

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151553	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER HELPING HEARTS HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 E WALNUT ST PO BOX 760 WASHINGTON, IN 47501		
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L000000	<p>This was a hospice federal recertification & state re-licensure survey.</p> <p>Survey Dates: 7-8-13, 7-9-13, & 7-11-13</p> <p>Facility #: 009372</p> <p>Medicaid Vendor #: 200107060A</p> <p>Surveyors: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>July 18, 2013</p>	L000000			

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

TITLE

(X6) DATE

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

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L000503	<p>418.52(a)(2) NOTICE OF RIGHTS AND RESPONSIBILITIES (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. Based on clinical record and hospice policy review and interview, the hospice failed to ensure records included documentation of whether or not the patients had executed an advance directive in 4 (#s 6, 8, 10, and 11) of 11 records reviewed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6 evidenced a start of care date of 1-19-13. The record failed to evidence documentation of whether or not the patient had executed an advance directive. 2. Clinical record number 8 evidenced a start of care date of 6-24-13. The record failed to evidence documentation of whether or not the patient had executed an advance directive. 3. Clinical record number 10 evidenced a start of care date of 1-18-13. The record 	L000503	<p>1. How corrected? The emergency plan documentation form was updated to read: "Executed Advanced Directives have been obtained from the patient and are on file in the patient record". 2. How to prevent from reoccurring? Remove old forms from folders and replaced with updated document. Will monitor for compliance on an ongoing basis. 3. Who is responsible? The Hospice Supervisor</p>	08/09/2013	

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	<p>failed to evidence documentation of whether or not the patient had executed an advance directive.</p> <p>4. Clinical record number 11 evidenced a start of care date of 1-10-13. The record failed to evidence documentation of whether or not the patient had executed an advance directive.</p> <p>5. The hospice administrator, employee F, and the patient care coordinator, employee G, were unable to provide any additional documentation and/or information when asked on 7-11-13 at 10:00 AM, central time.</p> <p>6. The hospice's 01-00 "Advance Directives" policy number 14 states, "Helping Hearts Hospice complies with all State and Federal laws regarding advance directive . . . In the administrative section of the patient's clinical record, the hospice nurse or Social Worker documents . . . whether the patient has or has not executed an advance directive."</p>				

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L000533	<p>418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure the medical social services (MSS) and spiritual care counselor (SCC) portions of the comprehensive assessments had been updated at least every 15 days in 8 (#s 1, 2, 3, 4, 6, 7, 10, and 11) of 8 records reviewed of patients that had been on service for longer than 15 days creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a medical social services (MSS) assessment dated 6-24-13 and a SCC assessment dated 6-22-13 that had been completed as a part of the initial comprehensive</p>			L000533	<p>1. How corrected? The Chaplin and Social Worker will be inserviced on the Comprehensive Assessment of Hospice Patients every 15 day documentation requirements. 2. How prevented in the future? After inservice has been completed, records will be audited for compliance every two weeks on an ongoing basis. 3. Who is responsible? Hospice Supervisor</p>		08/09/2013

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	<p>assessment. The record failed to evidence the MSS and SCC portions of the comprehensive assessment had been updated.</p> <p>2. Clinical record number 2 evidenced the initial comprehensive assessment had been updated on 4-15-13, 4-30-13, 5-13-13, 5-28-13, 6-11-13, and 6-25-13. The record failed to evidence the MSS and SCC portions of the assessment had been updated.</p> <p>3. Clinical record number 3 evidenced a MSS assessment dated 6-17-13 and a SCC assessment dated 6-15-13 that had been completed as a part of the initial comprehensive assessment. The record failed to evidence the MSS and SCC portions of the comprehensive assessment had been updated.</p> <p>4. Clinical record number 4 evidenced a MSS and SCC assessment dated 5-29-13 that had been completed as a part of the initial comprehensive assessment. The record failed to evidence the MSS and SCC portions of the comprehensive assessment had been updated.</p> <p>5. Clinical record number 6 evidenced the comprehensive assessment had been updated on 5-13-13, 5-28-13, 6-11-13, and 6-25-13. The record failed to</p>			

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	<p>evidence the MSS and SCC portions of the assessment had been updated.</p> <p>6. Clinical record number 7 evidenced a MSS assessment dated 4-24-13 and a SCC assessment dated 4-23-13 that had been completed as a part of the initial comprehensive assessment. The record failed to evidence the MSS and SCC portions of the comprehensive assessments had been updated.</p> <p>7. Clinical record number 10 evidenced the comprehensive assessment had been updated on 5-13-13, 5-28-13, 6-11-13, and 6-25-13. The record failed to evidence the MSS and the SCC portions of the assessment had been updated.</p> <p>8. Clinical record number 11 evidenced the comprehensive assessment had been updated on 3-19-13 and 4-2-13. The record failed to evidence the MSS and the SCC portions of the assessment had been updated.</p> <p>9. The hospice administrator, employee F, and the patient care coordinator, employee G, were unable to provide any additional documentation and/or information when asked on 7-11-13 at 10:00 AM, central time.</p> <p>10. The hospice's 12-08 "Updates to the</p>				

