<p>Based on clinical record and hospice policy review and interview, it was determined the hospice failed to ensure plans of care were established and reviewed by all members of the interdisciplinary group (IDG) in 11 of 11 records reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice failed to ensure plans of care had been established by the interdisciplinary group (IDG) in 9 of 11 records reviewed creating the potential to affect both of the hospice's current patients. (See L 537). 2. The hospice failed to ensure plans of care had been established by the interdisciplinary group (IDG) in collaboration with the attending physicians in 9 of 11 records reviewed creating the potential to affect both of the hospice's current patients. (See L 543). 3. The hospice failed to ensure plans of care identified those care and services the patient and/or caregivers would be responsible for and failed to include plans 	L0536	<p>The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) on the requirement of documentation to support the Plans of Care are establishment and reviewed by all members of the IDG. 100% of admissions will be reviewed to ensure all required members of the IDG have reviewed the Plan of Care. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>for education and training related to the patient and/or caregiver responsibilities in 11 of 11 records reviewed. (See V 544).</p> <p>4. The hospice failed to ensure the all members of the interdisciplinary group (IDG), in collaboration with the attending physician, had reviewed the plans of care in 6 of 9 records reviewed of patients that had been on service for longer than 15 days and failed to ensure the registered nurse member of the IDG had advised the physician of the need to revise the plan of care in 7 of 11 records reviewed creating the potential to affect both of the hospice's current patients. (See V 552).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0537	<p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care had been established by the interdisciplinary group (IDG) in 9 (#s 1, 2, 3, 5, 6, 7, 9, 10, and 11) of 11 records reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's undated "Plan of Care" policy number PFC.P15 states, "Hospice services provided to patients/caregivers are in accordance with a written plan of care established by the hospice interdisciplinary team in collaboration with the patient's attending physician." 2. Clinical record number 1 included a plan of care dated 5-3-12. The record failed to evidence the medical social worker (MSW) and spiritual care counselor (SCC) members of the IDG had participated in the preparation of the plan of care. 	L0537	The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) on the requirement of documentation to support the Plans of Care are establishment by the IDG. 100% of admissions will be reviewed to ensure all required members of the IDG have participated in the establishment of the Plan of Care. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. Clinical record number 2 included a plan of care dated 6-7-12. The record failed to evidence the MSW or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>4. Clinical record number 3 included a plan of care dated 6-1-11. The record failed to evidence the medical director or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>5. Clinical record number 5 included a plan of care dated 10-5-11. The record failed to evidence the medical director, the MSW, or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>6. Clinical record number 6 included a plan of care dated 1-10-12. The record failed to evidence the MSW or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>7. Clinical record number 7 included a plan of care dated 2-1-12. The record failed to evidence the medical director, the MSW, or the SCC members of the IDG had participated in the preparation of the plan of care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>8. Clinical record number 9 included a plan of care dated 4-19-12. The record failed to evidence the medical director, the MSW, or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>9. Clinical record number 10 included a plan of care dated 3-6-12. The record failed to evidence the medical director, the MSW, or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>10. Clinical record number 11 included a plan of care dated 3-20-12. The record failed to evidence the MSW or SCC members of the IDG had participated in the preparation of the plan.</p> <p>11. The hospice director, employee B, indicated, on 6-13-12 at 1:05 PM Central Time, "After the order is received for hospice care, the RN goes out and does the initial assessment. She then calls the other IDT members to establish the plan of care. It should be documented in the care coordination notes."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0543	<p>418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care had been established by the interdisciplinary group (IDG) in collaboration with the attending physicians in 9 (#s 1, 2, 3, 5, 6, 7, 9, 10, and 11) of 11 records reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's undated "Plan of Care" policy number PFC.P15 states, "Hospice services provided to patients/caregivers are in accordance with a written plan of care established by the hospice interdisciplinary team in collaboration with the patient's attending physician." 2. Clinical record number 1 included a plan of care dated 5-3-12. The record failed to evidence the medical social worker (MSW) and spiritual care counselor (SCC) members of the IDG had participated in the preparation of the plan 	L0543	The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) on the requirement of documentation to support the plans of care are established by the IDG in collaboration with the attending physician (if applicable). 100% of admissions will be reviewed to ensure all required members of the IDG have participated in the establishment of the Plan of Care in collaboration with the attending physician. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of care.</p> <p>3. Clinical record number 2 included a plan of care dated 6-7-12. The record failed to evidence the MSW or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>4. Clinical record number 3 included a plan of care dated 6-1-11. The record failed to evidence the medical director or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>5. Clinical record number 5 included a plan of care dated 10-5-11. The record failed to evidence the medical director, the MSW, or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>6. Clinical record number 6 included a plan of care dated 1-10-12. The record failed to evidence the MSW or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>7. Clinical record number 7 included a plan of care dated 2-1-12. The record failed to evidence the medical director, the MSW, or the SCC members of the IDG had participated in the preparation of the plan of care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>8. Clinical record number 9 included a plan of care dated 4-19-12. The record failed to evidence the medical director, the MSW, or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>9. Clinical record number 10 included a plan of care dated 3-6-12. The record failed to evidence the medical director, the MSW, or the SCC members of the IDG had participated in the preparation of the plan of care.</p> <p>10. Clinical record number 11 included a plan of care dated 3-20-12. The record failed to evidence the MSW or SCC members of the IDG had participated in the preparation of the plan.</p> <p>11. The hospice director, employee B, indicated, on 6-13-12 at 1:05 PM Central Time, "After the order is received for hospice care, the RN goes out and does the initial assessment. She then calls the other IDT members to establish the plan of care. It should be documented in the care coordination notes."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0544	<p>418.56(b) PLAN OF CARE The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care identified those care and services the patient and/or caregivers would be responsible for and failed to include plans for education and training related to the patient and/or caregiver responsibilities in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p> <p>1. The hospice's undated "Plan of Care" policy number PFC.P15 states, "Members of the interdisciplinary team provide education and training to the patient/caregiver as appropriate to the care and services identified in the patient's plan of care."</p> <p>The hospice's undated "Patient/Caregiver Education" policy number CES.P15 states, "Patients/caregivers are provided with written and verbal education and information as appropriate and needed."</p>	L0544	<p>The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) on documenting and educating patients/caregivers on responsibilities of the care and services to be provided as outlined in the Plan of Care. The POC will include patient/family responsibilities. 100% of admissions will be reviewed to ensure the patients/caregivers receive education on responsibilities of the care and services as outlined in the Plan of Care. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. Clinical record number 1 identified the patient was a resident of a skilled nursing facility (SNF) and included a plan of care dated 5-3-12. The plan of care failed to identify SNF caregiver responsibilities related to the hospice care and services that were to be provided and failed to provide for the education and training of the SNF staff related to those responsibilities.</p> <p>3. Clinical record number 2 identified the patient was a resident of a SNF and included a plan of care dated 6-7-12. The plan of care failed to identify SNF caregiver responsibilities related to the hospice care and services that were to be provided and failed to provide for the education and training of the SNF staff related to those responsibilities.</p> <p>4. Clinical record number 3 included a plan of care dated 6-1-11. The plan of care failed to identify patient and/or caregiver responsibilities related to the hospice care and services that were to be provided and failed to provide for the education and training of the patient and/or caregiver related to those responsibilities.</p> <p>5. Clinical record number 4 identified the patient was a resident of a SNF and included a plan of care dated 9-1-11. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>plan of care failed to identify SNF caregiver responsibilities related to the hospice care and services that were to be provided and failed to provide for the education and training of the SNF staff related to those responsibilities.</p> <p>6. Clinical record number 5 included a plan of care dated 10-5-11. The plan of care failed to identify patient and/or caregiver responsibilities and failed to provide for the education and training of the patient and/or caregiver related to those responsibilities.</p> <p>7. Clinical record number 6 included a plan of care dated 1-10-12. The plan of care failed to identify patient and/or caregiver responsibilities and failed to provide for the education and training of the patient and/or caregiver related to those responsibilities.</p> <p>8. Clinical record number 7 included a plan of care dated 2-1-12. The plan of care failed to identify patient and/or caregiver responsibilities and failed to provide for the education and training of the patient and/or caregiver related to those responsibilities.</p> <p>9. Clinical record number 8 included a plan of care dated 1-26-12. The plan of care failed to identify patient and/or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>caregiver responsibilities and failed to provide for the education and training of the patient and/or caregiver related to those responsibilities.</p> <p>10. Clinical record number 9 included a plan of care dated 4-19-12. The plan of care failed to identify patient and/or caregiver responsibilities and failed to provide for the education and training of the patient and/or caregiver related to those responsibilities.</p> <p>11. Clinical record number 10 included a plan of care dated 3-6-12. The plan of care failed to identify patient and/or caregiver responsibilities and failed to provide for the education and training of the patient and/or caregiver related to those responsibilities.</p> <p>12. Clinical record number 11 included a plan of care dated 3-20-12. The plan of care failed to identify patient and/or caregiver responsibilities and failed to provide for the education and training of the patient and/or caregiver related to those responsibilities.</p> <p>13. The hospice director, employee B, indicated, on 6-15-12 at 11:35 AM Central Time, plans of care did not specify if SNF staff or patients or their caregivers would be responsible for some</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interventions on the plan of care and did not provide for education and training of the caregivers if needed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0552	<p>418.56(d) REVIEW OF THE PLAN OF CARE The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.