

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER PEACE HOSPICE AND PALLIATIVE CARE INDIANA CORPORAT				STREET ADDRESS, CITY, STATE, ZIP CODE 9200 CALUMET AVE STE N204 MUNSTER, IN 46321			
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S0000	<p>This visit was an initial hospice state licensure survey.</p> <p>Survey date: 5/22/12 to 5/23/12</p> <p>Facility #: 012545</p> <p>Surveyors: Tonya Tucker, RN, PHNS Bridget Boston, RN, PHNS</p> <p>Census: 3</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 30, 2012</p>	S0000					

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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S0534	<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 staff interview, the hospice failed to ensure data collected for the data elements was collected by hospice staff in 3 of 3 clinical records reviewed with the potential to effect all hospice patients. (#s 1, 2, and 3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On May 22, 2012, at 10 AM, employee F indicated the data elements collected on the comprehensive assessment was pain and whether the patient was constipated or not. She indicated the tool utilized was the <i>Wong - Baker</i> scale with the option of the patient to point out a facial expression to report one's pain or the option to verbalize one's pain at level 1 through 10. On May 23, 2012, at 5:40 PM, employee B indicated the hospice only has a process in which to assess verbal patients. She indicated the hospice does not have an approved tool which all 	S0534	S 534 Agency is in compliance and ensured that the comprehensive assessment included data elements that allow for measurement of outcomes. Agency measured and documented data in the same way for all patients and ensured data was collected by hospice staff. The data elements took into consideration aspects of care related to hospice and palliation. Going forward, the Agency will continue to ensure compliance and ensure that the comprehensive assessment includes data elements that allow for measurement of outcomes. Agency will continue to measure and document data in the same way for all patients and ensure data is collected by hospice staff. The data elements will take into consideration aspects of care related to hospice and palliation. The Administrator in-serviced all staff on June 4, 2012 on the outcome of the survey. The administrator instructed all staff to ensure continual compliance with and ensure that the comprehensive assessment: (a) includes data elements that allow	06/18/2012			

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	<p>appropriate personnel are to use and have been instructed to use that objectively measures non verbal signs and symptoms of pain in a patient who is unable to verbalize their pain. She further indicated that the hospice did not have a process or plan in place to assess the patients for pain at 24, 48, and 72 hours and indicated the patient's verbalization of pain is objective and if the patient cannot verbally respond then they will use the caregiver and aide's report if necessary and indicated the patients have a Wong-Baker scale in their homes, delivered at admission.</p> <p>3. The policy titled "Pain Assessments" dated 12/26/11 states, "At the time of admission, the patient's pain shall be assessed according to the Wong-Baker Scale. ... If the patient is able to respond for him/herself, the nurse's assessment should include the question: "Are you uncomfortable because of pain?" The level of pain at admission is to be documented in the 24 hour section of the admission Pain Assessment in Consolo. The level of pain assessed between 24 hours and 28 hours after admission is documented in the 48 hour section of the Admission Pain Assessment in Consolo. The level of pain assessed between 48 hours and 72 hours after admission is documented in the 72 hour section of the</p>		<p>for measurement of outcomes, (b) that Agency continues to measure and document data in the same way for all patients, data is collected by hospice staff; and (c) that data elements take into consideration aspects of care related to hospice and palliation.</p> <p>100% of all new admissions will be audited by a registered nurse (other than the admitting nurse) within 96 hours of such admission for evidence that the comprehensive assessment: (a) includes data elements that allow for measurement of outcomes, (b) that Agency continues to measure and document data in the same way for all patients, data is collected by hospice staff; and (c) that data elements take into consideration aspects of care related to hospice and palliation.</p> <p>The Clinical Director and the QA/PI Coordinator will be responsible for monitoring to ensure continued compliance. The Clinical Director and the QA/PI Coordinator will be responsible for monitoring these corrective actions to ensure that Agency will remain in compliance.</p>				

