

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151583	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNITY HOSPICE OF NORTHWEST INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7020 BROADWAY MERRILLVILLE, IN 46410
--	--

(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
L000000	<p>This visit was for a Hospice federal and state complaint survey.</p> <p>Survey date: July 1 - 2, 2013</p> <p>Complaint #: IN00129697 - Unsubstantiated: lack of sufficient evidence. An urelated deficiency was cited.</p> <p>Facility #: 002379</p> <p>Medicaid Vendor #: 200461590</p> <p>Surveyors: Ingrid Miller, RN, PHNS</p> <p>QA: Linda Dubak, R.N. July 8, 2013</p>	L000000	<p><u>Credible Allegation of Correction and Compliance:</u> For purposes of any allegation that Unity Hospice of Northwest Indiana, LLC ("Hospice") is not in compliance with theregulations as set forth in this statement of deficiencies, this Plan ofCorrection constitutes Hospice's credible allegation of correction andcompliance. The preparation and execution of this Response and Plan of Correction donot constitute an admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw</p>	

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

TITLE

(X6) DATE

Any deficiencystatement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 151583		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/02/2013	
NAME OF PROVIDER OR SUPPLIER UNITY HOSPICE OF NORTHWEST INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 7020 BROADWAY MERRILLVILLE, IN 46410			
(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			
L000679	<p>418.104(b) AUTHENTICATION All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.</p> <p>Based on clinical record review, policy review, and interview, the hospice failed to ensure that entries were legible for 2 of 3 (1-3) clinical records reviewed with the potential to affect all patients of the hospice.</p> <p>Findings</p> <p>1. The policy titled "How to correct an error in the medical record" with an effective date of January 17, 3013 stated, "Draw a single line through the erroneous entry. Briefly describe the error [e.g. (for example wrong date, chart) add your signature, your title, the date, and the time of the correction ... Do not scribble over documentation."</p> <p>2. Clinical record #1 evidenced a document titled "IDG [interdisciplinary group] update from 12/12/12 - 12/25/12" with a date of 12/12/12 with signatures of the medical director, Employee B, Director of Clinical Services, Employee D, Registered Nurse, Employee J, Master's of Social Work, and Employee F, Chaplain and Bereavement</p>	L000679	<p>How will you correct each deficiency? All members of the hospice team that make an entry in a patient's medical record have been in-serviced on appropriate authentication in accordance with hospice policy and currently accepted standards of practice (See attached Exhibit 679 pages 1-5 for copies of the in-services completed).</p> <p>How will you prevent the deficiency from recurring in the future? Medical record staff will audit 10% of patient records every other month to ensure that all entries are legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice. Any non-compliant entries will be reported by medical record staff to the Director of Clinical Services for follow up with specific staff involved for additional training.</p> <p>Who will be responsible for ensuring the Plan of Correction is implemented? The Director of Clinical Services is responsible for ensuring the Plan of Correction identified above is effectively implemented.</p>	07/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151583		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/02/2013	
NAME OF PROVIDER OR SUPPLIER UNITY HOSPICE OF NORTHWEST INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 7020 BROADWAY MERRILLVILLE, IN 46410			
(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>Coordinator. This document had the attending physician name crossed out with one line and the error and the initials of Employee , RN, and an added name of the physician. There was no single line through the erroneous entry. There was no brief description of the error. There was no addition of a signature, title, date or time of the correction.</p> <p>3. Clinical record #2 evidenced a document titled "Comprehensive Admission Assessment" with a date of 12/12/12 and signed by Employee K, Registered Nurse, stated, "How many times has the patient been hospitalized in past 6 months: 2." The "2" had been written over a diagonal line. The next line stated, How many times has patient been to emergency room in past 6 months? 4" The " 4 " was written over a "3." There was no single line through the erroneous entry. There was no brief description of the error. There was no addition of a signature, title, date or time of the correction.</p> <p>4. On 7/2/13 at 3:30 PM, Employee B, director of clinical services, indicated the errors were not corrected according to agency policy.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151583	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNITY HOSPICE OF NORTHWEST INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7020 BROADWAY MERRILLVILLE, IN 46410
--	--

(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