

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/14/2014
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NAME OF PROVIDER OR SUPPLIER ENTRUST HEALTH SERVICES INC COMMUNITY HOSPICE PRC	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 WEST 42ND STREET, SUITE 225 INDIANAPOLIS, IN 46208
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L000000	This was a hospice Federal recertification and State relicensure survey. Survey dates: July 9, 10, 11, and 14, 2014 Facility Number: IN003313 Medicaid Number: 200393780 Surveyor: Tonya Tucker, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN July 16, 2014	L000000		
L000523	418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT 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. Based on clinical record and policy review and interview, the hospice failed to ensure the initial psychosocial and spiritual assessments were completed within 5 days after the election of hospice care in 1 of 9 active patient records reviewed creating the potential to affect all new patients of the hospice. (#3)	L000523	<u>L0523</u> The Clinical Nursing Director has reviewed and in-serviced all staff on agency's policy & procedure for completing the initial Psychosocial and Spiritual Assessment within 5 days of admission to the hospice program. The hospice team reviewed our current admission process and confirmed need to	07/31/2014

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.

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L000547	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #3, election date 1/27/14, evidence an initial psychosocial and an initial spiritual assessment completed on 2/2/14 by the social worker, 6 days after the election of hospice. 2. The hospice policy dated 1/10/2012 titled "Social Work Services Admission Assessment - Addendum" states, "Social Worker will make initial contact with patient within 5 days of admission to complete the <i>Initial Assessments</i>. ... Social worker will complete the initial assessment packet which includes: 1. Initial Psychosocial Assessment ... 3. Initial Spiritual Assessment ... <u>TIME LINE</u>: Social worker will complete all initial assessments within 5 days." 3. On 7/14/14 at 12:50 PM, employee M (administrator) indicated the initial psychosocial and initial spiritual assessments need to be completed within the first 5 days. <p>418.56(c)(2) CONTENT OF PLAN OF CARE [The plan of care must include all services</p>		<p>implement changes. 7/22/14 Clinical Nursing Director, Social Workers, & Spiritual Counselor will discontinue current process & procedure for completion of 5 day assessment. The hospice team will develop and implement a more efficient process & procedure for completion of the Psychosocial and Spiritual Assessment within 5 days of admission to the hospice program. 7-31-14 The Clinical Nursing Director will implement a tracking log of all new admissions to hospice, and monitor the revised policy & procedure changes on a daily basis. The QI team will monitor and audit 100% of the charts for compliance every 30 days. The Clinical Nursing Director will be responsible for monitoring these corrected deficiencies to ensure that there is no re-occurrences.</p>	

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	<p>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 hospice failed to ensure the written plan of care included a detailed statement of scope and frequency of services necessary to meet the specific patient and family needs in 9 of 9 active records reviewed. (#1-9)</p> <p>Findings include:</p> <p>1. Clinical record #1, election date 3/24/14, evidenced an established plan of care dated 3/24/14 stating, "Frequency & reason for care by discipline ... MSW [medical social worker]: Initial evaluation, recommendation, consultation, PRN [as needed] as patient requests ... Licensed counselor / Clergy As needed / PRN" The plan of care failed to evidence scope and total number of PRN visits necessary to meet the patient and family needs.</p> <p>2. Clinical record #2, election date 6/30/14, evidenced an established plan of care dated 6/30/14 stating, "Frequency & reason for care by discipline ... MSW: Initial evaluation, recommendation,</p>	L000547	<p><u>L0547</u> The Clinical Nursing Director has in-serviced all staff and reviewed agency's written policy regarding the written plan of care which must include a detailed statement of scope and frequency of services necessary to meet the specific patient and family needs. 7/22/14 Clinical Nursing Director and IDG team members will revise the plan of care implementation process, to ensure that the written plan of care include a detailed statement of scope and frequency of services necessary to meet the specific patient and family needs. The IDG team will monitor this process every 14 days. The QI team will monitor for compliance and report any trends, patterns and compliance issues every 30 days. 100% of the charts will be audited. 7/31/14 The Clinical Nursing Director will be responsible for monitoring corrected deficiencies to ensure agency is compliant and that there is no reoccurrence.</p>	07/31/2014