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	<p>Admission Pain Assessment in Consolo. ... Documentation in the notes section of the Admission Pain Assessments shall include indication that the Wong-Baker scale was used, how the measurement was obtained (such as phone call, conversation with PCG [primary caregiver] / SNF RN [skilled nursing facility registered nurse], visit, patient described), and the responses. ... Pain assessments shall be performed on an ongoing basis with follow up and teaching as appropriate."</p> <p>4. The policy titled "Quality Assurance / Performance Improvement" identified as # 4.050, approved by the governing body and effective date 12/26/11, stated, "Peace Hospice shall routinely assess, measure, and improve the adequacy, appropriateness, and effectiveness of services. ... The Peace Hospice approach to improving performance shall include the following processes: a) monitoring performance through data collection ... measuring outcomes as established by the QA/PI committee."</p> <p>5. Clinical record # 1 evidenced employee F completed the initial assessment dated 5/1/12 for the purpose of admission into hospice. The assessment identified the admission diagnosis to be congestive heart failure and included the documentation within</p>						

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	<p>the comprehensive assessment "Oriented X1, forgetful, disoriented, agitated, ... Neurology Fatigue (easily), coordination (very poor), speech unintelligible. ... Pain info Patient relief desire, primary pain site (generalized upon touch), description of onset (unable to describe), cause of pain (unable to describe), description how pain feels to patient (unable to describe), brief pain history (patient's viewpoint)(unable to describe), pain relieved by (N/A), pain is worsened by (increased movement), breakthrough pain comments (unable to describe), comments (no pain medication in home on admission, pt [patient] had no insurance per family. MD called, stat order received, pharmacy called. order placed. family aware. pt [patient] repositioned for comfort. medication teaching done with [family member], verbalized understanding."</p> <p>A. The clinical record evidenced a skilled nurse visit note dated 5/2/12 and stated, "Communication / Sensation forgetful, altered level of consciousness (disoriented), ... Neurology ... Speech unintelligible."</p> <p>B. The clinical record documentation titled "Pain Assessment" stated, "24 hour assessment 5/1/12 pain level 8/10 per Wong-Baker scale, new order received.</p>						

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	<p>Evaluator [employee F]. 48 hour assessment, date 5/2/12, pain 0/10 per Wong-Baker Scale evaluator [employee F]. 72 hour assessment, date 5/3/12, pain level 0/10 per Wong-Baker Scale, evaluator [employee F]." The clinical record failed to evidence any nurse went to the patients home and assessed the patient on 5/3/12.</p> <p>C. On May 23, 2012, at 3:24 PM, the electronic medical record was reviewed with employee B who indicated there was not a skilled nurse visit made on 5/3/12 to assess the patients pain.</p> <p>D. The clinical record failed to evidence the caregiver was educated as to how to administered and interpret the Wong-Baker scale.</p> <p>6. Clinical record # 2 evidenced employee F completed the initial assessment dated 3/29/12 for the purpose of admission into hospice. The assessment identified the admission diagnosis to be lung cancer and included the documentation within the comprehensive assessment "Forgetful, Altered level of consciousness (alert) ... elimination incontinent (urinary), LBM, LBM date (03/29/2012) ... Pain Info Primary pain site (0/10 per Wong-Baker scale), comments (denies pain per</p>						

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	<p>Wong-Baker scale) Pain relief Methods tried Medication (Tylenol #4 PRN).</p> <p>A. The clinical record documentation titled "Pain Assessment" stated, "24 hour assessment 03/29/2012 pain level 0/10 per Wong-Baker scale" evaluator employee F. "48 hour assessment, date 03/30/2012, pain 2/10 per Wong-Baker scale-pt able to tolerate pain, decline medication." evaluator employee F. "72 hour assessment, date 03/31/2012, pain level 1/10 Wong-Baker scale." evaluator employee F. The clinical record failed to evidence any nurse went to the patients home and assessed the patient on 3/31/2012.</p> <p>B. The clinical record documentation titled "Nurse Note" stated, "Nurse Note Dated: 03/31/2012, [employee F], note summary called patient to make sure patient was comfortable [family member] states that pain is acceptable level of 2 per Wong Baker scale. no other problems. visit type phone call"</p> <p>C. On May 23, 2012, at 1135 am, the electronic record and policy titled "Pain Assessments" was reviewed with employee B who indicated it is acceptable to assess the patient's pain via phone per family and that this is what happened on the pain assessment dated 03/31/2012.</p>						

