

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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
L 0000  Bldg. 00	<p>This was a hospice Federal recertification and State re-licensure survey.</p> <p>Survey Dates: 11-17-15, 11-18-15, 11-19-15, and 11-20-15</p> <p>Facility #: 004208</p> <p>Medicare Provider #: 15-1589</p> <p>Medicaid Vendor #: 200513260</p> <p>Census: 15 home patients 29 skilled nursing facility residents 44 total</p> <p>Sample: 3 records reviewed with home visits 10 records reviewed without home visits 13 total records reviewed, 3 total home visits</p>	L 0000	This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence/credible allegation of compliance. The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
L 0543  Bldg. 00	<p>418.56(b) PLAN OF CARE</p> <p>All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or</p>			

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.</p> <p>Based on record review and interview, the hospice failed to ensure services had been provided in accordance with the written plan of care in 6 (#s 4, 5, 6, 7, 10, and 11) of 13 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 4 included an update to the plan of care dated 9-30-15. The update evidenced orders for skilled nurse (SN) services 2 times per week. <ul style="list-style-type: none"> <li>A. The record evidenced only 1 SN visit had been provided the week of 10-11-15.</li> <li>B. The Director of Clinical Services indicated, on 11-19-15 at 10:55 AM, only 1 visit had been made the week of 10-11-15. The director stated, "There was a missed visit."</li> </ul> </li> <li>Clinical record number 5 included an update to the plan of care dated 10-21-15. The update evidenced orders for SN services 2 times per week. <ul style="list-style-type: none"> <li>A. The record evidenced only 1 SN visit had been provided the week of 10-25-15.</li> </ul> </li> </ol>	L 0543	<p>To correct the deficiency, the Hospice Clinical Director and Administrator instituted a new electronic process for scheduling to ensure services have been provided in accordance with the written plan of care. Inservice will be provided to clinical staff on 12/28/15. The Hospice Clinical Director and Administrator will be responsible for monitoring the effectiveness of the new process. Bi-weekly audits of 20% of live patients will be completed for 2 months or longer until 90% compliance is met. To maintain compliance a focus audit will be added to QA quarterly for one year. The Hospice Clinical Director will be responsible to ensure that the plan is followed so that the deficiency is corrected and will not recur.</p>	12/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>B. The Director of Clinical Services stated, on 11-19-15 at 2:55 AM, "The second visit was not made that week."</p> <p>3. Clinical record number 6 included an update to the plan of care dated 9-30-15. The update evidenced orders for home health aide services 2 times per week.</p> <p>A. The record evidenced only 1 home health aide visit had been provided the week of 10-11-15.</p> <p>B. The Director of Clinical Services indicated, on 11-19-15 at 3:40 PM, only 1 home health aide visit had been provided the week of 10-11-15.</p> <p>4. Clinical record number 7 included an update to the plan of care dated 10-7-15 that evidenced orders for home health aide services 2 times per week.</p> <p>A. The record evidenced only 1 home health aide visit had been provided the week of 10-11-15.</p> <p>B. The Director of Clinical Services indicated, on 11-20-15 at 9:45 AM, home health aide visits had not been provided as ordered.</p> <p>5. Clinical record number 10 included an</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>update to the plan of care dated 10-14-15. The update evidenced orders for SN services 2 times per week.</p> <p>A. The record failed to evidence any SN visits had been provided the week of 10-25-15.</p> <p>B. The Director of Clinical Services indicated, on 11-20-15 at 1:00 PM, SN visits had not been provided as ordered.</p> <p>6. Clinical record number 11 included an update to the plan of care dated 10-28-15. The update evidenced orders for volunteer services 1 time per week.</p> <p>A. The record failed to evidenced any volunteer services had been provided the weeks of 11-1-15 or 11-8-15.</p> <p>B. The Volunteer Coordinator stated, on 11-20-15 at 1:20 PM, "I didn't have a volunteer for [the patient]. I went myself some of the time. I do not know why I did not go every week."</p> <p>7. The hospice's 2-2-12 "Plan of Care" policy number PC.P40 states, "Hospice care and services provided to patients and their families are in accordance with an individualized, written plan of care established by the hospice IDG [interdisciplinary group] in collaboration</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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