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	<p>Comprehensive Assessment" policy number 19 states, "The hospice's IDG updates the comprehensive assessment and reassesses the patient's response to care on a regular basis . . . A patient's progress toward desired outcomes and response to care is reassessed as often as required by the patient's condition but no less frequently than every 15 days."</p> <p>A. The hospice's 12-08 "Social Work Services" policy number 84 states, "The Social Worker reassesses the patient / caregiver needs every 15 days and, with the IDG, updates the patient's plan of care."</p> <p>B. The hospice's 12-08 "Spiritual Care Services" policy number 85 states, "The patient / caregiver's spiritual needs are reassessed every 15 days and changes are reflected in the patient's updated plan of care."</p>			

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L000543	<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, the hospice failed to ensure all services had been provided in accordance with the hospice plan of care in 1 (# 4) of 11 records reviewed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 included an update to the plan of care established by the interdisciplinary group (IDG) on 5-27-13 dated 5-29-13 that evidenced the spiritual care counselor was to provide services 2 times per month for 2 months.</p> <p>The record failed to evidence any spiritual care counseling services had been provided during the month of June 2013.</p> <p>2. The patient care coordinator, employee G, stated, on 7-11-13 at 10:15 AM, central time, "The chaplain had talked</p>	L000543	<p>1. How corrected? The Chaplin will be in-serviced on how to correctly document spiritual care counseling of visits and client refusal of service. 2. How to prevent reoccurring? Documentation will be audited every 2 weeks on an ongoing basis 3. Who is responsible? Hospice Supervisor</p>	08/09/2013			

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	<p>with the patient and family and had planned to do telephone calls and visit when needed. The plan of care was not updated."</p> <p>3. The hospice's 12-08 "Plan of Care" policy number 76 states, "Hospice care and services provided to patient and their families are in accordance with an individualized, written plan of care."</p>			

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L000545	<p>418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care included individualized interventions to address identified psychosocial and spiritual needs in 11 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11) of 11 records reviewed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <p>1. Clinical records numbered 1 through 11 included "Team Care Plans" that evidenced identical psychosocial and spiritual care interventions. The interventions found in all of the plans of care included "Listening, Meaning making, Provide emotional support, Assess patient / family / caregivers for s/s of ineffective coping, Assess mental status for changes, Assess pt [patient] / family / caregivers for s/s depression</p>	L000545	<p>1. How corrected? In-services will be provided to the social worker and Chaplin on documentation of psychosocial interventions in the plan of care. 2. How to prevent from reoccurring? The plan of care will be audited for documentation of psychosocial interventions every two weeks and on ongoing basis. 3. Who is responsible? Hospice Supervisor</p>	08/09/2013	

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	<p>and/or anxiety, Pastoral presence, Prayer, Assess for changes, Provide emotional support when appropriate, Assess ability to stay in current environment safely."</p> <p>2. Clinical record number 1 included an initial medical social services (MSS) assessment dated 6-24-13 that identified the patient's illness had been "stressful" for the family, the patient "came to feel bad about being a burden on children. Decided to d/c [discontinue] dialysis . . . when minister came to plan funeral [the patient] wasn't ready . . . not clear whether or not pt and children in complete harmony on decision to d/c dialysis. Some indications of depression & stress for caregivers."</p> <p>The "Team Care Plan as of 6-25-13" failed to evidence patient specific, individualized interventions to address the identified psychosocial problems.</p> <p>2. Clinical record number 2 included "Team Care Plans" dated 4-15-13, 4-30-13, 5-13-13, 5-28-13, 6-11-13, and 6-25-13 that failed to evidence patient specific, individualized interventions to address any psychosocial and/or spiritual care concerns.</p> <p>3. Clinical record number 3 included an initial psychosocial assessment dated</p>				

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	<p>6-17-13 that identified the patient had been "fighting CA [cancer] last 9 yrs [years] / Last 7-8 mo [months] increased stressful . . . still adjusting . . . don't like losing independence . . . conflict with [adult child]." The assessment identifies the patient's significant other "may have [increased] stress as well as loneliness when pt dies."</p> <p>The "Team Care Plan as of 6-25-13" failed to evidence patient specific, individualized interventions to address the identified psychosocial needs.</p> <p>4. Clinical record number 4 included an initial psychosocial assessment dated 5-29-13 that states, "No obvious risks. However, family has been through loss of pt's [spouse], [sibling], & [child] in last 2 yrs. [Sibling] was 20 yrs younger & death was sudden . . . has Rx [prescription] for depression."</p> <p>The "Team Care Plan as of 6-11-13" and the "Team Care Plan as of 6-25-13" failed to evidence patient specific, individualized interventions to address the identified psychosocial needs.</p> <p>5. Clinical record number 5 included a plan of care dated 7-2-13. The plan of care failed to include patient specific, individualized interventions to address</p>						