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	<p>D. The clinical record failed to evidence the caregiver was educated as to how to administered and interpret the Wong-Baker scale.</p> <p>7. Clinical record #3 evidenced employee F completed the initial assessment dated 5/10/2012 for the purpose of admission into hospice. The assessment identified the admission diagnosis to be lung cancer and included the documentation within the comprehensive assessment "elimination constipation, incontinent (both), elimination aids (colace, lactulose), LBM (small), LBM date (05/08/2012), comments (Hx of constipation) constipation intensity moderate ... self-esteem / mental status lethargic ... pain info primary pain site (0/10 per Wong-Baker scale), comments (denies pain per 0/10 Wong-Baker scale) pain relief methods tried medication (tramadol)"</p> <p>A. The clinical record documentation titled "Pain Assessment" stated, "24 hour assessment 05/10/2012 pain level 0/10 per Wong-Baker scale" evaluator employee F. "48 hour assessment, date 05/11/2012, pain 0/10 per Wong-Baker scale" evaluator employee F. "72 hour assessment, date 05/12/2012, pain level 0/10 Wong-Baker scale per wife talking</p>			

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	<p>to pt." evaluator employee F. The clinical record failed to evidence any nurse went to the patient's home and assessed the patient on 05/12/2012.</p> <p>B. The clinical record documentation titled "Nurse Note" stated, "Nurse Note Dated: 05/12/2012, [employee F], note summary Well being check, per [family member] signs of pain per Wong-Baker scale. visit type phone call".</p> <p>C. On May 23, 2012, at 11:35 am, the electronic record and policy titled "Pain Assessments" was reviewed with employee B who indicated it is acceptable to assess the patient's pain via phone per family and that this is what happened on the pain assessment dated 05/12/2012.</p> <p>D. The clinical record failed to evidence the caregiver was educated as to how to administered and interpret the Wong-Baker scale.</p>						

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S0535	<p>418.54(e)(2) PATIENT OUTCOME MEASURES (2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure data for the data elements was collected by hospice staff to ensure a systematic collection of data for 3 of 3 clinical records reviewed with the potential to effect all hospice patients. (#s 1, 2, and 3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On May 22, 2012, at 10 AM, employee F indicated the data elements collected on the comprehensive assessment was pain and whether the patient was constipated or not. She indicated the tool utilized was the <i>Wong - Baker</i> scale with the option of the patient to point out a facial expression to report one's pain or the option to verbalize one's pain at level 1 through 10. On May 23, 2012, at 5:40 PM, employee B indicated the hospice only 	S0535	<p>S 535 Agency is in compliance and ensured that: (a) the data elements are an integral part of the comprehensive assessment, (b) the data for the data elements are collected by hospice staff and documented in a systematic and retrievable way for each patient, (c) data elements for each patient are used in individual patient care planning and in the coordination of services; and (d) data elements are used in the aggregate for the Agency's quality assessment and performance improvement program. Going forward, Agency will continue to ensure compliance and that: (a) the data elements are an integral part of the comprehensive assessment, (b) the data for the data elements are collected by hospice staff and documented in a systematic and retrievable way for each patient, (c) data elements for each patient are used in individual patient care planning and in the coordination of services; and (d) data elements are used in the</p>	06/18/2012			