</p> <p>Based on clinical record and hospice policy review, the hospice failed to ensure the all members of the interdisciplinary group (IDG), in collaboration with the attending physician, had reviewed the plans of care in 7 (#s 1, 3, 4, 5, 7, 8, and 10) of 9 records reviewed of patients that had been on service for longer than 15 days and failed to ensure the registered nurse member of the IDG had advised the physician of the need to revise the plan of care in 7(#s 1, 2, 3, 4, 5, 10, and 11) of 11 records reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced the plan of care had been revised by the licensed practical nurse (LPN), employee I, per verbal physician orders, on 5-7-12 and and 6-6-12.</p> <p>A. The record included three (3) "Physician Verbal Orders" dated 5-7-12</p>	L0552	The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) regarding the need for documentation to support all members of the IDG in collaboration with the attending physician (if applicable) had reviewed the POC; the need to change the practice of LPNs communicating with the physician prior to communicating with the RN. ISDH requires the LPN to first communicate with the RN prior to communicating with the physician, after conversing with the RN, the LPN may then communicate with the physician if directed to do so by the RN. 100% of charts will be reviewed to ensure the required members of the Interdisciplinary Group (IDG) collaborate patient care with the attending physician. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>for medication that had been signed and dated by the LPN, employee I.</p> <p>B. The record included a "Physician Verbal Order" dated 6-6-12 for a medication change that had been signed and dated by the LPN, employee I.</p> <p>C. The record evidenced the plan of care had been updated on 5-22-12 and 6-12-12. The reviews failed to evidence participation by the medical social worker.</p> <p>2. Clinical record number 2 evidenced the plan of care had been updated by the LPN, employee I, on 6-11-12 and 6-12-12.</p> <p>A. The record included a "Client Coordination Note Report", signed and dated by the LPN, employee I, on 6-11-12. The note states, "Call made to [attending physician/medical director] and family and updated on patient's declining condition."</p> <p>B. The record included "Physician Verbal Orders", signed and dated by the LPN, employee I, on 6-3-12 and 6-7-12 for medication changes.</p> <p>3. Clinical record number 3 included a plan of care dated 6-1-11 and evidenced</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the patient had been discharged on 7-22-11. The record evidenced the plan of care had been reviewed by the IDG on 6-7-11, 6-21-11, 7-5-11, 7-11-11, and 7-19-11.</p> <p>A. The 6-7-11 and 7-11-11 reviews of the plan of care failed to evidence collaboration with the attending physician.</p> <p>B. The record included a "Physician's Interim Order Report" that the plan of care had been updated per verbal orders by the LPN employee I, on 6-16-11, 6-30-11, 7-1-11, 7-19-11, 7-21-11, and 7-22-11.</p> <p>4. Clinical record number 4 included a plan of care dated 9-1-11 and evidenced the patient had been discharged on 9-23-11. The record evidenced the plan of care had been reviewed by the IDG on 9-6-11 and 9-20-11.</p> <p>A. The 9-6-11 review failed to evidence participation by the medical director who was also the patient's attending physician.</p> <p>B. The record included a "Physician's Interim Order Report" that evidenced the LPN, employee I, had received physician orders to update the plan of care on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>9-12-11, 9-19-11, 9-20-12, and 9-22-11.</p> <p>5. Clinical record number 5 included a plan of care dated 10-5-11 and evidenced the patient had been discharged on 12-21-11. The record evidenced the plan of care had been reviewed on 10-18-11, 11-1-11, 11-15-11, 11-29-11, 12-6-11, and 12-20-11.</p> <p>A. The 11-1-11 and 11-29-11 reviews failed to evidence the medical director had participated in the review and failed to evidence collaboration with the attending physician.</p> <p>B. The 12-6-11 review failed to evidence the medical director, the medical social worker (MSW), or the spiritual care counselor (SCC) members of the IDG had participated in the review.</p> <p>C. The 12-20-11 review failed to evidence the MSW and SCC members of the IDG had participated in the review.</p> <p>D. The record included a "Physician's Interim Order Report", signed and dated by the LPN, employee I, on 10-7-11, that evidenced the LPN had updated the plan of care with an order for medication changes.</p> <p>6. Clinical record number 7 included a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>plan of care dated 2-1-12 and evidenced the patient had been discharged on 2-21-12. The record evidenced the plan of care had been reviewed on 2-7-12, 2-14-12, and 2-21-12.</p> <p>The 2-7-12, 2-14-12, and 2-21-12 reviews failed to evidence collaboration with the attending physician.</p> <p>7. Clinical record number 8 included a plan of care dated 1-26-12 and evidenced the patient had been discharged on 2-25-12. The record evidenced the plan of care had been reviewed on 2-7-12, 2-14-12, and 2-21-12.</p> <p>The 2-7-12, 2-14-12, and 2-21-12 reviews of the plan of care failed to evidence collaboration with the attending physician.</p> <p>8. Clinical record number 10 included a plan of care dated 3-6-12 and evidenced the patient had been discharged on 5-27-12. The record evidenced the plan of care had been reviewed on 3-13-12, 3-22-12, 4-3-12, 4-10-12, 4-17-12, 5-1-12, and 5-8-12.</p> <p>A. The 3-13-12, 3-22-12, 4-3-12, 4-10-12, 4-17-12, 5-1-12, and 5-8-12 reviews failed to evidence collaboration with the attending physician.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>B. The record failed to evidence the plan of care had reviewed at least every 15 days. The last documented review was 5-8-12 and the patient was not discharged until 5-27-12.</p> <p>C. The record included a "Client Coordination Note Report", signed and dated by the LPN, employee I, on 3-29-12. The note states, "Call made to [medical director] to report patients constipation issue and feelings at times SOA [short of air]. New orders received."</p> <p>D. The record included a "Client Coordination Note Report", signed and dated by the LPN, employee I, on 3-29-12, that states, "Call made to [name of durable medical equipment company] to request and order O2 [oxygen] at 2 L [liters] per N/C [nasal cannula] as needed for SOA. Requested concentrator and portable."</p> <p>E. The record included a "Client Coordination Note Report", signed and dated by the LPN, employee I, on 4-23-12, that states, "Patient reports increased nausea. Current regiment effective briefly. Will notify M. D."</p> <p>F. The record included a "Client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Coordination Note Report", signed and dated by the LPN, employee I, on 4-25-12, that states, "1600 Received call from [name], NP [nurse practitioner] for [name of attending]. Orders received to discontinue MS Contin and order Oxycodone Elixir 10 mg every 6 hr prn for breakthrough pain. New orders called to [name of pharmacy]."</p> <p>The record included a "Physician Verbal Order", signed and dated by the LPN, employee I, on 4-25-12. The order was for the Oxycodone Elixir.</p> <p>G. The record included a "Client Coordination Note Report", signed and dated by the LPN, employee I, on 5-10-12 that states "Instructed patient that this nurse would notify and update M.D.'s nurse [name of nurse] on condition."</p> <p>A "Client Coordination Note Report", signed and dated by the LPN, employee I, on 5-10-12 states, "Call made to M.D. and spoke with [name of nurse] in great detail and updated on patients condition . . . orders received."</p> <p>H. The record included a "Physician Verbal Order", signed and dated by the LPN, employee I, on 5-18-12 that states, "DC [discontinue] aspirin."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>I. The record included a "Client Coordination Note Report", signed and dated by the LPN, employee I, on 5-22-12 that evidenced the LPN had called the attending physician and updated the physician's nurse regarding the patient having fallen with "right sided rib pain."</p> <p>J. A "Client Coordination Note Report", signed and dated by the LPN, employee I, on 5-22-12 evidenced the LPN had called the durable medical equipment company to "request delivery of bedside commode."</p> <p>K. The record included two (2) "Physician Verbal Order" forms, signed and dated by the LPN, employee I, on 5-24-12 that were for medication changes, Lantus and Ativan.</p> <p>L. The record included a Client Coordination Note Report", signed and dated by the LPN, employee I, on 5-24-12 that evidenced the LPN had call the patient's attending physician's office and had spoken with the nurse. The note evidenced the LPN had "updated on condition and reported appearance of left foot."</p> <p>M. The record included a Client Coordination Note Report", signed and dated by the LPN, employee I, on 5-25-12</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>that evidenced a "follow-up call made to [name of attending] . . . updated on patient's condition . . . no changes in orders at this time."</p> <p>9. Clinical record number 11 evidenced the licensed practical nurse, employee I, had advised the physician of a change in the patient's condition that suggested a need to revise the plan of care.</p> <p>A. The record included a "Client Coordination Note Report" signed and dated by the LPN, employee I, on 4-6-12. The note states, "Paged [name of attending/medical director] and updated on patients condition and events and orders received to increase Morphine drip to 18.5 mg and call back with any further needs."</p> <p>B. The record included a "Client Coordination Note Report" signed and dated by the LPN, employee I, on 4-7-12. The note states, "Call made to [attending/medical director] and updated on patients condition, new orders received to increase morphine drip to 20 mg."</p> <p>C. The record included two (2) "Client Coordination Note Report" documents, both signed and dated by the LPN on 4-8-12. The notes both evidence the LPN had called the patient's attending</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>physician (also the hospice's medical director) to inform her of a change in the patient's condition and to receive orders for updates to the plan of care.</p> <p>10. The hospice director, employee B, was unable to provide any additional documentation and/or information when asked on 6-15-12 at 11:35 AM Central Time.</p> <p>11. The hospice's undated "Plan of Care" policy number PFC.P15 states, "The plan of care is reviewed and updated by the interdisciplinary team every two weeks or more frequently if needed."</p> <p>12. The hospice's undated "Interdisciplinary Team" policy number PFC.I10 states, "The interdisciplinary team at Angels of Mercy Hospice includes, at a minimum, the following individuals: a. a doctor of medicine or osteopathy, b. a registered nurse, c. a social worker, d. a counselor . . . The interdisciplinary team is responsible for: establishing, implementing, reviewing and revising the patient's plan of care . . . A registered nurse member of the interdisciplinary team is designated as the RN Case Manager for each patient/caregiver. The RN Case Manager is responsible for . . . implementing the interdisciplinary plan of care."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L0579	<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.</p> <p>Based on observation, interview, hospice policy review, and Centers for Disease Control (CDC) recommendations review, the hospice failed to ensure individuals had provided care in accordance with hospice policy and the CDC guidelines in 2 (#s 1 and 2) of 2 home visit observations completed creating the potential for the spread of disease causing organisms among patients and staff.</p> <p>The findings include:</p> <p>1. The CDC "Standards Precautions" excerpt from the "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" 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 to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . IV.A.3. Perform hand hygiene: Before having direct contact with patients. After contact with blood, body fluids or excretions, mucous</p>	L0579	The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) regarding the practice to prevent the transmission of infections including use of standard precautions. Employee competencies for Infection control will be performed. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>membranes, nonintact skin, or wound dressings. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). If hands will be moving from a contaminated body site to a clean body site during patient care. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. After removing gloves."</p> <p>2. The hospice's undated "Infection Control - Standard Precautions" policy number CES.I55 states, "Hospice staff will use standard precautions in the care of all hospice patients, regardless of diagnosis or presumed infection status . . . Handwashing . . . Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments; Wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites . . . Gloves . . . Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms; and remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another patient, and wash hands</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>immediately to avoid transfer of microorganisms to other patients or environments."</p> <p>3. On 6-13-12 at 2:05 PM Central Time, employee I, a licensed practical nurse (LPN) was observed to provide care to patient number 1, a resident of a skilled nursing facility (SNF). The LPN entered the room and donned clean gloves without cleansing her hands. The LPN obtained the patient's temperature and a pulse oximetry reading, reached into her pocket with her gloved hand, and obtained an alcohol pad to clean her equipment. The LPN obtained the patient's blood pressure and reached into her pocket to obtain an alcohol pad to clean the blood pressure cuff. The LPN then listened to the patient's heart and lungs and again reached into her pocket and obtained an alcohol pad to clean the stethoscope.</p> <p>After obtaining the patient's vital signs, the LPN removed her gloves and touched her tablet to chart her findings. The LPN was not observed to cleanse her hands after removing her gloves. Without cleansing her hands, the LPN donned clean gloves removed the patient's blankets from the lower body, partially removed the adult diaper from the patient's buttocks, and observed the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>patient's sacrum. The nurse re-fastened the adult diaper, removed her gloves and failed to cleanse her hands. The LPN then touched her stethoscope and replaced the blankets onto the patient. The LPN then washed her hands.</p> <p>4. On 6-14-12 at 9:20 AM Central Time, employee F, a registered nurse (RN), was observed to provide care to patient number 2, a resident of a SNF. After holding the patient to one side while the SNF nurse removed the dressing to the patient's coccyx, the RN removed her gloves and cleansed her hands. The RN re-applied the patient's oxygen tubing and touched the patient's hair. The RN then donned clean gloves without cleansing her hands and adjusted the patient's oxygen tubing and touched the bed rail.</p> <p>The SNF nurse completed the dressing change and the hospice nurse held the patient over on one side. After completion of the dressing change the patient complained of pain. The hospice nurse left the room and obtained pain medication from the medication cart at the nurse's station. Upon return to the room, the hospice nurse donned clean gloves without cleansing her hands and administered the patient's pain medication. The nurse removed her gloves and failed to cleanse her hands.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The nurse touched the door to the patient's room and returned the medication to the medication cart at the nurse's station.</p> <p>5. The hospice director, employee B, indicated, on 6-14-12 at 11:30 AM Central Time, employees F and I had not followed the hospice's infection control and standard precautions policies while providing care to patients numbered 1 and 2.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L0598	<p>418.64(d)(3) COUNSELING SERVICES (3) Spiritual counseling The hospice must: (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 clinical record and hospice policy review and interview, the hospice failed to ensure assessments of patients' and families' spiritual needs had been completed in 11 (#s 1 through 11) of 11 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 identified the patient as a resident of a skilled nursing facility (SNF) and included a start of care nursing assessment completed by the registered nurse (RN), employee F, on 5-3-12. The record included an assessment completed by the medical social worker (MSW), employee L, on 5-8-12. The record failed to evidence a spiritual care counseling (SCC) assessment to identify any potential</p>	L0598	The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) regarding the documentation of assessments of patients' and families' spiritual needs on the comprehensive assessment. 100% of admissions will be reviewed to ensure documentation of assessments of patients' and families' spiritual needs on the comprehensive assessment. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>patient and/or family spiritual care needs.</p> <p>3. Clinical record number 2 identified the patient as a resident of a SNF and included a start of care nursing assessment completed by the RN, employee F, on 6-7-12. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual needs.</p> <p>4. Clinical record number 3 included a start of care nursing assessment completed by the RN, employee M, on 6-1-11 and a MSS assessment completed by employee L, the MSW, on 6-2-11. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>5. Clinical record number 4 identified the patient as a SNF resident and included a start of care nursing assessment completed by the RN, employee M, on 9-1-11. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>6. Clinical record number 5 included a start of care nursing assessment dated 10-5-11 completed by the RN, employee M. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>7. Clinical record number 6 included a start of care nursing assessment completed by the RN, employee N, on 1-10-12. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>8. Clinical record number 7 included a start of care nursing assessment completed by the RN, employee M, on 2-1-12. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>9. Clinical record number 8 included a start of care nursing assessment completed by the RN, employee M, on 1-26-12. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>10. Clinical record number 9 included a start of care nursing assessment completed by the RN, employee B, on 4-19-12. The record included an initial MSS visit note dated completed by employee L on 4-24-12. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>11. Clinical record number 10 included a start of care nursing assessment</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>completed by the RN, employee N, on 3-6-12 and an initial MSS visit note completed by employee L dated 3-6-12. The record failed to evidence a SCC assessment to identify any potential patient and/or family spiritual care needs.</p> <p>12. Clinical record number 11 included a start of care nursing assessment completed by the RN, employee N, on 3-20-12, and an initial MSS visit note completed by employee L on 4-3-12. The record failed to evidence a SCC assessment to identify any potential patient and/or spiritual care needs.</p> <p>13. The hospice director, employee B, indicated, on 6-15-12 at 11:35 AM Central Time, the records did not include complete comprehensive assessments. The director stated, "I know the SCC needs his own assessment and plan of care tools."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0647	<p>418.78(e) LEVEL OF ACTIVITY Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.</p> <p>Based on administrative record review and interview, the hospice failed to ensure volunteer hours reached the required 5 percent of the total paid hospice employee hours in 1 (2011) of 1 year reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's "2011 Volunteer Activity Record" evidenced the "% Utilization of Volunteers" was 1.84 %. 2. The hospice director, employee B, stated, on 6-18-12 at 2:40 PM Central Time, "I think the volunteer percentage calculation is a mathematical error. I need to re-figure that." 	L0647	<p>The Director of Nursing will ensure volunteer hours meet the required 5 percent of the total patient care hours of all paid hospice employee hours. The hospice volunteer program will be evaluated to ensure volunteer hours reach the required 5 percent of the total patient care hours of all paid hospice employee hours. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0648	<p>Based on hospice policy and personnel file review and interview, it was determined the hospice failed to all required services were available as needed on a 24 hour basis and failed to ensure all staff had been evaluated for the competent performance of their assigned duties creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice failed to ensure medical social services would be available to patients as needed on a 24-hour basis creating the potential to affect both of the hospice's current patients. (See L 653). 2. The hospice failed to ensure all employees and volunteers had been evaluated for the competent performance of their assigned job duties in 4 (files C, D, E, and I) of 9 personnel files reviewed. (See L 663). <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.100 Organization and Administration of Services.</p>	L0648	<p>The Director of Nursing will ensure all required services will be available as needed on a 24 hours basis and will ensure all staff and volunteers have been evaluated for the competent performance of their assigned duties. 100% of personnel files will be reviewed to ensure employees/volunteers are evaluated annually for job performance. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0653	<p>418.100(c)(2) SERVICES (2) Nursing services, physician services, and drugs and biologicals (as specified in §418.106) must be made routinely available on a 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.</p> <p>Based on hospice policy review and interview, the hospice failed to ensure medical social services would be available to patients as needed on a 24-hour basis creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice director, employee B, indicated, during the entrance conference on 6-13-12 at 11:15 AM Central Time, the hospice's medical social worker had left their employment a week ago but that employee C, a corporate employee, would be available to provide medical social services to patients of the hospice. 2. The surveyor requested a telephone interview with employee C on 6-18-12 at 1:50 PM Central Time. At 2:10 PM Central Time, the hospice director stated, "He [the medical social worker] is not available at this time. He might be working at his other job. He teaches. He 	L0653	The Director of Nursing will ensure medical social services will be available to patients as needed on a 24-hour basis. The medical social services position will include the requirement for availability as needed on a 24-hour basis. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>will be available to us 20 hours a week for IDT meetings."</p> <p>3. The hospice's undated "Availability 24/7" policy number PFC.A65 states, "Other hospice services, including social work services, spiritual care, and bereavement support, are available on an on-call basis as needed outside of normal business hours."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0663	<p>418.100(g)(3) TRAINING</p> <p>(3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.</p> <p>Based on personnel file and hospice policy review and interview, the hospice failed to ensure all employees and volunteers had been evaluated for the competent performance of their assigned job duties in 4 (files C, D, E, and I) of 9 personnel files reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been assigned to provide medical social services to patients on behalf of the hospice. The file failed to evidence the individual had been evaluated for the competent performance of medical social worker job duties. 2. Personnel file D evidenced the individual had been assigned to provide registered dietitian services to patients on behalf of the hospice. The file failed to evidence the individual had been evaluated for the competent performance 	L0663	The Director of Nursing will ensure all employees and volunteers will be evaluated for competent performance of their assigned job duties. 100% of employees and volunteers will be evaluated annually for competent performance of their assigned job duties. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of registered dietitian job duties.</p> <p>3. Personnel file E evidenced the individual had been assigned to provide spiritual care counseling to patients on behalf of the hospice. The file failed to evidence the individual had been evaluated for the competent performance of spiritual care counseling job duties.</p> <p>4. Personnel file I evidenced the individual had been assigned to provide licensed practical nursing services to patient on behalf of the hospice. The file failed to evidence the individual had been evaluated for the competent performance of nursing job duties.</p> <p>5. The hospice director, employee B, was unable to provide any additional documentation and/or information when asked on 6-18-12 at 1:55 PM Central Time.</p> <p>6. The hospice's undated "Competency Assessment" policy number WE.C10 states, "As a component of the "orientation process, new staff and volunteers complete a competency evaluation prior to providing care or assuming administrative responsibilities . . . Competency assessment occurs during the orientation process period, annually as a component of performance evaluations,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and as needed, when adverse patient outcomes are directly related to an individual's performance."