L 0545 Bldg. 00	<p>with the patient's attending physician (if any), and, if appropriate, the patient or representative or primary caregiver."</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 record review and interview, the hospice failed to ensure plans of care addressed all problems identified in the initial comprehensive assessments in 9 (#s 1, 3, 5, 6, 7, 9, 10, 12, and 13) of 13 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the interdisciplinary team (IDT) on 9-3-15. The plan of care failed to address problems identified in the initial comprehensive assessment dated 9-3-15.</p> <p>A. The initial comprehensive assessment identified the patient was both "continent" and "incontinent" of bowel and bladder "often." The plan of</p>	L 0545	To correct the deficiency, the Hospice Clinical Director will review hospice policy "Plan of Care-Content" and provide education to all staff by 12/28/15 to ensure that all problems identified in the initial comprehensive assessment are addressed in the written plan of care. Deficient charts will be corrected by 12/30/15. A focus audit of 20% of charts will be done quarterly x 2 quarters, or until 90% compliance is attained, and then will be monitored for 1 year with comprehensive chart audits to ensure improvement is sustained. The Clinical Director will be responsible to ensure that the plan is followed so that the deficiency is corrected and will not recur.	12/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>care failed to evidence interventions to address the episodes of bowel and bladder incontinence.</p> <p>B. The initial comprehensive assessment identified the patient had "generalized itching . . . takes Benadryl prn [as needed]" The plan of care failed to evidence interventions to address the itching or potential problems related to the itching other than the Benadryl listed on the medication list.</p> <p>C. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 11-18-15 at 8:55 AM.</p> <p>2. Clinical record number 3 included a plan of care established by the IDT on 10-23-15. The plan of care failed to address problems identified in the initial comprehensive assessment dated 10-23-15.</p> <p>A. The initial comprehensive assessment identified the patient was incontinent of bowel "every 2-3 days" and had urinary incontinence. The plan of care failed to evidence interventions to address the bowel and bladder incontinence.</p> <p>B. The Director of Clinical Services</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>was unable to provide any additional documentation and/or information when asked on 11-19-15 at 8:30 AM.</p> <p>3. Clinical record number 5 included a plan of care established by the IDT on 8-27-15. The plan of care failed to address problems identified in the initial comprehensive assessment dated 8-27-15.</p> <p>A. The initial comprehensive assessment identified the patient had "recent incont [incontinence] of stool and "occasional" urinary incontinence. The plan of care failed to evidence interventions to address the bowel and bladder incontinence.</p> <p>B. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 11-19-15 at 2:55 PM.</p> <p>4. Clinical record number 6 included a plan of care established by the IDT on 7-28-15. The plan of care failed to address problems identified in the initial comprehensive assessment dated 7-28-15.</p> <p>A. The initial comprehensive assessment identified the patient experienced "daily headaches" and had a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>history of syncope and seizures. The plan of care failed to include interventions to address the headaches and potential syncope and seizures.</p> <p>B. The initial comprehensive assessment identified the patient had occasional bowel incontinence. The plan of care failed to include interventions to address the bowel incontinence. The plan of care identifies the patient experienced "constipation."</p> <p>C. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 11-19-15 at 3:40 PM.</p> <p>5 Clinical record number 7 included a plan of care established by the IDT on 9-28-15. The plan of care failed to address problems identified in the initial comprehensive assessment dated 9-28-15.</p> <p>A. The initial comprehensive assessment identifies the patient experiences "transient vertigo [secondary] to brain radiation present." The plan of care failed to include interventions to address the vertigo.</p> <p>B. The initial comprehensive assessment identifies the patient had been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>"prescribed Bipap [bilevel positive airway pressure machine] at noc [night] d/t [due to] bronchitis collapse [secondary] to tumor growth." The plan of care failed to include interventions related to the use of the Bipap.</p> <p>C. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 11-20-15 at 9:45 AM.</p> <p>6. Clinical record number 9 included a plan of care established by the IDT on 9-25-15. The plan of care failed to address problems identified in the initial comprehensive assessment dated 9-28-15.</p> <p>A. The initial comprehensive assessment identifies the patient experiences anxiety and is "fearful of leaving family, friends." The plan of care failed to include interventions to address the anxiety.</p> <p>B. The initial comprehensive assessment identifies the patient has urinary incontinence. The plan of care failed to include interventions to address the urinary incontinence.</p> <p>C. The initial comprehensive assessment identifies the patient has</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>experienced the recent loss of a parent and sibling. The assessment identifies the spouse "becomes tearful when discussing [the patient's] disease process." The plan of care failed to include interventions to address the identifies psychosocial problems.</p> <p>D. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 11-20-15 at 1:00 PM</p> <p>7. Clinical record number 10 included a plan of care established by the IDT on 9-8-15. The plan of care failed to address problems identified in the initial comprehensive assessment dated 9-8-15.</p> <p>A. The initial comprehensive assessment identifies the patient experienced incontinence of bowel "multiple/day." The plan of care failed to include interventions to address the frequent bowel incontinence.</p> <p>B. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 11-20-15 at 1:00 PM.