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	<p>psychosocial and spiritual needs.</p> <p>6. Clinical record number 6 included an initial psychosocial assessment dated 1-21-13 that identified the the patient "expresses frustration [with] loss of independence. Pt is not apparently coherent about exact nature of illness" and that the family expressed "unpleasant surprise / shock. Pt had apparently had been getting check ups every 6 mo and doctor apparently failed to detect cancer." The assessment identified it was "difficult" for the patient a "a little stressful" for the family. "Afraid of not doing something right."</p> <p>The "Team Care Plans", dated 5-13-13, 5-28-13, 6-11-13, and 6-25-13, failed to evidence patient specific, individualized interventions to address the identified psychosocial needs.</p> <p>7. Clinical record number 7 included an initial psychosocial assessment dated 4-24-13 that identified the illness "has been stressful" for the family, that the patient "wants to be left alone", that the patient "has been used to doing everything by [the patient's] self, and that the patient's grandchild has been "in conflict [with] others in family RE [regarding] moving pt to NH [nursing home]. Pt's house belongs to a child unclear how</p>			

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	<p>[grandchild] will manage after pt dies."</p> <p>The "Team Care Plans', dated 5-13-13, 5-28-13, 6-11-13, and 6-25-13, failed to evidence patient specific, individualized interventions to address the identified psychosocial needs.</p> <p>8. Clinical record number 8 included an initial psychosocial assessment dated 6-25-13 that identifies the illness has been "difficult" for the family and that the patient's increased "dependence over last 6-9 mo difficult for whole family . . . Pt's [child] lost son 10 yrs ago & has [child] with chronic illness. Some potential for depression."</p> <p>The plan of care for the benefit period 6-24-13 to 9-21-13 failed to evidence patient specific, individualized interventions to address the identified needs.</p> <p>9. Clinical record number 9 included an initial psychosocial assessment dated 6-3-13 that identifies the patient's family stated, "Honestly, it's been hell. Done everything could do to make it [better] . . . [decreased] work to make time for pt . . . [the patient] hated (becoming dependent) . . . main goal has been to keep [the patient] happy." The assessment identifies the patient's death will "mean</p>				

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	<p>loss of constant companion / emotional support" and that the caregiver has had "excessive or prolonged emotional problems / mental illness."</p> <p>The plan of care for the benefit period 6-1-13 to 8-29-13 failed to evidence patient specific, individualized interventions to address the identified psychosocial needs.</p> <p>10. Clinical record number 10 included "Team Care Plans", dated 5-13-13, 5-28-13, 6-11-13, and 6-25-13. The plans failed to evidence patient specific, individualized interventions to address any identified psychosocial needs.</p> <p>11. Clinical record number 11 included "Team Care Plans" dated 3-19-13 and 4-2-13 that failed to evidence patient specific, individualized interventions to address any identified psychosocial needs.</p> <p>12. The hospice administrator, employee F, and the patient care coordinator, employee G, were unable to provide any additional documentation and/or information when asked on 7-11-13 at 10:00 AM, central time.</p> <p>13. The hospice's 12-08 "Plan of Care - Content" policy number 77 states, "The plan of care reflects patient and family</p>						

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	goals and interventions that are based on the problems identified in the initial, comprehensive and updated assessments."			

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L000548	<p>418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care included measurable outcomes in 11 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11) of 11 records reviewed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a "Team Care Plan as of 6-25-13" that failed to evidence measurable goals and outcomes specific to the patient.</p> <p>A. The plan of care evidenced pain management goals that included "pain managed at tolerable level, Analgesics effective, Patient / family / caregiver verbalizes pain control with pain at or below tolerable level as noted on pain assessment using the method of pain relief of client's choice."</p> <p>B. The plan of care evidenced "Terminal Illness" goals of "Positive Coping promoted, Open communication</p>	L000548	<p>1. How corrected? Staff is to be in-serviced on how to document their goal outcomes into the comment section of the patient record in a quantifiable manner. 2. How to prevent from reoccurring? Patient records will be audit for outcome documentation every two weeks for compliance and on ongoing basis. 3. Who is responsible? Hospice Supervisor</p>	08/09/2013			

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	<p>promoted, Effective emotional support, Peaceful Death with Dignity in Desired Place of Residence, and Signs and Symptoms of Anxiety and/or depression recognized and Reported to appropriate IDG members"</p> <p>C. The plan of care evidenced "Alteration in Nutrition / hydration" goals of "Adequate nutritional intake promoted, Adequate hydration promoted, and Nausea/vomiting signs and symptoms minimized."</p> <p>D. The plan of care evidenced a "Knowledge deficit medications" goal of "Knowledgeable and compliant with medication regime."</p> <p>E. The plan of care evidenced a "Knowledge deficit disease processes" goal of "Knowledgeable of disease processes."</p> <p>F. The plan of care evidenced an "Altered Mental Status" goal of "Orientation to person / place / time promoted" and "Patient safety promoted."</p> <p>G. The plan of care evidenced a durable medical equipment goal of "Patient / Family / Caregiver knowledgeable and compliant with DME [durable medical equipment]."</p>				