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0704	<p>418.108 SHORT-TERM INPATIENT CARE</p> <p>Based on administrative record review and interview, it was determined the hospice failed to ensure inpatient care was available to patients creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice failed to ensure inpatient care for pain control and symptom management was arranged for and available creating the potential to affect both of the hospice's current patients. (See L 705). 2. The hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that identified the inpatient services to be provided and specified the hospice must supply the provider with a copy of the patient's plan of care creating the potential to affect both of the hospice's current patients. (See L 711). 3. The hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that specified the provider had established policies 	L0704	The Director of Nursing will ensure inpatient care will be available to patients. An inpatient contract will be obtained and reviewed annually. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>consistent with the hospice and palliative care protocols creating the potential to affect both of the hospice's current patients. (See L 712).</p> <p>4. The hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that specified the inpatient clinical record was complete, that a discharge summary would be provided, and that a copy of the inpatient clinical record would be available creating the potential to affect both of the hospice's current patients. (See L 713).</p> <p>5. The hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that identified an individual responsible for implementation of the agreement creating the potential to affect both of the hospice's current patients. (See L 714).</p> <p>6. The hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that provided for the training of personnel and documentation of the training creating the potential to affect both of the hospice's current patients. (See L 715).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>7. The hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that provided for the verification that these requirements are met creating the potential to affect both of the hospice's current patients. (See L 716).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.108 Short-term Inpatient Care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0705	<p>418.108 SHORT-TERM INPATIENT CARE Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.</p> <p>Based on administrative record review and interview, the hospice failed to ensure inpatient care for pain control and symptom management was arranged for and available creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records failed to evidence a contract or written agreement with a provider to ensure inpatient care for the management of symptoms and pain control. 2. The hospice director, employee B, stated, on 6-18-12 at 11:50 AM, "We are currently working on a contract with [name of hospital]. We currently do not have one in place." 	L0705	The Director of Nursing will ensure inpatient care will be available to patients for pain control and symptom management. An inpatient contract will be obtained and reviewed annually. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L0711	<p>418.108(c)(1) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS</p> <p>If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-</p> <p>(1) That the hospice supplies the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;</p> <p>Based on administrative record review and interview, the hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that identified the inpatient services to be provided and specified the hospice must supply the provider with a copy of the patient's plan of care creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. The hospice's administrative records failed to evidence a contract or written agreement with an inpatient provider for the provision of pain control and symptom management that specified the hospice must provide the inpatient provider with a copy of the patient's plan of care and specified the inpatient services to be furnished.</p>	L0711	The Director of Nursing will ensure inpatient care will be available to patients for pain control and symptom management including supplying the provider with a copy of the patient's Plan of Care. An inpatient contract will be obtained and reviewed annually. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The hospice director, employee B, stated, on 6-18-12 at 11:50 AM, "We are currently working on a contract with [name of hospital]. We currently do not have one in place."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0712	<p>418.108(c)(2) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (2) That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients;</p> <p>Based on administrative record review and interview, the hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that specified the provider had established policies consistent with the hospice and palliative care protocols creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. The hospice's administrative records failed to evidence a contract or written agreement with an inpatient provider for the provision of pain control and symptom management that specified the provider had established policies consistent with the hospice and palliative care protocols creating the potential to affect both of the hospice's current</p>	L0712	The Director of Nursing will ensure inpatient care will be available to patients for pain control and symptom management. An inpatient contract will be obtained and reviewed annually. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>patients.</p> <p>2. The hospice director, employee B, stated, on 6-18-12 at 11:50 AM, "We are currently working on a contract with [name of hospital]. We currently do not have one in place."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0713	<p>418.108(c)(3) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (3) That the hospice patient's inpatient clinical record includes a record of all inpatient services furnished and events regarding care that occurred at the facility; that a copy of the discharge summary be provided to the hospice at the time of discharge; and that a copy of the inpatient clinical record is available to the hospice at the time of discharge;</p> <p>Based on administrative record review and interview, the hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that specified the inpatient clinical record was complete, that a discharge summary would be provided, and that a copy of the inpatient clinical record would be available creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. The hospice's administrative records failed to evidence a contract or written agreement with an inpatient provider for the provision of pain control and symptom management that specified that the inpatient clinical record would be</p>	L0713	The Director of Nursing will ensure inpatient care will be available to patients for pain control and symptom management and the inpatient contract will include all required language. An inpatient contract will be obtained and reviewed annually. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>complete, that a discharge summary would be provided, and that a copy of the inpatient clinical record would be available</p> <p>2. The hospice director, employee B, stated, on 6-18-12 at 11:50 AM, "We are currently working on a contract with [name of hospital]. We currently do not have one in place."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0714	<p>418.108(c)(4) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (4) That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement;</p> <p>Based on administrative record review and interview, the hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that identified an individual responsible for implementation of the agreement creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records failed to evidence a contract or written agreement with an inpatient provider for the provision of pain control and symptom management that identified an individual responsible for the implementation of the provisions of the agreement. 2. The hospice director, employee B, stated, on 6-18-12 at 11:50 AM, "We are currently working on a contract with 	L0714	The Director of Nursing will ensure inpatient care will be available to patients for pain control and symptom management and the inpatient contract will include all required language. An inpatient contract will be obtained and reviewed annually. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[name of hospital]. We currently do not have one in place."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0715	<p>418.108(c)(5) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (5) That the hospice retains responsibility for ensuring that the training of personnel who will be providing the patient's care in the inpatient facility has been provided and that a description of the training and the names of those giving the training is documented;</p> <p>Based on administrative record review and interview, the hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that provided for the training of personnel and documentation of the training creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records failed to evidence a contract or written agreement with an inpatient provider for the provision of pain control and symptom management that provided for the training of inpatient personnel and the documentation of the training including the name of the instructor(s). 2. The hospice director, employee B, 	L0715	The Director of Nursing will ensure inpatient care will be available to patients for pain control and symptom management; training will be conducted and documented; and the inpatient contract will include all required language. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	stated, on 6-18-12 at 11:50 AM, "We are currently working on a contract with [name of hospital]. We currently do not have one in place."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0716	<p>418.108(c)(6) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (6) A method for verifying that the requirements in paragraphs(c)(1) through (c)(5) of this section are met.</p> <p>Based on administrative record review and interview, the hospice failed to ensure a written agreement was in place for the provision of inpatient care for pain control and symptom management that provided for the verification that these requirements are met creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice's administrative records failed to evidence a contract or written agreement with an inpatient provider for the provision of pain control and symptom management that provided for the verification that the requirement in paragraphs (c)(1 through (c)(5) are met. The hospice director, employee B, stated, on 6-18-12 at 11:50 AM, "We are currently working on a contract with [name of hospital]. We currently do not have one in place." 	L0716	The Director of Nursing will ensure inpatient care will be available to patients for pain control and symptom management and the inpatient contract will include all required language. An inpatient contract will be obtained and reviewed annually. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0759	<p>Based on hospice policy and clinical record review, observation, and interview, it was determined the hospice failed to meet the requirements for the provision of hospice care and services to residents of skilled nursing facilities creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice failed to maintain professional management of their patients that were residents of skilled nursing facilities by failing to ensure hospice care and services had been provided by hospice staff in accordance with the hospice plan of care in 2 of 3 records reviewed of patients that were residents of skilled nursing facilities (SNF) resulting in patients not receiving ordered care and medications. (See L 762). 2. The hospice failed to ensure the written agreement provided for the notification of the hospice in the event of a patient's death in 1 of 2 SNF contracts reviewed creating the potential to affect both of the hospice's current patients. (See L 765). 3. The hospice failed to ensure the 	L0759	<p>The Director of Nursing will ensure to maintain professional management of patients who are residents of skilled nursing facilities. Staff will be educated about the Professional management responsibilities. 100% of clinical records are reviewed to ensure agency maintains professional management. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>written agreement specified the SNF would continue to provide the usual services at the same level of care before hospice care was elected in 1 of 2 SNF contracts reviewed creating the potential to affect both of the hospice's current patients. (See L 767).</p> <p>4. The hospice failed to ensure the written agreement addressed the level of care that would be provided by the hospice in 1 (#1) of 2 SNF contracts reviewed creating the potential to affect both of the hospice's current patients. (See L 768).</p> <p>5. The hospice failed to ensure the written agreement addressed the use of SNF staff in the provision of hospice care and services in 1 of 2 SNF contracts reviewed creating the potential to affect both of the hospice's current patients. (See L 770).