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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>151510 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>02/24/2012 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>HOSPICE OF THE WABASH VALLEY INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>400 8TH AVE<br>TERRE HAUTE, IN 47804 |
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| L0000              | <p>This visit was for a hospice federal recertification and state relicensure survey.</p> <p>Survey Dates: 2/21-24/12</p> <p>Facility #: 005127</p> <p>Medicaid Vendor #: 200142120A</p> <p>Name of Surveyor: Marty Coons, RN, PHNS</p> <p>Total Census-48<br/>Total Home Visits-3<br/>Total Record Review-11</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN<br/>March 2, 2012</p> | L0000         |   |                      |

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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| L0522  | <p>418.54(a)<br/>INITIAL ASSESSMENT</p> <p>The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with §418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)</p> <p>Based on clinical record and policy review, the hospice failed to ensure the registered nurse (RN) completed the initial assessment for 8 of 8 (# 1, 2, 3, 4, 5, 6, 7, and 9) active records reviewed creating the potential to affect all patients of the agency.</p> <p>The findings include:</p> <p>1. Policy and procedures:</p> <p>A. The policy "Policy Number REG. C45" titled "Comprehensive Assessment of the Patient" states, "1. The hospice nurse makes an initial assessment visit to the patient/caregiver within forty eight (48) hours after the patient elects hospice care in order to determine the patient's immediate care and support needs. 2. The comprehensive assessment of the IDG [interdisciplinary group] in consultation with the patient's attending physician no later than five (5) calendar days after the patient elects the hospice</p> | L0522   | L 522 418.54 (a) INITIAL ASSESSMENT The Hospice Supervisor inserviced all nursing staff members on 3-14-2012 on the correct terminology to be used to describe assessment functions at the admission of a patient. Education provided included the differences between an initial and comprehensive assessment, role of IDG members in each type of assessment, content of each and time frames for each. The nursing staff will immediately begin to document whether, during the admission visit, an initial assessment, a comprehensive assessment or both were completed. The Hospice Supervisor is responsible for monitoring staff compliance with this expectation. To correct this deficit practice in any open medical record, the Clinical Director is responsible to assure that notation is made in every open EMR, including the records identified during the survey, of the date/time that the comprehensive assessment was completed. This task will be completed by 3-30-12 Changes | 04/13/2012  |  |   |  |

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|  | <p>benefit. 3. The RN Case Manager coordinates the comprehensive assessment process and ensures that the patient's physical, emotional, psychosocial, spiritual and bereavement needs are assessed. 4. Each member of the IDG provides input into the comprehensive assessment within the scope of his/her practice and in accordance with the needs and desires of the patient. 5. Discipline-specific assessment tools obtain accurate and timely information that guide decisions for the development of the patient's plan of care. 6. The patient's comprehensive assessment is updated at a minimum every 15 days or more frequently if needed by the patient. 7. The IDG treats and prevents symptoms of the patient's disease and/or comorbidity factors based on findings in the comprehensive assessment and reassessments."</p> <p>B. The policy "Policy Number: REG. C50" titled "Comprehensive assessment-Content" states, "1. The comprehensive assessment of the patient consists of discipline-specific assessment tools that address ... g. an initial assessment of the bereavement needs of the patient's family and other involved individuals; 3. The IDG uses information obtained from the comprehensive assessment tools to</p> |   | <p>will be made to the assessment screens of our electronic medical record (EMR) to better distinguish initial and comprehensive nursing assessments by 4-13-2012. Staff will also be educated on those changes by that date. EMR system terminology will be changed to more closely reflect the language used in the hospice Condition of Participation Guidelines. We will assure that assessment screens for an initial assessment include assessment of immediate physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. Also, we will assure that the comprehensive assessment includes all factors listed in L524 Interpretive Guidelines. The Hospice Supervisor is responsible for working with a member of our quality review staff to review our EMR and make needed changes. The Hospice supervisor is responsible for holding the nursing staff accountable to correctly use the EMR screens. Corrective actions will be monitored by the hospice quality review nurse to ensure that the deficit does not recur. This person reports audit results to the Hospice Supervisor. Changes will be made to the audit tool by 4-13-2012, in alignment with EMR updates, to note use of initial or comprehensive assessments by the nursing staff, as well as date</p> |   |  |   |  |