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	<p>has a process in which to assess verbal patients. She indicated the hospice does not have an approved tool which all appropriate personnel are to use and have been instructed to use that objectively measures non verbal signs and symptoms of pain in a patient who is unable to verbalize their pain. She further indicated that the hospice did not have a process or plan in place to assess the patients for pain at 24, 48, and 72 hours and indicated the patient's verbalization of pain is objective and if the patient cannot verbally respond then they will use the caregiver and aide's report if necessary and indicated the patients have a Wong-Baker scale in their homes, delivered at admission.</p> <p>3. The policy titled "Pain Assessments" dated 12/26/11 states, "At the time of admission, the patient's pain shall be assessed according to the Wong-Baker Scale. ... If the patient is able to respond for him/herself, the nurse's assessment should include the question: "Are you uncomfortable because of pain?" The level of pain at admission is to be documented in the 24 hour section of the admission Pain Assessment in Consolo. The level of pain assessed between 24 hours and 28 hours after admission is documented in the 48 hour section of the Admission Pain Assessment in Consolo.</p>		<p>aggregate for the Agency's quality assessment and performance improvement program. The Administrator in-serviced all staff on June 4, 2012 on the outcome of the survey. The administrator instructed all staff to ensure continual compliance with and ensure that: (a) the data elements are an integral part of the comprehensive assessment, (b) the data for the data elements are collected by hospice staff and documented in a systematic and retrievable way for each patient, (c) data elements for each patient are used in individual patient care planning and in the coordination of services; and (d) data elements are used in the aggregate for the Agency's quality assessment and performance improvement program. 100% of all new admissions will be audited by a registered nurse (other than the admitting nurse) within 96 hours of such admission for evidence that: (a) the data elements are an integral part of the comprehensive assessment, (b) the data for the data elements are collected by hospice staff and documented in a systematic and retrievable way for each patient, (c) data elements for each patient are used in individual patient care planning and in the coordination of services; and (d) data elements are used in the aggregate for the Agency's quality assessment and performance improvement program.</p>				

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	<p>The level of pain assessed between 48 hours and 72 hours after admission is documented in the 72 hour section of the Admission Pain Assessment in Consolo. ... Documentation in the notes section of the Admission Pain Assessments shall include indication that the Wong-Baker scale was used, how the measurement was obtained (such as phone call, conversation with PCG [primary caregiver] / SNF RN [skilled nursing facility registered nurse], visit, patient described), and the responses. ... Pain assessments shall be performed on an ongoing basis with follow up and teaching as appropriate."</p> <p>4. The policy titled "Quality Assurance / Performance Improvement" identified as # 4.050, approved by the governing body and effective date 12/26/11, stated, "Peace Hospice shall routinely assess, measure, and improve the adequacy, appropriateness, and effectiveness of services. ... The Peace Hospice approach to improving performance shall include the following processes: a) monitoring performance through data collection ... measuring outcomes as established by the QA/PI committee."</p> <p>5. Clinical record # 1 evidenced employee F completed the initial assessment dated 5/1/12 for the purpose of admission into hospice. The</p>		<p>The Clinical Director and the QA/PI Coordinator will be responsible for monitoring to ensure continued compliance. The Clinical Director and the QA/PI Coordinator will be responsible for monitoring these corrective actions to ensure that Agency will remain in compliance.</p>				

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	<p>assessment identified the admission diagnosis to be congestive heart failure and included the documentation within the comprehensive assessment "Oriented X1, forgetful, disoriented, agitated, ... Neurology Fatigue (easily), coordination (very poor), speech unintelligible. ... Pain info Patient relief desire, primary pain site (generalized upon touch), description of onset (unable to describe), cause of pain (unable to describe), description how pain feels to patient (unable to describe), brief pain history (patient's viewpoint)(unable to describe), pain relieved by (N/A), pain is worsened by (increased movement), breakthrough pain comments (unable to describe), comments (no pain medication in home on admission, pt [patient] had no insurance per family. MD called, stat order received, pharmacy called. order placed. family aware. pt [patient] repositioned for comfort. medication teaching done with [family member], verbalized understanding."</p> <p>A. The clinical record evidenced a skilled nurse visit note dated 5/2/12 and stated, "Communication / Sensation forgetful, altered level of consciousness (disoriented), ... Neurology ... Speech unintelligible."</p> <p>B. The clinical record documentation</p>			