</p> <p>8. Clinical record number 12 included a plan of care established by the IDT on 10-9-15. The plan of care failed to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>address problems identified in the initial comprehensive assessment dated 10-9-15.</p> <p>A. The initial comprehensive assessment identified the patient was incontinent of bowel and bladder. The plan of care failed to include interventions to address the incontinence.</p> <p>B. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 11-20-15 at 4:05 PM.</p> <p>9. Clinical record number 13 included a plan of care established by the IDT on 10-30-15. The plan of care failed to address problems identified in the initial comprehensive assessment dated 10-30-15.</p> <p>A. The initial comprehensive assessment identified the patient was incontinent of bowel and bladder. The plan of care failed to include interventions to address the incontinence.</p> <p>B. The Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 11-20-15 at 4:05 PM.</p> <p>10. The hospice's 2-2-12 "Plan of Care -</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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
L 0548 Bldg. 00	<p>Content" policy number PC.P45 states, "The plan of care reflects patient and family goals and interventions that are based on the problems identified in the initial, comprehensive, and updated assessments."</p> <p>418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.</p> <p>Based on record review and interview, the hospice failed to ensure plans of care included measurable outcomes in 10 (#s 2, 3, 4, 6, 7, 9, 10, 11, 12, &amp; 13) of 13 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the interdisciplinary team (IDT) on 7-17-15. The plan of care identified "Alteration of mood . . . anxiety" as a problem to be addressed. The plan failed to evidence a measurable outcome for the goal established for the anxiety.</p> <p>2. Clinical record number 3 included a</p>	L 0548	To correct the deficiency, the Hospice Clinical Director provided education to all staff on 12/7/15, regarding appropriate documentation of measurable outcomes for goals. All staff educated to use the data elements from their assessments to determine measurable outcomes as appropriate for symptom management. Deficient charts will be corrected by 12/30/15. A focus audit of 20% of charts will be done quarterly x 2 quarters, or until 90% compliance is attained, and then will be monitored for 1 year with comprehensive chart audits to ensure improvement is sustained. The Clinical Director will be responsible to ensure that the plan is followed so that the	12/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>plan of care established by the IDT on 10-23-15. The plan of care identified "Alteration in mood . . . hx [history] of anxiety." The plan of care failed to evidence a measurable outcome for goal established for the anxiety.</p> <p>3. Clinical record number 4 included a plan of care established by the IDT on 11-5-14. The plan of care identified "Alteration in mood . . . depression" as a problem. The plan of care failed to evidence a measurable outcome for the goal established for the depression.</p> <p>4. Clinical record number 6 included a plan of care established by the IDT on 7-28-15. The plan of care identified "Alteration of mood . . . anxiety" as a problem. The plan of care failed to evidence a measurable outcome for the goal established for the anxiety.</p> <p>5. Clinical record number 7 included a plan of care established by the IDT on 9-28-15. The plan of care identified "Alteration of mood . . . anxiety" as a problem. The plan of care failed to evidence a measurable outcome for the goal established for the anxiety.</p> <p>6. Clinical record number 9 included a plan of care established by the IDT on 9-25-15. The plan of care identified</p>		deficiency is corrected and will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>"Alteration of mood . . . depression . . . anxiety" as a problem. The plan of care failed to evidence a measurable outcome for the goal established for the anxiety and depression.</p> <p>7. Clinical record number 10 included a plan of care established by the IDT on 9-8-15. The plan of care identified "Alteration of mood . . . depression . . . anxiety . . . restlessness" as a problem. The plan of care failed to evidence a measurable outcome for the goal established for the anxiety.</p> <p>8. Clinical record number 11 included a plan of care established by the IDT on 9-2-15. The plan of care identified "Alteration of mood . . . depression" as a problem. The plan of care failed to evidence a measurable outcome for the goal established for the depression.</p> <p>9. Clinical record number 12 included a plan of care established by the IDT on 10-9-15. The plan of care identified "Alteration of mood . . . anxiety . . . restlessness" as a problem. The plan of care failed to evidence a measurable outcome for the goal established for the anxiety and the restlessness.</p> <p>10. Clinical record number 13 included a plan of care established by the IDT on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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