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|  | <p>develop an effective plan of care with interventions that address the identified needs of the patient/caregivers."</p> <p>C. The policy "Policy Number: REG. C55" titled "Comprehensive Assessment-Initial" states, "Policy Statement: An initial assessment to determine the patient's immediate care and support needs is conducted by the hospice nurse within 48 hours of the patients election of hospice. ... 4. Based on the patient's needs and findings from the initial assessment, the hospice RN coordinates disciplines that must participate in the comprehensive assessment of the patient within 5 days of his or her election of hospice care."</p> <p>D. The policy "Policy # 11" with an "Effective Date: 12/02/2008 titled "418.54 Condition of participation: Initial and comprehensive assessment of the patient. 418.54 (a) Standard: Initial assessment." states, "Hospice of the Wabash Valley registered nurse completes an initial assessment within 48 hours after the election of hospice care [in accordance with 418.24] is complete...."</p> <p>2. Clinical record # 1, election date 2/13/12, evidenced an initial visit by a RN on 2/13/12. The visit documentation failed to identify if the visit was for an</p> |   | <p>the comprehensive assessment is completed. Data collection will begin with charts to be audited from 4-13-2012 forward. The Hospice Supervisor is responsible for assuring that these chart audits are reported/discussed at the monthly QAPI meetings beginning with the May meeting.</p> |   |  |   |  |

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|                    | <p>initial assessment, a comprehensive assessment, or both.</p> <p>3. Clinical record # 2, election date 1/19/12, evidenced an initial visit by a RN on 1/19/12. The visit documentation failed to identify if the visit was for an initial assessment, a comprehensive assessment, or both.</p> <p>4. Clinical record # 3, election date 10/4/11, evidenced an initial visit by a RN on 10/4/11 and an initial visit by a social worker on 10/5/11. The visits failed to identify if the visits were for an initial assessment, a comprehensive assessment, or both.</p> <p>5. Clinical record # 4, election date 1/23/12, evidenced an initial visit by a RN on 1/23/12. The visit documentation failed to identify if the visit was for an initial assessment, a comprehensive assessment, or both.</p> <p>6. Clinical record # 5, election date 2/10/12, evidenced an initial visit by a RN on 2/10/12 and an initial visit by a social worker on 2/14/12. The visits failed to identify if the visits were for an initial assessment, a comprehensive assessment, or both.</p> <p>7. Clinical record # 6, election date</p> |               |   |                      |

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|  | <p>1/25/12, evidenced an initial visit by a RN on 1/25/12 and an initial visit by a social worker on 1/27/12. The visits failed to identify if the visits were for an initial assessment, a comprehensive assessment or both.</p> <p>8. Clinical record # 7, election date 12/16/11, evidenced an initial visit by a RN on 12/16/11. The visit documentation failed to identify if the visit was for an initial assessment, a comprehensive assessment, or both.</p> <p>9. Clinical record # 9, election date 2/13/12, evidenced an initial visit by a RN on 2/13/12 and an initial visit by a social worker on 2/16/12. The visits failed to identify if the visits were for an initial assessment, a comprehensive assessment, or both.</p> |   |   |                      |   |

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| L0523  | <p>418.54(b)<br/>TIMEFRAME FOR COMPLETION OF ASSESSMENT<br/>The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure assessments were completed timely for 8 of 8 (# 1, 2, 3, 4, 5, 6, 7 and 9) active records reviewed creating the potential to affect all other assessments to the patients of the agency.</p> <p>The findings include:</p> <p>1. Policy and procedures:</p> <p>A. The policy "Policy Number REG. C45" titled "Comprehensive Assessment of the Patient" states, "1. The hospice nurse makes an initial assessment visit to the patient/caregiver within forty eight (48) hours after the patient elects hospice care in order to determine the patient's immediate care and support needs. 2. The comprehensive assessment of the IDG [interdisciplinary group] in consultation with the patient's attending physician no later than five (5) calendar days after the patient elects the hospice</p> |   |  | L0523   | <p>L523 418.54 (B) TIMEFRAME FOR COMPLETION OF ASSESSMENT To assure that comprehensive assessments are completed and documented timely, by 3-21-2012 the Hospice Supervisor will re-educate IDG members on the importance of and the policies for documenting in the patient record regarding the specific communication of the IDG at the start of care. This includes documentation of the determination of patient/family needs and identification of disciplines who are to visit the patient within the first five days of care. Responsibility for documentation of IDG communication in the patient's EMR rests with the RN. The Hospice Supervisor will monitor open medical records to validate that this practice is being followed. Corrective actions will be monitored on an ongoing basis by the Hospice Quality Review nurse, who reports audit results to the Hospice Supervisor. The hospice medical record audit tool will be modified by 3-30-12 to include specific criteria to track IDG</p> |   | 03/30/2012           |