</p> <p>6. The hospice failed to ensure the written agreement provided for the notification of the reporting of suspected abuse in 1 of 2 SNF contracts reviewed creating the potential to affect both of the hospice's current patients. (See L 771).</p> <p>7. The hospice failed to ensure the written agreement provided for bereavement services to SNF staff in 1 of 2 SNF contracts reviewed creating the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>potential to affect both of the hospice's current patients. (See L 772).</p> <p>8. The hospice failed to ensure plans of care reflected coordination with the SNF in 3 of 3 records reviewed of patients that were residents of a SNF creating the potential to affect both of the hospice's current patients. (See L 773).</p> <p>9. The hospice failed to ensure plans of care reflected coordination with the SNF, identified all needed care and services and specified which provider was responsible for the care in 3 of 3 records reviewed of patients that were residents of a SNF creating the potential to affect both of the hospice's current patients. (See L 774).</p> <p>10. The hospice failed to ensure plans of care reflected participation of SNF staff in the planning of the care in 3 of 3 records reviewed of patients that were residents of a SNF creating the potential to affect both of the hospice's current patients. (See L 775).</p> <p>11. The hospice failed to ensure changes in the hospice plan of care were approved by the hospice in 2 of 3 records reviewed of patients that were residents of SNF resulting in patients not receiving ordered care and medications. (See L 776).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>12. The hospice failed to ensure plans of care and updates specific to each patient had been provided to the SNF in 2 of 2 home visits made to SNFs resulting in patients not receiving ordered hospice care and services. (See L 781).</p> <p>13. The hospice failed to ensure hospice orientation had been provided to SNF staff in 2 of SNFs reviewed creating the potential to affect both of the hospice's current patients. (See L 782).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.112 Hospices That Provide Hospice Care to Residents of a SNF/NF or ICF/MR.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0762	<p>418.112(b) PROFESSIONAL MANAGEMENT</p> <p>The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §418.100 and §418.108.</p> <p>Based on clinical record review and hospice policy review and interview, the hospice failed to maintain professional management of their patients that were residents of skilled nursing facilities by failing to ensure hospice care and services had been provided by hospice staff in accordance with the hospice plan of care in 2 (#s 1 and 2) of 3 records reviewed of patients that were residents of skilled nursing facilities (SNF) resulting in patients not receiving ordered care and medications.</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced the patient was a resident of a SNF with a hospice diagnosis of dementia. The record failed to evidence the hospice had retained professional management responsibility of the care of the patient.</p> <p>A. The hospice record included a "Client Medication Report" that identified</p>	L0762	The Director of Nursing will ensure to maintain professional management of patients who are residents of skilled nursing facilities in accordance with the hospice plan of care. 100% of clinical records are reviewed to ensure agency maintains professional management. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Bactrim DS, an antibiotic, had been started on 5-11-12 and that the hospice was responsible for the medication.</p> <p>B. The SNF record was reviewed during a home visit to patient number 1 on 6-13-12 at 2:05 PM. The SNF record evidenced an order signed and dated by SNF staff on 5-9-12 that states, "In & out cath for U/A, C/S [urinalysis, culture and sensitivity]."</p> <p>C. A SNF "Nurses Note", dated 5-9-12 states, "MD aware of res. [resident] foul urine & dark in color. & N.O. [new order] received & noted." A "Nurses Note" dated 5-10-12 states, "attempted to obtain U/A for lab & was unsuccessful." A "Nurses Note" dated 5-11-12 states, "attempted to catheterize for urine specimen. Res. uncooperative, yelling, clenching legs, grabbing at groin area. [Attending physician, also the hospice medical director] notified . . . Angel of Mercy RN notified of difficulty with urine specimen collection. States will speak with [attending physician/hospice medical director] today . . . Hospice nurse here N.O. Bactrim DS . . . UTI symptoms, refused U/A. Call if urinary retention occurs."</p> <p>The SNF record included an order, signed and dated by SNF staff on 5-11-12</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>at 11:30 AM, that states, "Bactrim DS . . . call if urinary retention occurs."</p> <p>D. The hospice record included a skilled nurse visit note, signed and dated by the licensed practical nurse (LPN), employee I, on 5-9-12. The visit note failed to evidence any mention of the patient's urinary tract problem and the order in the SNF record to obtain a urine specimen for testing.</p> <p>1.) A visit note completed by employee N, a hospice RN, on 5-11-12 at 5:45 PM, states, "Dark cloudy foul urine noted and obtained order for antibiotics."</p> <p>2.) The hospice record included a physician verbal order dated 5-11-12 11:10 AM that states, "Begin Bactrim DS."</p> <p>2. Clinical record number 2 included a hospice plan of care established by the interdisciplinary group on 6-7-12. The plan of care states, "SN for administration of decubitus wound care. Cleanse with NS [normal saline] or wound cleanser. Cover with Optifoam with silver using clean technique. SNF to change daily."</p> <p>A. A home visit was made to patient number 2 on 6-14-12 at 9:20 AM with employee F, a registered nurse (RN). A</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>SNF staff member was observed to change the dressing on the patient's coccyx. The hospice nurse assisted by holding the patient over on the patient's side.</p> <p>B. The hospice nurse indicated, on 6-14-12 at 9:20 AM Central Time, the dressing change was the responsibility of the hospice. The nurse stated, "I see the patient 2 or 3 times a week but the SNF staff change the dressing every day."</p> <p>C. On 6-14-12 at 10:05 AM Central Time, the SNF nurse stated, "I don't remember the dressing change being every day. We have been changing it every other day."</p> <p>The SNF treatment records indicated the dressing was to be changed every other day and included documentation the dressing had been changed on 6-7-12, 6-9-12, 6-11-12, and 6-13-12 per SNF staff.</p> <p>D. The SNF nurse stated, on 6-14-12 at 10:05 AM Central Time, "I am used to the hospice nurses writing the orders. That is what [name of another hospice] does. These hospice nurse do not. I do. They just call and tell us what the orders are."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>E. Upon completion of the dressing change by the SNF nurse on 6-14-12 at 9:55 AM, the patient complained of severe pain and rated it as a "10" on a scale of 1 to 10 with 10 being the worse pain. The hospice nurse stated to the patient, "[SNF nurse] will get you your pain medicine." The SNF nurse indicated she would get the patient's pain medication but had to "answer a call light first." The hospice nurse began talking to the patient's spouse explaining the purpose of heel protectors. The hospice nurse was asked if she could administer the pain medication. The hospice nurse said, "I can but the medication is at the nurse's station in a locked cart. I will have to wait until the [SNF nurse] comes back to get the key." The hospice nurse finished her instructions to the patient's spouse and proceeded to obtain the patient's pain medication and administer it.</p> <p>F. The SNF record was reviewed on 6-14-12 at 10:10 AM Central Time. The record included an order signed and dated by a SNF nurse for occupational and physical therapy. The hospice plan of care failed to evidence any therapy orders.</p> <p>G. The hospice nurse, employee F, was asked, on 6-14-12 at 12:15 PM Central Time if she had followed-up with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the patient's pain relief. The nurse replied, "No, I didn't. The SNF staff are usually pretty good at following up."</p> <p>H. On 6-14-12 at 12:20 PM Central Time, the hospice director, employee B, stated, "I just wanted to acknowledge I heard the nurse say she did not follow-up with the pain medication administered to patient number 2."</p> <p>3. The hospice director, employee B, stated, on 6-14-12 at 11:30 AM Central Time, "We get the orders [for the hospice patients that are residents of a SNF] per telephone and then call the SNF. They write the orders. I did not know there were orders for physical and occupational therapy on patient number 2's chart."</p> <p>4. The hospice's undated "Hospice Care for Nursing Facility Residents" policy number PFC.H15 states, "The hospice assumes full responsibility for the professional management of the facility patient's hospice care and routinely provides all core services including nursing, medical social services and counseling . . . The hospice may use the facility's nursing personnel to assist in the administration of prescribed therapies included in the patient's plan of care only to the extent that the hospice would routinely utilize the services of a hospice</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	patient's family in implementing the plan of care."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0765	<p>418.112(c)(2) WRITTEN AGREEMENT [The written agreement must include at least the following:] (2) A provision that the SNF/NF or ICF/MR immediately notifies the hospice if-</p> <ul style="list-style-type: none"> (i) A significant change in a patient's physical, mental, social, or emotional status occurs; (ii) Clinical complications appear that suggest a need to alter the plan of care; (iii) A need to transfer a patient from the SNF/NF or ICF/MR arises, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions; or (iv) A patient dies. <p>Based on hospice contract review and interview, the hospice failed to ensure the written agreement provided for the notification of the hospice in the event of a patient's death in 1 (#1) of 2 skilled nursing facility (SNF) contract reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Contract number 1 was a written agreement with with a SNF for the provision of hospice services to residents of the SNF. The contract was signed and dated by the hospice director and a representative of the SNF on 5-31-07. The contract failed to include a provision for the notification of the hospice in the event of a patient's death. 	L0765	The Director of Nursing will ensure the written agreement with skilled nursing facilities includes required language. Skilled nursing facility contracts will be reviewed by the Director of Nursing. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The hospice director, employee B, indicated, on 6-18-12 at 12:20 PM Central Time, contract number 1 was the only one in place for this particular SNF. The director stated, "I thought it had been updated [to reflect the new hospice regulations]."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0767	<p>418.112(c)(4) WRITTEN AGREEMENT [The written agreement must include at least the following:] (4) An agreement that it is the SNF/NF or ICF/MR responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.</p> <p>Based on hospice contract review and interview, the hospice failed to ensure the written agreement specified the SNF would continue to provide the usual services at the same level of care before hospice care was elected in 1 (#1) of 2 skilled nursing facility (SNF) contracts reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. Contract number 1 was a written agreement with with a SNF for the provision of hospice services to residents of the SNF. The contract was signed and dated by the hospice director and a representative of the SNF on 5-31-07. The contract failed to specify the SNF would continue to provide room and board, personal care, and nursing care that the patient's caregivers would have provided in the home before hospice care was elected.</p>	L0767	The Director of Nursing will ensure the written agreement with skilled nursing facilities includes required language. Skilled nursing facility contracts will be reviewed by the Director of Nursing. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The hospice director, employee B, indicated, on 6-18-12 at 12:20 PM Central Time, contract number 1 was the only one in place for this particular SNF. The director stated, "I thought it had been updated [to reflect the new hospice regulations]."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0768	<p>418.112(c)(5) WRITTEN AGREEMENT [The written agreement must include at least the following:] (5) An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/MR resident were in his or her own home.