

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/13/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591
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L000000	<p>This was a hospice Federal recertification and State re-licensure survey.</p> <p>Survey Dates: 5-8-14, 5-9-14, 5-12-14, & 5-13-14</p> <p>Facility #: 007520</p> <p>Medicaid Vendor #: 200147600A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Good Samaritan Hospice was found to be out of compliance with IC 16-25-3 and Conditions of Participation 42 CFR 418.54 Initial and Comprehensive Assessment of the Patient; 42 CFR 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services; 42 CFR 418.76 Hospice Aide and Homemaker Services; 42 CFR 418.108 Short-term Inpatient Care; and 42 CFR 418.112 Hospices That Provide Hospice Care to Residents of a SNF/NF or ICF/MR.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 20, 2014</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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L000520	Based on clinical record and hospice policy review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure the registered nurse had conducted a complete assessment of the patients' physical, psychosocial, emotional, and spiritual needs in 7 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 521); by failing to ensure all members of the the interdisciplinary group (IDG) had participated in the completion of the comprehensive assessments in 13 of 13 records reviewed and failed to evidence the IDG had consulted with the attending physicians to complete the comprehensive assessments in 12 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 523); by failing to ensure comprehensive assessments identified the patients' psychosocial, emotional, and spiritual needs in 3 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 524); by failing to ensure comprehensive assessments included an initial	L000520	L520 The Hospice Patient Care Coordinator conducted staff education on 05/21 regarding the comprehensive assessment. Education stressed the importance of completing all information on the comprehensive assessment and that all questions/sections in the assessment are to be completed on all patients. A new auditing process has been implemented in that each member of the patient's treatment team will audit the assessment section of the team member before them to ensure that it is complete. The Hospice Patient Care Coordinator has revised the new patient checklist to audit that all sections of the comprehensive assessment (including psychosocial, emotional, and spiritual) are completed. In order to ensure that all members of the Hospice Interdisciplinary Group (IDG), in consultation with the attending physician, participate in the completion of the comprehensive assessment, it will now be faxed to both the Hospice Medical Director and the patient's attending physician for review and signatures upon completion by the IDG members. The comprehensive assessment form	05/21/2014

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	<p>bereavement assessment in 1 of 13 records reviewed creating the potential to affect all of the hospice's new patients (See L 531); by failing to ensure all identified problems had been reviewed for new needs and that the attending physician had contributed to the reviews and updates in 13 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 533); by failing to ensure comprehensive assessments included data elements to be used for the measurement of outcomes in 13 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 534); and by failing to ensure data elements had been incorporated into comprehensive assessments in a systematic and retrievable way in 13 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 535).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.54 Initial and Comprehensive Assessment of the Patient.</p>		<p>has also been amended to include the signature of all appropriate IDG team members for the patient prior to faxing to the Hospice Medical Director and the patient's attending physician. The Hospice Patient Care Coordinator conducted staff education on 05/21 regarding the importance of completing all sections of the comprehensive assessment, including the bereavement assessment which is part of the psychosocial assessment. The bereavement assessment will be completed and placed in the patient's chart within 5 days of admission to the Hospice program. The Hospice Patient Care Coordinator has also developed a revised "checklist" to review each patient's chart for completeness. The checklist now includes a listing for the bereavement assessment. The IDG meets every 14 days to review and update the assessment and care plan for each hospice patient. The review considers any changes that have taken place since the initial/last assessment and will include information on the patient's progress toward desired outcomes as well as a reassessment of the patient's response to care. At the conclusion of the IDG assessment review, the IDG assessment update will be faxed to the Hospice Medical Director and the patient's attending</p>		

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			<p>physician for review and signature and then faxed back to the hospice office. Education for all appropriate staff regarding the importance of completing each section of the updated assessment was conducted by the Hospice Patient Care Coordinator on 05/21/2014. The PCC will also audit each updated assessment performed by the IDG to ensure that all identified problems have been reviewed for new needs. The Hospice Patient Care Coordinator has identified elements within the comprehensive assessment to allow for measurement of outcomes. The measures specifically include bowel function while on opioid pain medication. New forms were created to allow for ease of measurement and monitoring. 100% of Hospice comprehensive assessments will be audited to ensure compliance with the requirement that all questions/sections are addressed and completed, including the bereavement section. 100% of patient care records will be audited to ensure that the comprehensive assessment is completed by all appropriate IDG members, including the Hospice Medical Director and the patient's attending physician. 100% of patient charts will be audited every 2 weeks by the Hospice Patient Care Coordinator to ensure compliance with the timeliness and completeness of</p>		

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L000521	<p>418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT</p> <p>The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure the registered nurse (RN) had conducted a complete assessment of the patients' physical, psychosocial, emotional, and spiritual needs in 7 (#s 1,</p>	L000521	<p>the update/review of the patient's comprehensive assessment and to ensure that the Hospice Medical Director and the patient's attending physician have contributed to the reviews and updates. 100% of charts will be monitored/audited monthly and results reported quarterly to the Hospital-Wide Performance Improvement for bowel program with opioid use. Committee. A goal of 90% of patients experiencing improvement or maintaining stability has been set. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>L521 The Hospice Patient Care Coordinator conducted staff education on 05/21 regarding the comprehensive assessment. Education stressed the importance of completing all information on the</p>	05/21/2014

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	<p>2, 3, 4, 5, 9, and 12) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a comprehensive nursing assessment completed by the RN, employee M, on 12-27-13. The effectiveness of the current pain medications and treatments, barriers to pain management, if nutrition/hydration was a problem, urinary tract infection, current sleep pattern, change in sleep pattern, if sedatives were used, fall risk assessment, and psychosocial assessment portions of the assessment had been left blank. 2. Clinical record number 2 included a comprehensive nursing assessment completed the RN, employee F, on 2-27-14. The treatments or meds the patient received for pain, barriers to pain management, urine color, frequency of urinary tract infections, physical mobility, and durable medical equipment and supplies in the home and/or needed portions of the assessment had been left blank. 3. Clinical record number 3 included a comprehensive nursing assessment completed by the RN, employee N, on 		<p>comprehensive assessment and that all questions/sections in the assessment are to be completed on all patients. A new auditing process has been implemented in that each member of the patient's treatment team will audit the assessment section of the team member before them to ensure that it is complete. The Hospice Patient Care Coordinator has revised the new patient checklist to audit that all sections of the comprehensive assessment (including psychosocial, emotional, and spiritual) are completed. 100% of Hospice new comprehensive assessments will be audited by the Hospice Patient Care Coordinator to ensure compliance with the requirement that all questions/sections are addressed and completed. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>3-17-14. The frequency of urinary tract infections and sleep pattern portions of the assessment had been left blank.</p> <p>4. Clinical record number 4 included a comprehensive nursing assessment completed by the RN, employee M, on 5-2-14. The kinds of things that make the patient's pain worse, barriers to pain management, type and size of the tracheotomy, and the neurological functioning portion of the assessment had been left blank.</p> <p>5. Clinical record number 5 included a comprehensive nursing assessment completed by the RN, employee M, on 4-16-14. The level of pain assessment, last bowel movement, urine color, activities of daily living, and psychosocial portions of the assessment had been left blank.</p> <p>6. Clinical record number 9 included a comprehensive nursing assessment completed by the RN, employee M, on 3-31-14. The assessment identified the patient had "no pain". The assessment states, also, "meds, repositioning" makes the pain better and that walking makes the pain worse. The assessment indicates the current pain medication is "effective" and that the pain is "aching." The pain at its worst in the past week, right now, and</p>			

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	<p>acceptable level of pain portion of the assessment had been left blank.</p> <p>7. Clinical record number 12 included a comprehensive nursing assessment completed by the RN, employee ? (signature page missing) on 4-4-14. The current sleep pattern and change in sleep pattern and psychosocial portions of the assessment had been left blank.</p> <p>8. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>9. The hospice's 5/12 "Scope of Services" policy states, "A comprehensive initial assessment will be performed by an RN, to collect data about the patient and their environment within 72 hours of admission into the hospice program . . . Assessments may include: . . . pertinent physical findings i.e. sensory, integumentary, respiratory, elimination, neurological status; severity of symptoms and factors that alleviate or exacerbate physical symptoms, problems, needs, strengths, limitations and goals, psychosocial status, nutritional status . . . functional status."</p>			

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L000523	<p>418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT</p> <p>The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.</p> <p>Based on clinical record review and interview, the hospice failed to ensure all members of the the interdisciplinary group (IDG) had participated in the completion of the comprehensive assessments in 13 (#s 1 through 13) of 13 records reviewed and failed to evidence the IDG had consulted with the attending physicians to complete the comprehensive assessments in 12 (#s 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, and 13) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a comprehensive assessment dated 12-31-13. The assessment failed to evidence participation by the medical director member of the IDG and failed to evidence consultation with the attending physician. 2. Clinical record number 2 included a comprehensive assessment dated 	L000523	L523 In order to ensure that all members of the Hospice Interdisciplinary Group (IDG), in consultation with the attending physician, participate in the completion of the comprehensive assessment, it will now be faxed to both the Hospice Medical Director and the patient's attending physician for review and signatures upon completion by the IDG. The assessment form has also been amended to include the signature of all appropriate IDG team members for the patient prior to faxing to the Hospice Medical Director and the patient's attending physician. 100% of patient care records will be audited to ensure that the comprehensive assessment is completed by all appropriate IDG members, including the Hospice Medical Director and the patient's attending physician. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	05/21/2014	

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	<p>2-27-14. The assessment failed to evidence participation by the medical director or the spiritual care counselor members of the IDG and failed to evidence consultation with the attending physician.</p> <p>3. Clinical record number 3 included a comprehensive assessment dated 3-19-14. The assessment failed to evidence participation by the medical director or the spiritual care counselor members of the IDG and failed to evidence consultation with the attending physician.</p> <p>4. Clinical record number 4 included a comprehensive assessment dated 5-2-14. The assessment failed to evidence participation by the medical director member of the IDG.</p> <p>5. Clinical record number 5 included a comprehensive assessment dated 4-16-14. The assessment failed to evidence participation by the medical director member of the IDG and failed to evidence consultation with the attending physician.</p> <p>6. Clinical record number 6 included a comprehensive assessment dated 4-30-14. The assessment failed to evidence participation by the medical</p>				

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	<p>director and spiritual care counselor members of the IDG and failed to evidence consultation with the attending physician.</p> <p>7. Clinical record number 7 included a comprehensive assessment dated 11-8-13. The assessment failed to evidence participation by the medical director member of the IDG and failed to evidence consultation with the attending physician.</p> <p>8. Clinical record number 8 included a comprehensive assessment dated 5-5-14. The assessment failed to evidence participation by the medical director, medical social worker, and spiritual care counselor members of the IDG and failed to evidence consultation with the attending physician.</p> <p>9. Clinical record number 9 included a comprehensive assessment dated 3-31-14. The assessment failed to evidence participation by the medical director and spiritual care counselor members of the IDG and failed to evidence consultation with the attending physician.</p> <p>10. Clinical record number 10 included a comprehensive assessment dated 12-31-13. The assessment failed to</p>			

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	<p>evidence participation by the medical director member of the IDG and failed to evidence consultation with the attending physician.</p> <p>11. Clinical record number 11 included a comprehensive assessment dated 11-28-12. The assessment failed to evidence participation by the medical director member of the IDG and failed to evidence consultation with the attending physician.</p> <p>12. Clinical record number 12 included a comprehensive assessment dated 4-8-14. The assessment failed to evidence participation by the medical director and spiritual care counselor members of the IDG and failed to evidence consultation with the attending physician.</p> <p>13. Clinical record number 13 included a comprehensive assessment dated 10-17-13. The assessment failed to evidence participation by the medical director member of the IDG and failed to evidence consultation with the attending physician.</p> <p>14. The patient care coordinator stated, on 5-8-14 at 10:05 AM, "We call the attending physician to get the order to start hospice services. We consult with the doctor or the nurse at that time." The</p>			

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L000524	<p>patient care coordinator was unable to provide documentation of the consultations when asked on 5-13-14 at 10:00 AM.</p> <p>15. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>418.54(c) CONTENT OF COMPREHENSIVE ASSESSMENT The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. Based on clinical record and hospice policy review and interview, the hospice failed to ensure comprehensive assessments identified the patients' psychosocial, emotional, and spiritual needs in 3 (#s 3, 6, and 8) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a</p>	L000524	L524 In order to ensure that all members of the Hospice Interdisciplinary Group (IDG), in consultation with the attending physician, participate in the completion of the comprehensive assessment, it will now be faxed to both the Hospice Medical Director and the patient's attending physician for review and signatures upon completion by the IDG. The assessment form has also been amended to include the signature of all appropriate IDG team members	05/28/2014

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	<p>psychosocial comprehensive assessment completed by the medical social worker, employee E, on 3-19-14. The assessment states, "SC [spiritual care] 1 X eval [one time for evaluation]."</p> <p>The record failed to evidence a spiritual care counselor had assessed the patient to identify any spiritual needs.</p> <p>2. Clinical record number 6 included a psychosocial comprehensive assessment completed by the medical social worker, employee E, on 4-30-14. The assessment states, "SC 1 X Eval per [patient's child]."</p> <p>The record failed to evidence a spiritual care counselor had assessed the patient to identify any spiritual needs.</p> <p>3. Clinical record number 8 included a comprehensive nursing assessment completed on 5-5-14. The record failed to evidence the patient's psychosocial and emotional needs had been assessed by the medical social worker and failed to evidence the patient's spiritual needs had been assessed by the spiritual care counselor.</p> <p>The record included a "Spiritual Care Request Form" dated 5-5-14. The form states, "Spiritual Needs: Pt [patient]"</p>		<p>for the patient prior to faxing to the Hospice Medical Director and the patient's attending physician. Furthermore, the Hospice Patient Care Coordinator has developed a revised "checklist" for completeness. The new checklist includes assessing for the presence of the psychosocial and spiritual assessments. 100% of patient care records will be audited to ensure that the comprehensive assessment is completed by all appropriate IDG members, including the Hospice Medical Director and the patient's attending physician. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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L000531	<p>stated [the patient] just wants to talk to someone. Does not want a prayer shawl."</p> <p>4. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>5. The hospice's 5/12 "Scope of Services" policy states, "Assessments may include: . . psychosocial status-emotional/behavioral status . . . cultural, religious needs, spiritual needs and concerns."</p> <p>418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care. Based on clinical record and hospice policy review and interview, the hospice failed to ensure comprehensive assessments included an initial</p>	L000531	L531 The Hospice Patient Care Coordinator conducted staff education on 05/21 regarding the importance of completing all sections of the comprehensive	05/21/2014

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L000533	<p>bereavement assessment in 1 (# 8) of 13 records reviewed creating the potential to affect all of the hospice's new patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 8, start of care 5-2-14, included a comprehensive nursing assessment dated 5-5-14. The record failed to evidence an initial bereavement assessment had been completed. 2. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM. 3. The hospice's 5/12 "Scope of Services" policy states, "Assessments may include: . . . anticipated discharge needs including bereavement and funeral needs, support group needs . . . survivor risk factors." <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</p>		<p>assessment, including the bereavement assessment which is part of the psychosocial assessment. The bereavement assessment will be completed and placed in the patient's chart within 5 days of admission to the Hospice program. The Hospice Patient Care Coordinator has also developed a revised "checklist" to review each patient's chart for completeness. The checklist now includes a listing for the bereavement assessment. 100% of patient charts will be audited for the presence of the bereavement assessment to ensure the comprehensive assessment is complete. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>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 review and interview, the hospice failed to ensure all identified problems had been reviewed for new needs and that the attending physician had contributed to the reviews and updates in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included an initial comprehensive assessment dated 12-31-13. The record evidenced the assessment had been reviewed and updated by the interdisciplinary group (IDG) on 3-28-14, 4-11-14, 4-25-14, and 5-9-14. The record failed to evidence the attending physician had participated in the reviews.</p> <p>A. The 3-28-14 update failed to evidence the patient's urinary status had been reviewed and updated.</p> <p>B. The 5-9-14 update failed to</p>	L000533	L533 The IDG meets every 14 days to review and update the assessment and care plan for each hospice patient. The review considers any changes that have taken place since the initial/last assessment and will include information on the patient's progress toward desired outcomes as well as a reassessment of the patient's response to care. At the conclusion of the IDG assessment review, the IDG assessment update will be faxed to the Hospice Medical Director and the patient's attending physician for review and signature and then faxed back to the hospice office. Education for all appropriate staff regarding the importance of completing each section of the updated assessment was conducted by the Hospice Patient Care Coordinator on 05/21/2014. The PCC will also audit each updated assessment performed by the IDG to ensure that all identified problems have been reviewed for new needs. 100% of patient charts will be audited every 2 weeks by the Hospice Patient Care	05/30/2014	

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	<p>evidence the patient's psychosocial and spiritual status had been reviewed and updated.</p> <p>2. Clinical record number 2 included an initial comprehensive assessment dated 2-27-14. The record evidenced the IDG had reviewed and updated the assessment on 3-14-14, 3-28-14, 4-11-14, 4-25-14, and 5-9-14. The record failed to evidence the attending physician had participated in the reviews.</p> <p>3. Clinical record number 3 included an initial comprehensive assessment dated 3-19-14. The record evidenced the IDG had reviewed and updated the assessment. The record evidenced the IDG had reviewed and updated the assessment on 3-28-14, 4-11-14, 4-25-14, and 5-9-14. The record failed to evidence the attending physician had participated in the reviews.</p> <p>A. The 3-28-14 update failed to evidence the patient's nutrition / hydration, bowel elimination, urinary status, integumentary, neurological / mental status, sleep, endocrine status, and mobility status had been updated.</p> <p>B. The 4-11-14 update failed to evidence the patient's bowel elimination, urinary status, integumentary,</p>		<p>Coordinator to ensure compliance with the completeness of the update/review of the patient's assessment and to ensure that the Hospice Medical Director and the patient's attending physician have contributed to the reviews and updates. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>neurological / mental status, sleep status, and endocrine status had been updated.</p> <p>C. The 4-25-14 update failed to evidence the patient's nutrition / hydration status, sleep and endocrine status had been updated.</p> <p>4. Clinical record number 4 included an initial comprehensive assessment dated 5-2-14. The record evidenced the assessment had been updated on 5-9-14 by the IDG. The record failed to evidence the attending physician had participated in the review and update.</p> <p>5. Clinical record number 5 included an initial comprehensive assessment dated 4-16-14. The record failed to evidence the assessment had been reviewed and updated at any time.</p> <p>6. Clinical record number 6 included an initial comprehensive assessment dated 4-30-14. The record evidenced the assessment had been updated on 5-9-14 by the IDG. The record failed to evidence the attending physician had participated in the review and update.</p> <p>7. Clinical record number 7 included an initial comprehensive assessment dated 11-8-13. The record evidenced the assessment had been updated on 3-14-14,</p>			

