

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151535	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2014
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NAME OF PROVIDER OR SUPPLIER KING'S DAUGHTERS' HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2670 MICHIGAN RD MADISON, IN 47250
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L000000	<p>This was a hospice federal recertification and state relicensure survey.</p> <p>Survey Dates: August 19, 20, 21, and 22, 2014</p> <p>Facility #: 008792</p> <p>Medicaid #: 200141690 A</p> <p>Surveyors: Bridget Boston, RN, PHNS Shannon Pietraszewski, RN, PHNS Nina Koch, RN, PHNS</p> <p>Kings Daughters Health Home Care & Hospice was found out of compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.54 Initial and Comprehensive Assessment of the Patient, 418.58 Quality Assessment and Performance Improvement, and 418.106 Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment.</p> <p>Census: 56</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 8, 2014</p>	L000000		
L000503	418.52(a)(2) NOTICE OF RIGHTS AND			

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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	<p>RESPONSIBILITIES</p> <p>(2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.</p> <p>Based on admission document and policy review and interview, the hospice failed to ensure the information distributed to the patients regarding Advance Directives was current and included the description of the current law for 9 (#s 1 through 9) of 9 active records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 8/19/14 at 10 AM, the Patient Rights documents and admission information as explained and delivered to the patient / legal representative upon admission was received from employee H, the hospice director. She indicated the information was current and was representative of the information given to the current patients 1, 2, 3, 4, 5, 6, 7, 8, and 9 upon their admission to the hospice. <p>The admission packet information failed to evidence the most recent information on Indiana Advance Directives, revision date July 1, 2013. The admission packet information</p>	L000503	<p>On 8/19/14, the most recent information on Indiana Advance Directives (Revision date 7/13) (attachment A) was located by the director, placed in all new admission packets, and distributed to current patients. On 9/10/14, this deficiency was reviewed with staff and education on the most current Indiana advance directive information. The director will be responsible for updating the Indiana Advance Directive Information that is provided to patients. This will be done by verifying with the Indiana State Department of Health at least yearly.</p>	09/10/2014	

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L000505	<p>contained a copy of the Indiana Advance Directives was dated 1999.</p> <p>2. The hospice's policy titled "Patient Rights and Responsibilities" dated effective 12/96 states, "The home care and hospice agency must inform and distribute written information to the patient, in advance, concerning it's policies on advance directives, including a description of applicable state law."</p> <p>3. The Administrator and Nursing Supervisor indicated on 08/19/14 at 10:40 AM that she was not aware of the updated version of the Indiana Advance Directives.</p> <p>418.52(b)(1) EXERCISE OF RIGHTS/RESPECT FOR PROPERTY/PERSON (1) The patient has the right: (i) To exercise his or her rights as a patient of the hospice; (ii) To have his or her property and person treated with respect; (iii) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and (iv) To not be subjected to discrimination or reprisal for exercising his or her rights.</p>			
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	<p>Based on document review and interview, the agency failed to ensure the correct agency contact information to file a grievance / complaint was provided to patients upon admission creating the potential to affect all 9 patients currently receiving services with the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The admission packet was provided on 8/19/14 at 10:00 AM. The "Hospice Family Handbook" indicated the Home Health and Hospice Coordinator (Name of Employee # P), Home Care Director (Name of Employee # O), and hospital President (Name of # Q) were identified as the people to report complaints to. <p>The admission packet given to the patients failed to include the correct phone number and the correct responsible person to report grievance / complaint in the admission folder that was distributed to the patients at the start of care.</p> <ol style="list-style-type: none"> The Patient Care Coordinator, Employee G, indicated on 8/19/14 at 10:40 AM that Employee O, P, and Q were former employees. The Director of Clinical Services indicated the Administrator for hospice manages the grievances / complaints. 	L000505	<p>On 8/19/14, the Hospice Family Handbook was updated to include names and phone numbers of the Coordinator, Director, and Hospital CEO for report of grievances(see attachment B). For all current patients, Hospice provided the revised names and numbers also. On 9/10/14, this deficiency was reviewed with all staff. The director is responsible for updating contact information when any changes occur in the Hospice Family Handbook as well as reviewing annually.</p>	09/10/2014

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L000520	<p>Based on clinical record and policy review and interview, it was determined the hospice failed to ensure all members of the the interdisciplinary group (IDG) had participated in the completion of the comprehensive assessments in 8 of 8 active records reviewed receiving service for more than 5 days (See L 523); failed to include as a part of the comprehensive assessment a complete a review of all of the patient's prescription and over the counter drugs to include potential drug interactions, duplicate therapy and side effects for 1 of 9 clinical record reviewed (See L 530); failed to ensure comprehensive assessments reflected updates specific to all members of the IDG in 6 of 8 records reviewed of patients on service for longer than 15 days (See L 533); and failed to ensure comprehensive assessments included data elements that had been documented in a systematic and retrievable way for all patients in 8 of 8 active records reviewed (See L 534 and L 535).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with the Condition of Participation 418.54 Initial and Comprehensive Assessment of the</p>	L000520	This condition deficiency has been corrected. The plan of correction for the level citations attached to this condition will ensure that these problems have been resolved and will not recur.	09/10/2014
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L000523	<p>Patient.</p> <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 interdisciplinary group (IDG) had participated in the completion of the comprehensive assessments in 9 of 9 records reviewed creating the potential to affect all of the hospice's 9 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 included a comprehensive assessment dated 7-22-14. The assessment failed to evidence participation by the spiritual care counselor member of the IDG. 2. Clinical record number 5 included a comprehensive assessment dated 6-10-14. The assessment failed to evidence participation by the spiritual care counselor member of the IDG. 	L000523	<p>This deficiency was reviewed with all staff on 9/10/14. All members of IDG will participate in the completion of the comprehensive assessment. All patients beginning on 9/10/14 will have an initial spiritual assessment completed by the chaplain within the 5 day period after election of Hospice care. This assessment will be included in the development of the Hospice plan of care. All current patients, that have not been previously assessed by the Hospice chaplain will be assessed by 9/15/14. The spiritual assessment will be documented on the appropriate form and placed in the patient's chart. (See attachment C). 100% of all Hospice admissions will be audited for 6 months for a completed initial spiritual assessment completed by the hospice chaplain. The Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected</p>	09/15/2014

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L000530	<p>3. Clinical record number 9 included a comprehensive assessment dated 9-29-13. The assessment failed to evidence participation by the spiritual care counselor member of the IDG.</p> <p>4. Employee R, a Volunteer Director, indicated on 8-20-14 at 3:10 PM that there was no Chaplains on staff with the agency and hospital and the Chaplain volunteers fill this role. Employee R indicated she obtains referrals from the nurses after they make their assessment. Employee R indicated the Chaplains do not document all of their visits, telephone calls, and encounters.</p> <p>5. Employee K, a Registered Nurse, indicated on 8-22-14 at 1:00 PM she was not aware a spiritual assessment was needed within 5 days of admission. When asked how spiritual care was addressed to families and patients, Employee K began to describe the Chaplain personalities instead of the benefit of the service.</p> <p>418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative</p>		and will not recur. This data will be reported to the KDH Quality Council on a quarterly basis		

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	<p>treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:</p> <ul style="list-style-type: none"> (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. <p>Based on clinical record and policy review and observation, The agency failed to include as a part of the comprehensive assessment a complete review of all of the patient's prescription and over the counter drugs to include potential drug interactions, duplicate therapy, and side effects for 1 (#1) of 9 clinical record reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A home admission visit was made to the home of patient #1 at 12:30 pm on 8/19/2014. Employee K, a registered nurse, reviewed the list from the patients clinical record of medications provided in the recent hospital recent discharge packet during the assessment but failed to compare the list with the medications in the patients home and failed to evaluate for duplicate drug therapy, actual or potential drug interactions, or drug side effects. 	L000530	<p>This deficiency was reviewed with all staff on 9/10/14. Agency policy was also reviewed with staff. On admission all drugs, including prescription, OTC, herbal, and alternate treatments will be reviewed by the nurse. This includes effectiveness of drug therapy, side effects, actual/potential drug interactions, duplicate drug therapy. The current list of meds will be reconciled with the drugs found in the patient's home. To ensure this deficiency does not recur, 100% of Hospice admits will be supervised for one month, then 2 Hospice admits every month for 6 months. These visits will be supervised by the Director, Hospice Coordinator, or Intake Coordinator for appropriate medication review and reconciliation of the current medication list with the actual medications in the patient's home. (See Hospice Admission Supervisory Visit- Attachment H). This data will be reported to the KDH Quality Council on a quarterly basis The Director will be responsible for monitoring</p>	09/10/2014