</p> <p>Based on hospice contract review and interview, the hospice failed to ensure the written agreement addressed the level of care that would be provided by the hospice in 1 (#1) of 2 skilled nursing facility (SNF) contracts reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Contract number 1 was a written agreement with with a SNF for the provision of hospice services to residents of the SNF. The contract was signed and dated by the hospice director and a representative of the SNF on 5-31-07. The contract failed to specify the hospice would provide the same level of care to the SNF resident as would have been provided if the patient were in his/her own home. The hospice director, employee B, indicated, on 6-18-12 at 12:20 PM Central Time, contract number 1 was the 	L0768	The Director of Nursing will ensure the written agreement with skilled nursing facilities includes required language. Skilled nursing facility contracts will be reviewed by the Director of Nursing. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	only one in place for this particular SNF. The director stated, "I thought it had been updated [to reflect the new hospice regulations]."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L0769	<p>418.112(c)(6) WRITTEN AGREEMENT [The written agreement must include at least the following:] (6) A delineation of the hospice's responsibilities, which include, but are not limited to the following: providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); social work; provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>Based on hospice contract review and interview, the hospice failed to ensure the written agreement included a delineation of the hospice's responsibilities and specific services in 1 (#1) of 2 skilled nursing facility (SNF) contract reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. Contract number 1 was a written agreement with with a SNF for the provision of hospice services to residents of the SNF. The contract was signed and dated by the hospice director and a representative of the SNF on 5-31-07. The contract failed to evidence a delineation of the specific hospice</p>	L0769	The Director of Nursing will ensure the written agreement with skilled nursing facilities includes required language. Skilled nursing facility contracts will be reviewed by the Director of Nursing. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>services necessary for the management of the patient's terminal illness.</p> <p>2. The hospice director, employee B, indicated, on 6-18-12 at 12:20 PM Central Time, contract number 1 was the only one in place for this particular SNF. The director stated, "I thought it had been updated [to reflect the new hospice regulations]."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0770	<p>418.112(c)(7) WRITTEN AGREEMENT [The written agreement must include at least the following:] (7) A provision that the hospice may use the SNF/NF or ICF/MR nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/MR to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care.</p> <p>Based on hospice contract review and interview, the hospice failed to ensure the written agreement addressed the use of skilled nursing facility (SNF) staff in the provision of hospice care and services in 1 (#1) of 2 SNF contracts reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. Contract number 1 was a written agreement with with a SNF for the provision of hospice services to residents of the SNF. The contract was signed and dated by the hospice director and a representative of the SNF on 5-31-07. The contract failed to evidence a provision that the hospice would use SNF staff for hospice care and services only to the extent the hospice would use the patient's family.</p>	L0770	The Director of Nursing will ensure the written agreement with skilled nursing facilities includes required language. Skilled nursing facility contracts will be reviewed by the Director of Nursing. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The hospice director, employee B, indicated, on 6-18-12 at 12:20 PM Central Time, contract number 1 was the only one in place for this particular SNF. The director stated, "I thought it had been updated [to reflect the new hospice regulations]."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0771	<p>418.112(c)(8) WRITTEN AGREEMENT [The written agreement must include at least the following:] (8) A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation.</p> <p>Based on hospice contract review and interview, the hospice failed to ensure the written agreement provided for the notification of the reporting of suspected abuse in 1 (#1) of 2 skilled nursing facility (SNF) contracts reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. Contract number 1 was a written agreement with with a SNF for the provision of hospice services to residents of the SNF. The contract was signed and dated by the hospice director and a representative of the SNF on 5-31-07. The contract failed to address the hospice's obligation to report all alleged violations involving abuse to the SNF administrator within 24 hours of becoming aware of the allegations.</p>	L0771	The Director of Nursing will ensure the written agreement with skilled nursing facilities includes required language. Skilled nursing facility contracts will be reviewed by the Director of Nursing. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The hospice director, employee B, indicated, on 6-18-12 at 12:20 PM Central Time, contract number 1 was the only one in place for this particular SNF. The director stated, "I thought it had been updated [to reflect the new hospice regulations]."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L0772	<p>418.112(c)(9) WRITTEN AGREEMENT [The written agreement must include at least the following:] (9) A delineation of the responsibilities of the hospice and the SNF/NF or ICF/MR to provide bereavement services to SNF/NF or ICF/MR staff.</p> <p>Based on hospice contract review and interview, the hospice failed to ensure the written agreement provided for bereavement services to SNF staff in 1 (#1) of 2 skilled nursing facility (SNF) contracts reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Contract number 1 was a written agreement with with a SNF for the provision of hospice services to residents of the SNF. The contract was signed and dated by the hospice director and a representative of the SNF on 5-31-07. The contract failed to address the hospice's responsibility to provide bereavement services to SNF staff. The hospice director, employee B, indicated, on 6-18-12 at 12:20 PM Central Time, contract number 1 was the only one in place for this particular SNF. The director stated, "I thought it had been updated [to reflect the new hospice 	L0772	The Director of Nursing will ensure the written agreement with skilled nursing facilities includes required language. Skilled nursing facility contracts will be reviewed by the Director of Nursing. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0773	<p>418.112(d) HOSPICE PLAN OF CARE In accordance with §418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care reflected coordination with the skilled nursing facility (SNF) in 3 (#s 1, 2, and 4) of 3 records reviewed of patients that were residents of a skilled nursing facility (SNF) creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced the patient was a resident of a SNF with a hospice diagnosis of dementia.</p> <p>A. The record included a start of care nursing assessment dated 5-3-12 that identifies the patient's needs. The assessment states the patient was "not oriented to place . . . time . . . immobility . . . incoherence . . . abnormal [skin] turgor . . . abnormal breath sounds . . . dysphasia . . . high nutritional risk . . . Client is incontinent of B/B [bowel and bladder]. On R buttock a red blanchable area of redness is noted. Also redness to peri</p>	L0773	The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) regarding documentation of plans of care that reflect the coordination with skilled nursing facility (SNF). 100% of charts will be reviewed to ensure the required members of the Interdisciplinary Group (IDG) document plans of care that reflect the coordination with skilled nursing facility (SNF). The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>area and groin notes. Foul odor present. Client is nonverbal . . . Client is blind bilat and HOH [hard of hearing]. No hearing aids. Client meds must be crushed in applesauce . . . has no teeth and does not wear dentures d/t [due to] improper fit. Client has hx [history] of frequent UTI [urinary tract infection] and constipation . . . completely dependent on ADLs [activities of daily living]. Client is unable to ambulate, unable to dress or groom self, unable to perform any hygiene. Client is incontinent of B/B constantly."</p> <p>B. The hospice plan of care, established by the IDG on 5-3-12, failed to evidence coordination with the SNF to develop an integrated plan of care that specified which provider would be responsible for each intervention to address all of the patient's identified needs.</p> <p>2. Clinical record number 2 evidenced the patient was a resident of a SNF with a hospice diagnosis of malignant neoplasm of the kidney.</p> <p>A. The record included a start of care nursing assessment dated 6-7-12 that identifies the patient's needs. The assessment states, "Musculoskeletal swelling, gain/ambulation disturbance . . .</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>transfers bed to chair with maximal assistance, [requires assistance with] housekeeping, shopping, meal prep, bathing , dressing, grooming, toileting . . . limitations . . . mobility/endurance . . . Client currently has a deceits ulcer on coccyx/buttocks and weeping fluid from bilat lower extremities . . . client has severe anxiety today rating depression/anxiety 10/10. Client and family are having a difficult time making adjustments related to clients declining health status. Client is depressed, anxious, scared to die."</p> <p>B. The hospice plan of care, established by the IDG on 6-7-12, failed to evidence coordination with the SNF to develop an integrated plan of care that specified which provider would be responsible for each intervention to address all of the patient's identified needs.</p> <p>3. Clinical record number 4 evidenced the patient was a resident of a SNF with a hospice diagnosis of cerebral artery occlusion with infarct.</p> <p>A. The record included a start of care nursing assessment dated 9-1-11 that identifies the patient's needs. The assessment identifies the patient was "cognitively impaired . . . unable to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>verbalize presence of pain . . . left heel three small scabbed areas 0.6 cm x 0.3 cm progressing towards healed. No redness or drainage. Open to air with foam boot in place for pressure reduction . . .</p> <p>dyspnea with exertion . . . oxygen 2L nasal cannula concentrator . . .</p> <p>incontinence adult undergarments . . . SNF changes adult diapers as needed . . .</p> <p>dry mouth . . . incontinent [of bowel] . . . The patient is taking opioids and is on a bowel regimen . . . needs assistance with feeding . . . Pt is a two assist hooyer lift to w/c [wheelchair] by SNF . . . SNF provides pt care. Hospice aide 3 xs weekly to assist with bathing and other personal care needs . . . Unable to do most activity . . . Unable to take medications . . . SNF administers meds . . . disoriented . . . anxious . . . agitated, lethargic . . . communication barrier . . . agitated/Irritable . . . intermittent confusion . . . chair bound . . . Pt up to w/c with hooyer lift and two assist of nursing home staff. Pt requires assist with feeding. Pt requires frequent med changes for pain control, anxiety, and behavioral issues."</p> <p>B. The hospice plan of care, established by the IDG on 9-1-11 failed to evidence coordination with the SNF to develop an integrated plan of care that specified which provider would be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>responsible for each intervention to address all of the patient's identified needs.</p> <p>4. The hospice director, employee B, was unable to provide any additional documentation and/or information when asked on 6-15-12 at 11:35 AM.</p> <p>5. The facility's undated "Hospice Care For Nursing Facility Residents - Hospice Plan of Care" policy number PFC.H20 states, "The plan of care for the facility patient identified the care and services that are needed and specifically identifies which provider is responsible for performing the respective functions that have been agreed upon and included in the plan of care."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0774	<p>418.112(d)(1) HOSPICE PLAN OF CARE</p> <p>The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care reflected coordination with the skilled nursing facility (SNF), identified all needed care and services and specified which provider was responsible for the care in 3 (#s 1, 2, and 4) of 3 records reviewed of patients that were residents of a skilled nursing facility (SNF) creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced the patient was a resident of a SNF with a hospice diagnosis of dementia.