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	<p>titled "Pain Assessment" stated, "24 hour assessment 5/1/12 pain level 8/10 per Wong-Baker scale, new order received. Evaluator [employee F]. 48 hour assessment, date 5/2/12, pain 0/10 per Wong-Baker Scale evaluator [employee F]. 72 hour assessment, date 5/3/12, pain level 0/10 per Wong-Baker Scale, evaluator [employee F]." The clinical record failed to evidence any nurse went to the patients home and assessed the patient on 5/3/12.</p> <p>C. On May 23, 2012, at 3:24 PM, the electronic medical record was reviewed with employee B who indicated there was not a skilled nurse visit made on 5/3/12 to assess the patients pain.</p> <p>D. The clinical record failed to evidence the caregiver was educated as to how to administered and interpret the Wong-Baker scale.</p> <p>6. Clinical record # 2 evidenced employee F completed the initial assessment dated 3/29/12 for the purpose of admission into hospice. The assessment identified the admission diagnosis to be lung cancer and included the documentation within the comprehensive assessment "Forgetful, Altered level of consciousness (alert) ... elimination incontinent (urinary), LBM,</p>						

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	<p>LBM date (03/29/2012) ... Pain Info Primary pain site (0/10 per Wong-Baker scale), comments (denies pain per Wong-Baker scale) Pain relief Methods tried Medication (Tylenol #4 PRN).</p> <p>A. The clinical record documentation titled "Pain Assessment" stated, "24 hour assessment 03/29/2012 pain level 0/10 per Wong-Baker scale" evaluator employee F. "48 hour assessment, date 03/30/2012, pain 2/10 per Wong-Baker scale-pt able to tolerate pain, decline medication." evaluator employee F. "72 hour assessment, date 03/31/2012, pain level 1/10 Wong-Baker scale." evaluator employee F. The clinical record failed to evidence any nurse went to the patients home and assessed the patient on 3/31/2012.</p> <p>B. The clinical record documentation titled "Nurse Note" stated, "Nurse Note Dated: 03/31/2012, [employee F], note summary called patient to make sure patient was comfortable [family member] states that pain is acceptable level of 2 per Wong Baker scale. no other problems. visit type phone call"</p> <p>C. On May 23, 2012, at 1135 am, the electronic record and policy titled "Pain Assessments" was reviewed with employee B who indicated it is acceptable</p>						

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	<p>to assess the patient's pain via phone per family and that this is what happened on the pain assessment dated 03/31/2012.</p> <p>D. The clinical record failed to evidence the caregiver was educated as to how to administered and interpret the Wong-Baker scale.</p> <p>7. Clinical record #3 evidenced employee F completed the initial assessment dated 5/10/2012 for the purpose of admission into hospice. The assessment identified the admission diagnosis to be lung cancer and included the documentation within the comprehensive assessment "elimination constipation, incontinent (both), elimination aids (colace, lactulose), LBM (small), LBM date (05/08/2012), comments (Hx of constipation) constipation intensity moderate ... self-esteem / mental status lethargic ... pain info primary pain site (0/10 per Wong-Baker scale), comments (denies pain per 0/10 Wong-Baker scale) pain relief methods tried medication (tramadol)"</p> <p>A. The clinical record documentation titled "Pain Assessment" stated, "24 hour assessment 05/10/2012 pain level 0/10 per Wong-Baker scale" evaluator employee F. "48 hour assessment, date 05/11/2012, pain 0/10 per Wong-Baker</p>						

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	<p>scale" evaluator employee F. "72 hour assessment, date 05/12/2012, pain level 0/10 Wong-Baker scale per wife talking to pt." evaluator employee F. The clinical record failed to evidence any nurse went to the patient's home and assessed the patient on 05/12/2012.</p> <p>B. The clinical record documentation titled "Nurse Note" stated, "Nurse Note Dated: 05/12/2012, [employee F], note summary Well being check, per [family member] signs of pain per Wong-Baker scale. visit type phone call".</p> <p>C. On May 23, 2012, at 11:35 am, the electronic record and policy titled "Pain Assessments" was reviewed with employee B who indicated it is acceptable to assess the patient's pain via phone per family and that this is what happened on the pain assessment dated 05/12/2012.</p> <p>D. The clinical record failed to evidence the caregiver was educated as to how to administered and interpret the Wong-Baker scale.</p>						