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L000533	<p>2. An agency policy dated 12/11 titled "# 200 Patient Assessment (Patient Initial Assessment)" states, "A pharmacist or registered nurse assesses the patients current medications for efficacy, possible drug interactions, and possible adverse reactions."</p> <p>418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. Based on clinical record and policy review and interview, the hospice failed to ensure comprehensive assessments reflected updates specific by all members of the interdisciplinary group (IDG) in 6 of 8 records reviewed of patients on service for longer than 15 days. (#2, 3, 5, 6, 8, and 9) The findings include:</p>	L000533	<p>these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>This deficiency was reviewed with all staff on 9/10/14. Policy #300 "Care Planning Coordination of Services" also reviewed with staff. Beginning 9/10/14 all IDG members will bring a written summary of each patient's progress and response to care with identified and treated issues since the last IDG meeting. A plan for the proceeding 14 days will be developed at the IDG</p>	09/10/2014

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	<p>1. Clinical record number 2 evidenced the comprehensive assessment had been updated on 7-24-14 and 8-7-14. The plan of care update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>2. Clinical record number 5 evidenced the comprehensive assessment had been updated on 6-12-14, 6-26-14, 7-10-14, 7-24-14, and 8-7-14.</p> <p>A. The 6-12-14 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>B. The 6-26-14 update failed to evidence an evaluation of the patient's current spiritual status.</p> <p>C. The 7-10-14 update failed to evidence an evaluation of the patient's current spiritual status.</p> <p>D. The 7-24-14 update failed to evidence an evaluation of the patient's current spiritual status.</p> <p>E. The 8-7-14 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>3. Clinical record number 9 evidenced</p>		<p>meeting based upon the review provided by each discipline. This will validate participation of all members. This process will be monitored at every IDG meeting by the facilitator. 100% participation by all IDG members will be maintained at each meeting. Monitoring of the participation of all members at IDG will be ongoing. The Director will be responsible for monitoring compliance with these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>the comprehensive assessment had been updated on 5-29-14, 6-12-14, 6-26-14, 7-10-14, 7-24-14, and 8-7-14.</p> <p>A. The 5-29-14 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>B. The 6-12-14 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>C. The 6-26-14 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>D. The 7-10-14 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>E. The 7-24-14 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>F. The 8-7-14 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>4. On 8/21/14 at 10 AM, employee U, volunteer chaplain, indicated he did not assess the patients prior to the IDG updates.</p> <p>5. Clinical record number 3 evidenced</p>			

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	<p>the comprehensive assessment had been updated on 5/29/14, 6/12/14, 6/26/14, 7/10/14, 7/24/14, 8/9/14, and 8/21/14. The plan of care updates failed to evidence an evaluation of the patient's current spiritual status.</p> <p>6. Clinical record number 6 evidenced the comprehensive assessment had been updated on 8/9/14, and 8/21/14. The plan of care update failed to evidence an evaluation of the patient's current spiritual status.</p> <p>8. Clinical record number 8 evidenced the comprehensive assessment had been updated on 5/29/14, 6/12/14, 6/26/14, 7/10/14, 7/24/14, 8/9/14, and 8/21/14. The plan of care updates failed to evidence an evaluation of the patient's current spiritual status.</p> <p>9. . The hospice policy number 300a titled "Care Planning Coordination of Services (Hospice)" revision date 12/11 stated, "The IDG meets at least every 14 days to evaluate care provided, the patient's response to care and to make revisions to the plan of care as necessary. Questions asked include: ... Are the goals identified in the initial / comprehensive assessment(s) measurable? Are they met?"</p>			

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L000534	<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 palliation.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure comprehensive assessments included data elements to be collected and measured in the same way for all patients in 8 active (#s 2 through 9) of 8 active records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 3 evidenced an initial comprehensive assessment had been completed on 5/18/14. The assessment failed to evidence identifiable data elements had been incorporated into the assessment. Clinical record number 4 evidenced an initial comprehensive assessment had been completed on 7/4/14. The assessment failed to evidence identifiable data elements had been incorporated into the assessment. 	L000534	<p>This deficiency was reviewed with all staff on 9/10/14. On 9/9/14 the QAPI plan was revised to include specific data elements to measure for each patient. (See attachment D- QAPI plan; highlighted elements have been added to the new plan).</p> <p>100% of new admit charts will be audited to ensure that these data elements are being completed. These measures will be monitored on a quarterly basis and ongoing need for monitoring or the development of new processes will be determined. These measures will also be reported to the KDH Quality Council on a quarterly basis. The Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	09/10/2014
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	<p>3. Clinical record number 6 evidenced an initial comprehensive assessment had been completed on 7/25/14. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>4. Clinical record number 7 evidenced an initial comprehensive assessment had been completed on 8/9/14. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>5. Clinical record number 8 evidenced an initial compressive assessment had been completed on 5/25/14. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>6. The director, employee H, was unable to provide any additional documentation and/or information when asked on 8/19/14 at 2:35 PM.</p> <p>7. The facility policy titled "Clinical Records" revision date 12/12, stated, "KDG Home and Hospice clinical records contain the following: ... Outcome measure data elements."</p> <p>8. Clinical record number 2 included an</p>			

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L000535	<p>initial comprehensive assessment dated 7-22-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>9. Clinical record number 5 included an initial comprehensive assessment dated 6-10-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>10. Clinical record number 9 included an initial comprehensive assessment dated 9-23-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>11. 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 8-19-14 at 2 PM.</p> <p>418.54(e)(2) PATIENT OUTCOME MEASURES (2) The data elements must be an integral part of the comprehensive assessment and</p>						

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	<p>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 policy review and interview, the hospice failed to ensure comprehensive assessments included data elements that had been documented in a systematic and retrievable way for all patients in 8 (#s 2 through 9) of 8 active records reviewed .</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced an initial comprehensive assessment had been completed on 5/18/14. The assessment failed to evidence identifiable data elements had been incorporated into the assessment. 2. Clinical record number 4 evidenced an initial comprehensive assessment had been completed on 7/4/14. The assessment failed to evidence identifiable data elements had been incorporated into the assessment. 3. Clinical record number 6 evidenced an initial comprehensive assessment had been competed on 7/25/14. The 	L000535	<p>This deficiency was reviewed with all staff on 9/10/14. On 9/9/14 the QAPI plan was revised to include specific data elements to measure for each patient. (See attachment D- QAPI plan; highlighted elements have been added to the new plan). 100% of new admit charts will be audited to ensure that these data elements are being completed. These measures will be monitored on a quarterly basis and ongoing need for monitoring or the development of new processes will be determined. These measures will also be reported to the KDH Quality Council on a quarterly basis The Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	09/10/2014

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	<p>assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>4. Clinical record number 7 evidenced an initial comprehensive assessment had been completed on 8/9/14. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>5. Clinical record number 8 evidenced an initial compressive assessment had been completed on 5/25/14. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>6. The director, employee H, was unable to provide any additional documentation and/or information when asked on 8/19/14 at 2:35 PM.</p> <p>7. The facility policy titled "Clinical Records" revision date 12/12, stated, "KDG Home and Hospice clinical records contain the following: ... Outcome measure data elements."</p> <p>8. Clinical record number 2 included an initial comprehensive assessment dated 7-22-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p>			

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L000544	<p>9. Clinical record number 5 included an initial comprehensive assessment dated 6-10-14. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>10. Clinical record number 9 included an initial comprehensive assessment dated 9-29-13. The assessment failed to evidence data elements for the measurement of patient outcomes.</p> <p>11. 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 8-19-14 at 2 PM.</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 and agency policy review, the hospice failed to</p>	L000544	This deficiency was reviewed with all staff on 9/10/14. Agency policy	09/10/2014			