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|  | <p>benefit. 3. The RN Case Manager coordinates the comprehensive assessment process and ensures that the patient's physical, emotional, psychosocial, spiritual and bereavement needs are assessed. 4. Each member of the IDG provides input into the comprehensive assessment within the scope of his/her practice and in accordance with the needs and desires of the patient. 5. Discipline-specific assessment tools obtain accurate and timely information that guide decisions for the development of the patient's plan of care. 6. The patient's comprehensive assessment is updated at a minimum every 15 days or more frequently if needed by the patient. 7. The IDG treats and prevents symptoms of the patient's disease and/or comorbidity factors based on findings in the comprehensive assessment and reassessments."</p> <p>B. The policy "Policy Number: REG. C50" titled "Comprehensive assessment-Content" states, "1. The comprehensive assessment of the patient consists of discipline-specific assessment tools that address ... g. an initial assessment of the bereavement needs of the patient's family and other involved individuals; 3. The IDG uses information obtained from the comprehensive assessment tools to</p> |   | <p>communication in the first five days of care, as well as date of completion of the comprehensive assessment. It is the responsibility of the Hospice Supervisor to report audit results at the monthly QAPI meeting beginning with the May meeting to allow for one month's data collection. To correct this deficit practice in any open medical records, including those identified during the survey, the Clinical Director is responsible for reviewing all open records and making a notation in every open EMR of the date/time the comprehensive assessment was completed. This task will be completed by 3-30-12.</p> |   |  |   |  |

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|                    | <p>develop an effective plan of care with interventions that address the identified needs of the patient/caregivers."</p> <p>C. The policy "Policy Number: REG. C55" titled "Comprehensive Assessment-Initial" states, "Policy Statement: An initial assessment to determine the patient's immediate care and support needs is conducted by the hospice nurse within 48 hours of the patients election of hospice. ... 4. Based on the patient's needs and findings from the initial assessment, the hospice RN coordinates disciplines that must participate in the comprehensive assessment of the patient within 5 days of his or her election of hospice care."</p> <p>D. The policy "Policy # 12" with an "Effective Date: 12/02/2008 titled "418.54 Condition of participation: Timeframe for completion of the comprehensive assessment of the patient. 418.54 (b) Standard: Timeframe for completion of the comprehensive assessment" states, "Hospice of the Wabash Valley IDT, [interdisciplinary team] in consultation with the individual's attending physician (if any), must completes the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with 418.24."</p> |               |   |                      |

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|                    | <p>2. Clinical record # 1, election date 2/13/12, evidenced an initial visit by a RN on 2/13/12. The visit documentation failed to identify if the visit was for an initial assessment, a comprehensive assessment, or both.</p> <p>3. Clinical record # 2, election date 1/19/12, evidenced an initial visit by a RN on 1/19/12. The visit documentation failed to identify if the visit was for an initial assessment, a comprehensive assessment, or both.</p> <p>4. Clinical record # 3, election date 10/4/11, evidenced an initial visit by a RN on 10/4/11 and an initial visit by a social worker on 10/5/11. The visits failed to identify if the visits were for an initial assessment, a comprehensive assessment, or both.</p> <p>5. Clinical record # 4, election date 1/23/12, evidenced an initial visit by a RN on 1/23/12. The visit documentation failed to identify if the visit was for an initial assessment, a comprehensive assessment, or both. The visit documentation failed to address the patient's immediate psychosocial, spiritual, or initial bereavement status.</p> <p>The clinical record evidenced the first</p> |               |   |                      |