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	<p>3-28-14, 4-11-14, and 5-9-14. The record failed to evidence the attending physician had participated in the reviews and updates.</p> <p>A. The record failed to evidence the assessment had been reviewed at least every 15 days. The assessment was updated on 4-11-14 and not again until 5-9-14.</p> <p>B. The 3-14-14 update failed to evidence the patient's comfort, cardiorespiratory status, nutrition / hydration status, bowel elimination, urinary status, integumentary status, neurological / mental status, sleep status, endocrine status, mobility status, self-care status, and psychosocial status had been updated.</p> <p>C. The 5-9-14 update failed to evidence the patient's mobility and psychosocial status had been updated.</p> <p>8. Clinical record number 8 included an initial comprehensive assessment dated 5-5-14. The record evidenced the assessment had been updated on 5-9-14. The record failed to evidence the attending physician had participated in the review and update.</p> <p>The review failed to evidence the</p>						

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	<p>patient's comfort due to pain status, cardiorespiratory status, nutrition / hydration status, bowel elimination status, neurological / mental status, sleep status, mobility status, self-care status, and psychosocial status had been updated.</p> <p>9. Clinical record number 9 included an initial comprehensive assessment dated 3-31-14. The record evidenced the assessment had been updated by the IDG on 4-11-14, 4-25-14, and 5-9-14. The updates failed to evidence the attending physician had participated in the reviews.</p> <p>A. The 4-11-14 review failed to evidence the patient's psychosocial and spiritual status had been updated.</p> <p>B. The 5-9-14 review failed to evidence the patient's psychosocial status had been updated.</p> <p>10. Clinical record number 10 included an initial comprehensive assessment dated 12-31-13. The record evidenced the IDG had updated the comprehensive assessment on 3-28-14, 4-11-14, and 4-25-14. The updates failed to evidence participation by the attending physician.</p> <p>11. Clinical record number 11 included an initial comprehensive assessment</p>			

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	<p>dated 11-28-12. The record evidenced the IDG had updated the comprehensive assessment on 2-28-14, 3-14-14, 3-28-14, 4-11-14, and 5-9-14. The updates failed to evidence participation by the attending physician.</p> <p>A. The record evidenced the assessment was updated on 4-11-14 and not again until 5-9-14, a period of 28 days between reviews.</p> <p>B. The 3-14-14 review failed to evidence the patient's integumentary status and mobility status had been updated.</p> <p>12. Clinical record number 12 included an initial comprehensive assessment dated 4-8-14. The record evidenced the assessment had been updated by the IDG on 4-11-14, 4-25-14, and 5-9-14. The record failed to evidence the attending physician had participated in the updates.</p> <p>The 5-9-14 review failed to evidence the patient's psychosocial or spiritual status had been updated.</p> <p>13. Clinical record number 13 included an initial comprehensive assessment dated 10-17-13. The record evidenced the assessment had been updated by the IDG on 4-11-14, 4-25-14, and 5-9-14.</p>			

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L000534	<p>The record failed to evidence the attending physician had participated in the updates.</p> <p>A. The 4-11-14 review failed to evidence the patient's comfort, cardiorespiratory , nutrition / hydration, bowel, urinary, neurological / mental, sleep, and endocrine status had been updated.</p> <p>B. The 4-25-14 review failed to evidence the patient's nutrition / hydration, neurological / mental, endocrine, and mobility status had been updated.</p> <p>14. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>418.54(e)(1) PATIENT OUTCOME MEASURES (1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and</p>				

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	<p>palliation.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure comprehensive assessments included data elements to be used for the measurement of outcomes in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included an initial comprehensive assessment dated 12-31-13. The assessment failed to evidence data elements for the measurement of patient outcomes. 2. Clinical record number 2 included an initial comprehensive assessment dated 2-27-14. The assessment failed to evidence data elements for the measurement of patient outcomes. 3. Clinical record number 3 included an initial comprehensive assessment dated 3-19-14. The assessment failed to evidence data elements for the measurement of patient outcomes. 4. Clinical record number 4 included an initial comprehensive assessment dated 5-2-14. The assessment failed to evidence data elements for the 	L000534	<p>L534 The Hospice Patient Care Coordinator has identified elements within the comprehensive assessment to allow for measurement of outcomes. The measures specifically include bowel function while on opioid pain medication. New forms were created to allow for ease of measurement and monitoring. 100% of charts will be monitored/audited monthly and results reported quarterly to the Hospital-Wide Performance Improvement Committee for the bowel program on opioid pain medication. A goal of 90% of patients experiencing improvement or maintaining stability has been set. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	05/28/2014

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	<p>measurement of patient outcomes.</p> <p>5. Clinical record number 5 included an initial comprehensive assessment dated 4-16-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>6. Clinical record number 6 included an initial comprehensive assessment dated 4-30-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>7. Clinical record number 7 included an initial comprehensive assessment dated 11-8-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>8. Clinical record number 8 included an initial comprehensive assessment dated 5-5-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>9. Clinical record number 9 included an initial comprehensive assessment dated 3-31-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>10. Clinical record number 10 included an initial comprehensive assessment</p>			

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	<p>dated 12-31-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>11. Clinical record number 11 included an initial comprehensive assessment dated 11-28-12. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>12. Clinical record number 12 included an initial comprehensive assessment dated 4-8-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>13. Clinical record number 13 included an initial comprehensive assessment dated 10-17-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>14. The hospice director and the patient care coordinator were unable to provide a list of the data elements that comprise the hospice's comprehensive assessments and were unable to explain how the data elements were used in the hospice's quality assessment performance improvement program when asked on 5-13-14 at 2:50 PM.</p> <p>15. The hospice's 01/06 "Performance Improvement" policy failed to evidence</p>			

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L000535	<p>data elements were to be incorporated into the comprehensive assessment and failed to evidence a process to retrieve the data and incorporate them into the hospice's quality assessment performance program.</p> <p>418.54(e)(2) PATIENT OUTCOME MEASURES (2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure data elements had been incorporated into comprehensive assessments in a systematic and retrievable way in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included an initial comprehensive assessment dated 12-31-13. The assessment failed to evidence data elements for the</p>	L000535	L535 The Hospice Patient Care Coordinator has identified elements within the comprehensive assessment to allow for measurement of outcomes. The measures specifically include bowel function while on opioid pain medication. New forms were created to allow for ease of measurement and monitoring. 100% of charts will be monitored/audited monthly and results reported quarterly to the Hospital-Wide Performance Improvement Committee for the bowel program on opioid pain medication. A goal of 90% of patients experiencing improvement or maintaining stability has been set. The	05/28/2014

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	<p>measurement of patient outcomes.</p> <p>2. Clinical record number 2 included an initial comprehensive assessment dated 2-27-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>3. Clinical record number 3 included an initial comprehensive assessment dated 3-19-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>4. Clinical record number 4 included an initial comprehensive assessment dated 5-2-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>5. Clinical record number 5 included an initial comprehensive assessment dated 4-16-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>6. Clinical record number 6 included an initial comprehensive assessment dated 4-30-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>7. Clinical record number 7 included an initial comprehensive assessment dated</p>		Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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	<p>11-8-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>8. Clinical record number 8 included an initial comprehensive assessment dated 5-5-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>9. Clinical record number 9 included an initial comprehensive assessment dated 3-31-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>10. Clinical record number 10 included an initial comprehensive assessment dated 12-31-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>11. Clinical record number 11 included an initial comprehensive assessment dated 11-28-12. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>12. Clinical record number 12 included an initial comprehensive assessment dated 4-8-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p>			

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L000536	<p>13. Clinical record number 13 included an initial comprehensive assessment dated 10-17-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>14. The hospice director and the patient care coordinator were unable to provide a list of the data elements that comprise the hospice's comprehensive assessments and were unable to explain how the data elements were used in the hospice's quality assessment performance improvement program when asked on 5-13-14 at 2:50 PM.</p> <p>15. The hospice's 01/06 "Performance Improvement" policy failed to evidence data elements were to be incorporated into the comprehensive assessment and failed to evidence a process to retrieve the data and incorporate them into the hospice's quality assessment performance program.</p> <p>Based on clinical record and hospice policy review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure all members of the</p>	L000536	L536 The Hospice Patient Care Coordinator has revised a new patient "checklist" to ensure completeness. The checklist includes audits to ensure that all members of the IDG (e.g.	06/12/2014

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	interdisciplinary group had participation in the establishment of the plan of care in 1 of 13 records reviewed and failed to ensure consultation with the attending physician in the establishment of the plan of care had been accomplished in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 537); by failing to ensure the comprehensive plans of care addressed all identified needs in 7 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 538); by failing to ensure the attending physician had participated in the establishment of the plans of care in 13 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 543); by failing to ensure plans of care included patient and/or caregiver education regarding the use of medical equipment in 1 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 544); by failing to ensure the comprehensive plans of care included interventions based on comprehensive assessments in 7 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 545); by failing to ensure plans of care included a detailed statement of what disciplines were responsible for the implementation		medical director, social worker, spiritual care counselor) have participated in the development of and signed the plan of care. Furthermore, completed plans of care will be faxed to the Hospice Medical Director and the patient's attending physician for review, comment, and signature. On 05/21/2014 the Hospice Patient Care Coordinator conducted education with all applicable staff regarding the importance of all members of the IDG, including the patient's attending physician participate in the establishment of the plan of care. The above process was explained at that time. On 06/02/2014 the Hospice Patient Care Coordinator will provide education to all staff members regarding the need to educate patients, patient's care giver(s), and SNF staff regarding the proper functioning, utilization, and proper response to problems for all medical equipment provided by Hospice to the patient. PCC will also educate staff on the proper documentation of the provision of this education in the patient's record. The Hospice Plan of Care is being revised to reflect elements in the comprehensive assessment more accurately. On 05/21/2014 the Patient Care Coordinator conducted education for all staff to emphasize that all issues identified on the comprehensive assessment are to be reflected on the patient's plan of care. This		

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	<p>of interventions related to identified problems in 13 of 13 records reviewed (See L 547); by failing to ensure plans of care included measurable patient outcomes in 13 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 548); and by failing to ensure plans of care had been reviewed and revised at least every 15 days in 3 (#s 5, 7, and 11) of 13 records reviewed and failed to ensure plans of care had been updated to address new identified needs in 5 of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients (See L 552).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services.</p>		<p>education will be repeated on 06/02/2014. The Hospice Patient Care Coordinator has revised the new patient "checklist" to include auditing of the plan of care for issues identified in the comprehensive assessment and updates. The Hospice Patient Care Coordinator provided education to staff on 05/21/2014 on the selecting and documenting the appropriate discipline(s) that will be involved in the interventions identified on the patient's plan of care. Specifically, staff were instructed to select only those disciplines that were responsible for performing the intervention identified in the care plan. On 5/21/2014 the Hospice Patient Care Coordinator provided education to all staff regarding how to write objectives and goals in the plan of care so that planned interventions will have measureable outcomes. Staff are now required to write interventions in plans of care that are specific, objective, and measureable. On 05/21/2014 the Hospice Patient Care Coordinator developed a new process and provided education to all staff that all plans of care will be reviewed by the IDG every 14 days and faxed to the Hospice Medical Director and the patient's attending physician for review, coordination, and signature. Staff are to ensure that plans of care have been updated to address new identified needs from the</p>		

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			IDG updated assessment or as identified by staff at any time in the course of care and treatment. 100% of charts will be audited every 14 days utilizing the patient checklist by the Hospice Patient Care Coordinator to ensure all members of the IDG (including the Medical Director and the patient's attending physician) have participated in the development of the plan of care. 100% of patient records will be audited every 14 days by the Patient Care Coordinator to ensure that staff are providing and documenting in the plan of care education to patients, patient's care giver(s), and staff at SNF regarding any medical equipment Hospice supplies to the patient. 100% of charts will be audited every 14 days utilizing the patient checklist by the Hospice Patient Care Coordinator to ensure that all issues identified in the patient's comprehensive assessment and issues identified in the IDG updated assessment are accurately reflected on the patient's plan of care. 100% of patient charts will be audited every 14 days to ensure that plans of care identify those disciplines that are responsible for completing the intervention identified on the patient's care plan. 100% of patient care plans will be audited every 14 days by the Hospice Patient Care Coordinator to ensure that identified goals are written so that	

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L000537	<p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.</p> <p>Based on clinical record and hospice policy review, the hospice failed to ensure all members of the interdisciplinary group (IDG) had participation in the establishment of the plan of care in 1 (# 8) of 13 records reviewed and failed to ensure consultation with the attending physician in the establishment of the plan of care had been accomplished in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p>	L000537	<p>L537 The Hospice Patient Care Coordinator has revised a new patient "checklist" to ensure completeness. The checklist includes audits to ensure that all members of the IDG (e.g. medical director, social worker, spiritual care counselor) have participated in the development of and signed the plan of care. Furthermore, completed plans of care will be faxed to the Hospice Medical Director and the patient's attending physician for review, comment, and signature. On 05/21/2014 the Hospice Patient Care Coordinator conducted</p>	05/28/2014	

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	<p>The findings include:</p> <p>Regarding all members of the IDG participation:</p> <ol style="list-style-type: none"> 1. Clinical record number 8, start of care 5-2-14, included a plan of care dated 5-2-14. The plan of care failed to evidence the medical director, the social worker, or the spiritual care counselor had participated in the establishment of the plan or consultation with the attending physician had been accomplished. 2. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM. 3. The hospice's 05/12 "Scope of Services" policy states, "Criteria for Plan of Care. The attending physician, the medical director or physician designee and the IDG prior to providing care, develops and initiates the IDG care plan within twenty-four (24) hours." <p>Regarding attending physician consultation:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a comprehensive plan of care (POC) 		<p>education with all applicable staff regarding the importance of all members of the IDG, including the patient's attending physician participate in the establishment of the plan of care. The above process was explained at that time. 100% of charts will be audited every 2 weeks utilizing the new patient checklist by the Hospice Patient Care Coordinator to ensure all members of the IDG (including the Medical Director and the patient's attending physician) have participated in the development of the plan of care. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>established by the IDG on 12-26-13. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>2. Clinical record number 2 included a comprehensive POC established by the IDG on 2-26-14. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>3. Clinical record number 3 included a comprehensive POC established by the IDG on 3-14-14. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>4. Clinical record number 4 included a comprehensive POC dated 5-1-14. The plan of care failed to evidence the medical director, the medical social worker, or the spiritual care counselor members of the IDG had participated in the establishment of the plan. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>5. Clinical record number 5 included a comprehensive POC established by the IDG on 4-15-14. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>6. Clinical record number 6 included a</p>						

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	<p>comprehensive POC established by the IDG on 4-29-14. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>7. Clinical record number 7 included a comprehensive POC established by the IDG on 11-5-13. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>8. Clinical record number 8 included a comprehensive POC established by the IDG on 5-2-14. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>9. Clinical record number 9 included a comprehensive POC established by the IDG on 3-29-14. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>10. Clinical record number 10 included a comprehensive POC established by the IDG on 12-29-13. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>11. Clinical record number 11 included a comprehensive POC established by the IDG on 11-27-12. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p>				

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L000538	<p>12. Clinical record number 12 included a comprehensive POC established by the IDG on 4-3-14. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>13. Clinical record number 13 included a comprehensive POC established by the IDG on 10-16-13. The record failed to evidence the IDG had consulted with the attending to establish the plan.</p> <p>14. The patient care coordinator stated, on 5-8-14 at 10:05 AM, "When the IDG establishes the plan of care, the whole plan is not sent to the attending, just the signature page."</p> <p>15. The hospice's 01/04 "Provision of Services" policy states, "The attending physician reviews and approves the interdisciplinary group care plan."</p> <p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions. Based on clinical record and hospice</p>	L000538	L538 The Hospice Plan of Care is	06/12/2014

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	<p>policy review and interview, the hospice failed to ensure the comprehensive plans of care addressed all identified needs in 7 (#s 2, 3, 5, 6, 8, 9, & 12) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included an initial comprehensive nursing assessment dated 2-27-14. The assessment identifies the patient experiences shortness of breath with exertion, a "cough", and diminished lung sounds. The assessment indicates the patient has Type II diabetes controlled with an oral hypoglycemic medication and identifies "Alteration in Endocrine System" as a problem.</p> <p>A. The comprehensive plan of care dated 2-26-14 failed to evidence the shortness of breath, cough, and diminished lung sounds had been addressed.</p> <p>B. The plan of care identifies the patient as "diabetic" and on a diet "as tolerated."</p> <p>C. The record included an initial psychosocial assessment dated 2-27-14 that identifies "depression" as a problem. The assessment states, "Pt [patient]</p>		<p>being revised to reflect elements in the comprehensive assessment more accurately. On 06/02/2014 the Patient Care Coordinator will conduct education for all staff to emphasize that all issues identified on the comprehensive assessment are to be reflected on the patient's plan of care. The Hospice Patient Care Coordinator has revised the new patient "checklist" to include auditing of the plan of care for issues identified in the comprehensive assessment. 100% of charts will be audited utilizing the new patient checklist by the Hospice Patient Care Coordinator to ensure that all issues identified in the patient's comprehensive assessment are accurately reflected on the patient's plan of care. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>expressed concern re: primary cg [caregiver] . . . ability to cope [with] cgiving [caregiving] tasks. Pt also has raised / cared for [grandchild] since [grandchild] was 5 wks [weeks] old. [Patient] does not have custody. Concern expressed re: [grandchild's] reaction to pt's illness & declining health as well as when [the patient] dies."</p> <p>D. The comprehensive plan of care dated 2-26-14 failed to address the patient concerns and needs related to the grandchild.</p> <p>2. Clinical record number 3 included an initial comprehensive nursing assessment dated 3-17-14. The assessment identifies the patient has "palpitations, fainting / dizziness, and nocturnal dyspnea."</p> <p>The plan of care dated 3-14-14 failed to evidence the identified problems had been addressed.</p> <p>3. Clinical record number 5 included an initial comprehensive nursing assessment dated 4-16-14. The assessment identifies the patient "uses a cane when up . . . mainly in bed . . . unable to str [stand]/walk." The initial psychosocial assessment dated 4-16-14 identifies the patient has a history of alcohol abuse.</p>			