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	<p>ensure that each patient and the primary care givers received education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care in 1 of 9 records reviewed (#1).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee K, a registered nurse (RN), reviewed the list of medications provided in the recent hospital recent discharge packet during the assessment but failed to compare the list with the medication in the patient's home to ensure that the caregiver was assisting the patient to take medications as ordered on the hospital discharge list. The skilled nurse failed to evaluate the caregivers knowledge of the patient's medication regimen and ability to safely administer medications to the patient. 2. A "comfort kit" was presented to the caregiver for patient number 1 at the time of the admission visit. The comfort kit is a prefilled emergency drug kit with medications for the caregiver to use for symptom management. The kit contained concentrated liquid morphine solution to be administered under the tongue with an oral syringe and Tylenol suppositories and compazine 		<p>"Medication Administration and Management" (Attachment E) was also revised to include the determination of patient/caregiver to safely administered medications. On admission all drugs, including prescription, OTC, herbal, and alternate treatments will be reviewed by the nurse. This includes effectiveness of drug therapy, side effects, actual/potential drug interactions, duplicate drug therapy. The current list of meds will be reconciled with the drugs found in the patient's home. Education on all medications will be completed on admission, as well as the patient/caregiver will be assessed for the ability to safely administer medications in the home. These interventions will also be documented in the chart when completed. The policy on "Medication Administration and Management" will also be included in the admission packet for review with the patient as well. To ensure this deficiency does not recur, 100% of Hospice admits will be supervised for one month, then 2 Hospice admits every month for 6 months until we see consistent improvement. These visits will be supervised by the Director, Hospice Coordinator, or Intake Coordinator for appropriate medication review, education, and reconciliation of the current medication list with the actual medications in the patient's</p>				

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L000545	<p>suppositories to be administered rectally. The RN failed to provide teaching about how to administer these medications and when they should be given.</p> <p>3. An agency policy dated 12/89 and revised 10/13 titled "#400 Patient and Family Education" states, "The patient and family receive education about medication use including possible drug interactions,side effects and when and how to take medications."</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 plans of care were individualized and included patient specific interventions to address identified problems in 2 (#'s 2 and 9) of 9 records reviewed creating the potential to affect all of the hospice's 9 current</p>	L000545	<p>home. (See Hospice Admission Supervisory Visit- Attachment H) The Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>This deficiency was reviewed with all staff on 9/10/14. On admission, problems are identified in the assessment of "immediate needs". Interventions and goals for each problem identified are developed. Beginning on 9/10/14, a review of each patient for IDG will include a review of the problems/issues</p>	09/10/2014

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	<p>patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included an initial comprehensive assessment completed by the registered nurse (RN), employee K, on 6-10-14. The assessment identified the patient had "anxiety reaction after last chemotherapy session that required hospitalization ... takes Lyrica for tingling in feet ... instructed patient / spouse on the comfort kit: Roxanol for pain relief ... expressive aphasia. Patient is aware of this and has slight frustration with condition ... right sided extremity weakness ... patient cannot write any more ... instructed patient / spouse on the comfort kit: Ativan for anxiety ... " The plan of care, established by the interdisciplinary group (IDG) on 6-12-14, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>A. Comprehensive assessment completed by employee K on 6-23-14 stated, "Patient states [the patient] feels weaker recently ... States [his/her] comprehension of the written word is about 25%. Patient believes [he/she] has had a down turn." The plan of care, established by the interdisciplinary group</p>		<p>identified in the past 14 day period along with a review of the immediate needs and progress toward established goals or development of new goals if indicated. The necessary frequency of each service will also be reviewed for each patient. (See attachment L) At IDG, all services will provide their review of the patient's progress/problems from the past 14 days. The problems will be discussed in line with the immediate needs that are identified on the initial comprehensive assessment. The IDG group will review this during the meeting and update the care plan with a plan for the next 14 days. This will ensure that all problems will be reviewed by the IDG, and that an appropriate update will be made to the patient's plan of care. The facilitator of IDG (Director, Coordinator, Intake Coordinator) will be responsible for ensuring that this complete review is done at each IDG meeting.</p>		

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	<p>on 6-26-14, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>B. Comprehensive assessment completed by employee K on 7-3-14 indicated the patient's spouse had notified the hospice about the increase in anxiety shown by the patient. The spouse had indicated there were things on the patient's mind that was causing the patient anxiety. Comprehensive assessment completed by employee K dated 7-10-14 stated, "Patient spouse did report [him/her] having pacing / restlessness / skin crawling episode ... " The plan of care, established by the interdisciplinary group on 7-10-14 failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>C. Comprehensive assessment completed by employee K on 7-17-14 indicated the patient was having difficulty sleeping, slightly restless, and had a decrease in appetite. The plan of care, established by the interdisciplinary group (IDG) on 7/24/14, failed to include individualized, patient-specific interventions to address the identified problems.</p>						

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	<p>2. Clinical record number 9 included an comprehensive assessment completed by employee S, a RN, on 5-30-14. The assessment identified the patient had difficulty sleeping. A comprehensive assessment completed by employee S on 6-3-14 identified the patient had some difficulty with managing pain to the right leg and back. A comprehensive assessment completed by employee S on 6-6-14 identified that the patient's appetite was poor, sleeping more, and "good days are less and bad days are more." A comprehensive assessment completed by employee S on 6-10-14 identified the spouse being tearful about the patient's decline and indicating the patient not eating and drinking well. The plan of care, established by the IDG on 6-12-14, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>A. A comprehensive assessment completed by employee S on 6-13-14 identified the patient had an episode of pain to the back that was not relieved with Norco but found relief with Roxanol. A comprehensive assessment completed by employee S on 6-25-14 identified the patient was having pain to the right and left side and requested Duragesic patch to be increased to 100 mcg (micrograms). The plan of care,</p>			

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L000547	<p>established by the IDG on 6-26-14, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>B. A comprehensive assessment completed by employee K on 8-4-14 identified the patient had occasional pain and took hydrocodone, otherwise continued on the Duragesic patch; identified sherbert for phlegm control, otherwise had difficulty with shortness of breath during meals; and continued to have diminished lung sounds with crackles. The plan of care, established by the IDG on 8-7-14, failed to include individualized, patient-specific interventions to address the identified problems.</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 frequency of services necessary to meet the specific patient and family needs. Based on clinical record and hospice policy review and interview, the hospice</p>	L000547	This deficiency was reviewed with all staff on 9/10/14. On admission, problems are	09/10/2014			

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	<p>failed to ensure plans of care included detailed, patient-specific interventions to address identified problems in 2 (#s 2 and 9) of 9 records reviewed creating the potential to affect all of the hospice's 9 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included an initial comprehensive assessment completed by the registered nurse (RN), employee K, on 6-10-14. The assessment identified the patient had "anxiety reaction after last chemotherapy session that required hospitalization ... takes Lyrica for tingling in feet ... instructed patient / spouse on the comfort kit: Roxanol for pain relief ... expressive aphasia. Patient is aware of this and has slight frustration with condition ... right sided extremity weakness ... patient cannot write any more ... instructed patient / spouse on the comfort kit: Ativan for anxiety ... " The plan of care, established by the interdisciplinary group (IDG) on 6-12-14, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>A. Comprehensive assessment completed by employee K on 6-23-14 stated, "Patient states [the patient] feels</p>		<p>identified in the assessment of "immediate needs". Interventions and measurable goals for each problem identified are developed. Beginning on 9/10/14, a review of each patient for IDG will include a review of the problems/issues identified in the past 14 day period along with a review of the immediate needs and progress toward established measurable goals or development of new goals if indicated. The necessary frequency of each service will also be reviewed for each patient. (see attachment L) At IDG, all services will provide their review of the patient's progress/problems from the past 14 days. The problems will be discussed in line with the immediate needs that are identified on the initial comprehensive assessment. The IDG group will review this during the meeting and update the care plan with a plan for the next 14 days. This will ensure that all problems will be reviewed by the IDG, and that an appropriate update will be made to the patient's plan of care. The facilitator of IDG (Director, Coordinator, Intake Coordinator) will be responsible for ensuring that this complete review is done at each IDG meeting.</p>		

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	<p>weaker recently ... States [his/her] comprehension of the written word is about 25%. Patient believes [he/she] has had a down turn." The plan of care, established by the interdisciplinary group on 6-26-14, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>B. Comprehensive assessment completed by employee K on 7-3-14 indicated the patient's spouse had notified the hospice about the increase in anxiety shown by the patient. The spouse had indicated there were things on the patient's mind that was causing the patient anxiety. Comprehensive assessment completed by employee K dated 7-10-14 stated, "Patient spouse did report [him/her] having pacing / restlessness / skin crawling episode ... " The plan of care, established by the interdisciplinary group on 7-10-14 failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>C. Comprehensive assessment completed by employee K on 7-17-14 indicated the patient was having difficulty sleeping, slightly restless, and had a decrease in appetite. The plan of care, established by the interdisciplinary</p>			