L 0553  Bldg. 00	<p>11-2-15. The plan of care identified "Alteration of mood . . .depression, anxiety, restlessness" as a problem. The plan of care failed to evidence a measurable outcome for the goal established for the depression, anxiety, and restlessness.</p> <p>11. The Director of Clinical Services stated, on 11-18-15 at 8:55 AM, "We use the 1 to 10 scale when possible for pain, anxiety, nausea, shortness of breath, and depression on the plan of care to make our goals measurable." The Director indicated records numbered 2, 3, 4, 6, 7, 9, 10, 11, 12, and 13 did not evidence measurable outcomes for identified goals.</p> <p>12. The hospice's 2-2-12 "Plan of Care - Content" policy number PC.P45 states, "The plan of care includes, but is not limited to: . . . measurable outcomes anticipated from implementing and coordinating the plan of care."</p> <p>418.56(d) REVIEW OF THE PLAN OF CARE A revised plan of care must include information from the patient's updated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.</p> <p>Based on record review and interview, the hospice failed to ensure updates to the plan of care included progress towards outcomes and goals in 11 (#s 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, and 12 ) of 11 records reviewed of patients that had been on service for longer than 4 weeks.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the interdisciplinary team (IDT) on 9-3-15.</p> <p>A. The record included an update to the plan of care dated 9-16-15. The update evidenced alteration in neurological/cognitive status, alteration in genitourinary (GU)/gastrointestinal (GI) status, alteration in respiratory status, alteration in cardiac/circulatory status, alteration in skin integrity, alteration in patient care safety, knowledge deficit, spiritual/existential, and psychosocial status as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to the ongoing problems.</p> <p>B. The record included an update to</p>	L 0553	<p>To correct the deficiency on 12/7/15, the Director of Clinical Services provided education to all clinical staff to ensure that the updates to the plan of care include progress towards outcomes and goals. All staff educated to use the data elements from their assessments as part of the update to the plan of care. The Plan of Care updates will show movement towards the expected outcomes or a revision of the goals. New Forms have been developed. Education to staff and implementation will be completed by 12/28/15. All charts found deficient will be corrected by 12/30/15. A focus audit of 20%of charts will be done quarterly x 2 quarters, or until 90% of all components is attained, and then will be monitored for 1 year with comprehensive chart audits to ensure improvement is sustained. The Clinical Director will be responsible to ensure that the plan is followed so that the deficiency is corrected and will not recur.</p>	12/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>the plan of care dated 9-30-15. The update evidenced alteration in neurological/cognitive status, alteration in GU/GI status, alteration in respiratory status, alteration in cardiac status, alteration in skin integrity, patient care safety, knowledge deficit, spiritual, and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>C. The record included an update to the plan of care dated 10-14-15. The update evidenced alteration in GU/GI status, alteration in respiratory status, alteration in cardiac status, alteration in skin integrity, patient care safety, knowledge deficit, and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>D. The record included an update to the plan of care dated 10-28-15. The update evidenced alteration in neurological/cognitive status, alteration in GU/GI status, alteration in respiratory status, alteration in cardiac status, alteration in skin integrity, patient care safety, knowledge deficit, and volunteer as ongoing problems. The update failed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>E. The record included an update to the plan of care dated 11-11-15. The update evidenced alteration in neurological/cognitive status, alteration in nutrition, alteration in GU/GI status, alteration in respiratory status, alteration in cardiac status, alteration in skin integrity, patient care safety, and knowledge deficit as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>2. Clinical record number 2 included a plan of care established by the IDT on 7-17-15.</p> <p>A. The record included an update to the plan of care dated 10-7-15. The update evidenced alteration in GU/GI status, alteration in cardiac status, alteration in skin integrity, patient care safety and knowledge deficit as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>B. The record included an update to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>the plan of care dated 10-21-15. The update evidenced alteration in neurological/cognitive status, alteration in GU/GI status, alteration in cardiac status, alteration in skin integrity, knowledge deficit, spiritual, and psychosocial as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>C. The record included an update to the plan of care dated 11-4-15. The update evidenced alteration in neurological/cognitive status, alteration in GU/GI status, alteration in respiratory status, alteration in cardiac status, alteration in skin integrity, knowledge deficit, and spiritual as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>3. Clinical record number 4 included a plan of care established by the IDT on 11-5-14.</p> <p>A. The record included an update to the plan of care dated 9-30-15. The update evidenced alteration in nutrition, alteration in GU/GI status, patient care safety, knowledge deficit, and spiritual as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>B. The record included an update to the plan of care dated 10-14-15. The update evidenced alteration in functional status, alteration in neurological/cognitive status, alteration in GU/GI alteration in skin integrity, patient care safety, knowledge deficit, spiritual, and psychosocial as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>C. The record included an update to the plan of care dated 10-28-15. The update identified alteration in comfort, neurological status, GU/GI status, skin integrity, patient care safety, and knowledge deficit as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>4. Clinical record number 5 included a plan of care established by the IDT on 8-26-15.