

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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
S000000	<p>This was a hospice state licensure survey.</p> <p>Facility: #011593</p> <p>Dates: December 30 and 31, 2013, and January 2 and 3, 2014</p> <p>Medicaid: # N/A</p> <p>Surveyors: Susan Sparks RN, PHNS</p> <p>Census: 69 patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 9, 2014</p>	S000000		
S000523	<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 policy review and interview, the hospice failed to ensure each member of the</p>	S000523	The Clinical Director will inservice the clinical team regarding the requirement to complete the comprehensive assessment within 5 days of admission. To assure ongoing compliance,	01/31/2014

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: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/03/2014
NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241		
(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>interdisciplinary group completed the comprehensive assessment within 5 days after the election of hospice for 4 of 13 clinical records reviewed (1, 7, 8, and 12) with the potential to affect all 69 patients.</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 3/27/13, evidenced a skilled nursing evaluation on 3/27/13, a spiritual evaluation on 4/8/13 (on the twelfth day), a bereavement evaluation on 3/27/13, and a psychosocial evaluation on 3/30/13.</p> <p>2. Clinical record 7, SOC 12/19/13, evidenced a skilled nursing evaluation on 12/19/13. The clinical record failed to evidence a spiritual or a psychosocial evaluation.</p> <p>3. Clinical record 8, SOC 9/20/13, evidenced a skilled nursing evaluation on 9/20/13, a spiritual evaluation on 9/23/13, a psychosocial evolution on 9/24/13, and a volunteer evaluation on the nineteenth day 10/8/13.</p> <p>4. Clinical record 12, SOC 6/28/13, evidenced a skilled nursing evaluation on 6/28/13, a spiritual evaluation on 7/3/13 and a psychosocial evaluation on</p>		<p>effective immediately, all hospice IDG team members to be involved in the care of the patient, including nursing, spiritual care counselor, medical director, and social worker will be identified and notified of the hospice admission. All disciplines will complete their comprehensive assessment within five (5) days of admission. The Scheduler will be responsible to monitor for the completion of the comprehensive assessment visits in the electronic medical record. The scheduler will notify the clinical manager of any discipline that has rescheduled or missed a planned visit or does not have an assessment visit scheduled by day three (3) after admission. The clinical manager will follow up with identified disciplines to confirm completion of their portion of the comprehensive assessment within 5 days. The Clinical Director/Manager and the scheduler will monitor the agency summary report daily to ensure protocols are followed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/03/2014	
NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241			
(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 eleventh day, 7/9/13.</p> <p>5. On 1/2/14 at 4 PM, Employee F, Director of Clinical Management indicated the comprehensive assessments had not been completed in a timely manner.</p> <p>6. A policy titled "Assessment-Comprehensive Assessment of the Patient", Policy Number: PC-A80, Revised 12/2/08, states, "2. The comprehensive assessment of the patient is completed by members of the interdisciplinary team in consultation with the patient's attending physician (if any) no later than five (5) calendar days after the patient elects the hospice benefit."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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
S000530	<p>418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:</p> <ul style="list-style-type: none"> (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. <p>Based on clinical record review, policy review, and interview, the hospice failed to ensure a drug profile was completed that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring in 13 of 13 active clinical records reviewed (#1-3, 6-15) with the potential to affect all 69 patients.</p> <p>Findings include:</p>	S000530	The Clinical Director will re-educate the nursing staff on the needed requirement for a complete medication profile review between the nurse and the pharmacist, including effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy and drug therapy currently associated with laboratory monitoring. Standard practice for the nurses will assure that each medication profile will be reviewed upon admission and throughout the course of care by the nurse and the pharmacist for the above item. Documentation of this review by the nurse and the pharmacist will be completed and added to current clinical records immediately. Physician orders for medications noted in	01/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/03/2014
NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241		
(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. Clinical record #1, start of care (SOC) 3/27/13, failed to evidence a medication profile had been completed that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring for the SOC comprehensive assessment dated 3/27/13.</p> <p>2. Clinical record #2, SOC 12/2/13, failed to evidence a medication profile had been completed that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring for the SOC comprehensive assessment dated 12/2/13.</p> <p>3. Clinical record #3, SOC 12/16/13, failed to evidence a medication profile had been</p>		<p>the electronic medical record will be compared with those on the pharmacy record/printout. The EMR and Pharmacy medication profiles will be reconciled upon admission and at a minimum of each IDG meeting by the RN case manager or other designated RN. Copies of the pharmacy medication profile and noted review of the profile will be kept in the patient clinical record. The Clinical Manager will monitor for on-going medication reviews by auditing all admission documentation. EMR records will be audited by the clinical case manager for each of their patients routinely and, at the least, prior to recertification. Every IDT meeting will include a drug regime review for each patient. Re-training by EMR trainers will be completed on the proper use of the HomeCareHomeBase system so as to properly document the drug profile and review.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/03/2014	
NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241			
(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 that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring for the SOC comprehensive assessment dated 12/16/13.</p> <p>4. Clinical record #6, SOC 10/15/13, failed to evidence a medication profile had been completed that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring for the SOC comprehensive assessment dated 10/15/13.</p> <p>5. Clinical record #7, SOC 12/19/13, failed to evidence a medication profile had been completed that included effectiveness of drug therapy, drug side effects, actual or</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/03/2014
NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241		
(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 drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring for the SOC comprehensive assessment dated 12/19/13.</p> <p>8. Clinical record #8, SOC 9/20/13, failed to evidence a medication profile had been completed that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring for the SOC comprehensive assessment dated 9/20/13.</p> <p>9. Clinical record #9, SOC 5/13/13, failed to evidence a medication profile had been completed that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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>laboratory monitoring for the SOC comprehensive assessment dated 5/13/13.</p> <p>10. Clinical record #10, SOC 12/20/12, failed to evidence a medication profile had been completed that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring for the SOC comprehensive assessment dated 12/20/12.</p> <p>11. Clinical record #11, SOC 11/19/12, failed to evidence a medication profile had been completed that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring for the SOC comprehensive assessment dated 11/19/12.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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>12. Clinical record #12, SOC 6/28/13, failed to evidence a medication profile had been completed that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring for the SOC comprehensive assessment dated 6/28/13.</p> <p>13. Clinical record #13, SOC 11/11/13, failed to evidence a medication profile had been completed that included effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring for the SOC comprehensive assessment dated 11/11/13.</p> <p>14. On 1/2/14 at 4 PM, Employee F, Director of Clinical</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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>Management indicated there was no documentation the medication profiles had been completed.</p> <p>15. A policy titled "Assessment-Content of the Comprehensive Assessment", Policy Number: PC-A85, undated, states, "1. The comprehensive assessment of the patient consists of the following discipline-specific assessment tools: ... e. the medication and treatment profile. ... 7. The hospice medication Orders form, Medication Profile form, and Active Medication Report form reviews all of the patient's prescription and over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: a. effectiveness of drug therapy; b. drug side effects; c. actual or potential drug interactions; d. duplicate drug therapies; e. drug therapy currently associated with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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
S000543	<p>laboratory monitoring."</p> <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 review and interview, the agency failed to ensure visits were provided as ordered on the plan of care developed by the interdisciplinary team in 9 of 13 clinical records reviewed (2, 3, 6, 7, 8, 9, 10, 12, and 13) with the potential to affect all 69 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 2, start of care (SOC) 12/2/13, evidenced physician orders for hospice aide (HA) 2 times a week. The record failed to evidence 2 visits for weeks 2 and week 4. 2. Clinical record 3, SOC 12/16/13, evidenced physician orders for HA 2 times a week and social worker 1 time a week. The clinical record failed to evidence 2 HA visits week 1. 	S000543	<p>All clinical staff will be re-educated by the Clinical Manager on the process for writing and adhering to ordered frequencies on the Plan of Care. The re-education will include the use of HCHB software to track adherence to the frequency as ordered in the Plan of Care. The Scheduler will run the Visits to Orders Frequencies Report at least weekly. Any discrepancies will immediately be addressed with the appropriate staff member. The completed reports will be printed and placed in a binder for review by the Clinical Manager at least weekly.</p>	01/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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>3. Clinical record 6, SOC 10/15/13, evidenced physician orders for HA 2 times a week; skilled nurse (SN) 3 times week then 2 times a week; Volunteers 1-2 times a month; Chaplain 1 time a week for 1 week, 2 times a week for 1 week, then 1 times week for 12 weeks; social worker 1 times a week, 2 times a week for 1 week, then 1 time week for 12 weeks. The clinical record failed to evidence 2 HA visits week 1, 3 SN visits week 1, 1 chaplain visit week 2, 1 social worker visit week 10, and a volunteer visit in the month of December.</p> <p>4. Clinical record 7, SOC 12/19/13, evidenced physician orders for HA 2 times a week. The clinical record failed to evidence 2 HA visits week 2.</p> <p>5. Clinical record 8, SOC 9/20/13, evidenced physician orders for SN 1 time for week 1, 2 times a week for 12 weeks, chaplain 1 time week for 1 week. The clinical record failed to evidence 2 SN visits week 10. The clinical record evidenced a chaplain visit every week.</p> <p>6. Clinical record 9, SOC 5/13/13, evidenced physician orders for SN 2 times week and social worker 1 times week. The clinical record failed to evidence 1 social work visit week 4 and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/03/2014	
NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241			
(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 SN visits week 6.</p> <p>7. Clinical record 10, SOC 12/20/13, evidenced physician orders for SN 2 times week. The clinical record failed to evidence 2 SN visits week 3 and week 8.</p> <p>8. Clinical record 12, SOC 6/28/13, evidenced physician orders for 9/26/13 to 12/24/13 for SN 2 times a week, Chaplain 1 time a week, and a supplemental order dated 11/10/13 for social worker 1 time a week. The clinical record failed to evidence chaplain visits or the refusal for such during the certification period and social worker visits week 8, 9, 11, 12, 13, and 14.</p> <p>9. Clinical record 13, SOC 11/11/13, evidenced physician orders SN 3 times week for one week and social worker 1 times week. The clinical record failed to evidence 3 SN visits week 1 and 1 social worker visit week 5.</p> <p>10. On 1/2/14 at 3 PM, Employee F, Director of Clinical Management indicated visits had been missed and not followed the plan of care.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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
S000547	<p>418.56(c)(2) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure volunteers had a detailed statement of scope and frequency of services on the plan of care in 4 of 13 clinical records reviewed (6, 10, 11, and 12) with the potential to affect all 69 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 6, start of care (SOC) 10/15/13, failed to evidence a detailed statement of scope and frequency of services for volunteers when volunteers were requested. Clinical record 10, SOC 12/20/13, failed to evidence a detailed statement of scope and frequency of services for volunteers when volunteers were 	S000547	<p>Education will be completed by the Clinical Manager with the volunteer coordinator and other members of the IDG to assure that the scope and frequency for the volunteer services for each patient are ordered by the plan of care and are met by the volunteer. The Case Manager and /or Social Worker (or designee) will give the volunteer coordinator a request for volunteer services including the purpose and the scope and frequency of services and any other relevant information. The Case Manager will ensure the appropriate physician order is up to date and in place at the time of initiation of Volunteer Services. This order will be noted on the plan of care under the scope and frequency of services. Upon initiation of Volunteer Services for each patient, the volunteer coordinator will be given a copy of the current Plan of Care which</p>	01/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/03/2014
NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241		
(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>requested.</p> <p>3. Clinical record 11, SOC 11/19/12, failed to evidence a detailed statement of scope and frequency of services for volunteers when volunteers were requested.</p> <p>4. Clinical record 12, SOC 6/28/13, failed to evidence a detailed statement of scope and frequency of services for volunteers when volunteers were requested.</p> <p>5. On 1/2/14 at 3:30 PM, Employee F, Director of Clinical Management, indicated there were no orders for scope and frequency of services for the volunteers.</p> <p>6. A policy titled "Plan of Care, Policy Number: PC.P40, states, "2. The contents of the plan of care include, but are not limited to: ... b. a detailed statement of the scope and frequency of services necessary to meet the specific patient / family / caregiver needs;"</p>		<p>will clearly indicate the Scope and frequency of the desired volunteer services. The volunteer coordinator will communicate the orders to the volunteers providing the service. The volunteer coordinator will provide a monthly report to the clinical manager identifying which patients are receiving volunteer services and the frequency of those services for each patient. The volunteer coordinator will track the scope and frequency orders in the EMR bi-weekly for each patient and will provide direction to the volunteers to assure that the scope and frequency is met. Volunteer frequency will be monitored and orders for volunteers adjusted at the IDG meeting or as needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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