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	<p>group (IDG) on 7/24/14, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>2. Clinical record number 9 included an comprehensive assessment completed by employee S, a RN, on 5-30-14. The assessment identified the patient had difficulty sleeping. A comprehensive assessment completed by employee S on 6-3-14 identified the patient had some difficulty with managing pain to the right leg and back. A comprehensive assessment completed by employee S on 6-6-14 identified that the patient's appetite was poor, sleeping more, and "good days are less and bad days are more." A comprehensive assessment completed by employee S on 6-10-14 identified the spouse being tearful about the patient's decline and indicating the patient not eating and drinking well. The plan of care, established by the IDG on 6-12-14, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>A. A comprehensive assessment completed by employee S on 6-13-14 identified the patient had an episode of pain to the back that was not relieved with Norco but found relief with Roxanol. A comprehensive assessment</p>			

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L000548	<p>completed by employee S on 6-25-14 identified the patient was having pain to the right and left side and requested Duragesic patch to be increased to 100 mcg (micrograms). The plan of care, established by the IDG on 6-26-14, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>B. A comprehensive assessment completed by employee K on 8-4-14 identified the patient had occasional pain and took hydrocodone, otherwise continued on the Duragesic patch; identified sherbert for phlegm control, otherwise had difficulty with shortness of breath during meals; and continued to have diminished lung sounds with crackles. The plan of care, established by the IDG on 8-7-14, failed to include individualized, patient-specific interventions to address the identified problems.</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</p>			

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	<p>related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.</p> <p>Based on clinical record and policy review, the hospice failed to ensure plans of care included measurable goals and outcomes in 3 (#s 3, 6, and 8) of 8 active records reviewed of patients on service for more than 5 days.</p> <p>The findings include:</p> <p>1. Clinical record # 3, start of care 5/18/14, included a plan of care for the certification period 8/16/18 through 11/13/14. The plan of care identified multiple problems to be addressed by the interdisciplinary group (IDG). The identified problems and expected outcomes included the following:</p> <p>A. "Nutrition ... Plan / Goal: PT [Patient] intake will be at an acceptable level for patient and family will accept natural decline as disease progresses."</p> <p>B. "Activity / Mobility ... Plan / Goal: PT will remain at an activity level that is acceptable to patient. Pt will remain safe and free of mobility complications."</p> <p>C. "Bereavement ... plan / Goal: PT and family grief issues will be resolved</p>	L000548	<p>This deficiency was reviewed with all staff on 9/10/14. All problems identified on the Hospice Plan of Care will include measurable goals/outcomes beginning 9/10/14. The Hospice Coordinator will audit 100% of the Hospice Plan of Cares on admission to ensure that goals/outcomes are measurable. This has been added to the Hospice plan of care audit tool (attachment K) used by the Coordinator. Goals/outcomes will also be discussed by the IDG at each meeting to ensure that goals/outcomes continue to be measurable. The Director will monitor that the audit is being performed and the result of the audits.</p>	09/10/2014	

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	<p>by expressing concerns to HSP [hospice] staff."</p> <p>D. "Integumentary ... PT with open area to coccyx 1 X 1 X 0.1 CM [centimeter]. ... Plan / Goal: PT will remain free of skin breakdown. PT / family will voice U/S [understanding] of repositioning and pressure relief techniques."</p> <p>E. "Neuro: ... Plan / Goal: PT and family will be able to express needs and concerns to HSP staff. PT and family needs will be met."</p> <p>2. Clinical record # 6, start of care 7/25/14, included a plan of care for the certification period 7/25/14 through 10/22/14. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>A. "Nutrition ... Plan / Goal Pt intake will be at an acceptable level for patient and family will accept natural decline as disease progresses."</p> <p>B. "Activity / Mobility ... Plan / Goal: Patient will remain at an activity level that is acceptable to patient. Pt will remain safe and free of mobility</p>						

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	<p>complications."</p> <p>C. "Bereavement ... plan / Goal: PT and family grief issues will be resolved by expressing concerns to HSP [hospice] staff."</p> <p>D. "Integumentary ... Plan / Goal: PT will remain free of skin breakdown. PT / family will voice U/S [understanding] of repositioning and pressure relief techniques."</p> <p>E. "Neuro: ... Plan / Goal: PT and family will be able to express needs and concerns to HSP staff. PT and family needs will be met."</p> <p>3. Clinical record # 8, start of care 5/25/14, included a plan of care for the certification period 5/25/14 through 8/22/14. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>A. "Nutrition ... Plan / Goal Pt intake will be at an acceptable level for patient and family will accept natural decline as disease progresses."</p> <p>B. "Activity / Mobility ... Plan / Goal: Patient will remain at an activity</p>				

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L000553	<p>level that is acceptable to patient. Pt will remain safe and free of mobility complications."</p> <p>C. "Bereavement ... plan / Goal: PT and family grief issues will be resolved by expressing concerns to HSP staff."</p> <p>D. "Integumentary ... Plan / Goal: PT will remain free of skin breakdown. PT / family will voice U/S of repositioning and pressure relief techniques."</p> <p>D. "Neuro: ... Plan / Goal: PT and family will be able to express needs and concerns to HSP staff. PT and family needs will be met."</p> <p>4. The facility policy titled "Care Planning of Services (Hospice)" revision date 12/11, stated, "The plan of care ... includes in detail ... f. establishment of goals to meet the patient's / family's needs."</p> <p>418.56(d) REVIEW OF THE PLAN OF CARE A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and</p>				

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	<p>goals specified in the plan of care.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure the interdisciplinary group (IDG) revised the plan of care and included information from the patient's updated comprehensive assessment and noted the patient's progress toward desired outcomes and goals specified in the plan of care for 8 of 8 records reviewed of patients on service for more than 15 days with the potential to affect all the hospice patients. (# 2, 3, 4, 5, 6, 7, 8, and 9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 2, with an established plan of care date of 7/22/14, evidenced a document titled "Kings Daughters' Health Home Care and Hospice Hospice IDG - Plan of Care Review and Update" dated 7/24/14, 8/7/14, and 8/21/14. The record failed to evidence an update to the comprehensive assessment that documented progress toward desired outcomes and was the basis for the revised plans of care. The revised plans of care failed to evidence patient specific interventions and measurable outcomes. 2. Clinical record # 3, with an 	L000553	<p>This deficiency was reviewed with all staff on 9/10/14. Each patient's Hospice Plan of Care will be reviewed and updated with entire IDG. Each plan of care and update will be signed by each IDG participant. The agency will no longer consider the form "King's Daughters' Health Home Care and Hospice IDG Plan of Care and Update" as approval of the IDG for updates to the comprehensive assessment. At IDG, the facilitator will oversee the review and update, with progress toward desired outcomes, of each patient's plan of care. Each plan will be signed for approval of the update by the IDG. The facilitator of IDG (Director, Coordinator, Intake Coordinator) will be responsible for ensuring that this complete review is done at each IDG meeting.</p>	09/10/2014	

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	<p>established plan of care date of 5/18/14, evidenced a document titled "Kings Daughters' Health Home Care and Hospice Hospice IDG - Plan of Care Review and Update" dated 5/29/14, 6/12/14, 6/26/14, 7/10/14, 7/24/14, 8/7/14, and 8/21/14. The record failed to evidence an update to the comprehensive assessment that documented progress toward desired outcomes and was the basis for the revised plans of care. The revised plans of care failed to evidence patient specific interventions and measurable outcomes.</p> <p>3. Clinical record # 4, with an established plan of care date of 7/04/14, evidenced a document titled "Kings Daughters' Health Home Care and Hospice Hospice IDG - Plan of Care Review and Update" dated 7/10/14, 7/24/14, 8/7/14, and 8/21/14. The record failed to evidence an update to the comprehensive assessment that documented progress toward desired outcomes and was the basis for the revised plans of care. The revised plans of care failed to evidence patient specific interventions and measurable outcomes.</p> <p>4. Clinical record # 5, with an established plan of care date of 6/10/14, evidenced a document titled "Kings Daughters' Health Home Care and</p>			