</p> <p>A. The record included an update to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>the plan of care dated 10-7-15. The update identified alteration in respiratory and cardiac status, patient care safety, knowledge deficit, and spiritual as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>B. The record included an update to the plan of care dated 10-21-15. The update identified alteration in respiratory and cardiac status, knowledge deficit and spiritual as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>C. The record included an update to the plan of care dated 11-4-15. The update identified alteration in neurological status, respiratory status, cardiac status, skin integrity, knowledge deficit, and spiritual as ongoing problems. The update failed to evidence progress towards outcome and goals specified in the plan of care related to these ongoing problems.</p> <p>5. Clinical record number 6 included a plan of care established by the IDT on 7-28-15.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>A. The record included an update to the plan of care dated 10-14-15. The update identified alteration in functional status, GU/GI status, cardiac status, knowledge deficit, spiritual, and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>B. The record included an update to the plan of care dated 10-28-15. The update identified alteration in nutrition, GU/GI status, cardiac, skin integrity, patient care safety, knowledge deficit, spiritual and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>C. The record included an update to the plan of care dated 11-11-15. The update identified alteration in nutrition, GU/GI status, cardiac status, skin integrity, patient care safety, knowledge deficit, spiritual and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these identified problems.</p> <p>6. Clinical record number 7 included a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>plan of care established by the IDT on 9-28-15.</p> <p>A. The record included an update to the plan of care dated 10-7-15. The update identified alteration in functional status, neurological status, cardiac status, skin integrity, patient care safety, knowledge deficit, and spiritual as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>B. The record included an update to the plan of care dated 10-21-15. The update identified alteration in neurological status, GU/GI status, cardiac status, patient care safety, knowledge deficit, and psychosocial as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>C. The record included an update to the plan of care dated 11-4-15. The update identified alteration in GU/GI status, cardiac status, skin integrity, patient care safety, knowledge deficit, and psychosocial as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>problems.</p> <p>7. Clinical record number 8 included a plan of care established by the IDT on 10-12-15.</p> <p>A. The record included an update to the plan of care dated 10-21-15. The update identified alteration in GU/GI status, cardiac status, skin integrity, and knowledge deficit as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>B. The record included an update to the plan of care dated 11-4-15. The update identified alteration in cardiac status, patient care safety, knowledge deficit, and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>8. Clinical record number 9 included a plan of care established by the IDT on 9-23-15.</p> <p>A. The record included an update to the plan of care dated 10-14-15. The update identified alteration in comfort, functional status, nutrition, GU/GI status,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>cardiac status, skin integrity, patient care safety, knowledge deficit, and spiritual as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care related to these ongoing problems.</p> <p>B. The record included an update to the plan of care dated 10-28-15. The update identified alteration in nutrition, GU/GI status, cardiac status, skin integrity, patient care safety, knowledge deficit, spiritual, and psychosocial as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care.</p> <p>C. The record included an update to the plan of care dated 11-11-15. The update identified alteration in nutrition, cardiac status, skin integrity, knowledge deficit, spiritual, and psychosocial as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care.</p> <p>9. Clinical record number 10 included a plan of care established by the IDT on 9-4-15.</p> <p>A. The record included an update to the plan of care dated 10-14-15. The update identified alteration in comfort, neurological status, nutrition, respiratory</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>status, cardiac status, skin integrity, patient care safety, knowledge deficit, spiritual and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care.</p> <p>B. The record included an update to the plan of care dated 10-28-15. The update identified alteration in respiratory status, cardiac status, skin integrity, patient care safety, knowledge deficit, spiritual, and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care.</p> <p>C. The record included an update to the plan of care dated 11-11-15. The update identified alteration in GU/GI status, respiratory status, cardiac status, skin integrity, patient care safety, knowledge deficit, spiritual and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care.