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	<p>H. The plan of care evidenced a general knowledge deficit goal of "Knowledgeable and compliant with instructions given."</p> <p>2. Clinical record number 2 included "Team Care Plans" dated 4-15-13, 4-30-13, 5-13-13, 6-11-13, and 6-25-13 that failed to evidence measurable goals and outcomes specific to the patient.</p> <p>A. The plans of care evidenced pain management goals that included "pain managed at tolerable level, Analgesics effective, Patient / family / caregiver verbalizes pain control with pain at or below tolerable level as noted on pain assessment using the method of pain relief of client's choice."</p> <p>B. The plans of care evidenced "Self Care Deficit" goals of "Patient will be maintained in desired place of residence" and "ADL needs met."</p> <p>C. The plans of care evidenced "Terminal Illness" goals of "Positive Coping promoted, Open communication promoted, Effective emotional support, Peaceful Death with Dignity in Desired Place of Residence, and Signs and Symptoms of Anxiety and/or depression recognized and Reported to appropriate</p>			

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	<p>IDG members"</p> <p>D. The plans of care evidenced "Alteration in Nutrition / hydration" goals of "Adequate nutritional intake promoted, Adequate hydration promoted, and Nausea / vomiting signs and symptoms minimized."</p> <p>E. The plans of care evidenced a "Knowledge deficit medications" goal of "Knowledgeable and compliant with medication regime."</p> <p>F. The plans of care evidenced a "Knowledge deficit disease processes" goal of "Knowledgeable of disease processes."</p> <p>G. The plans of care evidenced an "Altered Mental Status" goal of "Orientation to person / place / time promoted" and "Patient safety promoted."</p> <p>H. The plans of care evidence an "Altered Arterial Pressure" goal of "Blood pressure within acceptable limits."</p> <p>I. The plans of care evidenced a durable medical equipment goal of "Patient / Family / Caregiver knowledgeable and compliant with DME."</p>			

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	<p>J. The plans of care evidenced a "Depression" goal of "Symptoms of depression minimized."</p> <p>K. The plans of care evidenced a general knowledge deficit goal of "Knowledgeable and compliant with instructions given."</p> <p>3. Clinical record number 3 included a "Team Care Plan as of 06-25-13" that failed to evidence measurable goals and outcomes that were specific to the patient.</p> <p>A. The plan of care evidenced pain management goals that included "pain managed at tolerable level, Analgesics effective, Patient / family / caregiver verbalizes pain control with pain at or below tolerable level as noted on pain assessment using the method of pain relief of client's choice."</p> <p>B. The plan of care evidenced an "Alteration in swallowing" goal of "Dysphagia minimized."</p> <p>C. The plan of care evidenced "Terminal Illness" goals of "Positive Coping promoted, Open communication promoted, Effective emotional support, Peaceful Death with Dignity in Desired Place of Residence, and Signs and Symptoms of Anxiety and/or depression</p>						

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	<p>recognized and Reported to appropriate IDG [interdisciplinary group] members"</p> <p>D. The plans of care evidenced "Alteration in Nutrition / hydration" goals of "Adequate nutritional intake promoted, Adequate hydration promoted, and Nausea/vomiting signs and symptoms minimized."</p> <p>E. The plan of care evidenced a "Knowledge deficit medications" goal of "Knowledgeable and compliant with medication regime."</p> <p>F. The plan of care evidenced an "Altered Mental Status" goal of "Orientation to person/place/time promoted" and "Patient safety promoted."</p> <p>G. The plan of care evidence an "Altered Arterial Pressure" goal of "Blood pressure within acceptable limits."</p> <p>H. The plan of care evidenced a durable medical equipment goal of "Patient / Family / Caregiver knowledgeable and compliant with DME."</p> <p>I. The plans of care evidenced a general knowledge deficit goal of "Knowledgeable and compliant with instructions given."</p>						

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	<p>4. Clinical record number 4 included "Team Care Plans" as of 6-11-13 and 6-25-13 that failed to evidence measurable goals and outcomes that were specific to the patient.</p> <p>A. The plan of care evidenced pain management goals that included "pain managed at tolerable level, Analgesics effective, Patient / family / caregiver verbalizes pain control with pain at or below tolerable level as noted on pain assessment using the method of pain relief of client's choice."</p> <p>B. The plan of care evidenced an "Alteration in swallowing" goal of "Dysphagia minimized."</p> <p>C. The plan of care evidenced "Terminal Illness" goals of "Positive Coping promoted, Open communication promoted, Effective emotional support, Peaceful Death with Dignity in Desired Place of Residence, and Signs and Symptoms of Anxiety and/or depression recognized and Reported to appropriate IDG members"</p> <p>D. The plans of care evidenced "Alteration in Nutrition / hydration" goals of "Adequate nutritional intake promoted, Adequate hydration promoted, and</p>			

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	<p>Nausea / vomiting signs and symptoms minimized."</p> <p>E. The plan of care evidenced a "Knowledge deficit medications" goal of "Knowledgeable and compliant with medication regime."</p> <p>F. The plans of care evidenced a "Knowledge deficit disease processes" goal of "Knowledgeable of disease processes."</p> <p>5. Clinical record number 5 included a plan of care for the benefit period 7-2-13 to 9-29-13 that failed to evidence measurable goals and outcomes that were specific to the patient.</p> <p>The plan of care included the following goals and outcomes: "Patient / Family / Caregiver knowledgeable and compliant with DME, Knowledgeable and compliance with medication regime, Knowledgeable of disease process, Positive coping promoted, Open communication promoted, Effective emotional support, spiritual presence, spiritual comfort, Knowledgeable and compliant with instructions given, Pain managed at tolerable level, Adequate nutritional intake promoted, Adequate hydration promoted, Diabetes under control, no s/s [signs and symptoms of]</p>			