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	<p>Hospice Hospice IDG - Plan of Care Review and Update" dated 6/12/14, 6/26/14, 7/10/14, 7/24/14, 8/7/14, and 8/21/14. The record failed to evidence an update to the comprehensive assessment that documented progress toward desired outcomes and was the basis for the revised plans of care. The revised plans of care failed to evidence patient specific interventions and measurable outcomes.</p> <p>5. Clinical record # 6, with an established plan of care date of 7/25/14, evidenced a document titled "Kings Daughters' Health Home Care and Hospice Hospice IDG - Plan of Care Review and Update" dated 8/7/14 and 8/21/14. The record failed to evidence an update to the comprehensive assessment that documented progress toward desired outcomes and was the basis for the revised plans of care. The revised plans of care failed to evidence patient specific interventions and measurable outcomes.</p> <p>6. Clinical record # 7, with an established plan of care date of 8/9/14, evidenced a document titled "Kings Daughters' Health Home Care and Hospice Hospice IDG - Plan of Care Review and Update" dated 8/21/14. The record failed to evidence an update to the comprehensive assessment that documented progress toward desired</p>			

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	<p>outcomes and was the basis for the revised plans of care. The revised plans of care failed to evidence patient specific interventions and measurable outcomes.</p> <p>7. Clinical record # 8, with an established plan of care date of 5/25/14, evidenced a document titled "Kings Daughters' Health Home Care and Hospice Hospice IDG - Plan of Care Review and Update" dated 5/29/14, 6/12/14, 6/26/14, 7/10/14, 7/24/14, 8/7/14, and 8/21/14. The record failed to evidence an update to the comprehensive assessment that documented progress toward desired outcomes and was the basis for the revised plans of care. The revised plans of care failed to evidence patient specific interventions and measurable outcomes.</p> <p>8. Clinical record # 9, with an established plan of care date of 9/29/13, evidenced a document titled "Kings Daughters' Health Home Care and Hospice Hospice IDG - Plan of Care Review and Update" dated 5/29/14, 6/12/14, 6/26/14, 7/10/14, 7/24/14, 8/7/14, and 8/21/14. The record failed to evidence an update to the comprehensive assessment that documented progress toward desired outcomes and was the basis for the revised plans of care. The revised plans of care failed to evidence</p>			

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L000559	<p>patient specific interventions and measurable outcomes.</p> <p>9. The policy titled "Quality Assessment Performance Improvement Program" dated 12/2/08 states, "Care Plan Formation and Review at Team Meetings ... Interdisciplinary Team review after the Initial admission discussion will take place as needed, or at least every fifteen days thereafter, with updated comprehensive assessments demonstrating the patient's progress toward outcomes determined. Summaries of updates will be written and documented on the hospice IDG Meeting / Care Plan."</p> <p>10. The facility policy titled "Clinical Records" revision date 12/12 stated, "KDG Home and Hospice clinical records contain the following: ... Updated comprehensive assessments."</p> <p>11. On 8/19/14 at 10 AM, employee G indicated the updated plan of care was based on the most recent skilled nurse visit prior to the IDG meeting.</p> <p>418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT Based on document review and interview, it was determined the hospice</p>	L000559	This condition deficiency has been corrected. The plan of correction for the level citations	09/10/2014

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	<p>failed to maintain compliance with the quality assessment and performance improvement requirements.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice failed to ensure it had developed, implemented, and maintained an effective, on - going, hospice -wide data driven quality assessment and performance improvement (QAPI) program in 1 of 1 hospice reviewed. (See L 560). 2. The hospice failed to ensure the QAPI program showed measurable improvement in indicators for 1 of 1 hospice program reviewed. (See L 561). 3. The hospice failed to ensure the QAPI analyzed quality indicators and included adverse patient events for 1 of 1 hospice program reviewed. (See L 562). 4. The hospice failed to ensure it had a QAPI in place that used patient care and other relevant quality indicators in 1 of 1 hospice reviewed. (See L 563) 5. The hospice failed to ensure it had a QAPI in place that monitored the safety and effectiveness of patient care activities and identified opportunities and priorities for improvement in 1 of 1 hospice 		attached to this condition will ensure that these problems have been resolved and will not recur.		

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	<p>reviewed. (See L 564).</p> <p>6. The hospice failed to ensure it had developed, implemented, and maintained an effective, ongoing, hospice-wide data-driven QAPI approved by the hospice's governing body in 1 of 1 hospice reviewed. (See L 565)</p> <p>7. The hospice failed to ensure it had a QAPI in place that focused on high risk, high volume, or problem-prone areas in 1 of 1 hospice reviewed. (See L 566)</p> <p>8. The hospice failed to ensure the QAPI activities considered incidence, prevalence, and severity of high risk, high volume, or problem prone areas in 1 of 1 hospice reviewed with the potential to affect all hospice patients. (See L 567)</p> <p>9. The hospice failed to ensure the QAPI activities affected palliative outcomes, patient safety, and quality of care in 1 of 1 hospice reviewed. (See L 568)</p> <p>9. The hospice failed to ensure the QAPI tracked adverse events, analyzed their causes, and implemented preventative actions and mechanisms that included feedback and learning throughout the hospice in 1 of 1 hospice reviewed. (See L 569)</p>			

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	<p>10. The the hospice failed to ensure the QAPI included taking actions for improvement and implementing those actions to ensure improvements are sustained in 1 of 1 hospice reviewed. (See L 570).</p> <p>11. The hospice failed to ensure the QAPI program evaluated performance improvement projects in 1 of 1 hospice reviewed. (See L 571).</p> <p>12. The hospice failed to document the reason for conducting the QAPI projects and the measurable progress achieved on these projects in 1 of 1 hospice reviewed with the potential to affect all hospice patients. (See L 573).</p> <p>13. The hospice failed to ensure the governing body evaluated the QAPI program annually in 1 of 1 hospice reviewed with the potential to affect all hospice patients. (See L 574).</p> <p>14. The governing body failed to ensure the QAPI program included improvement actions, and they were evaluated for effectiveness in 1 of 1 hospice reviewed. (See L 575).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this</p>						

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L000560	<p>Condition of Participation 418.58 Quality Assessment and Performance Improvement.</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> <p>Based on administrative record and policy review and interview, the hospice failed to ensure it had developed, implemented, and maintained an effective, on - going, hospice -wide data driven quality assessment and performance improvement (QAPI) program in 1 of 1 hospice reviewed.</p> <p>The findings include</p> <p>1. The hospice failed to provide evidence</p>	L000560	This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every	09/10/2014

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	<p>a quality assessment and performance improvement program was in place that evaluated quality initiatives, involved all hospice services, and focused on indicators related to improved palliative outcomes and took actions to demonstrate improvement in hospice performance.</p> <p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p>		<p>patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data</p>				

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	<p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <p>1.) The average minutes spent completing the HH [home health] plan of treatment.</p> <p>2.) The average days to completion of home health plan of treatment.</p> <p>3.) Hospice patient pain admission assessment</p> <p>4.) Hospice patient 48 hour pain assessment.</p> <p>5.) Hospice bereavement program.</p> <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date</p>		<p>elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.</p>		

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L000561	<p>12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p> <p>418.58(a)(1) PROGRAM SCOPE (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.</p> <p>Based on document and policy review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program showed measurable improvement in indicators for 1 of 1</p>	L000561	This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI	09/10/2014			

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	<p>hospice program reviewed.</p> <p>The findings include</p> <p>1. The hospice failed to provide evidence a quality assessment and performance improvement program was in place that evaluated quality initiatives, involved all hospice services, and focused on indicators related to improved palliative outcomes and took actions to demonstrate improvement in hospice performance.</p> <p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p>		<p>attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in</p>		

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	<p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <p>1.) The average minutes spent completing the HH [home health] plan of treatment.</p> <p>2.) The average days to completion of home health plan of treatment.</p> <p>3.) Hospice patient pain admission assessment</p> <p>4.) Hospice patient 48 hour pain assessment.</p> <p>5.) Hospice bereavement program.</p> <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence</p>		<p>Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.</p>		

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L000562	<p>improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p> <p>418.58(a)(2) PROGRAM SCOPE (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.</p>	L000562	This deficiency was reviewed with all staff on 9/10/14. KDH Hospice	09/10/2014			

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	<p>Based on document and policy review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program analyzed quality indicators and included adverse patient events for 1 of 1 hospice program reviewed.</p> <p>The findings include</p> <p>1. The hospice was unable to provide evidence of a quality assessment and performance improvement program in place that analyzed quality indicators and included adverse patient events.</p> <p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their</p>		<p>revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to</p>				

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	<p>pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <p>1.) The average minutes spent completing the HH [home health] plan of treatment.</p> <p>2.) The average days to completion of home health plan of treatment.</p> <p>3.) Hospice patient pain admission assessment</p> <p>4.) Hospice patient 48 hour pain assessment.</p> <p>5.) Hospice bereavement program.</p> <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the</p>		<p>the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.</p>				