</p> <p>10. Clinical record number 11 included a plan of care established by the IDT on 9-2-15.</p> <p>A. The record included an update to the plan of care dated 10-14-15. The update identified alteration in respiratory</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>status, cardiac status, skin integrity, patient care safety, knowledge deficit, spiritual, and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care.</p> <p>B. The record included an update to the plan of care dated 10-28-15. The update identifies alteration in comfort, GU/GI status, respiratory status, cardiac status, patient care safety, knowledge deficit, spiritual, psychosocial, and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care.</p> <p>C. The record included an update to the plan of care dated 11-11-15. The update identifies alteration in GU/GI status, respiratory status, cardiac status, patient care safety, knowledge deficit, spiritual, psychosocial, and volunteer as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care.</p> <p>11. Clinical record number 12 included a plan of care established by the IDT on 10-6-15.</p> <p>A. The record included an update to the plan of care dated 10-21-15. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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
L 0579 Bldg. 00	<p>update identified alteration in functional status, GU/GI status, cardiac status, patient care safety, knowledge deficit, spiritual and psychosocial as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care.</p> <p>B. The record included an update to the plan of care dated 11-4-15. The update identified alteration in functional status, respiratory status, cardiac status, patient care safety knowledge deficit, spiritual and psychosocial as ongoing problems. The update failed to evidence progress towards outcomes and goals specified in the plan of care.</p> <p>12. The Director of Clinical Services indicated, on 11-20-15 at 4:05 PM, the updates to the plans of care did not evidence progress towards outcomes and goals as specified in the plans of care.</p> <p>418.60(a) PREVENTION The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. Based on record review, observation, and interview, the hospice failed to ensure staff had provided care in accordance</p>	L 0579	To correct this deficiency on 12/2/15 The Director of Clinical Services has assigned all staff hand washing in-service "Hand	12/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>with the Centers for Disease Control (CDC) Standard Precautions in 3 (#s 1, 2, and 3) of 4 home visit observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Employee G, a registered nurse (RN), was observed to provide care to patient number 1 on 11-17-15 at 11:15 AM (observation # 1). The RN was observed to retrieve a blood pressure cuff, thermometer, pulse oximeter, a stethoscope, hand soap, and gloves from her nursing bag. The RN placed the equipment on a clean field at the patient's bedside. The RN washed her hands and donned a clean glove on her left hand. The RN retrieved a pen from attached to a calendar hanging on the patient's refrigerator and, without washing her hand, donned a clean glove on the right hand.</li> </ol> <p>A. The RN completed an assessment of the patient, removed her gloves, and failed to cleanse her hands. The RN retrieved alcohol pads from her nursing bag and cleaned the equipment. The RN was not observed to clean the cuff of the blood pressure cuff prior to placing it back into her nursing bag.</p> <p>B. After cleaning the equipment, the</p>		<p>Hygiene:Protecting Yourself and Others." The in-services are to be completed by 12/30/15. All clinical staff will review the policy for infection control bag technique by 12/30/15. To prevent the deficiency from re-occurring,the Clinical Director will ensure annual education will continue to be provided to all staff on infection control. To monitor sustained improvement random on-site supervisory visits with clinical staff to monitor infection control will be made quarterly until 90% compliant with all components of the infection control audit and reported as part of QAPI program. The Clinical Director will be responsible to ensure that the plan is followed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>RN donned clean gloves without cleansing her hands, disposed of the clean field on the bedside table. The RN changed her gloves without cleansing her hands and cleaned the table with a disposable chlorine wipe. The RN removed her gloves, and without cleansing her hands, placed a clean field on the bedside table in preparation for a dressing change.</p> <p>C. After preparing the bedside table for the dressing change, the RN obtained the supplies needed for the dressing change from a supply kept in the patient's home. The RN checked the orders and donned clean gloves without cleansing her hands.</p> <p>2. Employee F, an RN, was observed to completed a dressing change on patient number 2 on 11-17-15 at 1:25 PM (observation number 2). The RN gathered the supplies to complete the dressing change and donned clean gloves without cleansing her hands. The RN measured the wound on the patient's upper coccyx and completed the dressing change. The RN removed her gloves, and without cleansing her hands, placed the unused supplies into a cabinet.</p> <p>3. Employee C, the medical social worker (MSW), was observed on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>11-18-15 at 11:20 AM with patient number 3 in a skilled nursing facility. The MSW spoke with the patient and touched the patient's shoulder and arm. The patient deferred the visit due to not feeling well. The MSW departed the room and failed to cleanse her hands after leaving the room.</p> <p>4. The Director of Clinical Services indicated on 11-18-15 at 11:00 AM, the employees had not provided services in accordance with Standard Precautions.</p> <p>5. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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