S000555	<p>418.56(e)(2) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (2) Ensure that the care and services are provided in accordance with the plan of care. Based on clinical record review and interview, the agency failed to ensure visits were provided as ordered on the plan of care developed by the interdisciplinary team in 9 of 13 clinical records reviewed (2, 3, 6, 7, 8, 9, 10, 12, and 13) with the potential to affect all 69 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 2, start of care (SOC) 12/2/13, evidenced physician orders for hospice aide (HA) 2 times a week. The record failed to evidence 2 visits for weeks 2 and week 4. 2. Clinical record 3, SOC 12/16/13, evidenced physician orders for HA 2 times a week and social worker 1 time a week. The clinical record failed to evidence 2 HA visits week 1. 3. Clinical record 6, SOC 10/15/13, evidenced physician orders for HA 2 times a week; skilled nurse (SN) 3 times week then 2 times a week; Volunteers 	S000555	All clinical staff will be re-educated by the Clinical Manager on the process for writing and adhering to ordered frequencies on the Plan of Care. The re-education will include the use of HCHB software to track adherence to the frequency as ordered in the Plan of Care. The Scheduler will run the Visits to Orders Frequencies Report at least weekly. Any discrepancies will immediately be addressed with the appropriate staff member. The completed reports will be printed and placed in a binder for review by the Clinical Manager at least weekly.	01/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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>1-2 times a month; Chaplain 1 time a week for 1 week, 2 times a week for 1 week, then 1 times week for 12 weeks; social worker 1 times a week, 2 times a week for 1 week, then 1 time week for 12 weeks. The clinical record failed to evidence 2 HA visits week 1, 3 SN visits week 1, 1 chaplain visit week 2, 1 social worker visit week 10, and a volunteer visit in the month of December.</p> <p>4. Clinical record 7, SOC 12/19/13, evidenced physician orders for HA 2 times a week. The clinical record failed to evidence 2 HA visits week 2.</p> <p>5. Clinical record 8, SOC 9/20/13, evidenced physician orders for SN 1 time for week 1, 2 times a week for 12 weeks, chaplain 1 time week for 1 week. The clinical record failed to evidence 2 SN visits week 10. The clinical record evidenced a chaplain visit every week.</p> <p>6. Clinical record 9, SOC 5/13/13, evidenced physician orders for SN 2 times week and social worker 1 times week. The clinical record failed to evidence 1 social work visit week 4 and 2 SN visits week 6.</p> <p>7. Clinical record 10, SOC 12/20/13, evidenced physician orders for SN 2 times week. The clinical record failed to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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 2 SN visits week 3 and week 8.</p> <p>8. Clinical record 12, SOC 6/28/13, evidenced physician orders for 9/26/13 to 12/24/13 for SN 2 times a week, Chaplain 1 time a week, and a supplemental order dated 11/10/13 for social worker 1 time a week. The clinical record failed to evidence chaplain visits or the refusal for such during the certification period and social worker visits week 8, 9, 11, 12, 13, and 14.</p> <p>9. Clinical record 13, SOC 11/11/13, evidenced physician orders SN 3 times week for one week and social worker 1 times week. The clinical record failed to evidence 3 SN visits week 1 and 1 social worker visit week 5.</p> <p>10. On 1/2/14 at 3 PM, Employee F, Director of Clinical Management indicated visits had been missed and not followed the plan of care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/03/2014
NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241		
(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	
S000629	<p>418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES (l) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse did an on-site visit to the patient's home no less frequently then every 14 days to assess the quality of care and services provided by the hospice aide in 5 of 7 clinical records reviewed of patients with hospice aide services (2, 6, 9, 10, and 11) with the potential to affect all patients with hospice aides.</p> <p>Findings:</p> <p>1. Clinical record 2, start of care (SOC) 12/2/13, included a plan of care with orders for home health aide (HHA) services, failed to evidence a registered nurse (RN) supervisory visit from 12/3/13 to 12/31/13, a period of 28 days.</p> <p>2. Clinical record 6, SOC 10/15/13, included a plan of care with orders for HHA services, failed to evidence a RN supervisory visit from 10/17/13 0</p>	S000629	<p>All RN Case Managers will be re-educated by the Clinical Manager on the process and frequency of Home Health Aide supervisory visits. Every RN visit scheduled will include supervisory components. The Physical Assessment Report, filtered for Supervisory Visits, will be run no less than weekly by the Clinical Manager for compliance and review. Any discrepancies identified will immediatley be addressed with the RN Case Manager by the Clinical Manager.</p>	01/20/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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>12/30/13, a period of 72 days.</p> <p>3. Clinical record 9, SOC 5/13/13, included a plan of care with orders for HHA services for the certification period 11/9/13 through 1/7/14. The record failed to evidence a RN supervisory visit from 11/27/13 to 12/20/13, a period of 26 days.</p> <p>4. Clinical record 10, SOC 12/20/12, included a plan of care with orders for HHA services for the certification period 10/16/13 through 12/14/13. The record failed to evidence a RN supervisory visit from 10/17/13 to 11/29/13, a period of 45 days.</p> <p>5. Clinical record 11, SOC 11/19/12, included a plan of care with orders for HHA services for the certification period 11/14/13 through 1/12/14. The record failed to evidence a RN supervisory visit from 12/11/13 to 12/26/13, a period of 15 days.</p> <p>6. On 1/2/14 at 3 PM, Employee F, Director of Clinical Management, indicated the supervisory visits had been missed and this did not follow the policies of the agency.</p> <p>7. A policy titled "Home Health Aide Supervision", Policy Number PC.H15,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW STE C INDIANAPOLIS, IN 46241
--	---

(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
	Revised 12/2/08, states, "2. The hospice RN makes an on-site visit to the patient's home: a. no less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs."			