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	<p>The comprehensive plan of care dated 4-15-14 failed to address the identified impaired physical mobility problems and history of alcohol abuse.</p> <p>4. Clinical record number 6 included an initial comprehensive nursing assessment dated 4-30-14. The assessment identifies the patient is hard of hearing and that "Alteration in Physical Mobility" is a problem.</p> <p>The comprehensive plan of care dated 4-29-14 failed to address the identified hearing and mobility problems.</p> <p>5. Clinical record number 8 included an initial comprehensive nursing assessment dated 5-5-14. The assessment identifies the patient has "fainting / dizziness, nocturnal dyspnea . . . pacemaker June 2013 . . . difficulty swallowing . . . problems starting [urinary] stream."</p> <p>A. The comprehensive plan of care dated 5-2-14 failed to address the needs identified on the nursing assessment.</p> <p>B. The update to the plan of care dated 5-9-14 failed to address the needs identified on the nursing assessment. The update states, "Cardiorespiratory status: oxygen, neb txs [nebulizer treatments] . . . urinary status: no new</p>			

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	<p>needs identified." The nutrition / hydration portion of the updated plan of care had been left blank.</p> <p>6. Clinical record number 9 included an initial comprehensive nursing assessment dated 3-31-14 that identifies the patient has dizziness, an "occasional cough", "problems with dietary intake . . . difficulty chewing." The initial psychosocial assessment dated 3-31-14 identifies the patient has depression.</p> <p>The comprehensive plan of care dated 3-29-14 failed to evidence the needs identified in the nursing and psychosocial assessments were addressed.</p> <p>7. Clinical record number 12 included an initial comprehensive nursing assessment dated 4-4-16. The assessment identifies the patient is a "bilateral amputee. [right] side paralysis" and that impaired physical mobility was a problem. The initial psychosocial assessment dated 4-8-14 identifies the patient is "anxious."</p> <p>The plan of care dated 4-3-14 failed to evidence the impaired physical mobility needs or the patient's anxiety had been addressed.</p> <p>8. The hospice director and the patient</p>						

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L000543	<p>care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>9. The hospice's 5/12 "Scope of Services" policy states, "Contents of the Plan of Care . . . Identification of problems, needs, strengths, medications, limitations and the establishment of appropriate goals."</p> <p>418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure the attending physician had participated in the establishment of the plans of care in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a</p>	L000543	L543 The Hospice Patient Care Coordinator has revised a new patient "checklist" to ensure completeness. The checklist includes audits to ensure that all members of the IDG (e.g. medical director, social worker, spiritual care counselor) have participated in the development of and signed the plan of care. Furthermore, completed plans of care will be faxed to the Hospice Medical Director and the patient's attending physician for review,	06/12/2014

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	<p>comprehensive plan of care (POC) established by the interdisciplinary group (IDG) on 12-26-13. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>2. Clinical record number 2 included a comprehensive POC established by the IDG on 2-26-14. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>3. Clinical record number 3 included a comprehensive POC established by the IDG on 3-14-14. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>4. Clinical record number 4 included a comprehensive POC dated 5-1-14. The plan of care failed to evidence the medical director, the medical social worker, or the spiritual care counselor members of the IDG had participated in the establishment of the plan. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>5. Clinical record number 5 included a comprehensive POC established by the IDG on 4-15-14. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p>		<p>comment, and signature. On 05/21/2014 the Hospice Patient Care Coordinator conducted education with all appropriate staff regarding the new care plan process. 100% of charts will be audited every 14 days utilizing the new patient checklist by the Hospice Patient Care Coordinator to ensure all members of the IDG (including the Medical Director and the patient's attending physician) have participated in the development of the plan of care. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>6. Clinical record number 6 included a comprehensive POC established by the IDG on 4-29-14. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>7. Clinical record number 7 included a comprehensive POC established by the IDG on 11-5-13. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>8. Clinical record number 8 included a comprehensive POC established by the IDG on 5-2-14. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>9. Clinical record number 9 included a comprehensive POC established by the IDG on 3-29-14. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>10. Clinical record number 10 included a comprehensive POC established by the IDG on 12-29-13. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>11. Clinical record number 11 included a comprehensive POC established by the IDG on 11-27-12. The record failed to</p>			

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L000544	<p>evidence the IDG had collaborated with the attending to establish the plan.</p> <p>12. Clinical record number 12 included a comprehensive POC established by the IDG on 4-3-14. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>13. Clinical record number 13 included a comprehensive POC established by the IDG on 10-16-13. The record failed to evidence the IDG had collaborated with the attending to establish the plan.</p> <p>14. The patient care coordinator stated, on 5-8-14 at 10:05 AM, "When the IDG establishes the plan of care, the whole plan is not sent to the attending, just the signature page."</p> <p>15. The hospice's 01/04 "Provision of Services" policy states, "The attending physician reviews and approves the interdisciplinary group care plan."</p> <p>418.56(b) PLAN OF CARE The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. Based on clinical record review and</p>	L000544	L544 On 06/02/2014 the Hospice	06/12/2014

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	<p>interview, the hospice failed to ensure plans of care included patient and/or caregiver education regarding the use of medical equipment in 2 (#s 8 and 11) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 8 included an initial comprehensive nursing assessment dated 5-5-14 that identified the patient had a "Pleur X vac left chest."</p> <p>A. A PleurX catheter system is designed to allow drainage of fluid that has accumulated in the chest or abdomen. This system allows patients to drain fluid from the comfort of their own home and reduces the need for frequent trips to the hospital or doctors office.</p> <p>B. The literature regarding the PleurX vac included detailed, step by step instructions for the draining of the device and describes the need to use sterile technique to perform the procedures.</p> <p>C. A skilled nurse visit note, dated 5-9-14 states, "Pt [patient] states that Friday [adult child] did not get much drainage out from PleurX vac. Resp [respirations] are slightly labored."</p>		<p>Patient Care Coordinator will provide education to all staff members regarding the need to educate patients, patient's care giver(s), and SNF staff regarding the proper functioning, utilization, and proper response to problems for all medical equipment provided by Hospice to the patient. PCC will also educate staff on the proper documentation of the provision of this education in the patient's record. 100% of patient records will be audited every 14 days by the Patient Care Coordinator to ensure that staff are providing and documenting in the plan of care education to patients, patient's care giver(s), and staff at SNF regarding any medical equipment Hospice supplies to the patient. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>D. The plan of care, established by the interdisciplinary group on 5-2-14, failed to provide for the education and training of the patient's family in the use of the PleurX vacuum.</p> <p>2. Observation during a home visit to patient number 11, on 5-13-14 at 9:15 AM, with employee E, the medical social worker, noted the patient using a pain pump. The registered nurse, employee F, was present adjusting the pain pump and indicated she had "just changed the subQ [subcutaneous] site." The patient used the pain pump to self-administer pain medication and was experiencing difficulty with the pump. The home visit was made to the patient in the skilled nursing facility.</p> <p>Clinical record number 11 included a plan of care dated 11-27-12 with updates completed on 3-14-14, 3-28-14, 4-11-4, and 5-9-14. The plan of care, and the updates, failed to provide for the education of the patient and the skilled nursing facility staff in the use of the pain pump.</p> <p>3. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at</p>				

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L000545	<p>10:00 AM.</p> <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 the comprehensive plans of care included interventions based on comprehensive assessments in 7 (#s 2, 3, 5, 6, 8, 9, & 12) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included an initial comprehensive nursing assessment dated 2-27-14. The assessment identifies the patient experiences shortness of breath with exertion, a "cough", and diminished lung sounds. The assessment indicates the patient has Type II diabetes controlled with an oral hypoglycemic medication, and identifies "Alteration in Endocrine System" as a problem.</p>	L000545	L545 The Hospice Plan of Care is being revised to reflect elements in the comprehensive assessment more accurately. On 05/21/2014 the Patient Care Coordinator conducted education for all staff to emphasize that all issues identified on the comprehensive assessment are to be reflected on the patient's plan of care. This education will be repeated on 06/02/2014. The Hospice Patient Care Coordinator has revised the new patient "checklist" to include auditing of the plan of care for issues identified in the comprehensive assessment and updates. 100% of charts will be audited every 14 days utilizing the new patient checklist by the Hospice Patient Care Coordinator to ensure that all issues identified in the patient's comprehensive assessment and issues identified in the IDG updated assessment are	06/12/2014

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	<p>A. The comprehensive plan of care dated 2-26-14 failed to evidence the shortness of breath, cough, and diminished lung sounds had been addressed.</p> <p>B. The plan of care identifies the patient as "diabetic" and on a diet "as tolerated."</p> <p>C. The record included an initial psychosocial assessment dated 2-27-14 that identifies "depression" as a problem. The assessment states, "Pt [patient] expressed concern re: primary cg [caregiver] . . . ability to cope [with] cgiving [caregiving] tasks. Pt also has raised / cared for [grandchild] since [grandchild] was 5 wks [weeks] old. [Patient] does not have custody. Concern expressed re: [grandchild's] reaction to pt's illness & declining health as well as when [the patient] dies."</p> <p>D. The comprehensive plan of care dated 2-26-14 failed to address the patient concerns and needs related to the grandchild.</p> <p>2. Clinical record number 3 included an initial comprehensive nursing assessment dated 3-17-14. The assessment identifies the patient has "palpitations, fainting /</p>		accurately reflected on the patient's plan of care. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

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	<p>dizziness, and nocturnal dyspnea."</p> <p>The plan of care dated 3-14-14 failed to evidence the identified problems had been addressed.</p> <p>3. Clinical record number 5 included an initial comprehensive nursing assessment dated 4-16-14. The assessment identifies the patient "uses a cane when up . . . mainly in bed . . . unable to str [stand]/walk." The initial psychosocial assessment dated 4-16-14 identifies the patient has a history of alcohol abuse.</p> <p>The comprehensive plan of care dated 4-15-14 failed to address the identified impaired physical mobility problems and history of alcohol abuse.</p> <p>4. Clinical record number 6 included an initial comprehensive nursing assessment dated 4-30-14. The assessment identifies the patient is hard of hearing and that "Alteration in Physical Mobility" is a problem.</p> <p>The comprehensive plan of care dated 4-29-14 failed to address the identified hearing and mobility problems.</p> <p>5. Clinical record number 8 included an initial comprehensive nursing assessment dated 5-5-14. The assessment identifies</p>			

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	<p>the patient has "fainting / dizziness, nocturnal dyspnea . . . pacemaker June 2013 . . . difficulty swallowing . . . problems starting [urinary] stream."</p> <p>A. The comprehensive plan of care dated 5-2-14 failed to address the needs identified on the nursing assessment.</p> <p>B. The update to the plan of care dated 5-9-14 failed to address the needs identified on the nursing assessment. The update states, "Cardiorespiratory status: oxygen, neb txs [nebulizer treatments] . . . urinary status: no new needs identified." The nutrition / hydration portion of the updated plan of care had been left blank.</p> <p>6. Clinical record number 9 included an initial comprehensive nursing assessment dated 3-31-14 that identifies the patient has dizziness, an "occasional cough", "problems with dietary intake . . . difficulty chewing." The initial psychosocial assessment dated 3-31-14 identifies the patient has depression.</p> <p>The comprehensive plan of care dated 3-29-14 failed to evidence the needs identified in the nursing and psychosocial assessments were addressed.</p>			

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L000547	<p>7. Clinical record number 12 included an initial comprehensive nursing assessment dated 4-4-16. The assessment identifies the patient is a "bilateral amputee. [right] side paralysis" and that impaired physical mobility was a problem. The initial psychosocial assessment dated 4-8-14 identifies the patient is "anxious."</p> <p>The plan of care dated 4-3-14 failed to evidence the impaired physical mobility needs or the patient's anxiety had been addressed.</p> <p>8. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>9. The hospice's 5/12 "Scope of Services" policy states, "Contents of the Plan of Care . . . Identification of problems, needs, strengths, medications, limitations and the establishment of appropriate goals."</p> <p>418.56(c)(2) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (2) A detailed statement of the scope and</p>						

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	<p>frequency of services necessary to meet the specific patient and family needs.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care included a detailed statement of what disciplines were responsible for the implementation of interventions related to identified problems in 13 (#s 1 through 13) of 13 records reviewed with the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 identified the patient was a resident of a skilled nursing facility (SNF) and included a plan of care dated 12-26-13. The plan of care identified knowledge deficit, potential for harm, altered circulatory status, altered neuro / sensory, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status, alteration in comfort, deficit in ADLs (activities of daily living), patient / caregiver adjustment to illness, death related to terminal diagnosis, and death and dying process as problems to be addressed. The plan of care indicated that all disciplines, the registered nurse (RN), physician, patient, caregiver, medical social worker (MSW), volunteer coordinator (VC), facility 	L000547	L547 The Hospice Patient Care Coordinator provided education to staff on 05/21/2014 on the selecting and documenting the appropriate discipline(s) that will be involved in the interventions identified on the patient's plan of care. Specifically, staff were instructed to select only those disciplines that were responsible for performing the intervention identified in the care plan. 100% of patient charts will be audited every 14 days to ensure that plans of care identify those disciplines that are responsible for completing the intervention identified on the patient's care plan. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	05/21/2014

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	<p>nurse, facility aide, and facility social services were responsible for all interventions related to all of the identified problems.</p> <p>2. Clinical record number 2 included a plan of care dated 2-26-14. The plan of care identified knowledge deficit, potential for harm, altered circulatory status, altered neuro/sensory, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status, alteration in comfort, deficit in ADLs, patient / caregiver adjustment to illness, death related to terminal diagnosis, death and dying process, and spiritual needs as problems to be addressed. The plan of care indicated that all disciplines, the RN, physician, patient, caregiver, and MSW were responsible for all interventions related to all of the identified problems except spiritual care needs.</p> <p>3. Clinical record number 3 included a plan of care dated 3-14-14. The plan of care identified knowledge deficit, potential for harm, altered circulatory status, altered neuro/sensory, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status, alteration in comfort, deficit in ADLs, patient / caregiver adjustment to illness, death related to</p>			

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	<p>terminal diagnoses, death and dying process, and spiritual needs as problems to be addressed. The plan of care indicated that all disciplines, the RN, physician, patient, caregiver, and MSW, were responsible for all interventions related to all of the identified problems except spiritual care needs.</p> <p>4. Clinical record number 4 included a plan of care dated 5-1-14. The plan of care identified knowledge deficit, potential for harm, altered circulatory status, altered neuro / sensory, altered elimination, and death and dying process as problems. The plan of care indicated that all disciplines to include the home health aide, RN, physician, caregiver, MSW, and bereavement coordinator were responsible for all of the interventions related to the identified problems.</p> <p>A. The plan identified alteration in comfort and deficit in ADLs as problems to be addressed. The plan indicated the RN, physician, caregiver, and MSW were responsible for all of the interventions related to the identified problems.</p> <p>B. The plan identified patient / caregiver adjustment to illness / death related to terminal diagnosis as a problem to be addressed. The plan of care indicated all disciplines, to include the</p>			

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	<p>home health aide, RN, physician, patient, caregiver, MSW, VC, spiritual care counselor, and bereavement coordinator were responsible for all of the interventions related to the identified problem.</p> <p>5. Clinical record number 5 identified the patient was a resident of a SNF and included a plan of care dated 4-15-14. The plan of care identified potential for harm, altered circulatory status, altered neuro/sensory status, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status, alteration in comfort, deficit in ADLs, death and dying process, and patient / caregiver adjustment to illness / death related to terminal diagnosis as problems to be addressed. The plan of care indicated all disciplines, to include the home health aide, RN, physician, patient, caregiver, MSW, facility nurse, facility aide, and facility social services, were responsible for all of the interventions related to the identified needs.</p> <p>6. Clinical record number 6 identified the patient was a resident of a SNF and included a plan of care dated 4-29-14. The plan of care identified knowledge deficit, potential for harm, altered circulatory status, altered neuro / sensory status, altered elimination, impaired skin</p>				

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	<p>integrity, altered nutritional status, altered respiratory status, deficit in ADLs, death and dying process, and patient / caregiver adjustment to illness/death related to terminal prognosis as problems to be addressed. The plan of care indicated all disciplines, to include the home health aide, RN, physician, patient, caregiver, MSW, facility nurse and aide, and facility social services, were responsible for all of the interventions related to the identified needs.</p> <p>The plan identified alteration in comfort as a need to be addressed. The plan failed to specify any discipline that was to be responsible for the interventions related to the identified needs.</p> <p>7. Clinical record number 7 included a plan of care dated 11-5-13. The plan of care identified knowledge deficit and potential for harm as problems to be addressed. The plan failed to evidence what disciplines were responsible to implement the specified interventions related to the identified needs.</p> <p>The plan identified altered circulatory status, altered neuro / sensory status, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status, alteration in comfort,</p>			

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	<p>deficit in ADLs, death and dying process, and patient / caregiver adjustment to illness/death related to the terminal prognosis as problems to be addressed. The plan indicated all disciplines, to include the home health aide, RN, physician, patient, caregiver, and MSW, were responsible for the implementation of all interventions related to the identified needs.</p> <p>8. Clinical record number 8 included a plan of care dated 5-2-14. The plan identified knowledge deficit, potential for harm, altered circulatory status, altered neuro / sensory status, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status, alteration in comfort, deficit in ADLs, and death and dying process as problems to be addressed. The plan indicated all disciplines, to include home health aide, RN, physician, patient, caregiver, and MSW were responsible for the implementation of all interventions related to the identified needs.</p> <p>9. Clinical record number 9 included a plan of care dated 3-29-14. The plan identified knowledge deficit, potential for harm, altered circulatory status, altered neuro/sensory status, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status,</p>						