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L000563	<p>hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p> <p>418.58(b)(1) PROGRAM DATA (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.</p> <p>Based on administrative document and</p>	L000563	This deficiency was reviewed with all staff on 9/10/14. KDH Hospice	09/10/2014			

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	<p>policy review and interview, the hospice failed to ensure it had a quality assessment/performance improvement program in place that used patient care and other relevant quality indicators in 1 of 1 hospice reviewed.</p> <p>The findings include:</p> <p>1. The hospice failed to provide evidence a quality assessment and performance improvement program was in place that evaluated quality initiatives, involved all hospice services, and focused on indicators related to improved palliative outcomes and took actions to demonstrate improvement in hospice performance.</p> <p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at</p>		<p>revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to</p>		

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	<p>admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <p>1.) The average minutes spent completing the HH [home health] plan of treatment.</p> <p>2.) The average days to completion of home health plan of treatment.</p> <p>3.) Hospice patient pain admission assessment</p> <p>4.) Hospice patient 48 hour pain assessment.</p> <p>5.) Hospice bereavement program.</p> <p>There was no evidence of data collected or any evaluation process for the items</p>		<p>the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.</p>		

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L000564	<p>listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p> <p>418.58(b)(2) PROGRAM DATA (2) The hospice must use the data collected to do the following: (i) Monitor the effectiveness and safety of services and quality of care.</p>			

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	<p>(ii) Identify opportunities and priorities for improvement.</p> <p>Based on administrative document and policy review and interview, the hospice failed to ensure it had a quality assessment / performance improvement program in place that monitored the safety and effectiveness of patient care activities and identified opportunities and priorities for improvement in 1 of 1 hospice reviewed.</p> <p>The findings include</p> <p>1. The hospice failed to provide evidence a quality assessment and performance improvement program was in place that monitored the safety and effectiveness of patient care activities and identified opportunities and priorities for improvement.</p> <p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated</p>	L000564	<p>This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and</p>	09/10/2014			

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	<p>timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <p>1.) The average minutes spent completing the HH [home health] plan of treatment.</p> <p>2.) The average days to completion of home health plan of treatment.</p> <p>3.) Hospice patient pain admission assessment</p> <p>4.) Hospice patient 48 hour pain assessment.</p>		<p>effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will</p>		

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L000565	<p>5.) Hospice bereavement program.</p> <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p>		assist in collecting data.		

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	<p>PROGRAM DATA</p> <p>(3) The frequency and detail of the data collection must be approved by the hospice's governing body.</p> <p>Based on administrative document and policy review and interview, the hospice failed to ensure it had developed, implemented, and maintained an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program approved by the hospice's governing body in 1 of 1 hospice reviewed.</p> <p>The findings include</p> <p>1. The hospice quality assessment and performance improvement program failed to evidence the program focused on high risk, high volume, or problem prone areas; involved all hospice services; focused on indicators related to improved palliative outcomes; and took actions to demonstrate improvement in hospice performance.</p> <p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection</p>	L000565	<p>This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of</p>	09/10/2014	

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	<p>control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <p>1.) The average minutes spent completing the HH [home health] plan of treatment.</p> <p>2.) The average days to completion of home health plan of treatment.</p> <p>3.) Hospice patient pain admission assessment</p>		<p>adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for</p>		

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	<p>4.) Hospice patient 48 hour pain assessment.</p> <p>5.) Hospice bereavement program.</p> <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p>		analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.		

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L000566	<p>418.58(c)(1)(i) PROGRAM ACTIVITIES (1) The hospice's performance improvement activities must: (i) Focus on high risk, high volume, or problem-prone areas.</p> <p>Based on administrative document and policy review and interview, the hospice failed to ensure it had a performance improvement program in place that focused on high risk, high volume, or problem-prone areas in 1 of 1 hospice reviewed.</p> <p>The findings include</p> <p>1. The hospice failed to provide evidence a quality assessment and performance improvement program was in place that evaluated quality initiatives, involved all hospice services, and focused on indicators related to improved palliative outcomes and took actions to demonstrate improvement in hospice performance.</p> <p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p>	L000566	<p>This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements,</p>	09/10/2014

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	<p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <p>1.) The average minutes spent completing the HH [home health] plan of treatment.</p> <p>2.) The average days to completion of home health plan of treatment.</p>		<p>identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis,</p>		

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	<p>3.) Hospice patient pain admission assessment</p> <p>4.) Hospice patient 48 hour pain assessment.</p> <p>5.) Hospice bereavement program.</p> <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone,</p>		with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.				

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L000567	<p>Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p> <p>418.58(c)(1)(ii) PROGRAM ACTIVITIES [The hospice's performance improvement activities must:] (ii) Consider incidence, prevalence, and severity of problems in those areas.</p> <p>Based on document and policy review and interview, the hospice failed to ensure the quality assessment and performance improvement program activities considered incidence, prevalence, and severity of high risk, high volume, or problem prone areas for 1 of 1 hospice reviewed with the potential to affect all hospice patients.</p> <p>The findings include:</p> <p>1. The hospice failed to provide evidence a quality assessment and performance improvement program was in place that evaluated quality initiatives, involved all hospice services, and focused on indicators related to improved palliative outcomes and took actions to demonstrate improvement in hospice performance.</p>	L000567	<p>This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for</p>	09/10/2014

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	<p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <p>1.) The average minutes spent completing the HH [home health] plan of</p>		<p>each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will</p>		

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	<p>treatment.</p> <p>2.) The average days to completion of home health plan of treatment.</p> <p>3.) Hospice patient pain admission assessment</p> <p>4.) Hospice patient 48 hour pain assessment.</p> <p>5.) Hospice bereavement program.</p> <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure</p>		<p>implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.</p>		

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L000568	<p>compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p> <p>418.58(c)(1)(iii) PROGRAM ACTIVITIES [The hospice's performance improvement activities must:] (iii) Affect palliative outcomes, patient safety, and quality of care.</p> <p>Based on document and policy review and interview, the hospice failed to ensure the quality assessment and performance improvement program activities affected palliative outcomes, patient safety, and quality of care for 1 of 1 hospice reviewed.</p> <p>The findings include</p> <p>1. The hospice failed to provide evidence of a quality assessment and performance that evidenced activities affected palliative outcomes, patient safety, and quality of care .</p> <p>A. The quality assurance projects or</p>	L000568	<p>This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method.</p>	09/10/2014

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	<p>initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <p>1.) The average minutes spent completing the HH [home health] plan of treatment.</p>		<p>The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is</p>		

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	<p>2.) The average days to completion of home health plan of treatment.</p> <p>3.) Hospice patient pain admission assessment</p> <p>4.) Hospice patient 48 hour pain assessment.</p> <p>5.) Hospice bereavement program.</p> <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality</p>		<p>improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.</p>	

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L000569	<p>requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p> <p>418.58(c)(2) PROGRAM ACTIVITIES (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.</p> <p>Based on document and policy review and interview, the hospice failed to ensure the quality assessment and performance improvement activities tracked adverse events, analyzed their causes, and implemented preventative actions and mechanisms that included feedback and learning throughout the hospice for 1 of 1 hospice reviewed.</p> <p>The findings include</p> <p>1. The hospice failed to provide evidence a quality assessment and performance improvement program was in place that tracked adverse events, analyzed their causes, and implemented preventative</p>	L000569	<p>This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method.</p>	09/10/2014

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	<p>actions and mechanisms that included feedback and learning throughout the hospice.</p> <p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and</p>		<p>The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is</p>		

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	<p>operated at the same location, included:</p> <ol style="list-style-type: none"> 1.) The average minutes spent completing the HH [home health] plan of treatment. 2.) The average days to completion of home health plan of treatment. 3.) Hospice patient pain admission assessment 4.) Hospice patient 48 hour pain assessment. 5.) Hospice bereavement program. <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the</p>		<p>improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.</p>	

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L000570	<p>home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p> <p>418.58(c)(3) PROGRAM ACTIVITIES (3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.</p> <p>Based on document and policy review and interview, the hospice failed to ensure the quality assessment and performance improvement program included taking actions for improvement and implementing those actions to ensure improvements are sustained for 1 of 1 hospice reviewed.</p> <p>Findings:</p>	L000570	This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are	09/10/2014

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	<p>1. The hospice failed to provide evidence a quality assessment and performance improvement program was in place that evaluated quality initiatives, involved all hospice services, and focused on indicators related to improved palliative outcomes and took actions to demonstrate improvement in hospice performance.</p> <p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will</p>		<p>being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts</p>		

