

| | | | | | |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/25/2012 |
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | | | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 | | |
| (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 | |
| L0000 | <p>This visit was for a hospice federal recertification and state relicensure survey.</p> <p>Survey Dates: 10/23-25/12</p> <p>Facility #: 004004</p> <p>Medicaid Vendor #: 200853790</p> <p>Name of Surveyor: Marty Coons, RN, PHNS</p> <p>Total Census-39 Total Home Visits-3 Total Record Review 12</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 31, 2012</p> | L0000 | | | |

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

TITLE

(X6) DATE

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

| | | | | | | | |
|---|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| L0543 | <p>418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.</p> <p>Based on clinical record review and interview, the hospice failed to ensure the Plan of Care (POC) was individualized to accommodate the patient's wishes for 1 (# 1) of 4 records reviewed of patients receiving hospice aide services with the potential to affect all patients of the hospice.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care (SOC) 5-8-12, evidenced a POC with goals and interventions dated 5-9-12 signed by the case manager, employee D, that identified the hospice was to provide hospice aide services related to functional limitations and safety. The initial and comprehensive nursing assessment completed 5-9-12 by employee D indicated the patient refused a hospice aide. The updated Interdisciplinary Team (IDT) summary and nursing assessments dated 7-6-12, 9-12-12, and 9-26-12 evidenced the</p> | L0543 | <p>The Director of Nursing and Director of Support Services has inserviced all nursing and psychosocial staff that the RN Case Manger is responsible for coordinating the care of all patients and disciplines will be assigned appropriately per the RN Assessment. A discipline and frequency will not be assigned if not appropriate per the RN Assessment.</p> <p>25% of all clinical records will be audited monthly for evidence that the appropriate disciplines and frequencies are being used per the IDT Plan of Care.</p> <p>The Administrator, Director of Nursing Services, Director of Support Services will be responsible for Monitoring these corrective actions to Ensure that this deficiency is corrected and will not reoccur.</p> | 11/23/2012 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/25/2012 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>patient was still declining a hospice aide. Signed IDT / physician orders on the plan of care for the same periods evidenced hospice aide visits were to be provided 1 to 3 times per week.</p> <p>3. On 10-25-12 at 3:30 PM, employee D, the case manager, indicated the patient had declined aide services and the orders for the aide services were a mistake on the POC.</p> | | | |

| | | | | | |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/25/2012 |
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | | | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 | | |
| (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 | |
| L0554 | <p>418.56(e)(1) 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-</p> <p>(1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure the interdisciplinary group (IDG) directed and coordinated the services provided for 1 (# 1) of 4 records reviewed of patients receiving hospice aide services with the potential to affect all patients of the hospice.</p> <p>The findings include:</p> <p>1. The policy titled "Coordination of Services" policy # PC.C45 states, "The IDG (interdisciplinary group) ensures that there is a coordinated and effective ongoing sharing of information amongst and between all disciplines. ... The RN (registered nurse) Case Manager coordinates the patient's plan of care and facilitates the ongoing sharing of information with the attending physician, ... other members of the IDG."</p> <p>2. The policy titled "Interdisciplinary Group" (IDG)" policy # PC.I55 states,</p> | L0554 | <p>The Director of Nursing and Director of Support Services has inserviced all nursing and psychosocial staff that the RN Case Manger is responsible for coordinating the care of all patients and disciplines will be assigned appropriately per the RN Assessment. A discipline and frequency will not be assigned if not appropriate per the RN Assessment.</p> <p>25% of all clinical records will be audited monthly for evidence that the appropriate disciplines and frequencies are being used per the IDT Plan of Care.</p> <p>The Administrator, Director of Nursing Services, Director of Support Services will be responsible for Monitoring these corrective actions to Ensure that this deficiency is corrected and will not reoccur.</p> | 11/23/2012 | |