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	<p>consultation, PRN as patient requests ... Licensed counselor / Clergy As needed / PRN" The plan of care failed to evidence scope and total number of PRN visits necessary to meet the patient and family needs.</p> <p>3. Clinical record #3, election date 1/27/14, evidenced an updated plan of care dated 4/29/14 stating, "Frequency & reason for care by discipline ... MSW: Initial evaluation, recommendation, consultation, PRN as patient requests ... Licensed counselor / Clergy As needed / PRN" The plan of care failed to evidence scope and total number of PRN visits necessary to meet the patient and family needs.</p> <p>4. Clinical record #4, election date 10/31/13, evidenced an established plan of care dated 10/31/13 and an updated plan of care dated 1/29/14 stating, "Frequency & reason for care by discipline ... MSW: Initial evaluation, recommendation, consultation, PRN as patient requests ... Licensed counselor / Clergy As needed/ PRN" The plan of care failed to evidence scope and total number of PRN visits necessary to meet the patient and family needs.</p> <p>5. Clinical record #5, election date 12/13/13, evidenced an established plan</p>			

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	<p>of care dated 12/13/13 and an updated plan of care dated 3/13/14 stating, "Frequency & reason for care by discipline ... MSW: Initial evaluation, recommendation, consultation, PRN as patient requests ... Licensed counselor / Clergy As needed / PRN" The plan of care failed to evidence scope and total number of PRN visits necessary to meet the patient and family needs.</p> <p>6. Clinical record #6, election date 12/12/13, evidenced an updated plan of care dated 6/11/14 stating, "Frequency & reason for care by discipline ... MSW: Initial evaluation, recommendation, consultation, PRN as patient requests ... Licensed counselor / Clergy As needed / PRN" The plan of care failed to evidence scope and total number of PRN visits necessary to meet the patient and family needs.</p> <p>7. Clinical record #7, election date 6/26/14, evidenced an established plan of care dated 6/26/14 stating, "Frequency & reason for care by discipline ... MSW: Initial evaluation, recommendation, consultation, PRN as patient requests ... Licensed counselor / Clergy As needed / PRN" The plan of care failed to evidence scope and total number of PRN visits necessary to meet the patient and family needs.</p>			

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	<p>8. Clinical record #8, election date 10/17/13, evidenced an updated plan of care dated 6/14/14 stating, "Frequency & reason for care by discipline ... MSW: Initial evaluation, recommendation, consultation, PRN as patient requests ... Licensed counselor / Clergy As needed / PRN" The plan of care failed to evidence scope and total number of PRN visits necessary to meet the patient and family needs.</p> <p>9. Clinical record #9, election date 8/30/13, evidenced an updated plan of care dated 6/26/14 stating, "Frequency & reason for care by discipline ... MSW: Initial evaluation, recommendation, consultation, PRN as patient requests ... Licensed counselor / Clergy As needed / PRN" The plan of care failed to evidence scope and total number of PRN visits necessary to meet the patient and family needs.</p> <p>6. On 7/10/14 at 2:22 PM, employee M (administrator) indicated PRN is used for all patients but if the patient needed and wanted the MSW or Counseling services, the frequency would then be documented on the plan of care.</p> <p>7. The undated hospice policy titled "Plan of Care - Content" states, "POLICY</p>			

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L000579	<p>STATEMENT: The plan of care reflects patient and family goals and interventions that are based on the problems identified in the initial, comprehensive and updated assessments PROCEDURES: 1. The patient's plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions. 2. The plan of care includes, but is not limited to: ... b. a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs"</p> <p>418.60(a) PREVENTION The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.</p>			