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	<p>hyperglycemia or hypoglycemia, ADL [activities of daily living] needs met, Orientation to person/place/time promoted, Patient safety promoted, Blood pressure within acceptable limits, wound healing promoted."</p> <p>6. Clinical record number 6 included "Team Care Plans", dated 5-13-13, 5-28-13, 6-11-13, and 6-25-13, that failed to evidence measurable goals and outcomes that were specific to the patient.</p> <p>A. The plan of care evidenced pain management goals that included "pain managed at tolerable level, Analgesics effective, Patient / family / caregiver verbalizes pain control with pain at or below tolerable level as noted on pain assessment using the method of pain relief of client's choice."</p> <p>B. The plans of care evidenced an "Alteration in swallowing" goal of "Dysphagia minimized."</p> <p>C. The plans of care evidenced "Self Care Deficit" goals that included "Patient will maintain optimal activity level as permitted by disease process, Patient will be maintained in desired place of residence, ADL needs met."</p> <p>D. The plan of care evidenced</p>			

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	<p>"Terminal Illness" goals of "Positive Coping promoted, Open communication promoted, Effective emotional support, Peaceful Death with Dignity in Desired Place of Residence, and Signs and Symptoms of Anxiety and/or depression recognized and Reported to appropriate IDG members"</p> <p>E. The plans of care evidenced "Alteration in Nutrition / hydration" goals of "Adequate nutritional intake promoted, Adequate hydration promoted, and Nausea / vomiting signs and symptoms minimized."</p> <p>F. The plans of care evidenced "Alteration or Potential alteration in GU [genitourinary] function" goals of "Adequate elimination promoted, foley catheter patent."</p> <p>G. The plan of care evidenced a "Knowledge deficit medications" goal of "Knowledgeable and compliant with medication regime."</p> <p>H. The plans of care evidenced a "Knowledge deficit disease processes" goal of "Knowledgeable of disease processes."</p> <p>I. The plans of care evidenced a "Constipation" goal of "Adequate bowel</p>			

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	<p>evacuation promoted."</p> <p>J. The plans of care evidenced a general knowledge deficit goal of "Knowledgeable and compliant with instructions given."</p> <p>7. Clinical record number 7 included a Plan of Care for the benefit period 4-22-13 to 7-20-13. The plan of care failed to evidence measurable goals and outcome specific to the patient.</p> <p>The plan of care included the following goals and outcomes: "Patient / Family / Caregiver knowledgeable and compliant with DME, Knowledgeable and compliance with medication regime, Knowledgeable of disease process, Positive coping promoted, Open communication promoted, Effective emotional support, spiritual presence, spiritual comfort, Knowledgeable and compliant with instructions given, Pain managed at tolerable level, Adequate nutritional intake promoted, Adequate hydration promoted, Diabetes under control, no s/s hyperglycemia or hypoglycemia, ADL needs met, Orientation to person/place/time promoted, Patient safety promoted, Blood pressure within acceptable limits, wound healing promoted."</p>			

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	<p>8. Clinical record number 8 included a Plan of Care for the benefit period 6-24-13 to 9-21-13. The plan of care failed to evidence measurable goals and outcome specific to the patient.</p> <p>The plan of care included the following goals and outcomes: "Patient / Family / Caregiver knowledgeable and compliant with DME, Knowledgeable and compliance with medication regime, Knowledgeable of disease process, Positive coping promoted, Open communication promoted, Effective emotional support, spiritual presence, spiritual comfort, Knowledgeable and compliant with instructions given, Pain managed at tolerable level, Adequate nutritional intake promoted, Adequate hydration promoted, Diabetes under control, no s/s hyperglycemia or hypoglycemia, ADL needs met, Orientation to person / place / time promoted, Patient safety promoted."</p> <p>9. Clinical record number 9 included a Plan of Care for the benefit period 6-1-13 to 8-29-13 that failed to evidence measurable goals and outcomes specific to the patient.</p> <p>The plan of care included the following goals and outcomes: "Positive Coping promoted, Open Communication</p>				

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	<p>promoted, Peaceful Death with Dignity in Desired Place of Residence, Effective emotional support, Spiritual presence, Spiritual comfort, Patient / Family / Caregiver knowledgeable and compliant with DME, Knowledgeable and compliance with medication regime, knowledgeable of disease processes, knowledgeable and compliance with instructions give, Pain managed at a tolerable level, Analgesics effective, Patient safety promoted, Dysphagia minimized, Adequate nutritional intake promoted, Adequate hydration promoted, Patient / family, PCG [patient care giver] will demonstrate how to deliver needed care, ADLS needs met, mobility and safety promoted."</p> <p>10. Clinical record number 10 included "Team Care Plans", dated 5-13-13, 5-28-13, 6-11-13, and 6-25-13 that failed to evidence measurable goals and outcomes specific to the patient.</p> <p>A. The plan of care evidenced pain management goals that included "pain managed at tolerable level, Analgesics effective, Patient / family / caregiver verbalizes pain control with pain at or below tolerable level as noted on pain assessment using the method of pain relief of client's choice."</p>						

