

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2014
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NAME OF PROVIDER OR SUPPLIER  HARBOR LIGHT HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1841 E SUMMIT ST CROWN POINT, IN 46307
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L000000	<p>This visit was for a hospice federal recertification and state relicensure survey.</p> <p>Survey dates: May 5 - 14, 2014</p> <p>Facility #: 009088</p> <p>Medicaid Vendor #: 200121780A</p> <p>Surveyor: Ingrid Miller, MS, BSN, RN, Public Health Nurse Surveyor</p> <p>Total census: 923 patients for the last 12 months 314 active patients on census</p> <p>Harbor Light Hospice was found out of compliance with IC 16-25-3 and the Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 21, 2014</p>	L000000		

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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L000501	<p>418.52 PATIENTS' RIGHTS The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights. Based on home visit observation, clinical record review, administrative document review, policy review, and interview, the hospice failed to protect and promote the patient's right to dignity and confidentiality for 1 of 2 home visits observed (patient #8) with a registered nurse (Employee K) with the potential to affect all patients receiving care from Employee K.</p> <p>Findings</p> <p>1. On 5/8/14 at 12:35 PM, Employee K, Registered Nurse, was observed to introduce herself to patient #8 who was finishing lunch in a locked memory unit / residential level of care dining room. After the lunch, Employee K pushed back the patient's plate, cup, silverware, and food debris from the patient's table area and proceeded to start her visit with the patient. She did not have the table</p>	L000501	<p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law"</b></p> <p>Tag Statement of Correction</p>	06/13/2014

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	<p>cleaned at this time. Employee K had arranged her nursing bag, stethoscope, blood pressure cuff and other supplies on the floor with a barrier under these supplies and proceeded to pick up her supplies including a stethoscope and blood pressure cuff. The patient was seated at this table with two other patients of the residential care center. Other patients were at nearby tables and were able to hear the conversation of the nurse and the patient including the patient's health assessment responses including pain status. At this time, Employee K assessed the patient's pain status, blood pressure, axillary temperature, oxygen saturation rate, bowel sounds, and lung sounds. She then placed her stethoscope and blood pressure cuff back on the barrier. Part of the stethoscope tubing was on the floor also.</p> <p>2. On 5/18/14 at 12:40 PM, Employee C, Registered Nurse and branch manager, indicated the residential unit staff preferred that the patients not be taken to their rooms for a nursing visit by the hospice.</p> <p>3 On 5/8/14 at 12:45 PM, the charge nurse of this unit of the residential facility indicated the hospice could conduct a private visit in the patient's</p>		<p>Plan</p> <p>Monitoring</p> <p><u>L501</u></p> <p><i>418.52 Patients' Rights</i></p> <p>ED or designee will ensure that all patients' rights are protected by the Hospice as per the hospice facility policies</p> <p>All Hospice staff will be re-educated on patients' rights including review of the Harbor Light Hospice Patient/Family Orientation Handbook, Harbor Light Hospice Policy 1GG entitled "Patients Rights and Responsibilities" and Harbor Light Hospice Policy 1A entitled "Company Mission and Vision"</p> <p>All Hospice staff will complete Relias course entitled "Patient Rights" and Relias course entitled "HIPAA Training" with passing percentage of 80% or greater.</p> <p>Patient Rights and Responsibilities will be reviewed with all staff upon on hire and annually with skills check off.</p> <p>ED or designee will monitor all</p>	

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	<p>room and not in the dining room with other patients listening to the conversation between the patient and nurse.</p> <p>4. Clinical record # 8 , start of care 3/13/13 and diagnosis of frailty, included a hospice informed consent for patient #8 that was signed on 3/1/13. This document evidenced the patient / caregiver had received a copy of the orientation booklet, patient rights, and patient notice of privacy as described below in finding #5.</p> <p>5. The patient handbook titled "Patient / Family Orientation for Hospice Care" with no effective date stated, "The mission of Harbor Light Hospice is to provide dignified end - of - life care and quality services that allow our patients and their families / significant others to live life richly, deeply and meaningfully for as long as it may last and to die with dignity in the setting of their choice ... Philosophy of Care ... It is the expectation of Harbor Light Hospice that all employees and volunteers are strongly committed to the dignity and worth of each individual human being ... Section III. Patient Rights and Responsibilities ... You have the right to: Exercise your rights as a hospice patient ... Have your property and person treated with respect</p>		<p>new hire orientation and competencies and annual competencies for existing staff for three consecutive months until 100% compliance is achieved.</p>				