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	<p>alteration in comfort, deficit in ADLs, and death and dying process as problems to be addressed. The plan indicated all disciplines, to include home health aide, RN, physician, patient, caregiver, the MSW, and the VC were responsible for the implementation of all interventions related to the identified needs.</p> <p>10. Clinical record number 10 included a plan of care dated 12-29-13. The plan identified knowledge deficit, potential for harm, altered circulatory status, altered neuro / sensory status, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status, alteration in comfort, deficit in ADLs, death and dying process, patient / caregiver adjustment to illness / death related to terminal prognosis, and spiritual needs as problems to be addressed. The plan indicated all disciplines, to include home health aide, RN, physician, patient, caregiver, the MSW, facility nurse and aide, and facility social services were responsible for the implementation of all interventions related to the identified needs.</p> <p>11. Clinical record number 11 identified the patient was a resident of SNF and included a plan of care dated 11-27-12. The plan identified knowledge deficit, potential for harm, altered circulatory</p>				

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	<p>status, altered neuro / sensory status, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status, alteration in comfort, deficit in ADLs, death and dying process, patient / caregiver adjustment to illness / death related to terminal prognosis, and spiritual needs as problems to be addressed. The plan indicated all disciplines, to include home health aide, RN, physician, patient, caregiver, the MSW, facility nurse and aide, and facility social services were responsible for the implementation of all interventions related to the identified needs.</p> <p>12. Clinical record number 12 identified the patient was a resident of a SNF and included a plan of care dated 4-3-14. The plan identified knowledge deficit, potential for harm, altered circulatory status, altered neuro / sensory status, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status, alteration in comfort, deficit in ADLs, death and dying process, and patient / caregiver adjustment to illness / death related to terminal prognosis as problems to be addressed. The plan indicated all disciplines, to include home health aide, RN, physician, patient, caregiver, the MSW, facility nurse and aide, and facility social services were responsible for the</p>			

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	<p>implementation of all interventions related to the identified needs.</p> <p>13. Clinical record number 13 identified the patient was a resident of a SNF and included a plan of care dated 10-16-13. The plan of care identified knowledge deficit, potential for harm, altered circulatory status, altered neuro / sensory status, altered elimination, impaired skin integrity, altered nutritional status, altered respiratory status, alteration in comfort, deficit in ADLs, death and dying process, and patient / caregiver adjustment to illness / death related to terminal prognosis as problems to be addressed. The plan indicated all disciplines, to include home health aide, RN, physician, patient, caregiver, the MSW, facility nurse and aide, and facility social services were responsible for the implementation of all interventions related to the identified needs.</p> <p>The plan of care identified spiritual needs as a problem to be addressed. The plan of care failed to specify the discipline responsible for the implementation of the interventions related to the identified needs.</p> <p>14. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or</p>			

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L000548	<p>information when asked on 5-13-14 at 10:00 AM.</p> <p>15. The hospice's 5/12 "Scope of Services" policy states, "Contents of the Plan of Care . . . identification of persons/disciplines responsible for each service."</p> <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 patient outcomes in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a comprehensive plan of care (POC) established by the interdisciplinary group</p>	L000548	L548 On 5/21/2014 the Hospice Patient Care Coordinator provided education to all staff regarding how to write objectives and goals in the plan of care so that planned interventions will have measurable outcomes. Staff are now required to write interventions in plans of care that are specific, objective, and measurable. 100% of patient care plans will be audited every 14 days by the Hospice Patient Care Coordinator to ensure that identified goals are written so that they are objective and have	05/21/2014

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	<p>(IDG) on 12-26-13. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified dehydration and low blood pressure as a problem / need with a goal of "Pt [patient] will maintain adequate circulatory status as long as possible within limits of the disease process."</p> <p>B. The POC identified sleep patterns as a problem / need with a goal of "Pt will maintain optimal level of independence, self determination, and quality of life . . . maintain optimal orientation and communication skills . . . achieve optimal sleep/rest pattern within 24 hours."</p> <p>C. The POC identified bladder spasms, constipation, and incontinence as problems / needs with goals of "elimination needs met to provide as much comfort as possible . . . bowel movement at a frequency which is comfortable for them."</p> <p>D. The POC identified "altered nutritional status" as a problem / need with goals of "adequate food & fluid to maintain comfort . . . adequate food and fluids as tolerated or desired . . . will feel supported regarding nutritional options</p>		<p>measurable outcomes. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>related to end of life care."</p> <p>E. The POC identified altered respiratory status related to "diminished bibasilar" with goals of "maintain adequate respiratory status to achieve comfort . . . satisfactory control of symptoms within 24 hours."</p> <p>F. The POC identified "Deficit in ADLs [activities of daily living] . . . ambulation, personal care . . . bed mobility" as a problem / need with goals of "optimal level of independence through assistance with ADLs . . . basic self care needs will be met."</p> <p>G. The POC identified anticipatory grief, funeral planning, need of life review, alcohol abuse, health concerns, and feelings of despair anger, guilt, and abandonment as problems/needs with goals of "emotional support to adequately cope with illness / death . . . exhibit functional coping skills."</p> <p>2. Clinical record number 2 included a comprehensive POC established by the IDG on 2-26-14. POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified altered circulatory status related to peripheral</p>			

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	<p>fluid volume, non-dependent edema, and color changes as a problem/need with the goal of "maintain adequate circulatory status as long as possible."</p> <p>B. The POC identified altered neurological / sensory status related to "forgetfulness @ times" as a problem/need with the goal to "maintain optimal level independence, self determination, and quality of life."</p> <p>C. The POC identified occasional bladder incontinence and occasional constipation as a problem / need with the goal to "have elimination needs met to provide as much comfort as possible."</p> <p>D. The POC identified dry skin as a problem / need with the goal "comfort will be promoted as skin integrity changes throughout disease and dying process."</p> <p>E. The POC identified altered nutritional status related to "diabetic" as a problem / need with the goal "Pt will have adequate food & fluid to maintain comfort."</p> <p>F. The POC identified altered respiratory status related to "cough non-productive . . . congestion" as a problem / need with the goal to "maintain</p>			

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	<p>adequate respiratory status to achieve comfort within disease process limitations."</p> <p>G. The POC identified alternation in comfort "nausea" as a problem / need with the goal "Pt will have maximum level of comfort."</p> <p>H. The POC identified financial issues, need of life review, "grand[child] is living [with] pt, history of previous losses, family problems, financial concerns, and mental health issues [with child] as problems / needs with the goals of "Pt/Cg [caregiver] will receive emotional support to adequately cope with illness/death . . . will exhibit functional coping skills."</p> <p>I. The POC identified spiritual needs related to "death and dying, impending death" with the goal "Pt/Cg [caregiver] will receive desired spiritual support throughout hospice care."</p> <p>3. Clinical record number 3 included a comprehensive POC established by the IDG on 3-14-14. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified altered circulatory status related to "fluid volume</p>			

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	<p>peripheral cardiac, edema non-dependent . . . irregular heart rate" with the goal to "maintain adequate circulatory status as long as possible within limits of disease process."</p> <p>B. The POC identified altered neurological / sensory status with goals to "maintain optimal level of independence, self-determination, and quality of life . . . optimal orientation and communication skills . . .optimal sleep/rest pattern."</p> <p>C. The POC identified bladder incontinence and constipation as problem / needs with the goal to "have elimination needs met to provide as much comfort as possible . . . bowel movement at a frequency which is comfortable for them."</p> <p>D. The POC identified impaired skin integrity related to decreased mobility as a problem / need with the goal "Comfort will be promoted as skin integrity changes throughout the disease and dying process."</p> <p>E. The POC identified decreased appetite as a problem / need with the goals "adequate food & fluid to maintain comfort . . . adequate food and fluids as tolerated or desired . . . Pt/Cg will feel supported regarding nutritional options."</p>				

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	<p>F. The POC identified altered respiratory status related to cough, dyspnea with exertion and at rest with diminished lung sounds with goals to "maintain adequate respiratory status to achieve comfort . . . express satisfactory control of symptoms."</p> <p>G. The POC identified occasional pain as a problem / need with the goal to "have maximum level of comfort."</p> <p>H. The POC identified "Deficit in ADLs . . . personal care, transfers, bed mobility" as a problem / need with the goal "have optimal level of independence through assistance with ADLs . . . basic self-care needs will be met."</p> <p>4. Clinical record number 4 included a comprehensive POC established by the IDG on 5-1-14. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified altered neurological/sensory status related to "vision . . . mental status . . . non-responsive . . . seizures . . . Pt is nonresponsive status post near drowning" with the goal "Pt and Cg will achieve optimal sleep / rest pattern within 24 hours."</p>			
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	<p>B. The POC identified bowel and bladder incontinence and constipation as a problem / need with the goal "Pt will have elimination needs met to provide as much comfort as possible . . . a bowel movement at a frequency which is comfortable for them."</p> <p>C. The POC identified altered nutritional status "PEG tube Mickey" as a problem / need with goals to "have adequate food and fluids as tolerated or desired . . . Pt/Cg will feel supported regarding nutritional options related to end of life care."</p> <p>D. The POC identified altered respiratory status "permanent tracheostomy . . . chronic respiratory failure, chronic lung disease, hx of apnea" as a problem / need with goals to "maintain adequate respiratory status to achieve comfort . . . express satisfactory control of symptoms."</p> <p>E. The POC identified generalized pain as a problem / need with the goal "Pt/Family/Cg will express satisfaction with the pain regime."</p> <p>F. The POC identified "Deficit in ADLs feeding, ambulation, personal care, bed mobility" as problem / needs with the</p>			
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	<p>goal "Pt will have optimal level of independence through assistance with ADLs . . . basic self-care needs will be met as tolerated."</p> <p>G. The POC identified anticipatory grief, funeral planning, financial issues, need of life review, anxiety, history of previous losses, family problems "multiple re to pt [parent]", financial concerns, legal and financial issues "multiple re to pt [parent]", feelings of despair, anger, guilt or abandonment with goals "Pt/Cg will receive emotional support to adequately cope with illness / death . . . will exhibit functional coping skills."</p> <p>5. Clinical record number 5 included a comprehensive POC established by the IDG on 4-15-14. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified altered circulatory status related to "fluid volume . . . cardiac" with the goal to "maintain adequate circulatory status as long as possible."</p> <p>B. The POC identified altered neurological / sensory status as a problem with the goal to "maintain optimal level of independence, self determination, and</p>				

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	<p>quality of life . . . maintain optimal orientation and communication skills . . . achieve optimal sleep/rest pattern."</p> <p>C. The POC identified altered elimination as a problem / need with goals to "have elimination needs met to provide as much comfort as possible . . . bowel movement at a frequency which is comfortable for them."</p> <p>D. The POC identified altered nutritional status related to decreased appetite and weight loss as a problem / need with goals to "have adequate food & fluid to maintain comfort . . . adequate food and fluids as tolerated or desired."</p> <p>E. The POC identified dyspnea with exertion and diminished lung sounds as a problem / need with the goal to "maintain adequate respiratory status to achieve comfort . . . will express satisfactory control of symptoms."</p> <p>F. The POC identified alteration in comfort, "occasional pain" and "numbness of soles of feet" with the goal to "have maximum level of comfort . . . satisfaction with the pain regime."</p> <p>G. The POC identified "Deficit in ADLs . . . ambulation, personal care, transfers, bed mobility" as problem /</p>			

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	<p>needs with the goal to "have optimal level of independence through assistance with ADLs . . . basic self-care needs will be met as tolerated."</p> <p>H. The POC identified anticipatory grief, need of life review, "potential unresolved war time issues - per [spouse]", and history of previous losses as problems / needs with goals to "receive emotional support to adequately cope will illness / death . . . exhibit functional coping skills . . . express feelings of grief/loss."</p> <p>6. Clinical record number 6 included a comprehensive POC established by the IDG on 4-29-14. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified altered circulatory status as evidenced by "color changes" with the goal to "maintain adequate circulatory status as long as possible within limits of disease process."</p> <p>B. The POC identified altered neurological / sensory status related to decreased level of consciousness, forgetfulness, and confusion with the goal to "maintain optimal level of independence, self determination, and quality of life throughout the disease</p>			

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	<p>process."</p> <p>C. The POC identified bladder and bowel incontinence as a problem / need with the goal to "have elimination needs met to provide as much comfort as possible."</p> <p>D. The POC identified altered nutritional status related to decreased level of consciousness with goals to "have adequate food & fluid to maintain comfort . . . adequate food and fluids as tolerated."</p> <p>E. The POC identified altered respiratory status related to a non-productive cough and diminished lung sounds with the goal to "maintain adequate respiratory status to achieve comfort."</p> <p>F. The POC identified intermittent aching in the back and anxiety as problems / needs with the goal to "have maximum level of comfort."</p> <p>G. The POC identified "Deficit in ADLs feeding . . . personal care, transfers, bed mobility" with goals to "have optimal level of independence through assistance with ADLs."</p> <p>H. The POC identified anticipatory</p>			

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	<p>grief, need of life review, anxiety, and history of previous losses as problems/needs with goals "Pt/Cg will receive emotional support to adequately cope with illness / death . . . will exhibit functional coping skills."</p> <p>I. The POC identified spiritual needs related to "death and dying, impending death" with the goals to "freely verbalize spiritual needs and concerns . . . will receive desired spiritual support."</p> <p>7. Clinical record number 7 included a comprehensive POC established by the IDG on 11-5-13. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified altered circulatory status related to "fluid volume peripheral . . . edema" as a problem/need with the goal to "maintain adequate circulatory status as long as possible."</p> <p>B. The POC identified altered neurological / sensory status related to hearing, speech / communication, confusion and sleep pattern with the goal to "maintain optimal level of independence, self determination, and quality of life . . . maintain optimal orientation and communication skills . . . optimal sleep/rest pattern."</p>			

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	<p>C. The POC identified bowel and bladder incontinence as a problem / need with the goal to "have elimination needs met to provide as much comfort as possible . . . have a bowel movement at a frequency which is comfortable for them."</p> <p>D. The POC identified altered nutritional status related to decreased level of consciousness and increased weakness as a problem / need with the goal to "have adequate food & fluid to maintain comfort . . . adequate food and fluids as tolerated . . . will feel supported regarding nutritional options related to end of life care." The POC identified altered respiratory status as a problem/need with the goal to "maintain adequate respiratory status to achieve comfort . . . will express satisfactory control of symptoms."</p> <p>E. The POC identified pain and "terminal restlessness" as problems / needs with the goal to "have maximum level of comfort . . . express satisfaction with the pain regime."</p> <p>F. The POC identified "Deficit in ADLs feeding, ambulation, personal care, transfers, bed mobility, home management" as problems / needs with</p>			

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	<p>goals to "have optimal level of independence . . . basic self-care needs will be met."</p> <p>G. The POC identified anticipatory grief, need of life review, history of previous losses, and communication issues as problems / needs with goals to "receive emotional support to adequately cope . . . exhibit functional coping skills."</p> <p>8. Clinical record number 8 included a comprehensive POC established by the IDG on 5-2-14. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified dependent edema as a problem / need with the goal to "maintain circulatory status as long as possible."</p> <p>B. The POC identified vision and hearing problems and forgetfulness as problems / needs with goals to "maintain optimal level of independence, self determination, and quality of life . . . maintain optimal orientation and communication skills . . . will achieve optimal sleep/rest pattern."</p> <p>C. The POC identified constipation as a problem/need with goals to "have elimination needs met to provide as much</p>				

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	<p>comfort as possible . . . have a bowel movement as a frequency which is comfortable for them."</p> <p>D. The POC identified altered nutritional status related to increased weakness with goals to "have adequate food & fluid to maintain comfort . . . have adequate food and fluids as tolerated or desired."</p> <p>E. The POC identified dyspnea with exertion and at rest and diminished lung sounds as a problem / need with goals to "maintain adequate respiratory status to achieve comfort . . . will express satisfactory control of symptoms."</p> <p>F. The POC identified intermittent back and chest wall pain, nausea, and anxiety as problems / needs with goals to "have maximum level of comfort . . . express satisfaction with the pain regime."</p> <p>9. Clinical record number 9 included a comprehensive POC established by the IDG on 3-29-14. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified high blood pressure as a problem / need with the goal to "maintain circulatory status as</p>			

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	<p>long as possible."</p> <p>B. The POC identified vision and hearing problems and confusion as problems / needs with goals to "maintain optimal level of independence, self determination, and quality of life . . . maintain optimal orientation and communication skills . . . achieve optimal sleep/rest pattern."</p> <p>C. The POC identified bowel and bladder incontinence and bladder spasms as problems / needs with goals of "have elimination needs met to provide as much comfort as possible . . . have a bowel movement at a frequency which is comfortable for them."</p> <p>D. The POC identified altered nutritional status as a problem / need with goals to "have adequate food & fluid to maintain comfort . . . adequate food and fluids as tolerated and desired . . . will feel supported regarding nutritional options related to end of life care."</p> <p>E. The POC identified diminished lung sounds as a problem / need with goals to "maintain adequate respiratory status to achieve comfort . . . express satisfactory control of symptoms."</p> <p>F. The POC identified intermittent,</p>						

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	<p>general back pain as a problem / need with the goal to "have maximum level of comfort . . . express satisfaction with the pain regime."</p> <p>G. The POC identified "Deficit in ADLs . . . ambulation . . . transfers, bed mobility" as problems / need with goals to "have optimal level of independence through assistance with ADLs . . . basic self care needs will be met."</p> <p>H. The POC identified anticipatory grief, need of life review, anxiety, and history of previous losses as problems / needs with goals to "receive emotional support to adequately cope with illness / death . . . will exhibit functional coping skills . . . will express feelings of grief/loss."</p> <p>I. The POC identified spiritual needs related to death and dying and impending death with goals "freely verbalize spiritual needs and concerns . . . will receive desired spiritual support throughout hospice care."</p> <p>10. Clinical record number 10 included a comprehensive POC established by the IDG on 12-29-13. The POC failed to include measurable patient outcomes for identified problems.</p>			

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	<p>A. The POC identified altered circulatory status related to "fluid volume peripheral, edema LLE . . . blood clot" as problems / needs with the goal to "maintain adequate circulatory status as long as possible."</p> <p>B. The POC identified speech / communication and seizures as problems / needs with goals to "maintain optimal level of independence, self determination, and quality of life . . . maintain optimal orientation and communication skills . . . achieve optimal sleep/rest pattern."</p> <p>C. The POC identified bowel and bladder incontinence as problems / needs with goals to "have elimination needs met to provide as much comfort as possible . . . have a bowel movement at a frequency which is comfortable for them."</p> <p>D. The POC identified altered nutritional status "decreased level of consciousness . . . PEG tube . . . NPO aspirations" as problems / needs with goals to "have adequate food & fluid to maintain comfort . . . adequate food and fluids as tolerated or desired . . . will feel supported regarding nutritional options related to end of life care."</p> <p>E. The POC identified altered</p>			