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S0550	<p>418.56(c)(5) 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:] (5) Medical supplies and appliances necessary to meet the needs of the patient.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure the written plan of care included medical equipment needed to meet the patient's needs in 1 of 3 (#1) records reviewed with the potential to effect all the hospice patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The policy # 5.230 titled "Comprehensive Interdisciplinary Plan of Care" approved by the governing body and effective date 12/30/10 stated, "Services shall be provided under the direction of the attending physician, medical director and interdisciplinary group (IDG) in accordance with the written plan of care. ... The interdisciplinary POC ... includes: ... safety measures to protect against abuse, injury, infection." Clinical record # 1 evidenced the patient resided in a private residence, election date 4/30/12 and start of care 5/3/12, and included an established plan 	S0550	<p>S 550 Agency is in compliance and did ensure that the written plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions, including medical supplies and appliances necessary to meet the needs of the patients. Going forward, Agency will continue to ensure compliance and that the written plan of care includes medical equipment needed to meet the patient's needs. The Administrator in-serviced all staff on June 4, 2012 on the outcome of the survey. The administrator instructed all staff to ensure continual compliance with and ensure that the written plan of care includes medical equipment needed to meet the patient's needs. 100% of all new admissions will be audited by a registered nurse (other than the admitting nurse) within 96 hours of such admission for evidence that the written plan of care includes medical equipment needed to meet the patient's needs. On an ongoing basis and, at a minimum, after every IDG meeting, the Clinical Director will audit all the written</p>	06/18/2012			

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	<p>of care dated 5/1/12 and updated POC dated 5/14/12 that failed to evidence a geriatric chair with a detachable tray and a hospital bed with full side rails.</p> <p>A. During a home visit on 5/23/12 at 12 PM, the patient presented in a hospital bed with full side rails on each side of the bed and a geriatric chair with a detachable tray. The caregiver indicated the geriatric - chair with the tray and the side rails on the bed are utilized daily. The Initial assessment completed by employee F indicated a low bed was ordered at the start of care.</p> <p>B. The clinical record evidenced a communication note dated 5/2/12 that stated, "[employee name] at 12:28 - pt [patient] with increased restlessness, bed switched from a low bed with half rails to a full electric with full rails--[name of employee B].</p> <p>C. On May 23, 2012, at 3:24 PM, the electronic medical record was reviewed with employee B who indicated the hospice had an order to use the DME that was needed; therefore, they did not require a physician order or a change in the plan of care.</p>		<p>plans of care to insure that they include medical equipment needed to meet the patient's needs.</p> <p>The Clinical Director and the QA/PI Coordinator will be responsible for monitoring to ensure continued compliance.</p> <p>The Clinical Director and the QA/PI Coordinator will be responsible for monitoring these corrective actions to ensure that Agency will remain in compliance.</p>				

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S0705	<p>418.108 SHORT-TERM INPATIENT CARE Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.</p> <p>Based on administrative document and policy review and interview, the hospice failed to ensure a written agreement was in place for the provision of in - patient care for pain control and symptom management purposes for 1 of 2 agreements reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A review of the contract agreement between the hospice and Timberview Healthcare Center dated 10/14/10, failed to evidence the Healthcare Center agreed to provide in-patient care for pain control and symptom management. 2. On 5/23/12 at 4:40 PM, employee B indicated the contract did not specify this and indicated the provider would only sign a general contract. 	S0705	<p>S 705 Agency is in compliance and did ensure that there was a written agreement dated October 14, 2010 (Exhibit N) was in place between Agency and Timberview for the provision of inpatient care for pain control and symptom management. Going forward, Agency will continue to ensure compliance and that a written agreement is in place for the provision of inpatient care for pain control and symptom management. The Administrator in-serviced all staff on June 4, 2012 on the outcome of the survey. The administrator instructed all staff to ensure continual compliance with and ensure that a written agreement is in place for the provision of inpatient care for pain control and symptom management. 100% of all agreements will be audited by the Director of Operations and Administrator for evidence that all written inpatient agreements include the provision of inpatient care for pain control and symptom management. At the staff in-service on June 4, 2012, the Administrator provided contracts (Exhibit N-1 and N-3) that were in compliance with standard for all inpatient agreements. These contracts are</p>	06/18/2012			

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			to be used going forward. The Director of Operations and Administrator will be responsible for monitoring to ensure continued compliance. The Director of Operations and Administrator will be responsible for monitoring these corrective actions to ensure that Agency will remain in compliance.	