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|                    | <p>social worker visit on 2/03/12. The documentation addressed the patients psychosocial, spiritual, and bereavement status 11 days after the election date.</p> <p>6. Clinical record # 5, election date 2/10/12, evidenced an initial visit by a RN on 2/10/12 and an initial visit by a social worker on 2/14/12. The visits failed to identify if the visits were for an initial assessment, a comprehensive assessment, or both.</p> <p>7. Clinical record # 6, election date 1/25/12, evidenced an initial visit by a RN on 1/25/12 and an initial visit by a social worker on 1/27/12. The visits failed to identify if the visits were for an initial assessment, a comprehensive assessment, or both.</p> <p>8. Clinical record # 7, election date 12/16/11, evidenced an initial visit by a RN on 12/16/11. The visit documentation failed to identify if the visit was for an initial assessment, a comprehensive assessment, or both.</p> <p>9. Clinical record # 9, election date 2/13/12, evidenced an initial visit by a RN on 2/13/12 and an initial visit by a social worker on 2/16/12. The visits failed to identify if the visits were for an initial assessment, a comprehensive assessment,</p> |               |   |                      |

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|                    | <p>or both.</p> <p>10. On 02/24 /12 at 4:15 PM, the hospice supervisor and the regulatory director indicated the documentation did not follow the agency policies.</p> |               |   |                      |

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE |   |
| L0533  | <p>418.54(d)<br/>UPDATE OF COMPREHENSIVE ASSESSMENT<br/>The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure the comprehensive assessment was updated and included information on the patient's progress toward desired outcomes as well as a reassessment of the patient's response to care for 5 of 8 records reviewed of patients that received services greater than 15 days. (#2, 3, 4, 6, and 7)</p> <p>Findings include:</p> <p>1. Policy and procedures:</p> <p>A. The policy "Policy Number REG.C45", titled "Comprehensive Assessment of the Patient" states, "6. The patient's comprehensive assessment is updated at a minimum every 15 days or</p> | L0533   | L533 418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT To assure that an update to the comprehensive assessment is completed for all patients by the IDG no less frequently than every 15 days, the Hospice Supervisor will re-educate the IDG on this expectation and related agency policies by 3-21-12. The RN case manager is responsible for documenting in the IDG clinical note no less frequently than every 15 days that the comprehensive assessment has been reviewed and updated and includes all disciplines/treatments/services currently involved in care, patient response to care, or any patient changes. If no changes, the RN case manager will identify and document the same. The IDG clinical note is reviewed by all team members at the IDG team | 04/13/2012           |   |

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|  | <p>more frequently if needed by the patient."</p> <p>B. The policy "Policy # 19" with an "Effective Date: 12/02/2008" titled "418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services. 418.56 (d) Standard: Review of the plan of care" states, "Hospice of the Wabash Valley IDT ... A revised plan of care includes information from the patient's updated comprehensive assessment and notes the patient's progress toward outcomes and goals specified in the plan of care."</p> <p>2. Clinical record # 2, election date 1/19/12, evidenced an initial plan of care (POC) dated 2/1/12. The record failed to evidence an updated assessment.</p> <p>3. Clinical record # 3, election date 10/4/11, evidenced an updated POC dated 1/2/12. The record failed to evidence an updated assessment.</p> <p>4. Clinical record # 4, election date 1/23/12, evidenced updated POC's dated 2/1/12 and 2/15/12. The record failed to evidence an updated assessment.</p> <p>5. Clinical record # 6, election date 1/25/12, evidenced updated POCs dated 2/1/12 and 2/15/12. The record failed to evidence updated assessments.</p> |   | <p>meeting. RN documentation will reflect the IDG members who are present and will briefly synopsise discussion and agreement with the plan of care, The EMR will be modified under the direction of the Hospice Supervisor to add a comprehensive 15th day assessment update for use by the nursing staff to capture this data. The EMR changes and staff education regarding the changes will be completed by 4-13-2012 under the responsibility of the Hospice Supervisor. These corrective actions will be monitored to ensure that the deficient practice does not recur. The Hospice medical record audit tool will be modified to include specific criteria to note whether the comprehensive assessment update is documented and reviewed at least every 15 days. Data collection by the Hospice Quality Review Nurse, who reports audit results to the Hospice Supervisor, will begin by 4-13-2012 for monthly reporting at the QAPI meeting beginning at the May meeting. The Hospice Supervisor is responsible for reporting/discussing results.</p> |                      |   |

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|                    | <p>6. Clinical record # 7, election date 12/17/11, evidenced updated POCs dated 1/4/12, 1/18/12, 2/1/12, 2/15/12, and 2/23/12. The record failed to evidence updated assessments.</p> <p>7. On 2/24/12 at 4:30 PM, the hospice supervisor indicated the updated comprehensive assessment was not found in the clinical record.</p> |               |   |                      |