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	<p>improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for 2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <ol style="list-style-type: none"> 1.) The average minutes spent completing the HH [home health] plan of treatment. 2.) The average days to completion of home health plan of treatment. 3.) Hospice patient pain admission assessment 4.) Hospice patient 48 hour pain assessment. 5.) Hospice bereavement program. <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care</p>		<p>will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.</p>				

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L000571	<p>& Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p> <p>418.58(d) PERFORMANCE IMPROVEMENT PROJECTS Beginning February 2, 2009, hospices must develop, implement and evaluate performance improvement projects.</p> <p>Based on document and policy review and interview, the hospice failed to ensure the quality assessment and performance improvement program evaluated performance improvement projects for 1 of 1 hospice reviewed.</p>	L000571	This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been	09/10/2014

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	<p>The findings include:</p> <p>1. The hospice failed to provide evidence a quality assessment and performance improvement program was in place that evaluated quality improvement projects.</p> <p>A. The quality assurance projects or initiatives listed for 2014 were in combined with the home health agency of the same name and operated at the same location included:</p> <p>1.) observation of staff during home visits for the evaluation of infection control practices.</p> <p>2.) Ensure medications were updated timely at the time a change occurs.</p> <p>3.) 100 % of patient's to have a pain assessment and documented at admission.</p> <p>4.) 100 % of patients to have their pain reassessed and documented 48 hours after admission.</p> <p>5.) HH [home health] CHAPS scores in specific care issues will improve by 25 %.</p> <p>B. The quality assurance projects or initiatives listed "2nd qtr [quarter] for</p>		<p>educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance.</p>		

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	<p>2013 [The date of the 2nd quarter was not identified.], combined with the home health agency of the same name and operated at the same location, included:</p> <ol style="list-style-type: none"> 1.) The average minutes spent completing the HH [home health] plan of treatment. 2.) The average days to completion of home health plan of treatment. 3.) Hospice patient pain admission assessment 4.) Hospice patient 48 hour pain assessment. 5.) Hospice bereavement program. <p>There was no evidence of data collected or any evaluation process for the items listed.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the</p>		<p>Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.</p>		

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L000574	<p>responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p> <p>418.58(e)(1) EXECUTIVE RESPONSIBILITIES The hospice's governing body is responsible for ensuring the following: (1)That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.</p> <p>Based on document and policy review and interview, the hospice failed to ensure the governing body evaluated the quality assessment and performance improvement (QAPI) program annually for 1 of 1 hospice reviewed with the potential to affect all hospice patients.</p> <p>Findings:</p>	L000574	This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that	09/10/2014

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	<p>1. Review of the hospice's QAPI program failed to evidence the governing body evaluated the QAPI program annually.</p> <p>2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance.</p> <p>3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."</p>		<p>appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice</p>		

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L000575	<p>418.58(e)(2) EXECUTIVE RESPONSIBILITIES [The hospice's governing body is responsible for ensuring the following:] (2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.</p> <p>Based on document and policy review and interview, the governing body failed</p>	L000575	<p>survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.</p> <p>This deficiency was reviewed with all staff on 9/10/14. KDH Hospice revised the QAPI program so that</p>	09/10/2014	

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	<p>to ensure the quality assessment and performance improvement (QAPI) program included improvement actions, and they were evaluated for effectiveness for 1 of 1 hospice reviewed with the potential to affect all hospice patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the hospice's documents failed to evidence the governing body ensured the QAPI program included improvement actions, and they were evaluated for effectiveness. 2. On 8/19/14 at 3 PM, employee H, the hospice director, indicated there was no further documentation to evidence improvement in the hospice performance. 3. The facility policy titled "Home Care & Hospice Services Performance Improvement Program" revision date 12/12 stated, "The director of home care and hospice services has the responsibility for the administration of the performance improvement program. ... Oversees the overall activities of the home care and hospice performance improvement program, ... for accurate data collection and performance improvement activities. ... Ensure compliance with performance / quality requirements of medicare, Indiana State 		<p>it is Hospice-wide and data driven. Quality initiatives will be evaluated, involve all hospice services, and focus on indicators related to improved palliative outcomes. (See QAPI attachments D). Staff has been educated on the revised QAPI plan in order to facilitate their documentation efforts that appropriate data elements are being documented on for every patient. The methodology used for performance improvement activities will be AIM, which stands for Analyze problems, Implement changes, and Monitor improvements. This is the KDH organizational approved method. The current PI projects are improving medication assessment on admission, and restructure of IDG to include the Hospice chaplain completing the initial spiritual assessment for each patient. The data collected on each item will be analyzed on a quarterly basis to show measurable improvements, identify areas that need further monitoring, and performance improvement opportunities. The revised QAPI program includes data element monitoring, process improvements, tracking of adverse patient events, and monitoring of safety and effectiveness of patient care with a focus on high risk, high volume, and problem prone areas. The QAPI updates will be submitted to the governing body on an at least</p>		

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L000686	Department of Health. ... Identifies patient populations that are high volume, high risk, or problem prone, Identifies patient care and operational processes that will be monitored on a routine and / or periodic basis."	L000686	annual basis for approval, review, and evaluation. This program will affect palliative outcomes and quality of patient care provided. Hospice will take actions to demonstrate improvement in Hospice performance. Performance improvement projects have been started as a direct result of the Hospice survey. 100% of Hospice charts will be audited for the QAPI data elements on the plan. All staff is involved in collection of data, results of analysis of data, and development/identification of new QAPI processes needed for Hospice. The data will be analyzed to determine if there is improvement in the outcome. If improvement is found, Hospice will continue to monitor if necessary. If no improvement/decline is found in the data analysis, Hospice will implement process improvement efforts to ensure improvement in outcome. QAPI data will be analyzed on a quarterly basis, with an at least annual report to the governing body. Minutes from the governing body meetings will be obtained for record of program evaluation and approval. The Director will be responsible for analysis of the data on a quarterly basis. The Hospice staff will assist in collecting data.	09/10/2014

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	Based on clinical record and agency policy review, interview, and observation, it was determined the agency failed to maintain compliance with this condition by failing to ensure that the skilled nurse recorded and signed verbal orders immediately and had the prescriber sign in accordance with state and federal regulations in 1 of 11 records reviewed creating the potential to affect all of the agency's 9 active patients (see L 690); failing to determine the ability of the patient or caregiver to self administer drugs in the home for 3 of 11 records reviewed with the potential to affect all of the agency's patients (see L 692); failing to discuss the hospice policies and procedures for safely managing, using and disposing of controlled drugs with the patient or caregiver in a manner they understood to ensure that they were educated regarding the safe use of controlled drugs for 3 of 9 clinical records reviewed with the potential to affect all of the agency's patients using controlled drugs (see L 696) failing to document in the patient's record that the written policies and procedures for managing controlled drugs was provided and discussed for 3 of 9 records reviewed with the potential to affect all of the agency's patients using controlled drugs (see L 697).		been corrected. The plan of correction for the level citations attached to this condition will ensure that these problems have been resolved and will not recur.		

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L000690	<p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation, 42 CFR 418.106 Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment.</p> <p>418.106(b) ORDERING OF DRUGS (1) Only a physician as defined by section 1861(r)(1) of the Act, or a nurse practitioner in accordance with the plan of care and State law, may order drugs for the patient. (2) If the drug order is verbal or given by or through electronic transmission- (i) It must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist, or physician; and (ii) The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with State and Federal regulations.</p>	L000690	Reviewed this deficiency with all staff on 9/10/14. All drug orders	09/10/2014
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	<p>Based on clinical record review and interview, the hospice failed to record and immediately sign verbal orders for medication from the physician for 1 (#7) of 9 clinical records reviewed creating the potential to affect all of the agency's 9 active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 7 includes an initial comprehensive assessment completed by the RN registered nurse on 8/9/2014. The medication profile, dated 8/11, lists "Ms [morphine sulfate] nebs." The record failed to include a verbal order written by the skilled nurse which identified the dose, volume, and concentration of morphine solution for inhalation that was ordered by the physician. 2. Skilled nursing visit notes dated 8/11/2014 and 8/13/2014 document that morphine sulfate nebulizer's are being used by the patient and the nurse prefills syringes with morphine solution to be left in the refrigeration to be used at a later time. The record failed to include an order for morphine sulfate. 3. Employee T, registered nurse (RN) on 8/21/2014 at 310 PM indicated the 		<p>will be recorded and signed immediately. The prescribing person will also sign the order in accordance with the State and Federal regulations. All medication orders will identify the patient, dose, volume, route, and frequency. All medications provided to the patient by Hospice will be taught to the patient/caregiver. Staff was also reminded of the appropriate documentation on medication orders on 9/10/14. Current Hospice patient's medications have been audited to ensure appropriate orders were written with all components identified (dose, volume, route, and frequency) as of 9/10/14. 100% of medication orders on the Plan of Care are audited by the Hospice Coordinator. This audit will include ensuring that all components of the medication order are included in the order (dose, volume, route, and frequency). The Director is responsible for ensuring that medication orders are audited for all components.</p>		