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S0712	<p>418.108(c)(2) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (2) That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients;</p> <p>Based on administrative document review and interview, the hospice failed to ensure a written agreement was in place for the provision of short-term inpatient care which, at a minimum, specifies the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols established by the hospice for its patients for 2 of 2 agreements reviewed with the potential to effect all hospice patients.</p> <p>Findings include:</p> <p>1. A review of the contract agreements between the hospice and Timberview Healthcare Center dated 10/14/10 and Sebo Nursing and Rehabilitation Center dated 6/6/11 failed to evidence the provision of short-term inpatient care which, at a minimum, specifies the inpatient provider has established patient</p>	S0712	S 712 Agency is in compliance and did ensure that the written agreement dated December 8, 2010 (Exhibit N-1) was in place between Agency and Timberview specified that the facility had established patient care policies consistent with those of the Agency and agreed to abide by the palliative care protocols established by the Agency for its patients. The Administrator in-serviced all staff on June 4, 2012 on the outcome of the survey. The administrator instructed all staff to ensure continual compliance with and that written agreements specify that the facility established patient	06/18/2012			

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	<p>care policies consistent with those of the hospice and agrees to abide by the palliative care protocols established by the hospice for its patients.</p> <p>2. On 5/23/12 at 4:40 PM, employee B indicated the providers had agreed to this provision when they signed the contract.</p>		<p>care policies consistent with those of the Agency and agreed to abide by the palliative care protocols established by the Agency for its patients. 100% of all agreements will be audited by the Director of Operations and Administrator for evidence that all written agreements specify that the facility established patient care policies consistent with those of the Agency and agreed to abide by the palliative care protocols established by the Agency for its patients. At the staff in-service on June 4, 2012, the Administrator provided contracts (Exhibit N-1 and N-3) that were in compliance with standard for all agreements. These contracts are to be used going forward. The Director of Operations and Administrator will be responsible for monitoring to ensure continued compliance. The Director of Operations and Administrator will be responsible for monitoring these corrective actions to ensure that Agency will remain in compliance.</p>				

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S0729	<p>418.110(e) PATIENT AREAS The hospice must provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort, and privacy of patients.</p> <p>(1) The hospice must provide-</p> <p>(i) Physical space for private patient and family visiting;</p> <p>(ii) Accommodations for family members to remain with the patient throughout the night; and</p> <p>(iii) Physical space for family privacy after a patient's death.</p> <p>(2) The hospice must provide the opportunity for patients to receive visitors at any hour, including infants and small children.</p> <p>Based on administrative document review and interview, the hospice failed to ensure a written agreement was in place for the provision of short-term inpatient care which, at a minimum, specifies the inpatient provider will provide a physical space for private patient and family visiting, accommodations for family members to remain with the patient throughout the night, and a physical space for family privacy after a patient's death for 1 of 2 agreements reviewed with the potential to effect all hospice patients.</p> <p>Findings include:</p> <p>1. A review of the contract agreement between the hospice and Timberview Healthcare Center dated 10/14/10 failed to evidence the Healthcare Center agreed</p>	S0729	S 729 Agency is in compliance and did ensure that the Agency will provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort and privacy of patients. The hospice provided through its written agreements with Timberview dated December 8, 2010 (Exhibit N-1) and the written Agreement with Sebo's Nursing & Rehabilitation Center dated August 25, 2011 (Exhibit N-3): (a) physical space for private patient and family visiting; (b) accommodations for family members to remain with the patient throughout the night; and (c) physical space for family privacy after a patient's death. The hospice also ensured that there was the opportunity for patients to receive visitors at any hour, including infants and small	06/18/2012			