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	<p>respiratory status related to ronchi and diminished lung sounds, "apnea episodes, recent aspiration pneumonia, sleep apnea" with the goal to "maintain adequate respiratory status to achieve comfort . . . will express satisfactory control of symptoms."</p> <p>F. The POC identified pain as a problem / need with goals to "have maximum level of comfort . . . will express satisfaction with the pain regime."</p> <p>G. The POC identified "Deficit in ADLs . . . personal care . . . bed mobility" as a problem / need with goals to "have optimal level of independence with ADLs . . . basic self care needs met as tolerated or desired."</p> <p>H. The POC identified anticipatory grief, need of life review, and communication issues as problems / needs with goals to "receive emotional support to adequately cope will illness/death . . . will exhibit functional coping skills . . . will express feeling of grief/loss."</p> <p>I. The POC identified spiritual needs related to death and dying, impending death, and meaning of life with the goals "Pt/Cg will freely verbalize spiritual</p>			

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	<p>needs and concerns . . . will receive desired spiritual support throughout hospice care."</p> <p>11. Clinical record number 11 included a comprehensive POC established by the IDG on 11-27-12. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified altered circulatory status as evidenced by weak thready pulse, low blood pressure, irregular heart rate, and vertigo with the goal to "Maintain adequate circulatory status as long as possible."</p> <p>B. The POC identified a urinary tract infection, foley catheter, and constipation as problems / needs with a goal to "have elimination needs met to provide as much comfort as possible."</p> <p>C. The POC identified decreased appetite and nausea as problems / needs with the goal for patient to "have adequate food & fluid to maintain comfort."</p> <p>D. The POC identified diminished lung sounds as a problem / need with goals to "maintain adequate respiratory status to achieve comfort . . . express satisfactory control of symptoms."</p>			

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	<p>E. The POC identified anxiety as a problem / need with the goal to "have maximum level of comfort."</p> <p>F. The POC identified "Deficit in ADLs . . . personal care, transfers . . . home management" with goals "have optimal level of independence through assistance with ADLs . . . basic self care needs will be met as tolerated or desired."</p> <p>G. The POC identified anticipatory grief, need of life review, adjustment to nursing facility placement, and history of previous losses as problems / needs with goals to "receive emotional support to adequately cope with illness / death . . . will exhibit functional coping skills . . . will express feelings of grief/loss."</p> <p>H. The POC identified "lack of spiritual support" as a problem / need. There were no measurable goals documented for the identified problem.</p> <p>12. Clinical record number 12 included a comprehensive POC established by the IDG on 4-3-14. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified altered circulatory status related to peripheral</p>			

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	<p>fluid volume, "bilateral amputee", high blood pressure, "CVA [cerebrovascular accident], A fib [atrial fibrillation], HTN [hypertension]" with a goal to "maintain adequate circulatory status as long as possible."</p> <p>B. The POC identified vision, speech / communication, 1 word responses, moving RUE but not aware with goals to "maintain optimal level of independence, self determination, and quality of life . . . maintain optimal orientation and communication skills . . . will achieve optimal sleep/rest patterns."</p> <p>C. The POC identified the patient has a foley catheter and is incontinent of bowel with goals to "have elimination needs met to provide as much comfort as possible . . . will have a bowel movement at a frequency which is comfortable for them."</p> <p>D. The POC identified decreased appetite, decreased level of consciousness, diabetic, mechanical soft diet and "fed by staff" as problems / needs with goals "have adequate food & fluid to maintain comfort . . . adequate food and fluids as tolerated or desired . . . will feel supported regarding nutritional options related to end of life care."</p>			

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	<p>E. The POC identified a non-productive cough, dyspnea at rest and diminished lung sounds as problems / needs with goals to "maintain adequate respiratory status to achieve comfort . . . will express satisfactory control of symptoms."</p> <p>F. The POC identified pain and "terminal restlessness" as problems / needs with goals to "have maximum level of comfort . . . will express satisfaction with the pain regime."</p> <p>G. The POC identified "Deficit in ADLs feeding, ambulation, personal care, transfers, bed mobility" as problems / needs with goal "basic self care needs will be met as tolerated or desired."</p> <p>H. The POC identified anticipatory grief, funeral planning, family frustration at hearing loss, and history of previous losses as problems / needs with goals to "receive emotional support to adequately cope with illness/death . . . will exhibit functional coping skills . . . will express feelings of grief/loss."</p> <p>I. The POC identified spiritual needs related to death and dying and impending death as problems / needs with goals to "freely verbalize spiritual needs and concerns . . . will receive desired spiritual</p>			

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	<p>support."</p> <p>13. Clinical record number 13 included a comprehensive POC established by the IDG on 10-16-13. The POC failed to include measurable patient outcomes for identified problems.</p> <p>A. The POC identified altered circulatory status related to "cardiac", weak thready pulse, and irregular heart beat as problems / needs with the goal to "maintain adequate circulatory status as long as possible."</p> <p>B. The POC identified vision and hearing problems, decreased level of consciousness and forgetfulness as problems / needs with goals to "maintain optimal level of independence, self determination, and quality of life . . . maintain optimal orientation and communication skills . . . achieve optimal sleep/rest pattern."</p> <p>C. The POC identified bowel and bladder incontinence as problems / needs with goals to "have elimination needs met to provide as much comfort as possible . . . have a bowel movement at a frequency which is comfortable for them."</p> <p>D. The POC identified decreased</p>						

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	<p>appetite and level of consciousness and increased weakness as problems / needs with goals to "maintain adequate food & fluid to maintain comfort . . . adequate food and fluids as tolerated or desired . . . will feel supported regarding nutritional options related to end of life care."</p> <p>E. The POC identified dyspnea at rest and diminished lung sounds as problems / needs with goals to "maintain adequate respiratory status to achieve comfort . . . will express satisfactory control of symptoms."</p> <p>F. The POC identified alteration in comfort (not specified) as a problem / need with goals to "have maximum level of comfort . . . will express satisfaction with the pain regime."</p> <p>G. The POC identified "Deficit in ADLs feeding, ambulation, personal care, transfers, bed mobility" as problems / needs with goals to "have optimal level of independence through assistance with ADLs . . . basic self care needs will be met as tolerated or desired."</p> <p>H. The POC identified anticipatory grief, history of previous losses, and illness of other family members as problems / needs with goals to "receive emotional support to adequately cope</p>			

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L000552	<p>with illness / death . . . exhibit functional coping skills . . . will express feelings of grief/loss."</p> <p>I. The POC identified spiritual needs related to death and dying, impending death, and meaning of life with goals to "freely verbalize spiritual needs and concerns . . . receive desired spiritual support throughout hospice care."</p> <p>14. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>15. The hospice's 5/12 "Scope of Services" policy states, "Contents of the Plan of Care . . . identification of problems, needs, strengths, medications, limitations and the establishment of appropriate goals."</p> <p>418.56(d) REVIEW OF THE PLAN OF CARE The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.</p>			

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	<p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care had been reviewed and revised at least every 15 days in 3 (#s 5, 7, and 11) of 13 records reviewed and failed to ensure plans of care had been updated to address new identified needs in 5 (#s 1, 2, 3, 5, 10) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>Regarding review every 15 days:</p> <ol style="list-style-type: none"> 1. Clinical record number 5 included a plan of care established by the interdisciplinary group (IDG) on 4-15-14. The record failed to evidence the plan of care had been reviewed and revised since its establishment. 2. Clinical record number 7 included a plan of care established by the IDG on 11-5-13. The record evidenced the plan of care had been reviewed on 4-11-14 and not again until 5-9-14, a period of 28 days between reviews. 3. Clinical record number 11 included a plan of care established by the IDG on 11-29-12. The record evidenced the plan of care had been reviewed on 4-11-14 	L000552	<p>L552 On 05/21/2014 the Hospice Patient Care Coordinator developed a new process and provided education to all staff that all plans of care will be reviewed by the IDG every 14 days and faxed to the Hospice Medical Director and the patient's attending physician for review, coordination, and signature. Staff are to ensure that plans of care have been updated to address new identified needs from the IDG updated assessment or as identified by staff at any time in the course of care and treatment. 100% of patient charts will be audited every 14 days by the Hospice Patient Care Coordinator to ensure that plans of care are reviewed every 14 days and include new issues identified from the updated assessment or in the course of care and treatment. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	06/12/2014			

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	<p>and not again until 5-9-14, a period of 28 days between reviews.</p> <p>4. The patient care coordinator stated, on 5-9-14 at 1:00 PM, "The original review of the plan of care documents are sent to the attending physicians for them to sign. Some of them may be out at doctors' offices.</p> <p>5. The hospice's 05/11 "Good Samaritan Hospice Interdisciplinary Group (IDG) policy states, "The IDG shall meet at least every fifteen days (15). The purpose of such meeting is . . . Establishment and review of the Patient Plan of Care."</p> <p>Regarding updates for new identified needs:</p> <p>1. Clinical record number 1 included an "Interdisciplinary Progress Note", signed and dated by the medical social worker (MSW), employee E on 4-10-14. The note identifies issues with billing and patient responsibility for payment of medications not covered by hospice. The note states, "This SW [social worker] asked clerk to get an updated bill generated [unreadable] as soon as possible for pt [patient] for peace of mind."</p>			

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	<p>The 4-11-14 update to the plan of care failed to address the billing and payment issues. The update states, "No new needs identified since last update."</p> <p>2. During a home visit to patient number 2, on 5-9-14 at 9:40 AM, with the registered nurse (RN), employee F, the patient expressed grief related to not seeing a grandchild the patient had raised. The patient's adult child (the grandchild's parent) had taken over the care of the grandchild.</p> <p>A. The initial plan of care, dated 2-26-14, identifies the grandchild lived with the patient. A medical social services (MSS) note dated 4-23-14 states, "[Patient's adult child] took the [grandchild] with and most of the clothes. Pt very sad."</p> <p>B. The 4-25-14 update to the plan of care failed to evidence the plan had been updated to address the patient's loss of the grandchild's caregiver role.</p> <p>3. Clinical record number 3 included an initial comprehensive nursing assessment dated 3-17-14. The assessment identifies the patient has "palpitations, fainting / dizziness, and nocturnal dyspnea."</p> <p>A. The plan of care dated 3-14-14</p>			

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	<p>failed to evidence the identified problems had been addressed.</p> <p>B. The update to the plan of care dated 3-28-14 identifies the patient had "syncope episode X 1" [dizziness & fainting]." The plan failed to evidence an update with interventions to address the dizziness and fainting episode.</p> <p>4. Clinical record number 5 included a "Change of Status" form dated 5-1-14 that identifies the patient had been transferred to a skilled nursing facility. The record failed to evidence the plan of care had been updated to reflect the patient's change in residence and that the care had been coordinated with the skilled nursing facility.</p> <p>5. Clinical record number 10 included an "Interdisciplinary Progress Note" dated 4-22-14 that indicated the skilled nursing facility nurse had talked to the hospice with a problem with the patient's feeding tube. The note states, "I explained that if it had to be replaced I did not think that would be covered by hospice . . . will call pt care coordinator. I asked her to call me back & keep me updated on situation."</p> <p>The update to the plan of care dated 4-25-14 states, "No new needs identified</p>						

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L000560	<p>since last update." The plan of care failed to evidence the problem with the feeding tube had been addressed by the responsible entity.</p> <p>6. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.</p>			

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	<p>Based on administrative record and hospice policy review and interview, the hospice failed to ensure its quality assessment performance improvement (QAPI) program used patient outcome measures from the comprehensive assessment to measure, analyze, and track palliative outcomes in 1 (2013) of 1 year reviewed with the potential to affect all the facility's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's QAPI program documentation for 2013 failed to evidence the use of patient outcome measures from the comprehensive assessments. 2. The hospice director and the patient care coordinator were unable to provide a list of the data elements that comprise the hospice's comprehensive assessments and were unable to explain how the data elements were used in the hospice's quality assessment performance improvement program when asked on 5-13-14 at 2:50 PM. 3. The hospice's 01/06 "Performance Improvement" policy failed to evidence data elements were to be incorporated into the comprehensive assessment and failed to evidence a process to retrieve 	L000560	<p>L560 The Hospice Patient Care Coordinator has identified elements within the comprehensive assessment to allow for measurement of outcomes. The measures specifically include bowel function while on pain medication. New forms were created to allow for ease of measurement and monitoring. These items will be incorporated into the QAPI. 100% of charts will be monitored/audited monthly and results reported quarterly to the Hospital-Wide Performance Improvement Committee regarding bowel program on opioid medication. A goal of 90% of patients experiencing improvement or maintaining stability has been set. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	06/12/2014			

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L000579	<p>the data and incorporate them into the hospice's quality assessment performance program.</p> <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 personnel file review and interview, the hospice failed to ensure all employees had received annual tuberculosis (TB) testing in accordance with the Centers for Disease Control recommendations and its own policy in 3 (files J, K, and M) of 13 personnel files reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's 01/05 "Screening for TB Disease and Infection" policy states, "Reference: CDC Core Curriculum on Tuberculosis, Fourth Edition (2000) Chapter IV . . . All GSHP employees will be tested according to Good Samaritan Hospital policy. Two step Mantoux skin test will be given to all employees upon hire and annually thereafter." 2. Personnel file J evidenced the 	L000579	L579 On 05/21/2014 the Director of Hospice and the Hospice Patient Care Coordinator will require all staff to receive a TB test at the time of hire and also require all staff to have an annual TB test at the same time each year. All current employees whose most recent TB test is more than 12 months old or whose TB test result will be more than 12 months old on the annual TB testing date will receive an updated TB test by 06/12/2014. 100% of staff will have current (less than 12 months old) TB test results in their employee health record at all times. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	06/12/2014

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L000607	<p>employee had received an annual TB skin test on 3-1-13 which was read on 3-4-13. The file failed to evidence a subsequent annual TB test had been administered in March 2014.</p> <p>3. Personnel file K evidenced the employee had received a TB skin test on 4-8-13 which was read on 4-10-13. The file failed to evidence a subsequent annual TB test had been administered in April 2014.</p> <p>4. Personnel file M evidenced the employee had received a TB skin test on 3-1-13 which was read on 3-4-13. The file failed to evidence a subsequent annual TB test had been administered in March 2014.</p> <p>5. Employee O stated, on 5-13-14 at 2:00 PM, "TB tests are administered upon hire and not again the next year until the hospital education day sometime in June usually."</p> <p>418.76 HOSPICE AIDE AND HOME MAKER SERVICES Based on personnel file and hospice policy review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure hospice aides had completed a</p>	L000607	L607 By 06/12/2014 the Hospice Patient Care Coordinator will revise the Hospice Homemaker and Aid competency evaluation form to ensure the inclusion of all elements of 42 CFR 418.76. All	06/12/2014

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	<p>hospice aide competency evaluation program in 2 of 2 hospice aide files reviewed of aides hired since the last federal survey on 4-8-11 creating the potential to affect all of the hospice's 13 current patients (See L 608); by failing to ensure hospice aides had completed a competency evaluation program 2 of 2 hospice aide files reviewed of aides hired since the last federal survey on 4-8-11 creating the potential to affect all of the hospice's 13 current patients (See L 609); by failing to ensure individuals had been evaluated for the competent performance of hospice aide tasks in 2 of 2 home health aide files reviewed of aides hired since the last federal survey on 4-8-11 creating the potential to affect all of the hospice's 13 current patients (See L 615); by failing to ensure it had maintained documentation that individuals had been evaluated for the competent performance of home health aide tasks in 2 of 2 home health aide files reviewed of aides hired since the last federal survey on 4-8-11 creating the potential to affect all of the hospice's 13 current patients (See L 619); by failing to ensure hospice aides had received at least 12 hours of inservice training in 1 of 2 files reviewed of home health aides employed prior to January 1, 2013, creating the potential to affect all of the hospice's 13 current patients (See L 620).</p>		<p>current HHA staff will be re-evaluated for competency utilizing the revised competency form. Furthermore, after completion of the survey, it was determined that HHA staff had in fact well over 12 hours of education annually. Documentation of this education is kept on an electronic system at the hospital and records/proof of completed education hours can be produced by the education department upon request. 100% of HHA employees will be re-evaluated for competency by 06/12/2014 utilizing the revised HHA Competency Assessment form that complies with all the required elements of 42 CFR 418.76. Attainment of the necessary education hours will continue to be monitored annually by the Hospice Patient Care Coordinator during the employees annual performance evaluation. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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L000608	<p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.76 Hospice Aide and Homemaker Services.</p> <p>418.76 HOSPICE AIDE AND HOME MAKER SERVICES All hospice aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the personnel requirements specified in paragraph (j) of this section. Based on personnel file and hospice policy review and interview, the hospice failed to ensure hospice aides had completed a hospice aide competency evaluation program in 2 (files H and J) of 2 hospice aide files reviewed of aides hired since the last federal survey on 4-8-11 creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. Personnel file H evidenced the individual had been hired on 2-27-12 to provide hospice aide services on behalf of the hospice. The file failed to</p>	L000608	L608 By 06/12/2014 the Hospice Patient Care Coordinator will revise the Hospice Homemaker and Aid competency evaluation form to ensure the inclusion of all elements of 42 CFR 418.76. All current HHA staff will be re-evaluated for competency utilizing the revised competency form. 100% of HHA employees will be re-evaluated for competency by 06/12/2014 utilizing the revised HHA Competency Assessment form that complies with all the required elements of 42 CFR 418.76. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected	06/12/2014

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	<p>evidence the individual had been evaluated for the competent performance of any of the subjects listed in paragraph (b)(3) of this section.</p> <p>2. Personnel file J evidenced the individual had been hired on 2-25-13 to provide hospice aide services on behalf of the hospice. The file failed to evidence the individual had been evaluated for the competent performance of any of the subjects listed in paragraph (b) of this section.</p> <p>3. Employee O stated, on 5-13-14 at 2:15 PM, "I cannot find the competency evaluations for [employees H and J]. I don't know if they were done or not."</p> <p>4. The hospice's 01/04 "Provision of Services" policy states, "Hospice Aide / Homemaker Services: . . . Services will be provided by trained and competent individuals and under the director [sic] of a Registered Nurse in accordance with all Federal and State regulations."</p> <p>The hospice's 12/05 "Orientation, Inservice Training, Skills Verification" policy states, "All employees will complete the employee orientation program and skills verification within thirty (30) days of employment and prior to any unsupervised patient care."</p>		and will not recur.	