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L000692	<p>medical director had given a verbal order for this medication then hand delivered the prescription to the dispensing pharmacy. The RN did not write an order and stated that she "prefilled the medication syringes using the instructions written on the medication bag dispensed by pharmacy."</p> <p>418.106(d) ADMINISTRATION OF DRUGS AND BIOLOGICALS (1) The interdisciplinary group, as part of the review of the plan of care, must determine the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in his or her home. (2) Patients receiving care in a hospice that provides inpatient care directly in its own facility may only be administered medications by the following individuals: (i) A licensed nurse, physician, or other health care professional in accordance with their scope of practice and State law; (ii) An employee who has completed a State-approved training program in medication administration; and (iii) The patient, upon approval by the interdisciplinary group. Based on clinical record and policy review, interview, and observation, the IDG (interdisciplinary group) failed to review the plan of care and determine the ability of the patient and family to safely</p>	L000692	Reviewed this deficiency with all staff on 9/10/14. The IDG determines , as a part of the plan of care review/update, the ability of the patient/caregiver to safely administer medications in the home. At every IDG meeting, the	09/10/2014

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	<p>administer drugs to the patient in the home for 2 (#1 and #7) of 9 records reviewed with the potential to affect all of the agency's patients.</p> <p>Findings:</p> <p>1. Employee K, a registered nurse (RN), completed an initial admission assessment for patient #1. The nurse reviewed the list of medications provided by the hospital discharge packet but failed to compare this with the bottles of medication in the patient's home. The skilled nurse failed to evaluate the caregiver's knowledge of the patient's medication regimen and ability to safely administer medications to the patient. The record failed to evidence the nurse conferred with the IDG to discuss the patient / caregivers ability to safely administer medications.</p> <p>A comfort kit including ativan 1 milligram and Roxanol (liquid morphine concentrate) 20 milligrams per milliliter was provided to patient #1. The nurse failed to provide instructions and evaluate the caregiver's understanding of when and how to administer medications from the comfort kit.</p> <p>2. Clinical record #7 included a comprehensive assessment completed on</p>		<p>ability of the patient/ caregiver to safely administer drugs in the home will be assessed. The facilitator of IDG (Director, Coordinator, Intake Coordinator) is responsible to ensure that medication safety is discussed each meeting for each patient.</p>		

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L000696	<p>8/9/2014. The assessment indicated the skilled nurse would set up medication planner boxes weekly and it was the patient's responsibility for nebulized morphine sulfate and all other inhalation treatments. A note completed by the skilled nurse dated 8/11 states " skilled nurse is going to set up med box weekly for patient ... Pt [patient] is getting more confused with medication and this would be easier for [patient]." The record failed to evidence the IDG was notified to discuss the patient's ability to administer medication.</p> <p>3. An agency policy dated 12/89 and updated 12/11 titled #300 Care Planning and Coordination of Services states, "Communication among the IDG members regarding the establishment of the plan of care will be evidenced in the medical record."</p> <p>418.106(e)(2)(i)(B) LABEL DISPOSE STORAGE DRUGS [At the time when controlled drugs are first ordered the hospice must:] (B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand</p>				

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	<p>to ensure that these parties are educated regarding the safe use and disposal of controlled drugs;</p> <p>Based clinical record and agency policy review, the hospice failed to ensure the written policies and procedures for managing controlled drugs was provided in 3 (#1, 2, 4) of 9 clinical records reviewed with the potential to affect all of the agency's patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> Employee K, a registered nurse, reviewed the list of medications provided by the hospital discharge packet but failed to compare this with the bottles of medication in the patients home. A comfort kit including ativan 1 milligram and Roxanol (liquid morphine concentrate) 20 milligrams per milliliter was provided to the patient. The record failed to evidence the skilled nurse provided teaching during the admission visit about the agency policy for managing controlled drugs. Clinical record number 7 included a comprehensive assessment completed on 8/9/2014. The medication profile lists Morphine Sulfate Nebulizer, ativan 1 milligram and Roxanol 20 milligrams per milliliter. The record failed to evidence the nurse provided written policies and 	L000696	<p>This deficiency was reviewed with all staff on 9/10/14. The staff discusses with each patient, the policies for managing the safe use and disposal of all drugs (including controlled drugs) with the patient/caregiver. (Attachment E, I, J) Copies of these policies are also provided for the patient to review in the admission folder. The education provided by the RN will be documented in the visit note. 100% of all Hospice admits for one month, then 2 admits per month for 6 months will be supervised to observe the RN reviewing these policies with the patient/caregiver during admission visit. The visits will be supervised by either the director, coordinator, or intake coordinator. The Director will be responsible for ensuring that these supervisory visits are completed.</p>	09/10/2014

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L000697	<p>procedures for managing and disposing of the controlled drugs.</p> <p>3. Clinical record number 4 included a comprehensive assessment completed on 7/4/2014. The medication profile lists fentanyl 25 micrograms, morphine 15 milligram immediate release tablets, and ativan 1 milligram oral tablets The record failed to evidence the nurse provided written policies and procedures for managing, using, and disposing of the controlled drugs.</p> <p>4. An agency policy #400, dated 12/89 revised 10/13, titled "Patient and Family Education" states, "The agency provides and supports patient and family education that is based on the patients needs...The KDH [Kings Daughter Hospice] clinical records contain the following ... Drug and dietary restriction orders."</p> <p>418.106(e)(2)(i)(C) LABEL DISPOSE STORAGE DRUGS [At the time when controlled drugs are first ordered the hospice must:] (C) Document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed.</p>						

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	<p>Based clinical record and agency policy review, the hospice failed to document in the patient's clinical record the written policies and procedures for managing controlled drugs was provided in 3 (#1, 2, 4) of 9 clinical records reviewed with the potential to affect all of the agency's patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Employee K, a registered nurse, reviewed the list of medications provided by the hospital discharge packet but failed to compare this with the bottles of medication in the patients home. A comfort kit including ativan 1 milligram and Roxanol (liquid morphine concentrate) 20 milligrams per milliliter was provided to the patient. The record failed to evidence the skilled nurse provided teaching during the admission visit about the agency policy for managing controlled drugs. 2. Clinical record number 7 included a comprehensive assessment completed on 8/9/2014. The medication profile lists Morphine Sulfate Nebulizer, ativan 1 milligram and Roxanol 20 milligrams per milliliter. The record failed to evidence the nurse provided written policies and procedures for managing and disposing of the controlled drugs. 	L000697	<p>This deficiency was reviewed with all staff on 9/10/14. The staff discusses with each patient, the policies for managing the safe use and disposal of all drugs (including controlled drugs) with the patient/caregiver. (Attachment E, I, J) Copies of these policies are also provided for the patient to review in the admission folder. The education provided by the RN will be documented in the visit note. 100% of all Hospice admits for one month, then 2 admits per month for 6 months will be supervised to observe the RN reviewing these policies with the patient/caregiver during admission visit. The visits will be supervised by either the director, coordinator, or intake coordinator. The Director will be responsible for ensuring that these supervisory visits are completed.</p>	09/10/2014			

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NAME OF PROVIDER OR SUPPLIER KING'S DAUGHTERS' HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2670 MICHIGAN RD MADISON, IN 47250
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. Clinical record number 4 included a comprehensive assessment completed on 7/4/2014. The medication profile lists fentanyl 25 micrograms, morphine 15 milligram immediate release tablets, and ativan 1 milligram oral tablets The record failed to evidence the nurse provided written policies and procedures for managing, using, and disposing of the controlled drugs.</p> <p>4. An agency policy #400, dated 12/89 revised 10/13, titled "Patient and Family Education" states, "The agency provides and supports patient and family education that is based on the patients needs...The KDH [Kings Daughter Hospice] clinical records contain the following ... Drug and dietary restriction orders."</p>			