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	<p>to provide provide a physical space for private patient and family visiting, accommodations for family members to remain with the patient throughout the night, and a physical space for family privacy after a patient's death.</p> <p>2. On 5/23/12 at 4:40 PM, employee B indicated the contract does not specify this and indicated the provider would only sign a general contract.</p>		<p>children. Going forward, Agency will continue to ensure compliance and that written agreements specify that the facility will provide (a) physical space for private patient and family visiting; (b) accommodations for family members to remain with the patient throughout the night; and (c) physical space for family privacy after a patient's death. The hospice will continue to ensure that there is the opportunity for patients to receive visitors at any hour, including infants and small children. The Administrator in-serviced all staff on June 4, 2012 on the outcome of the survey. The administrator instructed all staff to ensure continual compliance with and that written agreements specify that the facility will provide (a) physical space for private patient and family visiting; (b) accommodations for family members to remain with the patient throughout the night; and (c) physical space for family privacy after a patient's death. The hospice will continue to ensure that there is the opportunity for patients to receive visitors at any hour, including infants and small children. 100% of all agreements will be audited by the Director of Operations and Administrator for evidence that all written agreements specify that the facility will provide (a) physical</p>				

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			<p>space for private patient and family visiting; (b) accommodations for family members to remain with the patient throughout the night; and (c) physical space for family privacy after a patient's death. The hospice will continue to ensure that there is the opportunity for patients to receive visitors at any hour, including infants and small children. At the staff in-service on June 4, 2012, the Administrator provided contracts (Exhibits N-1 and N-3) that were in compliance with standard for all agreements. These contracts are to be used going forward. The Director of Operations and Administrator will be responsible for monitoring to ensure continued compliance. The Director of Operations and Administrator will be responsible for monitoring these corrective actions to ensure that Agency will remain in compliance.</p>		

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S9997	<p>IC 16-28-13-4 Aide Registry Sec. 4(a) Except as provided in subsection (b), a person who:</p> <p>1) operates or administers a health care facility; or</p> <p>2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility;</p> <p>shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department...</p> <p>b) A health care facility is not required to apply for the state nurse aide registry report ... required by subsection (a) if the health care facility contracts to use the services of a nurse aide or other unlicensed employee who is employed by an entity in the business of contracting to provide nurse aides or other unlicensed employees to health care facilities.</p> <p>Based on personnel record review and staff interview, the hospice failed to apply within three business days from the date a person is employed as a nurse aide for a copy of the person's state nurse aide registry report for the state department in 1 of 2 hospice aide personnel files reviewed. (employee J)</p> <p>Findings include:</p> <p>1. Personnel file J, date of hire and date of first patient contact 5/11/12, failed to</p>	S9997	S 9997 This deficiency was corrected on 5/24/2012. The home health aide registration was submitted on 5/24/2012 (Exhibit P-1), the result verified and printed on 5/31/2012 (Exhibit P). Exhibit P shows that the deficiency has been corrected. The Administrator in-serviced the Human Resource employees on 6/4/2012 (Exhibit O). The Administrator and Human Resource personnel will ensure that this deficiency does not occur in the future by ensuring that all home health aides employed by the Agency do not begin	06/04/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER PEACE HOSPICE AND PALLIATIVE CARE INDIANA CORPORAT				STREET ADDRESS, CITY, STATE, ZIP CODE 9200 CALUMET AVE STE N204 MUNSTER, IN 46321			
(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>evidence a state nurse aide registry report or evidence of the hospice applying for a copy of the nurse aide registry report within 3 days of hire.</p> <p>2. On 5/23/12 at 530 PM, employee C presented surveyor with Indiana Online Licensing report specifying license type of Certified Nurse Aide for employee J which employee C had just obtained from the registry.</p>		<p>employment and/or patient contact until registration with the home health aide registry is completed. The Director of Operations/Human Resource and Administrator will be responsible for monitoring to ensure continued compliance. The Director of Operations/Human Resource and Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency remains corrected and will not recur.</p>				