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L000609	<p>418.76(a)(1) HOSPICE AIDE QUALIFICATIONS (1) A qualified hospice aide is a person who has successfully completed one of the following: (i) A training program and competency evaluation as specified in paragraphs (b) and (c) of this section respectively. (ii) A competency evaluation program that meets the requirements of paragraph (c) of this section. (iii) A nurse aide training and competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry. (iv) A State licensure program that meets the requirements of paragraphs (b) and (c) of this section.</p> <p>Based on personnel file and hospice policy review and interview, the hospice failed to ensure hospice aides had completed a competency evaluation program for 2 (files H and J) of 2 hospice aide files reviewed of aides hired since the last federal survey on 4-8-11 creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. Personnel file H evidenced the individual had been hired on 2-27-12 to</p>	L000609	L609 By 06/12/2014 the Hospice Patient Care Coordinator will revise the Hospice Homemaker and Aid competency evaluation form to ensure the inclusion of all elements of 42 CFR 418.76. All current HHA staff will be re-evaluated for competency utilizing the revised competency form. 100% of HHA employees will be re-evaluated for competency by 06/12/2014 utilizing the revised HHA Competency Assessment form that complies with all the required elements of 42 CFR 418.76. The Hospice Patient Care Coordinator will be responsible for monitoring	06/12/2014			

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	<p>provide hospice aide services on behalf of the hospice. The file failed to evidence the individual had been evaluated for the competent performance of any of the subjects listed in paragraph (b)(3) of this section.</p> <p>2. Personnel file J evidenced the individual had been hired on 2-25-13 to provide hospice aide services on behalf of the hospice. The file failed to evidence the individual had been evaluated for the competent performance of any of the subjects listed in paragraph (b) of this section.</p> <p>3. Employee O stated, on 5-13-14 at 2:15 PM, "I cannot find the competency evaluations for [employees H and J]. I don't know if they were done or not."</p> <p>4. The hospice's 01/04 "Provision of Services" policy states, "Hospice Aide / Homemaker Services: . . . Services will be provided by trained and competent individuals and under the director [sic] of a Registered Nurse in accordance with all Federal and State regulations."</p> <p>The hospice's 12/05 "Orientation, Inservice Training, Skills Verification" policy states, "All employees will compete the employee orientation program and skills verification within</p>		these corrective actions to ensure that this deficiency is corrected and will not recur.	

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L000615	<p>thirty (30) days of employment and prior to any unsupervised patient care."</p> <p>418.76(c)(1) COMPETENCY EVALUATION An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient. Based on personnel file and hospice policy review and interview, the hospice failed to ensure hospice aides had been evaluated for the competent performance of hospice aide tasks in 2 (files H and J) of 2 hospice aide files reviewed of aides hired since the last federal survey on 4-8-11 creating the potential to affect all of the hospice's 13 current patients. The findings include: 1. Personnel file H evidenced the individual had been hired on 2-27-12 to provide hospice aide services on behalf</p>	L000615	L615 By 06/12/2014 the Hospice Patient Care Coordinator will revise the Hospice Homemaker and Aid competency evaluation form to ensure the inclusion of all elements of 42 CFR 418.76. All current HHA staff will be re-evaluated for competency utilizing the revised competency form. 100% of HHA employees will be re-evaluated for competency by 06/12/2014 utilizing the revised HHA Competency Assessment form that complies with all the required elements of 42 CFR 418.76. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure	06/12/2014	

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	<p>of the hospice. The file failed to evidence the individual had been evaluated for the competent performance of any of the subjects listed in paragraph (b)(3) of this section.</p> <p>2. Personnel file J evidenced the individual had been hired on 2-25-13 to provide hospice aide services on behalf of the hospice. The file failed to evidence the individual had been evaluated for the competent performance of any of the subjects listed in paragraph (b) of this section.</p> <p>3. Employee O stated, on 5-13-14 at 2:15 PM, "I cannot find the competency evaluations for [employees H and J]. I don't know if they were done or not."</p> <p>4. The hospice's 01/04 "Provision of Services" policy states, "Hospice Aide / Homemaker Services: . . . Services will be provided by trained and competent individuals and under the director [sic] of a Registered Nurse in accordance with all Federal and State regulations."</p> <p>The hospice's 12/05 "Orientation, Inservice Training, Skills Verification" policy states, "All employees will complete the employee orientation program and skills verification within thirty (30) days of employment and prior</p>		that this deficiency is corrected and will not recur.		

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L000619	<p>to any unsupervised patient care."</p> <p>418.76(c)(5) COMPETENCY EVALUATION (5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met. Based on personnel file and hospice policy review and interview, the hospice failed to ensure it had maintained documentation that individuals had been evaluated for the competent performance of home health aide tasks in 2 (files H and J) of 2 home health aide files reviewed of aides hired since the last federal survey on 4-8-11 creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file H evidenced the individual had been hired on 2-27-12 to provide hospice health aide services on behalf of the hospice. The file failed to evidence the individual had been evaluated for the competent performance of any of the subjects listed in paragraph (b)(3) of this section. 2. Personnel file J evidenced the individual had been hired on 2-25-13 to provide hospice aide services on behalf of the hospice. The file failed to 	L000619	L619 By 06/12/2014 the Hospice Patient Care Coordinator will revise the Hospice Homemaker and Aid competency evaluation form to ensure the inclusion of all elements of 42 CFR 418.76. All current HHA staff will be re-evaluated for competency utilizing the revised competency form. 100% of HHA employees will be re-evaluated for competency by 06/12/2014 utilizing the revised HHA Competency Assessment form that complies with all the required elements of 42 CFR 418.76. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	06/12/2014	

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L000620	<p>evidence the individual had been evaluated for the competent performance of any of the subjects listed in paragraph (b) of this section.</p> <p>3. Employee O stated, on 5-13-14 at 2:15 PM, "I cannot find the competency evaluations for [employees H and J]. I don't know if they were done or not."</p> <p>4. The hospice's 01/04 "Provision of Services" policy states, "Hospice Aide/Homemaker Services: . . . Services will be provided by trained and competent individuals and under the director [sic] of a Registered Nurse in accordance with all Federal and State regulations."</p> <p>The hospice's 12/05 "Orientation, Inservice Training, Skills Verification" policy states, "All employees will compete the employee orientation program and skills verification within thirty (30) days of employment and prior to any unsupervised patient care."</p> <p>418.76(d) IN-SERVICE TRAINING A hospice aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient. Based on personnel file and hospice</p>	L000620	L620 After completion of the	06/06/2014

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L000646	<p>policy review and interview, the hospice failed to ensure hospice aides had received at least 12 hours of inservice training during 2013 in 1 (file I) of 2 files reviewed of hospice aides employed prior to January 1, 2013, creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file I evidenced the individual had been hired on 8-23-89 to provide hospice aide services. The file evidenced the aide had received only 6 hours of inservice training during 2013. 2. Employee O indicated, on 5-13-14 at 2:20 PM, employee I had only received 6 hours of inservice training during 2013. 3. The hospice's 12/05 "Orientation, Inservice Training, Skills Verification" policy states, "All direct care staff will are [sic] required to have twelve (12) hours of in-services / training yearly." <p>418.78(d) COST SAVING The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following: (1) The identification of each position that is</p>		<p>survey, it was determined that HHA staff had in fact well over 12 hours of education annually. Documentation of this education is kept on an electronic system at the hospital and records/proof of completed education hours can be produced by the education department upon request. Attainment of the necessary education hours will continue to be monitored annually by the Hospice Patient Care Coordinator during the employees annual performance evaluation. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>occupied by a volunteer.</p> <p>(2) The work time spent by volunteers occupying those positions.</p> <p>(3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section.</p> <p>Based on volunteer documentation and hospice policy review and interview, the hospice failed to ensure it had documented the identification of positions occupied by volunteers and the work time spent by each volunteer in 12 (April 2013 through March 2014) of 12 months reviewed with the potential to affect all the facility's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice's "Volunteer Saving Summary", for April 2013 through March 2014, failed to identify the position occupied by the volunteer and failed to identify the amount of work time spent by each volunteer occupying the positions. The volunteer coordinator, employee G, stated, on 5-12-14 at 1:35 PM, "We don't have it broken down like that." The hospice's 01/04 "Provision of Services" policy states, "Volunteer Services: Volunteers will be utilized in 	L000646	L646 Information on volunteer hours and cost savings were previously kept as an aggregate figure. The Volunteer Coordinator has revised the method by which volunteer hours and cost savings are tracked so that the identification of positions occupied by volunteers and the work time spent by each volunteer in those positions can be tracked separately (and later aggregated). The Volunteer Coordinator has developed a new tracking form to achieve this. Education for volunteer staff on how to complete the tracking form will be completed by the Volunteer Coordinator by 06/12/2014. Cost savings will also be calculated for each volunteer position (and later aggregated). 100% of volunteer hours will be tracked by the Hospice Volunteer Coordinator by position for identification of cost savings and total volunteer hours. The Hospice Volunteer Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	06/12/2014

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L000647	<p>the delivery of hospice care and services in both administrative and direct patient care roles under the supervision of the volunteer with acceptable standards of hospice practice. Volunteers will provide a minimum of 5% of the total patient care house [sic]. Good Samaritan Hospice will document . . . the cost savings achieved through the use of volunteers."</p> <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 volunteer documentation and hospice policy review and interview, the hospice failed to ensure it had documented the percentage of patient care hours provided by volunteers in 12 (April 2013 through March 2014) of 12 months reviewed with the potential to affect all the facility's patients.</p> <p>The findings include:</p> <p>1. The hospice's "Volunteer Saving Summary", for April 2013 through March 2014, failed to evidence documentation</p>	L000647	L647 Information on volunteer hours and cost savings were previously kept as an aggregate figure. The Hospice Volunteer Coordinator has revised the method by which volunteer hours and cost savings are tracked so that the identification of positions occupied by volunteers and the work time spent by each volunteer in those positions can be tracked separately (and later aggregated). Cost savings will also be calculated for each volunteer position (and later aggregated). The Volunteer Coordinator has developed a new	06/12/2014			

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L000661	<p>of the percentage of patient care hours provided by volunteers.</p> <p>2. The volunteer coordinator, employee G, stated, on 5-12-14 at 1:35 PM, "We don't have it broken down like that."</p> <p>3. The hospice's 01/04 "Provision of Services" policy states, "Volunteer Services: Volunteers will be utilized in the delivery of hospice care and services in both administrative and direct patient care roles under the supervision of the volunteer with acceptable standards of hospice practice. Volunteers will provide a minimum of 5% of the total patient care house [sic]. Good Samaritan Hospice will document . . . the cost savings achieved through the use of volunteers."</p> <p>418.100(g)(1) TRAINING (1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact. Based on personnel file review and interview, the hospice failed to ensure all hospice staff had received hospice orientation and training in 1 (file D) of 11 files of reviewed of employees hired since the last federal survey on 4-8-11 creating the potential to affect all of the</p>	L000661	<p>tracking form to achieve this. Education for volunteer staff on how to complete the tracking form will be completed by the Volunteer Coordinator by 06/12/2014. The aggregated information on hours and cost savings will be utilized to ensure that volunteer hours at a minimum equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. 100% of volunteer hours will be tracked by the Hospice Volunteer Coordinator by position for identification of cost savings and total volunteer hours to ensure that volunteer hours at a minimum equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The Hospice Volunteer Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>L661 On 05/28/2014 the Hospice Patient Care Coordinator provided education and training to the Director of Hospice on the hospice philosophy. Documentation of the orientation of the Director of Hospice to the hospice philosophy was</p>	05/28/2014			

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L000672	<p>hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Personnel file D failed to evidence the date on which the individual had been hired as the hospice director. The file failed to evidence the individual had been provided with orientation regarding the hospice philosophy. Employee D was unable to provide any documentation the employee had been provided with orientation regarding hospice philosophy when asked on 5-13-14 at 1:40 PM. <p>418.104(a)(1) CONTENT Each patient's record must include the following: (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes. Based on clinical record review and interview, the hospice failed to ensure clinical records included updates to the plan of care in 3 (#s 5, 7, and 11) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p>	L000672	<p>completed on 05/28/2014 and documentation of same will be entered by the Hospice Patient Care Coordinator into the Hospital Education Record system which documents and tracks completion of educational requirements. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>L672 On 05/21/2014 the Hospice Patient Care Coordinator developed a new process and provided education to all staff that all plans of care will be reviewed by the IDG every 14 days and faxed to the Hospice Medical Director and the patient's attending physician for review, coordination, and signature. Staff are to ensure that plans of care have been updated to address</p>	05/21/2014	

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L000675	<p>1. Clinical record number 5 included a plan of care established by the interdisciplinary group (IDG) on 4-15-14. The record failed to evidence the plan of care had been reviewed and revised since its establishment.</p> <p>2. Clinical record number 7 included a plan of care established by the IDG on 11-5-13. The record evidenced the plan of care had been reviewed on 4-11-14 and not again until 5-9-14, a period of 28 days between reviews.</p> <p>3. Clinical record number 11 included a plan of care established by the IDG on 11-29-12. The record evidenced the plan of care had been reviewed on 4-11-14 and not again until 5-9-14, a period of 28 days between reviews.</p> <p>4. The patient care coordinator stated, on 5-9-14 at 1:00 PM, "The original review of the plan of care documents are sent to the attending physicians for them to sign. Some of them may be out at doctors' offices.</p> <p>418.104(a)(4) CONTENT [Each patient's record must include the following:] (4) Outcome measure data elements, as described in §418.54(e) of this subpart.</p>		<p>new identified needs from the updated assessment or as identified by staff at any time in the course of care and treatment. 100% of patient charts will be audited every 14 days by the Hospice Patient Care Coordinator to ensure that plans of care are reviewed every 14 days and include new issues identified from the updated assessment or in the course of care and treatment. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure clinical records included comprehensive assessments with data elements to be used for the measurement of outcomes in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included an initial comprehensive assessment dated 12-31-13. The assessment failed to evidence data elements for the measurement of patient outcomes. 2. Clinical record number 2 included an initial comprehensive assessment dated 2-27-14. The assessment failed to evidence data elements for the measurement of patient outcomes. 3. Clinical record number 3 included an initial comprehensive assessment dated 3-19-14. The assessment failed to evidence data elements for the measurement of patient outcomes. 4. Clinical record number 4 included an initial comprehensive assessment dated 5-2-14. The assessment failed to evidence data elements for the 	L000675	L675 The Hospice Patient Care Coordinator has identified elements within the comprehensive assessment to allow for measurement of outcomes. The measures specifically include bowel function while on opioid pain medication. New forms were created to allow for ease of measurement and monitoring. 100% of charts will be monitored/audited monthly and results reported quarterly to the Hospital-Wide Performance Improvement Committee regarding the bowel program on opioid medication. A goal of 90% of patients experiencing improvement or maintaining stability has been set. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	06/12/2014			

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	<p>measurement of patient outcomes.</p> <p>5. Clinical record number 5 included an initial comprehensive assessment dated 4-16-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>6. Clinical record number 6 included an initial comprehensive assessment dated 4-30-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>7. Clinical record number 7 included an initial comprehensive assessment dated 11-8-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>8. Clinical record number 8 included an initial comprehensive assessment dated 5-5-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>9. Clinical record number 9 included an initial comprehensive assessment dated 3-31-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>10. Clinical record number 10 included an initial comprehensive assessment</p>			

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	<p>dated 12-31-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>11. Clinical record number 11 included an initial comprehensive assessment dated 11-28-12. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>12. Clinical record number 12 included an initial comprehensive assessment dated 4-8-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>13. Clinical record number 13 included an initial comprehensive assessment dated 10-17-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>14. The hospice director and the patient care coordinator were unable to provide a list of the data elements that comprise the hospice's comprehensive assessments and were unable to explain how the data elements were used in the hospice's quality assessment performance improvement program when asked on 5-13-14 at 2:50 PM.</p> <p>15. The hospice's 01/06 "Performance Improvement" policy failed to evidence</p>			

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L000679	<p>data elements to be incorporated into the comprehensive assessment and failed to evidence a process to retrieve the data and incorporate them into the hospice's quality assessment performance program.</p> <p>418.104(b) AUTHENTICATION All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice. Based on clinical record and hospice policy review and interview, the hospice failed to ensure clinical notes were complete in 3 (#s 3, 10, & 13) of 4 records reviewed of patients that received volunteer services from the hospice creating the potential to affect all of the hospice's current patients that receive volunteer services from the hospice.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included "Volunteer Documentation Sheets" dated 3-19-14, 3-26-14, 4-11-14, 4-18-14, and 4-26-14. The volunteer documentation failed to evidence a description of the contact made by the volunteer with the patient and the patient's reaction and/or response to the contact.</p>	L000679	L679 A new form for hospice volunteer staff to use in documenting contacts with patients was developed by the Hospice Volunteer Coordinator. The new form allows for more detailed documentation of each encounter with a patient. By 06/12/2014 the Hospice Volunteer Coordinator will implement use of the new volunteer clinical contact note and provide education to volunteer staff on the need to document a detailed description of the contact with the patient and the patient's reaction and/or response to the contact. The Volunteer Coordinator will also emphasize the need for legibility in documentation. The Hospice Volunteer Coordinator will audit 100% of charts monthly, reviewing 2 volunteer notes per chart, to ensure volunteers are utilizing the new contact form and	06/12/2014