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	<p>B. The plans of care evidenced "Self Care Deficit" goals that included "Patient will maintain optimal activity level as permitted by disease process, Patient will be maintained in desired place of residence, ADL needs met."</p> <p>C. The plans of care evidenced "Alteration in elimination (incontinence)" goals of "Effective use of incontinence products, Skin breakdown minimized."</p> <p>D. The plan of care evidenced "Terminal Illness" goals of "Positive Coping promoted, Open communication promoted, Effective emotional support, Peaceful Death with Dignity in Desired Place of Residence, and Signs and Symptoms of Anxiety and/or depression recognized and Reported to appropriate IDG members"</p> <p>E. The plans of care evidenced "Alteration in Nutrition / hydration" goals of "Adequate nutritional intake promoted, Adequate hydration promoted, and Nausea/vomiting signs and symptoms minimized."</p> <p>F. The plan of care evidenced a "Knowledge deficit medications" goal of "Knowledgeable and compliant with medication regime."</p>						

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	<p>G. The plans of care evidenced a "Knowledge deficit disease processes" goal of "Knowledgeable of disease processes."</p> <p>H. The plans of care evidenced "Altered Arterial Pressure" goals of "Blood pressure within acceptable limits, No s/s of hypertension."</p> <p>I. The plan of care evidenced a durable medical equipment goal of "Patient / Family / Caregiver knowledgeable and compliant with DME."</p> <p>J. The plans of care evidenced a general knowledge deficit goal of "Knowledgeable and compliant with instructions given."</p> <p>11. Clinical record number 11 included "Team Care Plans" dated 3-19-13 and 4-2-13 that failed to evidence measurable goals and outcomes specific to the patient.</p> <p>A. The plans of care evidenced pain management goals that included "pain managed at tolerable level, Analgesics effective, Patient / family / caregiver verbalizes pain control with pain at or below tolerable level as noted on pain assessment using the method of pain relief of client's choice."</p>			

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	<p>B. The plans of care evidenced "Alteration in Cardiac Status" goals of "Presence of Chest Pain adequately evaluated and Reported, Symptoms of impaired cardiac function minimized as possible."</p> <p>C. The plans of care evidenced "Terminal Illness" goals of "Positive Coping promoted, Open communication promoted, Effective emotional support, Peaceful Death with Dignity in Desired Place of Residence, and Signs and Symptoms of Anxiety and/or depression recognized and Reported to appropriate IDG members"</p> <p>D. The plans of care evidenced "Alteration in Nutrition / hydration" goals of "Adequate nutritional intake promoted, Adequate hydration promoted, and Nausea / vomiting signs and symptoms minimized."</p> <p>12. The hospice administrator, employee F, and the patient care coordinator, employee G, were unable to provide any additional documentation and/or information when asked on 7-11-13 at 10:00 AM, central time.</p> <p>13. The hospice's 12-08 "Plan of Care - Content" policy number 77 states, "The</p>						

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	plan of care includes, but is not limited to: . . . measurable outcomes anticipated from implementing and coordinating the plan of care."			

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L000579	<p>418.60(a) PREVENTION</p> <p>The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. Based on observation, clinical record and hospice policy review, interview, and the Centers for Disease Control infection control practices review, the hospice failed to ensure staff members provided care in accordance with infection control standard practices and hospice policy in 2 (#s 1 and 2) of 3 home visits completed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's 12-08 "Compliance with Regulations" policy number 42 states, "Helping Hearts Hospice operates and furnishes services in compliance with all applicable Federal, State and local laws and regulations related to hospice care and the health and safety of patients." 2. The hospice's 12-08 "Infection Control - Standard Precautions" policy number 50 states, "Helping Hearts Hospice staff use standard precautions in the care of all hospice patients, regardless of diagnosis or presumed infection status." 3. The Centers for Disease Control 	L000579	<p>L579 - 4 1. How Corrected? Plan to re-educate staff on proper hand hygiene technique including alcohol based rubs verses soap & water hand washing. 2. How to prevent from reoccurring? Conduct monthly hand hygiene audits and provide feedback to staff. 3. Who is responsible? Hospice Supervisor L579-5 1. How corrected? The Individual staff member will be rein-serviced regarding appropriate use of gloves and standard precautions per CDC guidelines. 2. How to prevent from reoccurring? Audit of proper hand hygiene will be conducted in the home by direct observation and interview of patient / family. 3. Who is responsible? Hospice Supervisor</p>	08/09/2013			

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	"Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves				