L 0774 Bldg. 00	<p>site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>418.112(d)(1) HOSPICE PLAN OF CARE The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care. Based on record review and interview, the hospice failed to ensure plans of care identified the responsibilities of the hospice and the skilled nursing facility</p>	L 0774	To correct the deficiency, the Hospice Clinical Director will develop a new process for documenting to show delineation of responsibilities of the hospice	12/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>(SNF) in providing services to patients in 4 (#s 3, 11, 12, and 13) of 4 records reviewed of patients that are residents of SNFs.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 3 evidenced the patient was a resident of a SNF. The record included a plan of care established by the interdisciplinary team (IDT) on 10-22-15. The plan of care failed to clearly identify and delineate the provider responsible for interventions included on the plan of care.</li> </ol> <p>A. The plan of care states, "T/R [turn, reposition] Q [every] 2 [hours] float heels hospice completes PRN [as needed]. Apply barrier cream to bil [bilateral] buttocks, peri [perineal] area daily &amp; PRN [with] incontinence hospice completes on PRN. Apply antifungal powder topically in skin folds PRN for redness/excoriation (abdomen, right neck) hospice completes PRN. Monitor fingerstick BG [blood glucose] PRN for S/S [signs and symptoms] of hypoglycemia hospice completes PRN. Accu checks ac [before meals] and QHS [every hour of sleep] (see MAR for S/S [sliding scale] insulin orders, hospice completes PRN. Pressure sores to [right] [upper] outer thigh, [right] pannus, stage</p>		<p>and the skilled nursing facility. All staff will be educated on the process by 12/28/15. Deficient charts will be corrected by 12/30/15. To ensure continued compliance clinical staff orientation will include additional education on delineation of responsibilities with care planning. A focus audit of 20% of charts will be done quarterly x 2 quarters, or until 90% compliance is attained, and then will be monitored for 1 year with comprehensive chart audits to ensure improvement is sustained. The Clinical Director will be responsible to ensure the plan is followed so that the deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>2. Cleanse [with] N/S [normal saline]. Apply A &amp; D oint. Cover [with] dry dressing. (Skin prep to intact skin under tape). BID [two times per day] X 10 days."</p> <p>The plan of care failed to clearly identify and delineate when the hospice would be responsible for the interventions and when the SNF staff would be responsible.</p> <p>B. The plan of care identified the patient was unable to complete any activities of daily living (bathing, dressing, etc) and that a home health aide would be provided 2 times per week. The plan failed to clearly delineate when the home health aide would provide the care and when the SNF certified nursing assistant would provide the care. The plan of care failed to specify how coordination of the aide services with the SNF would occur.</p> <p>2. Clinical record number 11 evidenced the patient was a resident of a SNF. The record included a plan of care established by the interdisciplinary team (IDT) on 9-2-15. The plan of care failed to clearly identify and delineate the provider responsible for interventions included on the plan of care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>A. The plan of care states, "Skin prep [left] lateral great toe Q shift X 14 days; may D/C [discontinue] sooner if healed, hospice completes PRN. Float heels while in bed, hospice completes PRN HRN [hospice RN] HHA [home health aide]. Warm compresses X 10 min at a time PRN to remove crust in eyes/drainage, hospice completes PRN-HRN, HHA. Monthly weight. Hospice completes PRN HRN, HHA. Place 2 X 2 gauze between toes on [right] foot as preventative, hospice completes PRN, HRN, HHA. Apply Desitin to buttocks &amp; peri area BID [2 times per day] as preventative, hospice completes PRN HRN. House lotion to BLE [bilateral lower extremities] daily, hospice competes PRN, HHA, HRN. Foot cradle to bed to prevent pressure on toes. [No designation as to who is responsible]. Check Q2 [oxygen] sat [saturation] each shift [no designation as to who is responsible]. Increase fluid intake: 120 cc [cubic centimeters] / shift, hospice to complete PRN, HRN, HHA. Extend skin prep [every] shift to [left] lateral great toe X 14 days. May d/c sooner if healed, hospice to complete PRN. Clean abrasion to [right] elbow [with] soap and H2O, cover [with] dry dressing qd [every day] X 7d, hospice completes PRN, LTCF [long term care facility]. Nystatin cr [cream] apply to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>fungal (yeast) skin irritation on bilateral buttocks, sacrum, [lower] back BID X 10 d, [no designation as to who is responsible]. Geri sleeves to BUE [bilateral upper extremities]. Off for skin care only, hospice completes on: hospice/LTCF. Magic Butt cr Apply q shift &amp; PRN incont [incontinence] to red areas on buttocks/sacrum &amp; [lower] back, hospice completes on hospice/LTCF. Aquaphor Oint apply to BUEs &amp; BLEs dly [no designation as to who is responsible] . . . [No] briefs while in bed r/o hypersensitivity to briefs, hospice completes on hospice/LTCF."