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	<p>Based on observation, policy review, and interview, the hospice failed to ensure staff followed infection control practices while providing care for 1 of 3 home visit observations with the potential to affect all patients of the hospice. (#7)</p> <p>Findings include:</p> <p>1. During a home visit with patient #7 on 7/10/14, employee N (registered nurse) was observed at 10:15 AM to take a stethoscope out of her nurse's supply bag, use it during patient assessment, then place it back in the supply bag without properly cleaning the equipment.</p> <p>A. On 7/10/14 at 1:00 PM, employee M (administrator) indicated every patient has their own vital signs equipment in the home and employee N should not have been using her own to assess the patient. The employee indicated being aware that if vitals equipment is used on a patient, then it has to be sanitized before use on another patient.</p> <p>B. On 7/10/14 at 2:15 PM, employee N indicated taking the stethoscope out of the front pocket of her nurse's supply bag, using it to assess the patient and placing it in the center pocket of her supply bag without cleaning it first.</p>	L000579	<p><u>L0579</u> The Clinical Nursing Director has in-serviced staff on infection control in hospice. Pre and post test were done to ensure competency. All nurses were in-serviced on proper cleansing and storage of Stethoscope after each patient's usage. All staff reviewed current hospice policy and procedure for Infection Control. A documented form will be kept in the patient's chart of all supplies received on admission to the hospice program, to include a B/P cup and a Stethoscope for each individual patient. 7/22/14 Clinical Nursing Director/designee will monitor this process every 14 days and document compliance on the Nursing Supervisory Visit Form. QI team will monitor for documented compliance every 30 days. 100 % of the charts will be audited. The Clinical Nursing Director will be responsible for monitoring this corrective action to ensure this deficiency will not reoccur.</p>	07/22/2014

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L000671	<p>2. The undated agency policy titled "Infection control - Standard precautions" states, "POLICY STATEMENT: Hospice staff follows accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions in the care of all hospice patients, regardless of diagnosis or presumed infection status. PROCEDURES: ... 2. The use of the following standard precautions are required of all staff performing patient care: ... Patient-Care Equipment ... b. Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately"</p> <p>418.104 CLINICAL RECORDS A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. Bases on clinical record and policy review and interview, the hospice failed to ensure the clinical record contained correct information for discipline visit frequency and start of care dates in 9 of 9 active patient records reviewed creating the potential to affect all patients of the</p>	L000671	L0671 The Clinical Nursing Director has in-serviced all staff and reviewed agency's written policy and procedure regarding the records containing correct information for discipline visit frequency and start of care dates. IDG team reviewed samples of corrected	07/31/2014

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	<p>agency. (#1-9)</p> <p>Findings include:</p> <p>1. Clinical record #1, election date 3/24/14, evidenced an initial plan of care established by the physician stating, "Certification period: 032414 thru 062114 ... Frequency & reason for care by discipline Skilled Nurse: 1-2 x [times]/wk [week]/x 60 days ... HHA [home health aide]: 3/x/wk/x 60 days" The plan of care failed to document the discipline visit frequency to last for the 90 days of the initial certification period.</p> <p>The record contained a document titled "Initial Orders and Plan of care" stating, "SOC [start of care]: March 24, 2014 ... Form completed by : [employee O - Registered Nurse] SOC Date: 062214 ... Medical Director: [employee Q - Medical Director] '6/22/14' SOC Date: 062214."</p> <p>On 7/14/14 at 1:09 PM, employee B (office staff) indicated the SOC date for this patient was 3/24/14 and this was an updated plan of care signed by the registered nurse and medical director on 6/22/14. The employee indicated the form would need to be changed for accuracy of the clinical record.</p>		<p>documentation of visit frequency and start of care dates. Each patient's POC will be individualized to reflect the Initial 90-days, 2nd90-days, and 60-day frequencies (SOC / certification / re-certification frequencies). 7/22/14 IDG team to further review and revise process for ensuring information is correct regarding start of care dates and visit frequency documentation. IDG will develop tool to monitor compliance every 14 days. 7/31/14 QI will monitor and track performance every 30 days for compliance. 100% of the charts will be audited. Director of Nursing Services will be responsible for monitoring corrected deficiencies to ensure that they do not reoccur.</p>	