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	<p>when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>4. A home visit was made to patient number 1 on 7-8-13 at 11:30 AM, central time, with employee I, a registered nurse (RN). The employee was observed to assess and examine the patient. Employee I was observed to change her gloves and cleanse her hands with an alcohol based hand cleanser multiple times. At one point, the employee was observed to take the patient's vital signs and don clean gloves without cleansing her hands. When the employee was observed to cleanse her hands, the employee used an alcohol based hand cleanser instead of soap and water.</p> <p>A. Clinical record number 1 included a medical history dated 6-5-13 that evidenced the presence of a "recent C diff infection."</p> <p>B. The Association For Professionals in Infection Control and Epidemiology (APIC) "Guide to the Elimination of <i>Clostridium difficile</i> in Healthcare Settings" states, "Common antimicrobial agents (including alcohols, chlorhexidine, hexachlorophene, iodophors, PCMS, and</p>			

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	<p>triclosan) for hand washing are not active against spores. The benefit of hand washing with soap and water is the physical removal and dilution of spores from the hands."</p> <p>1.) The June 2010, Vol. 31, No 6, issue of the Infection Control and Hospital Epidemiology publication states, "Reexamining Methods and Messaging for Hand Hygiene in the Era of Increasing <i>Clostridium difficile</i> Colonization and Infection . . . Although ABHR [alcohol based hand rubs] has excellent germicidal activity against a broad spectrum of bacteria and viruses . . . ABHR is not efficacious against spore-forming organisms, such as <i>Clostridium difficile</i>."</p> <p>2.). The Centers for Disease Control and Prevention "Vital Signs: Stop <i>C. difficile</i> Infections" states, "Wear gloves and gowns when treating <i>C. difficile</i> patients, even during short visits. Hand sanitizer does not kill <i>C. difficile</i>, and hand washing may be be sufficient."</p> <p>5. A home visit was made to patient 2 on 7-9-13 at 9:15 AM, central time with employee H, an RN. The RN was observed to assess and examine the patient. A gastrointestinal (GI) tube was observed to be present in the patient's mid-abdomen. The RN was observed to</p>						

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	<p>take the patient's vital signs and examine the G-tube insertion site by moving the gauze from around the insertion site without wearing gloves.</p> <p>After examining the insertion site, the RN replaced the dressing and cleansed her hands. The RN rolled the patient to the right side and unfastened the adult diaper without wearing gloves. The RN indicated the patient was incontinent of bowel and bladder. The RN retrieved a clean adult diaper and cleansing wipes from a supply located in the patient's room. The RN then donned clean gloves without cleansing her hands after being prompted by the hospice administrator, employee F, who was also present during the home visit.</p> <p>6. The hospice administrator, employee A, and the patient care coordinator, employee G, indicated, on 7-11-13 at 10:00 AM, central time, the employees observed during home visits 1 and 2 did not follow standard precautions and hospice policy.</p>				

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L000647	<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. Based on administrative record review and interview, the hospice failed to ensure volunteer activity records included a calculation of the percentage of volunteer hours in relation to paid employee hours in 1 (2012) of 1 year reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice's 2012 volunteer statistical records failed to include a calculation of the percentage of volunteer hours in relation to paid employee patient care hours. The volunteer coordinator, employee G, indicated, on 7-11-13 at 10:30 AM, central time, the volunteer statistics did not evidence the percentage of volunteer hours in relation to the paid employee patient care hours. The coordinator stated, "The hospital has not provided us with the number of paid employee patient care hours so that we can calculate the percentage." 	L000647	<ol style="list-style-type: none"> How Corrected? The Hospice Director was educated on how to obtain productivity reports that shows actual paid employee hours and now can calculate volunteer hours and percentages to comply with the 5% volunteer requirement rule. 2. How to prevent from reoccurring? Director will calculate and report to Board Quality on a monthly basis. 3. Who is responsible? Hospice Director 	07/25/2013			

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L000663	<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 skills and competency had been evaluated in 3 (files C, F, and L) of 4 files reviewed of employees / volunteers hired since the last survey on 5-24-07 and failed to ensure policies and procedures were in place for the implementation of a competency evaluation program for all employees / volunteers creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <p>1. Personnel file C evidenced the individual had been retained on 3-7-08 as a volunteer to provide companion care services to patients. The file failed to evidence the individual's skills and competency had been evaluated.</p> <p>2. Personnel file F evidenced the</p>	L000663	<p>L663 - 1, 2 and 3 1. How Corrected? New hire skills and competency checklist were obtained from Human Resource while surveyor was here. They were completed but not immediately available they were provided to surveyor prior to exit interview. 2. How to prevent from reoccurring? Human Resources will be notified when surveyor on site to expedite obtaining files. 3. Who is responsible? Hospice Director L663-4 How corrected? Policy #19 Competency Assessment Policy was found misfiled in the Hospice Manual and placed in the correct order in the manual. How to prevent from reoccurring? Review manuals biennially and look through manual for misfile. 3. Who is responsible? Hospice Director</p>	07/11/2013	