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	<p>... confidentiality of written, verbal, and electronic information including your medical records, information about your health, social, and financial status or about what takes place in your home ... Notice of privacy practices ... state and federal laws require Hospice to maintain the privacy and your legal rights pertaining to health information it collects and maintains about you ... Standard Precaution and patient rights ... Standard Precautions means the prevention of disease transmission through the use of infection control practices with all patients. Harbor Light Hospice complies with the infection control practices required by Indiana State Department of Health [ISDH], which were adopted by Indiana law, Indiana Occupational Safety and Health Administration ... standards and Centers for Disease Control and Prevention."</p> <p>6. The agency policy titled "Notice of Patient Rights and Responsibilities" with a revised date of 12/2/08 stated, "It is the policy of the hospice to respect the rights of patients and families, to promote and protect the exercise of these rights, and to assure that patients are informed of their rights ... Exercise ... the patient has the right to have a confidential clinical record with access to or release of patient information ... The patient has the right</p>			

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L000516	<p>to exercise his / her rights as a patient of Hospice ... have his / her property treated with respect."</p> <p>418.52(c)(5) RIGHTS OF THE PATIENT [The patient has a right to the following:] (5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.</p> <p>Based on home visit observation, clinical record review, administrative document review, policy review, and interview, the hospice failed to protect and promote the patient's right to dignity and confidentiality for 1 of 2 home visits observed (patient #8) with a registered nurse (Employee K) with the potential to affect all patients receiving care from Employee K.</p> <p>Findings</p> <p>1. On 5/8/14 at 12:35 PM, Employee K, Registered Nurse, was observed to introduce herself to patient #8 who was finishing lunch in a locked memory unit / residential level of care dining room. After the lunch, Employee K pushed back</p>	L000516	<p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law"</b></p>	06/13/2014

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	<p>the patient's plate, cup, silverware, and food debris from the patient's table area and proceeded to start her visit with the patient. She did not have the table cleaned at this time. Employee K had arranged her nursing bag, stethoscope, blood pressure cuff and other supplies on the floor with a barrier under these supplies and proceeded to pick up her supplies including a stethoscope and blood pressure cuff. The patient was seated at this table with two other patients of the residential care center. Other patients were at nearby tables and were able to hear the conversation of the nurse and the patient including the patient's health assessment responses including pain status. At this time, Employee K assessed the patient's pain status, blood pressure, axillary temperature, oxygen saturation rate, bowel sounds, and lung sounds. She then placed her stethoscope and blood pressure cuff back on the barrier. Part of the stethoscope tubing was on the floor also.</p> <p>2. On 5/18/14 at 12:40 PM, Employee C, Registered Nurse and branch manager, indicated the residential unit staff preferred that the patients not be taken to their rooms for a nursing visit by the hospice.</p>		<p>Tag</p> <p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p> <p><u>L516</u></p> <p><i>418.52(c)(5) Rights of the Patient</i></p> <p>ED or designee will ensure that all patients' rights are protected by the Hospice as per the hospice facility policies</p> <p>All Hospice staff will be re-educated on patients' rights including review of the Harbor Light Hospice Patient/Family Orientation Handbook, Harbor Light Hospice Policy 1GG entitled "Patients Rights and Responsibilities" and Harbor Light Hospice Policy 1A entitled "Company Mission and Vision"</p> <p>All Hospice staff will complete Relias course entitled "Patient Rights" and Relias course entitled "HIPAA Training" with passing percentage of 80% or greater.</p> <p>Patient Rights and Responsibilities will be reviewed with all staff upon on hire and</p>	

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	<p>3 On 5/8/14 at 12:45 PM, the charge nurse of this unit of the residential facility indicated the hospice could conduct a private visit in the patient's room and not in the dining room with other patients listening to the conversation between the patient and nurse.</p> <p>4. Clinical record # 8 , start of care 3/13/13 and diagnosis of frailty, included a hospice informed consent for patient #8 that was signed on 3/1/13. This document evidenced the patient / caregiver had received a copy of the orientation booklet, patient rights, and patient notice of privacy as described below in finding #5.</p> <p>5. The patient handbook titled "Patient / Family Orientation for Hospice Care" with no effective date stated, "The mission of Harbor Light Hospice is to provide dignified end - of - life care and quality services that allow our patients and their families / significant others to live life richly, deeply and meaningfully for as long as it may last and to die with dignity in the setting of their choice ... Philosophy of Care ... It is the expectation of Harbor Light Hospice that all employees and volunteers are strongly committed to the dignity and worth of each individual human being ... Section</p>		<p>annually with skills check off.</p> <p>ED or designee will monitor all new hire orientation and competencies and annual competencies for existing staff for three consecutive months until 100% compliance is achieved.</p>		