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 | | | |
| (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>"IDG is responsible for providing or coordinating care and services in accordance with the patient's plan of care; The RN Case Manager is responsible for coordinating the care and services provided by the IDG, ensuring continuous assessment of patient / caregiver needs, and implementing the interdisciplinary plan of care."</p> <p>3. Clinical record #1, start of care (SOC) 5-8-12, evidenced a POC with goals and interventions dated 5-9-12 signed by the case manager, employee D, that identified the hospice was to provide hospice aide services related to functional limitations and safety. The initial and comprehensive nursing assessment completed 5-9-12 by employee D indicated the patient refused a hospice aide. The updated IDG summary and nursing assessments dated 7-6-12, 9-12-12, and 9-26-12 evidenced the patient was still declining a hospice aide. Signed IDG / physician orders on the plan of care for the same periods evidenced hospice aide visits were to be provided 1 to 3 times per week. The record failed to evidence any hospice aide services had been provided and that the IDG had directed and coordinated the care related to the hospice aide services.</p> <p>4. On 10-25-12 at 3:30 PM, employee D, the case manager, indicated the patient</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/25/2012 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 |
|---|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | had declined aide services and the orders for the aide services were a mistake on the POC. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/25/2012 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | | | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 | | |
| (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 | |
| L0555 | <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.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure services were provided as ordered on the plan of care for 1 (# 1) of 4 records reviewed of patients receiving hospice aide services with the potential to affect all patients of the hospice.</p> <p>The findings include:</p> <p>1. The policy titled "Interdisciplinary Group" (IDG) policy # PC.I55 states, "IDG is responsible for providing or coordinating care and services in accordance with the patient's plan of care; The RN Case Manager is responsible for coordinating the care and services provided by the IDG, ensuring continuous assessment of patient / caregiver needs, and implementing the interdisciplinary plan of care."</p> <p>2. Clinical record #1, start of care (SOC) 5-8-12, evidenced a POC with goals and interventions dated 5-9-12 signed by the</p> | L0555 | <p>The Director of Nursing and Director of Support Services has inserviced all nursing and psychosocial staff that the RN Case Manger is responsible for coordinating the care of all patients and disciplines will be assigned appropriately per the RN Assessment. A discipline and frequency will not be assigned if not appropriate per the RN Assessment.</p> <p>25% of all clinical records will be audited monthly for evidence that the appropriate disciplines and frequencies are being used per the IDT Plan of Care.</p> <p>The Administrator, Director of Nursing Services, Director of Support Services will be responsible for Monitoring these corrective actions to Ensure that this deficiency is corrected and will not reoccur.</p> | 11/23/2012 | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/25/2012 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 |
|---|--|

| (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>case manager, employee D, that identified the hospice was to provide hospice aide services related to functional limitations and safety. The initial and comprehensive nursing assessment completed 5-9-12 by employee D indicated the patient refused a hospice aide. The updated IDG summary and nursing assessments dated 7-6-12, 9-12-12, and 9-26-12 evidenced the patient was still declining a hospice aide. Signed IDG / physician orders on the plan of care for the same periods evidenced hospice aide visits were to be provided 1 to 3 times per week. The record failed to evidence any hospice aide services had been provided.</p> <p>3. On 10-25-12 at 3:30 PM, employee D, the case manager, indicated the patient had declined aide services and the orders for the aide services were a mistake on the POC.</p> | | | |

| | | | | | |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/25/2012 |
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | | | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 | | |
| (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 | |
| L0557 | <p>418.56(e)(4) 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-] (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure ongoing sharing of information among disciplines occurred for 1 (# 1) of 4 records reviewed of patients receiving hospice aide services with the potential to affect all patients of the hospice.</p> <p>The findings include:</p> <p>1. The policy titled "Coordination of Services" policy # PC.C45 states, "The IDG (interdisciplinary group) ensures that there is a coordinated and effective ongoing sharing of information amongst and between all disciplines. ... The RN (registered nurse) Case Manager coordinates the patient's plan of care and facilitates the ongoing sharing of information with the attending physician, ... other members of the IDG."</p> <p>2. The policy titled "Interdisciplinary</p> | L0557 | <p>The Director of Nursing and Director of Support Services has inserviced all nursing and psychosocial staff that the RN Case Manger is responsible for coordinating the care of all patients and disciplines will be assigned appropriately per the RN Assessment. A discipline and frequency will not be assigned if not appropriate per the RN Assessment.</p> <p>25% of all clinical records will be audited monthly for evidence that the appropriate disciplines and frequencies are being used per the IDT Plan of Care.</p> <p>The Administrator, Director of Nursing Services, Director of Support Services will be responsible for Monitoring these corrective actions to Ensure that this deficiency is corrected and will not reoccur.</p> | 11/23/2012 | |

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 | | | |
| (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>Group" (IDG)" policy # PC.I55 states, "IDG is responsible for providing or coordinating care and services in accordance with the patient's plan of care; The RN Case Manager is responsible for coordinating the care and services provided by the IDG, ensuring continuous assessment of patient / caregiver needs, and implementing the interdisciplinary plan of care."</p> <p>3. Clinical record #1, start of care (SOC) 5-8-12, evidenced a POC with goals and interventions dated 5-9-12 signed by the case manager, employee D, that identified the hospice was to provide hospice aide services related to functional limitations and safety. The initial and comprehensive nursing assessment completed 5-9-12 by employee D indicated the patient refused a hospice aide. The updated IDG summary and nursing assessments dated 7-6-12, 9-12-12, and 9-26-12 evidenced the patient was still declining a hospice aide. Signed IDG / physician orders on the plan of care for the same periods evidenced hospice aide visits were to be provided 1 to 3 times per week. The record failed to evidence any hospice aide services had been provided and that the information regarding the refusal of aide services had been shared.</p> <p>4. On 10-25-12 at 3:30 PM, employee D,</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151597 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/25/2012 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER HORIZON HOSPICE CARE INCORPORATED | STREET ADDRESS, CITY, STATE, ZIP CODE 252 MEADOW DRIVE, STE 6 DANVILLE, IN 46122 |
|---|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | the case manager, indicated the patient had declined aide services and the orders for the aide services were a mistake on the POC. | | | |