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	<p>individual had been hired on 2-20-12 as the hospice administrator. The file failed to evidence the individual's skills and competency had been evaluated.</p> <p>3. Personnel file L evidenced the individual had been hired on 8-23-12 to provide medical social services to patients. The file failed to evidence the individual's skills and competency had been evaluated.</p> <p>4. The hospice's policy and procedure manual, last reviewed by the governing body on 2-27-12, failed to evidence policies and procedures describing the hospice's method for assessing the competency of all individuals hired or retained to provide patient care.</p> <p>5. The hospice administrator, employee F, indicated, on 7-11-13 at 12:30 PM, central time, files C, F, and L did not evidence the individuals' skills and competency had been evaluated. The administrator indicated the hospice did not have any policies and procedures in place describing the hospice's method for assessing the competency of all individuals hired or retained to provide patient care.</p>				

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L000770	<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 contract review and interview, the hospice failed to ensure written agreements included a provision that skilled nursing facility (SNF) staff could only be used to provide services to the extent the hospice would utilize the patient's family and/or caregivers in 3 (#s 1, 2, and 3) of 3 SNF contracts reviewed creating the potential to affect all hospice patients that were residents of a SNF.</p> <p>The findings include:</p> <p>1. The hospice's contract with SNF "A" dated 1-1-09 failed to include a provision that the hospice could utilize SNF staff to provide hospice care and services only to the extent the patient's family and/or caregivers could be used.</p> <p>2. The hospice's contract with SNF "B" dated 1-1-09 failed to include a provision that the hospice could utilize SNF staff to</p>	L000770	<p>1. How Corrected? To ensure that facility responsibilities are clear the contract will be revised to read: SECTION III: SERVICES TO BE FURNISHED BY FACILITY "The Facility is responsible for providing 24-hour room and board, meeting the personal care and assisting 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." 2. How to prevent from reoccurring? Revised version of the contract will be utilized for all future contracts. 3. Who is responsible? Hospice Director</p>	08/09/2013			

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	<p>provide hospice care and services only to the extent the patient's family and/or caregivers could be used.</p> <p>3. The hospice's contract with SNF "C" dated 1-1-09 failed to include a provision that the hospice could utilize SNF staff to provide hospice care and services only to the extent the patient's family and/or caregivers could be used.</p> <p>4. The hospice administrator, employee F, indicated, on 7-11-13 at 1:15 PM, central time, the contracts did not include a provision regarding the use of SNF staff to provide hospice care and services only to the extent the patient's family and/or caregivers would be used.</p>				

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L000781	<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 and hospice policy review and interview, the hospice failed to ensure the skilled nursing facility (SNF) had been provided with updates to the plan of care in 1 (# 2) of 1 record reviewed of a patient that was a resident of a SNF creating the potential to affect all hospice patients that are residents of SNFs.</p> <p>The findings include:</p> <p>1. Clinical record number 2 evidenced the patient was a resident of a SNF. The record evidenced the plan of care had been reviewed and updated on 6-25-13.</p>	L000781	<p>1. How Corrected? Employee will be provided with 1:1 in-service on expectations as they relate to immediate access to patient plan of care. 2. How to prevent from reoccurring? Supervisor will monitor employee during home visit. 3. Who is responsible? Hospice Supervisor</p>	08/09/2013			

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	<p>A home visit was made to the patient with employee H, a registered nurse, on 7-9-13 at 9:15 AM, central time. The hospice record in the SNF failed to evidence the 6-25-13 review and update to the plan of care.</p> <p>2. Employee H, the registered nurse, indicated, on 7-9-13 at 9:45 AM, central time, she had not yet brought a copy of the updated plan of care to the SNF. She stated, "It must be on my desk back at the office."</p> <p>3. The hospice's 12-08 "Hospice Care for Nursing Facility Residents - Coordination of Care" policy number 42 states, "The following information is provided to the facility: the most recent hospice plan of care specific to each patient."</p>			

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L000782	<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 review of hospice policy, the hospice failed to ensure it had provided orientation regarding hospice care and services to skilled nursing facility (SNF) staff in 1 (SNF employee A) of 1 SNF employee interviewed creating the potential to affect all hospice patients that are residents of SNFs.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A home visit was made to patient number 2 with employee H, a registered nurse, on 7-9-13 to 9:15 AM, central time. When the visit had been completed, the SNF nurse responsible for patient number 2 was interviewed. The SNF nurse indicated she had not received any orientation regarding hospice care and services from this hospice. The SNF nurse indicated she had been employed at the SNF for approximately 2 months. 2. The hospice administrator, employee F, stated, on 7-11-13 at 10:00 AM, central 	L000782	<ol style="list-style-type: none"> 1. How Corrected? Hospice will create orientation packets to be provided to new employees at the SNF. 2. How to prevent from reoccurring? Will provide oreintation packets to SNF for new hires on a continuous basis. 3. Who is responsible? Hospice Director and Supervisor 	08/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151553	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/11/2013
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	<p>time, "Inservices are held at the SNFs every quarter." The administrator was unable to provide any information regarding how the hospice ensured new SNF employees received orientation regarding hospice care and services.</p> <p>3. The hospice's 12-08 "Professional Management" policy number 79 states, "The hospice provides education and training regarding the hospice's policies and procedures related to coordination of services and communication and documentation requirements as necessary to contracted providers."</p>			