</p> <p>A. The record included a start of care nursing assessment dated 5-3-12 that identifies the patient's needs. The assessment states the patient was "not oriented to place . . . time . . . immobility . . . incoherence . . . abnormal [skin] turgor . . . abnormal breath sounds . . . dysphasia . . . high nutritional risk . . . Client is</p>	L0774	<p>The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) regarding documentation of plans of care that reflect the coordination with skilled nursing facility (SNF) and documentation identifying all needed care and services specifying the responsibilities of each provider. 100% of charts will be reviewed to ensure the required members of the Interdisciplinary Group (IDG) document plans of care that reflect the coordination with skilled nursing facility (SNF). The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>incontinent of B/B [bowel and bladder]. On R buttock a red blanchable area of redness is noted. Also redness to peri area and groin notes. Foul odor present. Client is nonverbal . . . Client is blind bilat and HOH [hard of hearing]. No hearing aids. Client meds must be crushed in applesauce . . . has no teeth and does not wear dentures d/t [due to] improper fit. Client has hx [history] of frequent UTI [urinary tract infection] and constipation . . . completely dependent on ADLs [activities of daily living]. Client is unable to ambulate, unable to dress or groom self, unable to perform any hygiene. Client is incontinent of B/B constantly."</p> <p>B. The hospice plan of care, established by the IDG on 5-3-12, failed to evidence coordination with the SNF to develop an integrated plan of care that specified which provider would be responsible for each intervention to address all of the patient's identified needs.</p> <p>2. Clinical record number 2 evidenced the patient was a resident of a SNF with a hospice diagnosis of malignant neoplasm of the kidney.</p> <p>A. The record included a start of care nursing assessment dated 6-7-12 that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>identifies the patient's needs. The assessment states, "Musculoskeletal swelling, gain/ambulation disturbance . . . transfers bed to chair with maximal assistance, [requires assistance with] housekeeping, shopping, meal prep, bathing , dressing, grooming, toileting . . . limitations . . . mobility/endurance . . . Client currently has a deceits ulcer on coccyx/buttocks and weeping fluid from bilat lower extremities . . . client has severe anxiety today rating depression/anxiety 10/10. Client and family are having a difficult time making adjustments related to clients declining health status. Client is depressed, anxious, scared to die."</p> <p>B. The hospice plan of care, established by the IDG on 6-7-12, failed to evidence coordination with the SNF to develop an integrated plan of care that specified which provider would be responsible for each intervention to address all of the patient's identified needs.</p> <p>3. Clinical record number 4 evidenced the patient was a resident of a SNF with a hospice diagnosis of cerebral artery occlusion with infarct.</p> <p>A. The record included a start of care nursing assessment dated 9-1-11 that</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>identifies the patient's needs. The assessment identifies the patient was "cognitively impaired . . . unable to verbalize presence of pain . . . left hell three small scabbed areas 0.6 cm x 0.3 cm progressing towards healed. No redness or drainage. Open to air with foam boot in place for pressure reduction . . . dyspnea with exertion . . . oxygen 2L nasal cannula concentrator . . . incontinence adult undergarments . . . SNF changes adult diapers as needed . . . dry mouth . . . incontinent [of bowel] . . . The patient is taking opioids and is on a bowel regimen . . . needs assistance with feeding . . . Pt is a two assist hoyer lift to w/c [wheelchair] by SNF . . . SNF provides pt care. Hospice aide 3 xs weekly to assist with bathing and other personal care needs . . . Unable to do most activity . . . Unable to take medications . . . SNF administers meds . . . disoriented . . . anxious . . . agitated, lethargic . . . communication barrier . . . agitated/Irritable . . . intermittent confusion . . . chair bound . . . Pt up to w/c with hoyer lift and two assist of nursing home staff. Pt requires assist with feeding. Pt requires frequent med changes for pain control, anxiety, and behavioral issues."</p> <p>B. The hospice plan of care, established by the IDG on 9-1-11 failed to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>evidence coordination with the SNF to develop an integrated plan of care that specified which provider would be responsible for each intervention to address all of the patient's identified needs.</p> <p>4. The hospice director, employee B, was unable to provide any additional documentation and/or information when asked on 6-15-12 at 11:35 AM.</p> <p>5. The facility's undated "Hospice Care For Nursing Facility Residents - Hospice Plan of Care" policy number PFC.H20 states, "The plan of care for the facility patient identified the care and services that are needed and specifically identifies which provider is responsible for performing the respective functions that have been agreed upon and included in the plan of care."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0775	<p>418.112(d)(2) HOSPICE PLAN OF CARE</p> <p>The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care reflected participation of skilled nursing facility (SNF) staff in the planning of the care in 3 (#s 1, 2, and 4) of 3 records reviewed of patients that were residents of a skilled nursing facility (SNF) creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced the patient was a resident of a SNF with a hospice diagnosis of dementia.</p> <p>A. The record included a start of care nursing assessment dated 5-3-12 that identifies the patient's needs. The assessment states the patient was "not oriented to place . . . time . . . immobility . . . incoherence . . . abnormal [skin] turgor . . . abnormal breath sounds . . . dysphasia . . . high nutritional risk . . . Client is incontinent of B/B [bowel and bladder]. On R buttock a red blanchable area of redness is noted. Also redness to peri area and groin notes. Foul odor present.</p>	L0775	<p>The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) regarding documentation of the participation of skilled nursing facility (SNF) staff in the planning of patient care. 100% of charts will be reviewed to ensure the required members of the Interdisciplinary Group (IDG) document plans of care that reflect the participation of SNF staff in the planning of patient care. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Client is nonverbal . . . Client is blind bilat and HOH [hard of hearing]. No hearing aids. Client meds must be crushed in applesauce . . . has no teeth and does not wear dentures d/t [due to] improper fit. Client has hx [history] of frequent UTI [urinary tract infection] and constipation . . . completely dependent on ADLs [activities of daily living]. Client is unable to ambulate, unable to dress or groom self, unable to perform any hygiene. Client is incontinent of B/B constantly."</p> <p>B. The hospice plan of care, established by the IDG on 5-3-12, failed to evidence coordination with the SNF to develop an integrated plan of care that specified which provider would be responsible for each intervention to address all of the patient's identified needs.</p> <p>2. Clinical record number 2 evidenced the patient was a resident of a SNF with a hospice diagnosis of malignant neoplasm of the kidney.</p> <p>A. The record included a start of care nursing assessment dated 6-7-12 that identifies the patient's needs. The assessment states, "Musculoskeletal swelling, gain/ambulation disturbance . . . transfers bed to chair with maximal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>assistance, [requires assistance with] housekeeping, shopping, meal prep, bathing , dressing, grooming, toileting . . . limitations . . . mobility/endurance . . . Client currently has a deceits ulcer on coccyx/buttocks and weeping fluid from bilat lower extremities . . . client has severe anxiety today rating depression/anxiety 10/10. Client and family are having a difficult time making adjustments related to clients declining health status. Client is depressed, anxious, scared to die."</p> <p>B. The hospice plan of care, established by the IDG on 6-7-12, failed to evidence coordination with the SNF to develop an integrated plan of care that specified which provider would be responsible for each intervention to address all of the patient's identified needs.</p> <p>3. Clinical record number 4 evidenced the patient was a resident of a SNF with a hospice diagnosis of cerebral artery occlusion with infarct.</p> <p>A. The record included a start of care nursing assessment dated 9-1-11 that identifies the patient's needs. The assessment identifies the patient was "cognitively impaired . . . unable to verbalize presence of pain . . . left hell</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>three small scabbed areas 0.6 cm x 0.3 cm progressing towards healed. No redness or drainage. Open to air with foam boot in place for pressure reduction . . . dyspnea with exertion . . . oxygen 2L nasal cannula concentrator . . . incontinence adult undergarments . . . SNF changes adult diapers as needed . . . dry mouth . . . incontinent [of bowel] . . . The patient is taking opioids and is on a bowel regimen . . . needs assistance with feeding . . . Pt is a two assist hoier lift to w/c [wheelchair] by SNF . . . SNF provides pt care. Hospice aide 3 xs weekly to assist with bathing and other personal care needs . . . Unable to do most activity . . . Unable to take medications . . . SNF administers meds . . .disoriented . . . anxious . . . agitated, lethargic . . . communication barrier . . . agitated/Irritable . . . intermittent confusion . . . chair bound . . . Pt up to w/c with hoier lift and two assist of nursing home staff. Pt requires assist with feeding. Pt requires frequent med changes for pain control, anxiety, and behavioral issues."</p> <p>B. The hospice plan of care, established by the IDG on 9-1-11 failed to evidence coordination with the SNF to develop an integrated plan of care that specified which provider would be responsible for each intervention to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>address all of the patient's identified needs.</p> <p>4. The hospice director, employee B, was unable to provide any additional documentation and/or information when asked on 6-15-12 at 11:35 AM.</p> <p>5. The facility's undated "Hospice Care For Nursing Facility Residents - Hospice Plan of Care" policy number PFC.H20 states, "The plan of care reflects the participation of the hospice, the facility and the patient and his/her family to the extent possible."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0776	<p>418.112(d)(3) HOSPICE PLAN OF CARE Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.</p> <p>Based on clinical record review and hospice policy review and interview, the hospice failed to ensure changes in the hospice plan of care were approved by the hospice in 2 (#s 1 and 2) of 3 records reviewed of patients that were residents of skilled nursing facilities (SNF) resulting in patients not receiving ordered care and medications.</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced the patient was a resident of a SNF with a hospice diagnosis of dementia. The record failed to evidence the hospice had retained professional management responsibility of the care of the patient.</p> <p>A. The hospice record included a "Client Medication Report" that identified Bactrim DS, an antibiotic, had been started on 5-11-12 and that the hospice was responsible for the medication.</p> <p>B. The SNF record was reviewed during a home visit to patient number 1 on 6-13-12 at 2:05 PM. The SNF record</p>	L0776	<p>The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) regarding the need for documentation to support any changes in the hospice care plan are discussed with the patient or patient representative and skilled nursing facilities and approved by the hospice before implementation. 100% of charts will be reviewed to ensure that changes in the hospice plan of care are approved by the hospice. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>evidenced an order signed and dated by SNF staff on 5-9-12 that states, "In & out cath for U/A, C/S [urinalysis, culture and sensitivity]."</p> <p>C. A SNF "Nurses Note", dated 5-9-12 states, "MD aware of res. [resident] foul urine & dark in color. & N.O. [new order] received & noted." A "Nurses Note" dated 5-10-12 states, "attempted to obtain U/A for lab & was unsuccessful." A "Nurses Note" dated 5-11-12 states, "attempted to catheterize for urine specimen. Res. uncooperative, yelling, clenching legs, grabbing at groin area. [Attending physician, also the hospice medical director] notified . . . Angel of Mercy RN notified of difficulty with urine specimen collection. States will speak with [attending physician/hospice medical director] today . . . Hospice nurse here N.O. Bactrim DS . . . UTI symptoms, refused U/A. Call if urinary retention occurs."</p> <p>The SNF record included an order, signed and dated by SNF staff on 5-11-12 at 11:30 AM, that states, "Bactrim DS . . . call if urinary retention occurs."