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	<p>2. Clinical record #2, election date 6/30/14, evidenced an initial plan of care established by the physician stating, "Certification period: 063014 thru 092714 ... Frequency & reason for care by discipline Skilled Nurse: 1-2 x/wk/x 60 days ... HHA: 3/x/wk/x 60 days" The plan of care failed to document the discipline visit frequency to last for the 90 days of the initial certification period.</p> <p>On 7/14/14 at 1:10 PM, employee B indicated the form would need to be modified to make the visit frequency for the initial certification 90 days rather than 60.</p> <p>3. Clinical record #3 evidenced a document dated 1/27/14 titled "Election of Medicare Hospice Benefit." The record evidenced an initial plan of care established by the physician stating, "SOC: January 29, 2014 Certification period: 012914 thru 042814 Frequency & reason for care by discipline Skilled Nurse: 1-2 x/wk/x60 days ... attending physician: [physician signature] '1-29-14' SOC Date: 012914 Medical Director: [physician signature] '1-29-14' SOC date: 012914." The plan of care failed to document the correct SOC date and failed to document the discipline visit frequency to last for the</p>			

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	<p>90 days of the initial certification period.</p> <p>On 7/10/14 at 1:40 PM, employee M (administrator) indicated the SOC date for this patient is 1/27/14 and the initial plan of care is dated incorrectly.</p> <p>4. Clinical record #4, election date 10/31/13, evidenced an initial plan of care established by the physician stating, "Certification period: 103113 thru 012814 ... Frequency & reason for care by discipline Skilled Nurse: 1-2 x/wk/x 60 days" The plan of care failed to document the discipline visit frequency to last for the 90 days of the initial certification period.</p> <p>5. Clinical record #5, election date 12/13/13, evidenced an initial plan of care established by the physician stating, "Certification period: 121313 thru 031214 ... Frequency & reason for care by discipline Skilled Nurse: 1-2 x/wk/x 60 days" The plan of care failed to document the discipline visit frequency to last for the 90 days of the initial certification period.</p> <p>The record contained a document titled "Initial Orders and Plan of care" stating, "SOC: December 13, 2013 ... Form completed by : [name of Registered Nurse] SOC Date: 031314 ... Medical</p>			

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	<p>Director: [employee Q - Medical Director] '3/13/14' SOC Date: 031314."</p> <p>On 7/14/14 at 1:15 PM, employee B indicated the SOC date for this patient was 12/13/13.</p> <p>6. Clinical record #6 had an election date of December 12, 2013, and evidenced a document titled "Initial Orders and Plan of care" stating, "SOC: December 12, 2013 ... Form completed by : [name of Registered Nurse] SOC Date: '06/11/14' Medical Director: [employee Q - Medical Director] '6/10/14' SOC Date: 061014." The plan of care failed to document the correct SOC date.</p> <p>7. Clinical record #7, election date 6/26/14, evidenced an initial plan of care established by the physician stating, "Certification period: 062614 thru 092314 ... Frequency & reason for care by discipline Skilled Nurse: 1-2 x/wk/x 60 days ... HHA: 3/x/wk/x 60 days" The plan of care failed to document the discipline visit frequency to last for the 90 days of the initial certification period.</p> <p>8. Clinical record #8 had an election date of October 17, 2013, and evidenced a document titled "Initial Orders and Plan of care" stating, "SOC: October 17, 2013 ... Form completed by : [name of</p>			

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	<p>Registered Nurse] SOC Date: 061414 ... Medical Director: [employee Q - Medical Director] '6/14/14' SOC Date: 061414." The plan of care failed to document the correct SOC date.</p> <p>9. Clinical record #9 had an election date of August 30, 2013, and evidenced a document titled "Initial Orders and Plan of care" stating, "SOC: August 30, 2013 ... Form completed by: [name of Registered Nurse] SOC Date: 062614 ... Medical Director: [employee Q - Medical Director] SOC Date: '6/26/14'." The plan of care failed to document the correct SOC date.</p> <p>10. The undated hospice policy titled "Clinical Records" states, "POLICY STATEMENT: A clinical record is established and maintained for every patient receiving care and services from ENTRUST HEALTH SERVICES, INC., Community hospice program. The record is complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/14/2014
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NAME OF PROVIDER OR SUPPLIER ENTRUST HEALTH SERVICES INC COMMUNITY HOSPICE PRC	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 WEST 42ND STREET, SUITE 225 INDIANAPOLIS, IN 46208
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