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	<p>2. Clinical record number 10 included a "Volunteer Documentation Sheet" dated 1-2-14. The volunteer documentation failed to evidence a description of the contact made by the volunteer with the patient and the patient's reaction and/or response to the contact.</p> <p>3. Clinical record number 13 included "Volunteer Documentation Sheets" dated 4-5-14 and 4-24-14. The volunteer documentation failed to evidence a description of the contact made by the volunteer with the patient and the patient's reaction and/or response to the contact.</p> <p>4. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>5. The hospice's 04/09 "Clinical Records" policy states, "Each clinical record shall contain the following pertinent past and current medical and social data: . . . Complete documentation of all services and events . . . Volunteer Notes/Reports documents the type of contact, activity performed and time spent providing service."</p>		<p>for adequacy of details regarding the volunteer's encounter with the patient, particularly a description of the patient's reaction or response to the contact. The Hospice Volunteer Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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L000704	<p>418.108 SHORT-TERM INPATIENT CARE</p> <p>Based on administrative record and hospice policy review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure a written agreement was in place for the provision of general inpatient care that specified the hospice would provide a copy of the hospice plan of care and the inpatient services to be furnished creating the potential to affect all of the hospice's 13 current patients (See L 711); by failing to ensure a written agreement was in place for the provision of general inpatient care that specified the the inpatient provider has established policies consistent with the hospice's palliative protocols creating the potential to affect all of the hospice's 13 current patients (See L 712); by failing to ensure a written agreement was in place for the provision of general inpatient care that included specifications for clinical records and a discharge summary creating the potential to affect all of the hospice's 13 current patients (See L 713); by failing to ensure a written agreement was in place for the provision of general inpatient care that specified the inpatient facility would identify an individual responsible for the implementation of the provisions of the agreement creating the</p>	L000704	<p>L704 On 05/22/2014 the Director of Hospice presented the CEO of Good Samaritan Hospital a written agreement to provide inpatient hospice care, which he signed that day. The agreement specifies, among other things: hospice will provide a copy of the hospice plan of care, medical records, and the inpatient services to be furnished; the inpatient provider has established policies consistent with the hospice's palliative protocols; specifications for clinical records and a discharge summary; the hospital will identify an individual responsible for the implementation of the provisions of the agreement; hospice would be responsible for hospice orientation and training and documentation of the training; and the method for verifying the requirements of the agreement are met. The Director of Hospice will maintain an active agreement for the provision of inpatient care at all times and will review the agreement annually for compliance. The Director of Hospice will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	05/22/2014

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L000711	<p>potential to affect all of the hospice's 13 current patients (See L 714); by failing to ensure a written agreement was in place for the provision of general inpatient care that specified the hospice would be responsible for hospice orientation and training and documentation of the training creating the potential to affect all of the hospice's 13 current patients (See L 715); and by failing to ensure a written agreement was in place for the provision of general inpatient care that specified the method for verifying the requirements are met creating the potential to affect all of the hospice's 13 current patients (See L 716).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.108 Short-term Inpatient Care.</p> <p>418.108(c)(1) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies- (1) That the hospice supplies the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished; Based on administrative record and</p>	L000711	L711 On 05/22/2014 the Director	05/22/2014

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	<p>hospice policy review and interview, the hospice failed to ensure a written agreement was in place for the provision of general inpatient care that specified the hospice would provide a copy of the hospice plan of care and the inpatient services to be furnished creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records failed to evidence a written agreement with a hospital for the provision of general inpatient care that specified the hospice would furnish to the hospital a copy of the patient's plan of care and medical history. 2. The hospice director stated, on 5-13-14 at 1:00 PM, "We provide general inpatient care at the hospital. We do not have a contract with the hospital. We do have a contract with a hospital in Illinois for our Illinois patients." 3. The hospice's 5/11 "Inpatient Services" policy states, "General inpatient level of care will be provided in participating hospital . . . Hospice has a contract with the facility defining the roles of each provider in the Hospice POC [plan of care] . . . Responsibility of 		<p>of Hospice presented the CEO of Good Samaritan Hospital a written agreement to provide inpatient hospice care, which he signed that day. The agreement specifies, among other things: hospice will provide a copy of the hospice plan of care, medical records, and the inpatient services to be furnished; the inpatient provider has established policies consistent with the hospice's palliative protocols; specifications for clinical records and a discharge summary; the hospital will identify an individual responsible for the implementation of the provisions of the agreement; hospice would be responsible for hospice orientation and training and documentation of the training; and the method for verifying the requirements of the agreement are met. The Director of Hospice will maintain an active agreement for the provision of inpatient care at all times and will review the agreement annually for compliance. The Director of Hospice will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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L000712	<p>Hospice: . . . Furnish to the hospital, at the time of the patient's admission or as soon as possible, a copy of the patient's POC and medical history."</p> <p>418.108(c)(2) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (2) That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients; Based on administrative record and hospice policy review and interview, the hospice failed to ensure a written agreement was in place for the provision of general inpatient care that specifies the the inpatient provider has established policies consistent with the hospice's palliative protocols creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. The hospice's administrative records failed to evidence a written agreement with a hospital for the provision of general inpatient care that specified the</p>	L000712	L712 On 05/22/2014 the Director of Hospice presented the CEO of Good Samaritan Hospital a written agreement to provide inpatient hospice care, which he signed that day. The agreement specifies, among other things: hospice will provide a copy of the hospice plan of care, medical records, and the inpatient services to be furnished; the inpatient provider has established policies consistent with the hospice's palliative protocols; specifications for clinical records and a discharge summary; the hospital will identify an individual responsible for the implementation of the provisions of the agreement; hospice would be responsible for hospice	05/22/2014

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L000713	<p>inpatient provider has policies consistent with hospice palliative protocols.</p> <p>2. The hospice director stated, on 5-13-14 at 1:00 PM, "We provide general inpatient care at the hospital. We do not have a contract with the hospital. We do have a contract with a hospital in Illinois for our Illinois patients."</p> <p>3. The hospice's 5/11 "Inpatient Services" policy states, "General inpatient level of care will be provided in participating hospital . . . Hospice has a contract with the facility defining the roles of each provider in the Hospice POC [plan of care]."</p> <p>418.108(c)(3) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (3) That the hospice patient's inpatient clinical record includes a record of all inpatient services furnished and events regarding care that occurred at the facility; that a copy of the discharge summary be provided to the hospice at the time of discharge; and that a copy of the inpatient clinical record is available to the hospice at the time of discharge; Based on administrative record and</p>	L000713	orientation and training and documentation of the training; and the method for verifying the requirements of the agreement are met.The Director of Hospice will maintain an active agreement for the provision of inpatient care at all times and will review the agreement annually for compliance.The Director of Hospice will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	05/22/2014	L713 On 05/22/2014 the Director		

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	<p>hospice policy review and interview, the hospice failed to ensure a written agreement was in place for the provision of general inpatient care that included specifications for clinical records and a discharge summary creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records failed to evidence a written agreement with a hospital for the provision of general inpatient care that specified the inpatient clinical records would include a record of all inpatient services furnished, that a copy of the discharge summary would be available at the time of discharge, and the inpatient record would be available to the hospice at the time of discharge. 2. The hospice director stated, on 5-13-14 at 1:00 PM, "We provide general inpatient care at the hospital. We do not have a contract with the hospital. We do have a contract with a hospital in Illinois for our Illinois patients." 3. The hospice's 5/11 "Inpatient Services" policy states, "General inpatient level of care will be provided in participating hospital . . . Hospice has a 		<p>of Hospice presented the CEO of Good Samaritan Hospital a written agreement to provide inpatient hospice care, which he signed that day. The agreement specifies, among other things: hospice will provide a copy of the hospice plan of care, medical records, and the inpatient services to be furnished; the inpatient provider has established policies consistent with the hospice's palliative protocols; specifications for clinical records and a discharge summary; the hospital will identify an individual responsible for the implementation of the provisions of the agreement; hospice would be responsible for hospice orientation and training and documentation of the training; and the method for verifying the requirements of the agreement are met. The Director of Hospice will maintain an active agreement for the provision of inpatient care at all times and will review the agreement annually for compliance. The Director of Hospice will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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L000714	<p>contract with the facility defining the roles of each provider in the Hospice POC [plan of care]."</p> <p>418.108(c)(4) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (4) That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement; Based on administrative record and hospice policy review and interview, the hospice failed to ensure a written agreement was in place for the provision of general inpatient care that specified the inpatient facility would identify an individual responsible for the implementation of the provisions of the agreement creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <p>1. The hospice's administrative records failed to evidence a written agreement with a hospital for the provision of general inpatient care that specified the inpatient facility would identify an individual responsible for the</p>	L000714	L714 On 05/22/2014 the Director of Hospice presented the CEO of Good Samaritan Hospital a written agreement to provide inpatient hospice care, which he signed that day. The agreement specifies, among other things: hospice will provide a copy of the hospice plan of care, medical records, and the inpatient services to be furnished; the inpatient provider has established policies consistent with the hospice's palliative protocols; specifications for clinical records and a discharge summary; the hospital will identify an individual responsible for the implementation of the provisions of the agreement; hospice would be responsible for hospice orientation and training and documentation of the training;	05/22/2014

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L000715	<p>implementation of the provisions of the agreement.</p> <p>2. The hospice director stated, on 5-13-14 at 1:00 PM, "We provide general inpatient care at the hospital. We do not have a contract with the hospital. We do have a contract with a hospital in Illinois for our Illinois patients."</p> <p>3. The hospice's 5/11 "Inpatient Services" policy states, "General inpatient level of care will be provided in participating hospital . . . Hospice has a contract with the facility defining the roles of each provider in the Hospice POC [plan of care]."</p> <p>418.108(c)(5) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (5) That the hospice retains responsibility for ensuring that the training of personnel who will be providing the patient's care in the inpatient facility has been provided and that a description of the training and the names of those giving the training is documented; Based on administrative record and hospice policy review and interview, the hospice failed to ensure a written agreement was in place for the provision</p>	L000715	<p>and the method for verifying the requirements of the agreement are met. The Director of Hospice will maintain an active agreement for the provision of inpatient care at all times and will review the agreement annually for compliance. The Director of Hospice will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>L715 On 05/22/2014 the Director of Hospice presented the CEO of Good Samaritan Hospital a written agreement to provide inpatient hospice care, which he</p>	05/22/2014			

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	<p>of general inpatient care that specified the hospice would be responsible for hospice orientation and training and documentation of the training creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records failed to evidence a written agreement with a hospital for the provision of general inpatient care that specified the hospice would be responsible for hospice orientation and training and documentation of the training. 2. The hospice director stated, on 5-13-14 at 1:00 PM, "We provide general inpatient care at the hospital. We do not have a contract with the hospital. We do have a contract with a hospital in Illinois for our Illinois patients." 3. The hospice's 5/11 "Inpatient Services" policy states, "General inpatient level of care will be provided in participating hospital . . . Hospice has a contract with the facility defining the roles of each provider in the Hospice POC [plan of care] . . . Responsibility of Hospice: . . . Provide appropriate hospice care training to hospital personnel who will be providing inpatient care to 		<p>signed that day. The agreement specifies, among other things: hospice will provide a copy of the hospice plan of care, medical records, and the inpatient services to be furnished; the inpatient provider has established policies consistent with the hospice's palliative protocols; specifications for clinical records and a discharge summary; the hospital will identify an individual responsible for the implementation of the provisions of the agreement; hospice would be responsible for hospice orientation and training and documentation of the training; and the method for verifying the requirements of the agreement are met. The Director of Hospice will maintain an active agreement for the provision of inpatient care at all times and will review the agreement annually for compliance. The Director of Hospice will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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L000716	<p>hospice patients."</p> <p>418.108(c)(6) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (6) A method for verifying that the requirements in paragraphs(c)(1) through (c) (5) of this section are met. Based on administrative record and hospice policy review and interview, the hospice failed to ensure a written agreement was in place for the provision of general inpatient care that specified the method for verifying the requirements are met creating the potential to affect all of the hospice's 13 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's administrative records failed to evidence a written agreement with a hospital for the provision of general inpatient care that specified a method of verifying the requirements have been met. 2. The hospice director stated, on 5-13-14 at 1:00 PM, "We provide general inpatient care at the hospital. We do not have a contract with the hospital. We do 	L000716	L716 On 05/22/2014 the Director of Hospice presented the CEO of Good Samaritan Hospital a written agreement to provide inpatient hospice care, which he signed that day. The agreement specifies, among other things: hospice will provide a copy of the hospice plan of care, medical records, and the inpatient services to be furnished; the inpatient provider has established policies consistent with the hospice's palliative protocols; specifications for clinical records and a discharge summary; the hospital will identify an individual responsible for the implementation of the provisions of the agreement; hospice would be responsible for hospice orientation and training and documentation of the training; and the method for verifying the requirements of the agreement are met.The Director of Hospice will maintain an active agreement	05/22/2014	

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L000759	<p>have a contract with a hospital in Illinois for our Illinois patients."</p> <p>3. The hospice's 5/11 "Inpatient Services" policy states, "General inpatient level of care will be provided in participating hospital . . . Hospice has a contract with the facility defining the roles of each provider in the Hospice POC [plan of care]."</p> <p>Based on clinical record and hospice policy review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to maintain professional management responsibility for a patient's nursing care in 1 of 7 records reviewed of patients that were residents of skilled nursing facilities creating the potential to affect all of the hospice's 7 current patients that are residents of skilled nursing facilities (See L 762); by failing to it had consulted with skilled nursing facility (SNF) staff to establish and maintain plans of care in 7 of 7 records reviewed of patients that were residents of SNFs creating the potential to affect all of the hospice's 7 current patients that are residents of SNFs (See L 773); by failing to ensure plans of care identified all care and services needed by the patient and failed to</p>	L000759	<p>for the provision of inpatient care at all times and will review the agreement annually for compliance. The Director of Hospice will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>L759 On 05/21/2014 the Hospice Patient Care Coordinator provided education to staff on the need to: maintain professional management (core nursing services) responsibility for patients in nursing facilities; consult with skilled nursing facility staff; ensure plans of care identify all care and services needed by the patient in a skilled nursing facility and which provider is responsible for providing the identified care; ensure plans of care reflect participation by skilled nursing facility staff; and ensure hospice orientation and training has been provided to skilled nursing facility staff. A plan was developed and presented to hospice staff that hospice plans of care will be developed in collaboration with skilled nursing facilities (as appropriate to the patient) and that both the hospice and nursing</p>	06/12/2014			

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L000762	<p>specify which provider was responsible in 7 of 7 records reviewed of patients that were residents of SNFs creating the potential to affect all of the hospice's 7 current patients that are residents (See L 774); by failing to ensure plans of care reflected participation by skilled nursing facility (SNF) staff in 7 of 7 records reviewed of patients that were residents of SNFs creating the potential to affect all of the hospice's 7 current patients that are residents of SNFs (See L 775); and by failing to ensure hospice orientation and training had been provided to skilled nursing facility (SNF) staff in 1 of 2 SNF staff interviewed creating the potential to affect all of the hospice's 7 current patients that residents of SNF (See L 782).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this condition, 42 CFR 418.112 Hospices That Provide Hospice Care to Residents of a SNF/NF or ICF/MR.</p> <p>418.112(b) PROFESSIONAL MANAGEMENT The hospice must assume responsibility for</p>		<p>facility will reflect the same plan of care. On 05/21/2014 the Hospice Patient Care Coordinator completed education with hospice nursing staff regarding the need to educate skilled nursing facility staff regarding the professional management responsibility (core nursing services) of hospice staff for a patient's nursing care and hospice philosophy and orientation training. Hospice nursing staff will in turn provide this education to skilled nursing staff by 06/12/2014. 100% of patient charts will be audited every 14 days by the Hospice Patient Care Coordinator to ensure that plans of care are coordinated with nursing facilities (as appropriate to the patient), that all identified needs are included on the plan of care, that collaboration between hospice and the nursing facility is evident in the treatment plan, that responsibility for providing the care identified in the plan of care is clearly delineated, and that nursing facility staff are oriented and trained in the hospice philosophy. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §418.100 and §418.108.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to maintain professional management responsibility for a patient's nursing care in 1 (#1) of 7 records reviewed of patients that were residents of skilled nursing facilities creating the potential to affect all of the hospice's 7 current patients that are residents of skilled nursing facilities.</p> <p>The findings include</p> <p>1. Clinical record number 1 included a physician order dated 4-23-14 that states, "Cleanse open coccyx area [with] NS [normal saline]. Apply zinc oxide & cover [with] foam drsg [dressing]. [Change] every 3 days and prn [as needed] soiled loose drsg."</p> <p>A. The record included a skilled nurse visit note dated 4-23-14 that evidenced the dressing change had been completed by the hospice nurse, employee M. The record failed to evidence any further dressing changes by</p>	L000762	L762 On 05/21/2014 the Hospice Patient Care Coordinator provided education to staff on the need to: maintain professional management (core nursing services) responsibility for patients in nursing facilities. consult with skilled nursing facility staff; ensure plans of care identify all care and services needed by the patient in a skilled nursing facility and which provider is responsible for providing the identified care; ensure plans of care reflect participation by skilled nursing facility staff; and ensure hospice philosophy and orientation training has been provided to skilled nursing facility staff. A plan was developed and presented to hospice staff that hospice plans of care will be developed in collaboration with skilled nursing facilities (as appropriate to the patient) and that both the hospice and nursing facility will reflect the same plan of care. 100% of patient charts will be audited every 14 days by the Hospice Patient Care Coordinator to ensure that plans of care are coordinated with nursing facilities (as appropriate to the patient),	05/21/2014

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	<p>the hospice registered nurse.</p> <p>B. The skilled nursing facility (SNF) record was reviewed during a home visit to the patient on 5-9-14 at 10:35 AM. The record evidenced the SNF nurse had changed the dressing on 5-1-14 and 5-4-14. The SNF record included a verbal order signed and dated by the SNF nurse on 5-8-14 that identified the wound was healed and the dressing change discontinued.</p> <p>C. The record included an update to the plan of care dated 5-9-14 that states, "coccyx healed."</p> <p>2. The patient care coordinator stated, on 5-8-14 at 11:20 AM, "The dressing change was done every 3 days. The SNF nurse does it. The hospice nurse does 1 time per week when she makes her visit to assess the wound." The patient care coordinator indicated the hospice was responsible for the wound care.</p> <p>3. The hospice's 08/05 "Hospice Patient Residing in a Nursing Facility" policy states, "The Good Samaritan Hospice Team will maintain professional management of services for the patient."</p> <p>The hospice's 5/11 "Inpatient Services" policy states, "Responsibility of</p>		<p>that all identified needs are included on the plan of care, that collaboration between hospice and the nursing facility is evident in the treatment plan, and that responsibility for providing the care identified in the plan of care is clearly delineated so that hospice maintains professional management responsibility for the patient's nursing care. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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L000773	<p>Hospice: Retain professional management for continuity of services . . . All core services will be available and provided directly by Hospice employees and will not be delegated to the facility . . . The facility staff may administer prescribed therapies included in the plan of care only to the extent that Hospice would routinely utilize the patient's family or caregiver to implement the plan of care."</p> <p>418.112(d) HOSPICE PLAN OF CARE In accordance with §418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care. Based on clinical record and hospice policy review and interview, the hospice failed to ensure it had consulted with skilled nursing facility (SNF) staff to establish and maintain plans of care in 7 (#s 1, 5, 6, 10, 11, 12, and 13) of 7 records reviewed of patients that were residents of SNFs creating the potential to affect all of the hospice's 7 current patients that are residents of SNFs.</p> <p>The findings include:</p>	L000773	L773 On 05/21/2014 the Hospice Patient Care Coordinator provided education to staff on the need to: maintain professional management (core nursing services) responsibility for patients in nursing facilities. consult with skilled nursing facility staff; ensure plans of care identify all care and services needed by the patient in a skilled nursing facility and which provider is responsible for providing the identified care; ensure plans of care reflect	05/21/2014