</p> <p>D. The hospice record included a skilled nurse visit note, signed and dated by the licensed practical nurse (LPN), employee I, on 5-9-12. The visit note</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>failed to evidence any mention of the patient's urinary tract problem and the order in the SNF record to obtain a urine specimen for testing.</p> <p>1.) A visit note completed by employee N, a hospice RN, on 5-11-12 at 5:45 PM, states, "Dark cloudy foul urine noted and obtained order for antibiotics."</p> <p>2.) The hospice record included a physician verbal order dated 5-11-12 11:10 AM that states, "Begin Bactrim DS."</p> <p>2. Clinical record number 2 included a hospice plan of care established by the interdisciplinary group on 6-7-12. The plan of care states, "SN for administration of decubitus wound care. Cleanse with NS [normal saline] or wound cleanser. Cover with Optifoam with silver using clean technique. SNF to change daily."</p> <p>A. A home visit was made to patient number 2 on 6-14-12 at 9:20 AM with employee F, a registered nurse (RN). A SNF staff member was observed to change the dressing on the patient's coccyx. The hospice nurse assisted by holding the patient over on the patient's side.</p> <p>B. The hospice nurse indicated, on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>6-14-12 at 9:20 AM Central Time, the dressing change was the responsibility of the hospice. The nurse stated, "I see the patient 2 or 3 times a week but the SNF staff change the dressing every day."</p> <p>C. On 6-14-12 at 10:05 AM Central Time, the SNF nurse stated, "I don't remember the dressing change being every day. We have been changing it every other day."</p> <p>The SNF treatment records indicated the dressing was to be changed every other day and included documentation the dressing had been changed on 6-7-12, 6-9-12, 6-11-12, and 6-13-12 per SNF staff.</p> <p>D. The SNF nurse stated, on 6-14-12 at 10:05 AM Central Time, "I am used to the hospice nurses writing the orders. That is what [name of another hospice] does. These hospice nurse do not. I do. They just call and tell us what the orders are."</p> <p>E. Upon completion of the dressing change by the SNF nurse on 6-14-12 at 9:55 AM, the patient complained of severe pain and rated it as a "10" on a scale of 1 to 10 with 10 being the worse pain. The hospice nurse stated to the patient, "[SNF nurse] will get you your</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>pain medicine." The SNF nurse indicated she would get the patient's pain medication but had to "answer a call light first." The hospice nurse began talking to the patient's spouse explaining the purpose of heel protectors. The hospice nurse was asked if she could administer the pain medication. The hospice nurse said, "I can but the medication is at the nurse's station in a locked cart. I will have to wait until the [SNF nurse] comes back to get the key." The hospice nurse finished her instructions to the patient's spouse and proceeded to obtain the patient's pain medication and administer it.</p> <p>F. The SNF record was reviewed on 6-14-12 at 10:10 AM Central Time. The record included an order signed and dated by a SNF nurse for occupational and physical therapy. The hospice plan of care failed to evidence any therapy orders.</p> <p>G. The hospice nurse, employee F, was asked, on 6-14-12 at 12:15 PM Central Time if she had followed-up with the patient's pain relief. The nurse replied, "No, I didn't. The SNF staff are usually pretty good at following up."</p> <p>H. On 6-14-12 at 12:20 PM Central Time, the hospice director, employee B, stated, "I just wanted to acknowledge I</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>heard the nurse say she did not follow-up with the pain medication administered to patient number 2."</p> <p>3. The hospice director, employee B, stated, on 6-14-12 at 11:30 AM Central Time, "We get the orders [for the hospice patients that are residents of a SNF] per telephone and then call the SNF. They write the orders. I did not know there were orders for physical and occupational therapy on patient number 2's chart."</p> <p>4. The hospice's undated "Hospice Care for Nursing Facility Residents" policy number PFC.H20 states, "The plan of care reflects the participation of the hospice, the facility and the patient and his/her family to the extent possible."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0781	<p>418.112(e)(3) COORDINATION OF SERVICES The hospice must:] (3) Provide the SNF/NF or ICF/MR with the following information: (i) The most recent hospice plan of care specific to each patient; (ii) Hospice election form and any advance directives specific to each patient; (iii) Physician certification and recertification of the terminal illness specific to each patient; (iv) Names and contact information for hospice personnel involved in hospice care of each patient; (v) Instructions on how to access the hospice's 24-hour on-call system; (vi) Hospice medication information specific to each patient; and (vii) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>Based on clinical record review, observation, and interview, the hospice failed to ensure plans of care and updates specific to each patient had been provided to the skilled nursing facility (SNF) in 2 (#s 1 and 2) of 2 home visits made to SNFs resulting in patients not receiving ordered hospice care and services.</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced the patient was a resident of a SNF with a hospice diagnosis of dementia.</p> <p>A home visit was made to patient number number 1 on 6-13-12 at 2:05 PM.</p>	L0781	<p>The Director of Nursing will inservice staff/required members of Interdisciplinary Group (IDG) to ensure there is documentation to support plans of care and updates specific to each patient are provided to the skilled nursing facility (SNF). 100% of charts will be reviewed to ensure that patients' plans of care and updates are provided to skilled nursing facility (SNF). The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.</p>	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Observation noted hospice documents were kept in a separate binder at the nurse's station. The hospice binder was reviewed and failed to evidence a copy of the hospice plan of care and the interdisciplinary group(IDG) reviews and updates.</p> <p>2. Clinical record number 2 evidenced the patient was a resident of a SNF with a hospice diagnosis of kidney cancer. The record included a plan of care established by the IDG on 6-7-12 and included an order for a daily dressing change to a decubitus ulcer on the patient's coccyx.</p> <p>A. A home visit was made to patient number 2 on 6-14-12 at 9:20 AM with employee F, a registered nurse (RN). Observation noted the hospice documents were kept in a separate binder at the nurse's station. The hospice binder was reviewed and failed to evidence a copy of the hospice plan of care.</p> <p>B. The SNF treatment records indicated the dressing was to be changed every other day and included documentation the dressing had been changed on 6-7-12, 6-9-12, 6-11-12, and 6-13-12 per SNF staff.</p> <p>On 6-14-12 at 10:05 AM Central Time, the SNF nurse stated, "I don't</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>remember the dressing change being every day. We have been changing it every other day."</p> <p>3. The hospice director, employee B, was unable to provide any additional documentation and/or information when asked on 6-15-12 AM at 11:35 AM Central Time.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L0782	<p>418.112(f) ORIENTATION AND TRAINING OF STAFF Hospice staff must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.</p> <p>Based on interview and hospice policy review, the hospice failed to ensure hospice orientation had been provided to skilled nursing facility (SNF) staff in 2 (#s 1 and 2) of SNFs reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice director, employee B, was unable to provide any documentation of hospice orientation that had been provided to employees of SNF 1 and SNF 2 when asked on 6-18-12 at 11:50 AM. The director stated, "The SNF staff are trained quarterly. I don't know the last time it was done." The director was unable to verbalize how the hospice assures hospice orientation to employees hired by the SNF after any hospice orientation training had been completed. 2. The Director of Nursing of SNF 1 stated, on 6-13-12 at 2:45 PM Central 	L0782	The Director of Nursing will ensure that skilled nursing facilities (SNF) staff furnishing care to hospice patients will be provided hospice orientation. 100% of skilled nursing facilities providing care to this hospice agency's patients will be provided hospice orientation. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Time, "They [Angels of Mercy Hospice] have not done any training this year. They have in the past."</p> <p>3. A SNF staff nurse at SNF 2 stated, on 6-14-12 at 10:10 AM, "I have not received any hospice training from this hospice. I have from [name of another hospice]."</p> <p>3. The hospice's undated "Hospice Care For Nursing Facility Residents" policy number PFC.H15 states, "Hospice staff provides orientation and training to facility staff as needed and bereavement care to identified facility staff when appropriate."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L0796	<p>418.114(d)(2) CRIMINAL BACKGROUND CHECKS Criminal background checks must be obtained in accordance with State requirements. In the absence of State requirements, criminal background checks must be obtained within three months of the date of employment for all states that the individual has lived or worked in the past 3 years.</p> <p>Based on personnel file review and interview, the hospice failed to ensure a criminal history from the Indiana State Police repository in accordance with Indiana state requirements had been obtained in 1 (file K) of 3 volunteer files reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file K evidenced the individual provided volunteer companion care on behalf of the hospice. The file failed to evidence the hospice had obtained a limited criminal history check from the Indiana State Police repository in accordance with State requirements. 2. The hospice director, employee B, stated, on 6-18-12 at 2:30 PM Central Time, "I have given you everything I have on her." 	L0796	The Director of Nursing will ensure that criminal background checks are obtained on all employees/volunteers from the Indiana State Police repository in accordance with Indiana state requirements. 100% of personnel files will be reviewed to ensure criminal history has been obtained. The Director of Nursing will be responsible for monitoring these corrective actions ensuring that this deficiency is corrected and will not recur.	07/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2012	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S9998	<p>IC 16-25-6 Criminal History Sec. 2. (a) A person who owns or operates a hospice program shall apply, not more than three (3) business days after the date that an employee or volunteer begins to provide hospice services, for a copy of the employee's or volunteer's limited criminal history from the Indiana Central Repository for criminal history information under IC 5-2-5.</p> <p>(b) A hospice program may not employ an individual or allow a volunteer to provide hospice services for more than three business days without applying for that person's limited criminal history as required by subsection (a).</p> <p>Sec. 3 (b) A hospice program may not employ a person to or allow a volunteer to provide hospice services for more than twenty-one calendar days without receipt of that person's limited criminal history required by section 2 of this chapter, unless the Indiana Central Repository for criminal history information under IC 5-2-5 is solely responsible for failing to provide the person's limited criminal history to the hospice program within the time required under this subsection.</p> <p>Based on personnel file review and interview, the hospice failed to ensure a criminal history from the Indiana State Police repository had been obtained in 1 (file K) of 3 volunteer files reviewed creating the potential to affect both of the hospice's current patients.</p> <p>The findings include:</p>	S9998	The Director of Nursing will ensure that criminal background checks are obtained on all employees/volunteers from the Indiana State Police repository in accordance with Indiana state requirements. 100% of personnel files will be reviewed to ensure criminal history has been obtained. The Director of Nursing will be responsible for monitoring	07/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 511 E 4TH ST STE 111 HUNTINGBURG, IN 47542
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1. Personnel file K evidenced the individual provided volunteer companion care on behalf of the hospice. The file failed to evidence the hospice had obtained a limited criminal history check from the Indiana State Police repository.</p> <p>2. The hospice director, employee B, stated, on 6-18-12 at 2:30 PM Central Time, "I have given you everything I have on her."</p>		these corrective actions ensuring that this deficiency is corrected and will not recur.	