</p> <p>The plan of care failed to clearly identify and delineate when the hospice would be responsible for the interventions and when the SNF staff would be responsible.</p> <p>B. The plan of care identified the patient was unable to complete any activities of daily living (bathing, dressing, etc) and that a home health aide would be provided 2 times per week. The plan failed to clearly delineate when the home health aide would provide the care and when the SNF certified nursing assistant would provide the care. The plan of care failed to specify how coordination of the aide services with the SNF would occur.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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 12 evidenced the patient was a resident of a SNF. The record included a plan of care established by the interdisciplinary team (IDT) on 10-6-15. The plan of care failed to clearly identify and delineate the provider responsible for interventions included on the plan of care.</p> <p>A. The plan of care states, "Float heels Q shift, hospice completes PRN. May have 1 can of beer daily PRN [no designation as to which provider is responsible]. Monthly weights. Hospice completes PRN. Notify triage if temp &gt; 100.5 before treating temp, hospice to complete PRN. Apply skin prep around Duragesic patch &amp; cover [with] Tegaderm, hospice to complete PRN. Encourage fluids. hospice to complete PRN. Check placement of patch Q shift, hospice to complete PRN. Hydrophor ointment to BLE &amp; Feet daily, hospice to complete PRN. Vit A &amp; D ointment peri area Q shift for redness &amp; after incontinent episodes [no designation as to which provider is responsible]. Knee hi TED hose On in am-off hs, [no designation as to which provider is responsible]. Tubi-grip stockings to BLEs q shift remove for skin care [no designation as to which provider is responsible.]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>The plan of care failed to clearly identify and delineate when the hospice would be responsible for the interventions and when the SNF staff would be responsible.</p> <p>B. The plan of care identified the patient was unable to complete any activities of daily living (bathing, dressing, etc) and that a home health aide would be provided 2 times per week. The plan failed to clearly delineate when the home health aide would provide the care and when the SNF certified nursing assistant would provide the care. The plan of care failed to specify how coordination of the aide services with the SNF would occur.</p> <p>4. Clinical record number 13 evidenced the patient was a resident of a SNF. The record included a plan of care established by the interdisciplinary team (IDT) on 10-30-15. The plan of care failed to clearly identify and delineate the provider responsible for interventions included on the plan of care.</p> <p>A. The plan of care states, "Cleanse wound posterior [right] upper leg [with] cleanser. Pat dry, apply Bacitracin &amp; dry dressing BID, hospice to complete PRN. Weekly weights [no designation as to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>which provider is responsible]. Cleanse ST [?] to [right] forearm [with] wound cleanser, pat dry, apply steri strips X 1 &amp; PRN Q shift, hospice to complete PRN. Cleanse open area to [left] heel [with] N/S, pat dry, apply betadine &amp; dry dressing BID [no designation as to which provider is responsible]. Apply bil heel protectors when in bed, hospice completes PRN. Cleanse [right] calf O/A [open area] [with] N/S, pat dry apply Bacitracin, cover [with] Telfa &amp; secure [with] Kerlix daily &amp; PRN [with] dislodgement, [no designation as to which provider is responsible]. Carmex lip ointment topically to lips PRN, [no designation as to which provider is responsible]. Cleanse wound to [right] buttock [with] NS. Pat dry. Apply hydrogel to wound bed. Cover [with] foam dressing QD &amp; PRN [with] dislodgement X 10 days, then reassess, hospice to complete SN visit. Cleanse O/A to [left] heel [with] NS. Pat dry. Apply betadine. Cover [with] ABD pad, wrap with Kerlix &amp; secure [with] tape BID &amp; PRN [with] dislodgement X 10 days, then re-eval. [No designation as to which provider is responsible]. Cleanse wound to [right] calf [with] NS. Pat dry. Apply betadine cover with ABD pad, wrap [with] Kerlix &amp; secure [with] tape BID X 10 days, then re-eval, Hospice to complete SN visit."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151589	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 W BUENA VISTA RD STE 107 EVANSVILLE, IN 47710
--	--

(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>The plan of care failed to clearly identify and delineate when the hospice would be responsible for the interventions and when the SNF staff would be responsible.</p> <p>B. The plan of care identified the patient was unable to complete any activities of daily living (bathing, dressing, etc) and that a home health aide would be provided 2 times per week. The plan failed to clearly delineate when the home health aide would provide the care and when the SNF certified nursing assistant would provide the care. The plan of care failed to specify how coordination of the aide services with the SNF would occur.</p> <p>5. The Director of Clinical Services indicated, on 11-20-15 at 4:05 PM, the hospice plans of care did not evidence a delineation of the responsibilities of the hospice and the SNF in caring for the patient.</p>			