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	<p>1. Clinical record number 1 included a plan of care dated 12-26-13 and updates to the plan of care dated 3-28-14, 4-11-14, 4-25-14, and 5-9-14. The plan of care, and the updates, failed to evidence consultation with the SNF staff.</p> <p>2. Clinical record number 5 included a plan of care dated 4-15-14. The record evidenced the patient had transferred to a SNF on 5-1-14. The plan of care failed to evidence consultation with SNF staff when the patient transferred to the SNF.</p> <p>3. Clinical record number 6 included a plan of care dated 4-29-14 and an update to the plan of care dated 5-9-14. The plan of care, and the update, failed to evidence consultation with SNF staff.</p> <p>4. Clinical record number 10 included a plan of care dated 10 12-29-13 and updates to the plan of care dated 3-28-14, 4-11-14, and 4-25-14. The plan of care, and the updates, failed to evidence consultation with SNF staff.</p> <p>5. Clinical record number 11 included a plan of care dated 11-27-12. The record evidenced the patient had transferred to a SNF on 3-12-14. The plan of care, and the updates on 3-14-14, 3-28-14, 4-11-14, and 5-9-14, failed to evidence</p>		<p>participation by skilled nursing facility staff; and ensure hospice philosophy and orientation training has been provided to skilled nursing facility staff. A plan was developed and presented to hospice staff that hospice plans of care will be developed in collaboration with skilled nursing facilities (as appropriate to the patient) and that both the hospice and nursing facility will reflect the same plan of care. 100% of patient charts will be audited every 14 days by the Hospice Patient Care Coordinator to ensure that plans of care are coordinated with nursing facilities (as appropriate to the patient), that all identified needs are included on the plan of care, that collaboration between hospice and the nursing facility is evident in the treatment plan, and that responsibility for providing the care identified in the plan of care is clearly delineated so that hospice maintains professional management responsibility for the patient's nursing care. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>consultation with SNF staff.</p> <p>6. Clinical record number 12 included a plan of care dated 4-3-14 and updates completed on 4-11-14, 4-25-14, and 5-9-14. The plan of care, and the updates, failed to evidence consultation with SNF staff.</p> <p>7. Clinical record number 13 included a plan of care dated 10-16-13 with updates completed on 4-11-14, 4-25-14, and 5-09-14. The plan of care, and the updates, failed to evidence consultation with SNF staff.</p> <p>8. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>9. The hospice's 08/05 "Hospice Patient Residing in a Nursing Facility" policy states, "The Good Samaritan Hospice Team and the nursing facility team coordinate this POC [plan of care], for the nursing facility resident."</p> <p>The hospice's 5/11 "Inpatient Services" policy states, "A coordinated Plan of Care will be developed and agreed upon one POC for both providers . . . The plan of care will reflect the</p>			

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L000774	<p>participation of Hospice, the facility and if possible, the patient."</p> <p>418.112(d)(1) HOSPICE PLAN OF CARE The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care. Based on clinical record and skilled nursing facility (SNF) documentation review, interview, and hospice policy review, the hospice failed to ensure plans of care identified all care and services needed by the patient and failed to specify which provider was responsible in 7 (#s 1, 5, 6, 10, 11, 12, and 13) of 7 records reviewed of patients that were residents of SNFs creating the potential to affect all of the hospice's 7 current patients that are residents of SNFs.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care dated 12-26-13 and updates to the plan of care dated 3-28-14, 4-11-14, 4-25-14, and 5-9-14. The plan of care, and the updates, failed to identify all services needed and which provider would provide the services. The SNF care plan was obtained and reviewed.</p>	L000774	L774 On 05/21/2014 the Hospice Patient Care Coordinator provided education to staff on the need to: maintain professional management (core nursing services) responsibility for patients in nursing facilities. consult with skilled nursing facility staff; ensure plans of care identify all care and services needed by the patient in a skilled nursing facility and which provider is responsible for providing the identified care; ensure plans of care reflect participation by skilled nursing facility staff; and ensure hospice philosophy and orientation training has been provided to skilled nursing facility staff. A plan was developed and presented to hospice staff that hospice plans of care will be developed in collaboration with skilled nursing facilities (as appropriate to the patient) and that both the hospice and nursing facility will reflect the same plan of care. 100% of patient charts will be audited	05/21/2014

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	<p>A. The hospice plan of care and the SNF care plan (updated 7-2-14) indicate alteration in nutrition, altered elimination, and self-care deficit are identified problems/needs. The hospice plan of care failed to evidence coordination with the SNF to meet the patient's identified needs and to determine which provider was responsible for ensuring the patient's needs were met.</p> <p>B. The SNF care plan identifies the patient has "scattered seborrheic keratosis", a history of hepatitis B, impaired physical mobility, "dry eye: introcular lens implant, impaired skin and uses a Hoyer lift, and depression." The hospice plan of care failed to mention the needs identified by the SNF and failed to evidence coordination with the SNF to ensure the patient's identified needs were met.</p> <p>2. Clinical record number 5 included a plan of care dated 4-15-14. The record evidenced the patient had transferred to a SNF on 5-1-14.</p> <p>A. The hospice plan of care and the SNF care plan (dated 5-1-14) identify ADL deficit, alteration in circulation, potential for injury related to falls,</p>		<p>every 14 days by the Hospice Patient Care Coordinator to ensure that plans of care are coordinated with nursing facilities (as appropriate to the patient), that all identified needs are included on the plan of care, that collaboration between hospice and the nursing facility is evident in the treatment plan, and that responsibility for providing the care identified in the plan of care is clearly delineated so that hospice maintains professional management responsibility for the patient's nursing care. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>psychosocial needs, acute pain, cough, alteration in oxygenation, and impaired skin integrity as problems/needs. The hospice plan of care failed to evidence coordination with the SNF to ensure the patient's needs were met and to determine which provider was responsible for ensuring the needs were met.</p> <p>B. The SNF care plan (dated 5-1-14) identified potential for infection, constipation, alteration urinary incontinence, potential for side effects related to psychotropic drug use, and at risk for inadequate sleep/rest as problems/needs. The hospice plan of care failed to evidence any mention of the identified needs.</p> <p>3. Clinical record number 6 included a plan of care dated 4-29-14 and an update to the plan of care dated 5-9-14.</p> <p>A. The hospice plan of care and the SNF care plan (updated 2-22-14) identify cardiovascular disease, incontinent of bowel and bladder, nutritional needs, and altered skin integrity as problems/needs. The hospice plan of care failed to evidence coordination with the SNF to ensure the patient's needs were met and to determine which provider was responsible for ensuring the needs were met.</p>						

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	<p>B. The SNF care plan identified interest and activities, seizure disorder, resistive to care, hearing deficit, and memory/recall problems. The hospice plan of care failed to evidence any mention of these identified needs.</p> <p>4. Clinical record number 10 included a plan of care dated 10 12-29-13 and updates to the plan of care dated 3-28-14, 4-11-14 and 4-25-14.</p> <p>A. The hospice plan of care and the SNF care plan (dated 4-5-14) identify potential for skin breakdown, high risk for falls, altered nutrition and cardiac status, and self-care deficit as problems/needs. The hospice plan of care failed to evidence coordination with the SNF to ensure the patient's need were met and to determine which provider was responsible for ensuring the needs were met.</p> <p>B. The SNF care plan identified potential for impaired vision, communication issues, requires extensive assistance with activities, obstructive sleep apnea, and altered blood sugars . The hospice plan of care failed to evidence any mention of these identified needs.</p>				

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	<p>5. Clinical record number 11 included a plan of care dated 11-27-12. The record evidenced the patient had transferred to a SNF on 3-12-14. The plan of care evidenced updates on 3-14-14, 3-28-14, 4-11-14, and 5-9-14.</p> <p>A. The hospice plan of care and SNF care plan (dated 3.27.14) identified needs assistance with bathing, dressing, hygiene, potential for falls, alteration in comfort, altered nutrition, and altered respiratory status, and that the patient has a foley catheter. The hospice plan of care failed to evidence coordination with the SNF to ensure the patient's needs were met and failed to determine which provider was responsible for ensuring the identified needs were met.</p> <p>B. The SNF care plan dated 3-27-14 identified the need for assistance chair, bed mobility, increased anxiousness, weakness, and the preference to stay in the room. The hospice failed to evidence any mention of these identified needs.</p> <p>6. Clinical record number 12 included a plan of care dated 4-3-14 and updates completed on 4-11-14, 4-25-14, and 5-9-14.</p> <p>A. The hospice plan of care and the SNF care plan (dated 5-5-14) identify</p>						

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	<p>self-care deficit, altered elimination, and the presence of a foley catheter. The hospice plan of care failed to evidence coordination with the SNF to ensure the patient's need were met and failed to determine which provider was responsible for ensuring the identified needs were met.</p> <p>B. The SNF care plan identified attendance at activities, impaired physical mobility, potential for hypo-hyperglycemia, swallowing problems, and open areas on the patient's right buttock and stump. The hospice plan of care failed to include any mention of these identified needs.</p> <p>7. Clinical record number 13 included a plan of care dated 10-16-13 with updates completed on 4-11-14, 4-25-14, and 509-14.</p> <p>A. The hospice plan of care and the facility care plan (dated 3-5-14) identify the patient is incontinent of bowel and bladder, needs assistance with dressing, and needs assistance with mobility. The hospice plan of care failed to evidence coordination with the facility to ensure the patient's needs were met and failed to determine which provider was responsible for ensuring the needs were met.</p>			

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L000775	<p>B. The facility care plan identified the need for medication administration, three times per day blood sugar checks, and the use of a wheelchair. The hospice plan of care failed to evidence any mention of these identified needs.</p> <p>8. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>9. The hospice's 5/11 "Inpatient Services" policy states, "The POC [plan of care] will include the agreed upon responsibility for each hospice and the SNF/NF."</p> <p>418.112(d)(2) HOSPICE PLAN OF CARE The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible. Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care reflected participation by skilled nursing facility (SNF) staff in 7 (#s 1, 5, 6, 10, 11, 12, and 13) of 7 records reviewed of patients that were residents of SNFs creating the</p>	L000775	L775 On 05/21/2014 the Hospice Patient Care Coordinator provided education to staff on the need to: maintain professional management (core nursing services) responsibility for patients in nursing facilities. consult with skilled nursing facility staff; ensure plans	05/21/2014

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	<p>potential to affect all of the hospice's 7 current patients that are residents of SNFs.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a plan of care dated 12-26-13 and updates to the plan of care dated 3-28-14, 4-11-14, 4-25-14, and 5-9-14. The plan of care, and the updates, failed to evidence consultation with the SNF staff. 2. Clinical record number 5 included a plan of care dated 4-15-14. The record evidenced the patient had transferred to a SNF on 5-1-14. The plan of care failed to evidence consultation with SNF staff when the patient transferred to the SNF. 3. Clinical record number 6 included a plan of care dated 4-29-14 and an update to the plan of care dated 5-9-14. The plan of care, and the update, failed to evidence consultation with SNF staff. 4. Clinical record number included a plan of care dated 10 12-29-13 and updates to the plan of care dated 3-28-14, 4-11-14 and 4-25-14. The plan of care, and the updates failed to evidence consultation with SNF staff. 5. Clinical record number 11 included a 		<p>of care identify all care and services needed by the patient in a skilled nursing facility and which provider is responsible for providing the identified care; ensure plans of care reflect participation by skilled nursing facility staff; and ensure hospice orientation and training has been provided to skilled nursing facility staff. A plan was developed and presented to hospice staff that hospice plans of care will be developed in collaboration with skilled nursing facilities (as appropriate to the patient) and that both the hospice and nursing facility will reflect the same plan of care. 100% of patient charts will be audited every 14 days by the Hospice Patient Care Coordinator to ensure that plans of care are coordinated with nursing facilities (as appropriate to the patient), that all identified needs are included on the plan of care, that collaboration between hospice and the nursing facility is evident in the treatment plan, and that responsibility for providing the care identified in the plan of care is clearly delineated so that hospice maintains professional management responsibility for the patient's nurings care. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>plan of care dated 11-27-12. The record evidenced the patient had transferred to a SNF on 3-12-14. The plan of care, and the updates on 3-14-14, 3-28-14, 4-11-14, and 5-9-14, failed to evidence consultation with SNF staff.</p> <p>6. Clinical record number 12 included a plan of care dated 4-3-14 and updates completed on 4-11-14, 4-25-14, and 5-9-14. The plan of care, and the updates, failed to evidence consultation with SNF staff.</p> <p>7. Clinical record number 13 included a plan of care dated 10-16-13 with updates completed on 4-11-14, 4-25-14, and 5-9-14. The plan of care, and the updates, failed to evidence consultation with SNF staff.</p> <p>8. The hospice director and the patient care coordinator were unable to provide any additional documentation and/or information when asked on 5-13-14 at 10:00 AM.</p> <p>9. The hospice's 08/05 "Hospice Patient Residing in a Nursing Facility" policy states, "The Good Samaritan Hospice Team and the nursing facility team coordinate this POC [plan of care], for the nursing facility resident."</p>			

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L000782	<p>The hospice's 5/11 "Inpatient Services" policy states, "A coordinated Plan of Care will be developed and agreed upon one POC for both providers . . . The plan of care will reflect the participation of Hospice, the facility and if possible, the patient."</p> <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. Based on interview and review of hospice policy, the hospice failed to ensure hospice orientation and training had been provided to skilled nursing facility (SNF) staff in 1 (SNF # 1) of 2 SNF staff interviewed creating the potential to affect all of the hospice's 7 current patients that are residents of SNFs.</p> <p>The findings include:</p> <p>1. During a home visit to patient number 1, on 5-9-14 at 10:35 AM, the licensed practical nurse (LPN) caring for the patient at the time was interviewed. The LPN indicated this hospice had not</p>	L000782	L782 On 05/21/2014 the Hospice Patient Care Coordinator completed education with hospice nursing staff regarding the need to educate skilled nursing facility staff regarding the professional management responsibility (core nursing services) of hospice staff for a patient's nursing care and hospice philosophy and orientation training. Hospice nursing staff will in turn provide this education to skilled nursing staff by 06/12/2014. 100% of patient charts will be audited every 14 days by the Hospice Patient Care Coordinator to ensure that plans of care are coordinated with nursing facilities	05/21/2014			

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L000795	<p>provided any hospice orientation and/or training "to my knowledge."</p> <p>2. The hospice's 08/05 "Hospice Patient Residing in a Nursing Facility" policy states, "Good Samaritan Hospice will provide a continuing program of in-services to all contracted nursing facilities."</p> <p>The hospice's 5/11 "Inpatient Services" policy states, "Initial training about the hospice program and philosophy will be provided on an ongoing basis to the facility staff, patient, and families."</p> <p>418.114(d)(1) CRIMINAL BACKGROUND CHECKS The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records. Based on personnel file and Indiana Code review and interview, the hospice failed to ensure it had obtained criminal background checks from the Indiana central repository on all hospice employees in 4 (files D, G, K, and M) of 11 files reviewed of employees hired since the last federal survey on 4-17-08.</p>	L000795	<p>(as appropriate to the patient), that all identified needs are included on the plan of care, that collaboration between hospice and the nursing facility is evident in the treatment plan, that responsibility for providing the care identified in the plan of care is clearly delineated, and that nursing facility staff are oriented and trained in the hospice philosophy. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>L795 The hospice program implemented a policy on 05/22/2014 whereby all new employees will have a criminal background check completed within 3 days of hire. Documentation of the criminal background check will be maintained in the employees personnel file. All current</p>	06/12/2014			

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	<p>The findings include:</p> <ol style="list-style-type: none"> IC 16-25-6-2(a) states, "A person who owns or operated a hospice program shall apply, not more than three (3) business days after the date that an employee or volunteer begins to provide hospice services, for a copy of the employee's or volunteer's limited criminal history from the Indiana central repository for criminal history information under IC 10-13-1. (b) A hospice program may not employ an individual or allow a volunteer to provide hospice services form more than three (3) business days without applying for that individual's or volunteer's limited criminal history as required by subsection (a)." Employee file D evidenced the individual had been hired as the director of the hospice on an unknown date. The file failed to evidence the hospice had applied for a copy of the individual's limited criminal from the Indiana central repository as required. <p>Employee D stated, on 5-13-13 at 1:35 PM, "No, I don't have one."</p> <ol style="list-style-type: none"> Employee file G evidenced the individual had been hired on 4-2-12 to provide spiritual care counseling services 		<p>employees without a criminal background check in their personnel file will have once conducted and a copy placed in their file by 06/12/2014. 100% of employee personnel files will be audited by the Hospice Patient Care Coordinator to ensure that the files contain a documented criminal background check for each new employee within 3 days of hire. The Patient Care Coordinator will also ensure that all current employees have a completed criminal background check completed and on file by 06/12/2014. The Hospice Patient Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>on behalf of the hospice. The file failed to evidence the hospice had applied for a copy of the individual's limited criminal history from the Indiana central repository as required.</p> <p>4. Employee file K evidenced the individual had been hired on 4-8-13 as the patient care coordinator. The file evidenced the hospice had applied for a copy of the individual's limited criminal history from the Indiana central repository on 5-7-13, more than 3 days after the individual had begun to provide services on behalf of the hospice.</p> <p>5. Employee file M evidenced the individual had been hired on 12-5-12 to provide nursing services on behalf of the hospice. The file failed to evidence the hospice had applied for a copy of the individual's limited criminal history from the Indiana central repository.</p> <p>6. The office administrative person, employee O, indicated, on 5-13-14 at 2:00 PM, files D, G, K, and M did not include copies of the individuals' limited criminal histories from the Indiana central repository. The employee stated, "HR told me we did not have to get them from there anymore.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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