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	<p>III. Patient Rights and Responsibilities ... You have the right to: Exercise your rights as a hospice patient ... Have your property and person treated with respect ... confidentiality of written, verbal, and electronic information including your medical records, information about your health, social, and financial status or about what takes place in your home ... Notice of privacy practices ... state and federal laws require Hospice to maintain the privacy and your legal rights pertaining to health information it collects and maintains about you ... Standard Precaution and patient rights ... Standard Precautions means the prevention of disease transmission through the use of infection control practices with all patients. Harbor Light Hospice complies with the infection control practices required by Indiana State Department of Health [ISDH], which were adopted by Indiana law, Indiana Occupational Safety and Health Administration ... standards and Centers for Disease Control and Prevention."</p> <p>6. The agency policy titled "Notice of Patient Rights and Responsibilities" with a revised date of 12/2/08 stated, "It is the policy of the hospice to respect the rights of patients and families, to promote and protect the exercise of these rights, and to assure that patients are informed of their</p>			

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L000523	<p>rights ... Exercise ... the patient has the right to have a confidential clinical record with access to or release of patient information ... The patient has the right to exercise his / her rights as a patient of Hospice ... have his / her property treated with respect."</p> <p>418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5</p>			

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	<p>calendar days after the election of hospice care in accordance with §418.24.</p> <p>Based on clinical record review, interview, and policy review, the hospice failed to ensure the initial and comprehensive psychological assessments were completed within 5 days in 1 of 16 records reviewed (5) with the potential to affect all of the new patients of the hospice.</p> <p>Findings</p> <p>1. Clinical record #5, start of care and hospice election date of 1/24/14, evidenced an initial and comprehensive assessment completed on 1/31/14 by the social worker, more that 5 days from start of care.</p> <p>2. On 5/7/14 at 11:45 AM, Employee C, Registered Nurse and branch manager, indicated the psychosocial assessment was completed late.</p> <p>3. The agency policy titled "Initial and Comprehensive Assessment" with a date of 12/2/08 stated, "The hospice interdisciplinary group, in consultation with the attending physician, will complete a comprehensive assessment no later than 5 calendar days after the election of hospice care."</p>	L000523	<p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law"</b></p> <p>Tag</p> <p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p> <p><u>L523</u></p> <p><i>418.54(b) Timeframe for Completion of Assessment</i></p>	06/13/2014

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			<p>ED or designee will ensure that psychosocial assessments are completed by day five (5) on admissions and readmissions.</p> <p>All Hospice Social Workers and Chaplains will be re-educated on the requirement to complete their assessment within five (5) on admissions and readmissions.</p> <p>Hospice social workers and chaplains will complete Relias Training Course entitled "Psychosocial Assessment, Intervention, and Treatment Plan" with a passing percentage of 80% or greater.</p> <p>Hospice regulatory requirements for psychosocial assessments will be reviewed with social workers and chaplains upon hire and annually with skills check off.</p> <p>Admissions and readmissions will be reviewed by the ED or designee to ensure 100% timeliness of assessments for three consecutive months.</p>	

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L000537	<p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.</p> <p>Based on policy and clinical record review and interview, the hospice failed to ensure the written plan of care was developed with full participation of the interdisciplinary group in consultation with 1 of 16 records ( #7 ) reviewed with the potential to affect all of the hospice patients.</p> <p>Findings</p> <p>1. Clinical record #7, start of care 6/2912, included an established a plan of care for the benefit period of 2/19/14 - 4/19/14 that failed to evidence the signature of the chaplain.</p> <p>2. On 5/12/14 at 4:20 PM, Employee D, Registered Nurse, indicated the plan of</p>	L000537	<p>The QAPI committee will monitor clinical appropriateness audit quarterly.</p> <p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law"</b></p>	06/13/2014

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	care was not signed by the chaplain.  3. The hospice policy titled "Plan of Care" with a revision date of 12/2/08 stated, "The completed plan of care will be distributed to each member of the interdisciplinary group for signature."		Tag  Statement of Correction  Plan  Monitoring  <u>L537</u>  <i>418.56 IDG, Care Planning, Coordination of Services</i>  ED or designee will review IDG plan of care and update of plan of care during IDG review to ensure that all signatures are present on all plans of care.  All members of the IDG team will receive re-education and training on signature compliance with the plan of care for each patient.  All employees will received education and training regarding the Hospice IDG upon hire and annually thereafter.  IDG paperwork will be reviewed for 100% signature compliance at the time of designated IDG meetings by ED or designee for		

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L000559	<p>418.58 QUALITY ASSESSMENT &amp; PERFORMANCE IMPROVEMENT</p> <p>Based on administrative document and policy review and interview, it was determined the hospice failed to ensure it had developed, implemented, and maintained an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program in 1 of 1 hospice reviewed (See L 560); failed to ensure a quality assessment / performance improvement program had been implemented that was capable of showing improvement in palliative outcomes in 1 of 1 hospice reviewed (See L 561); failed to ensure it had a quality assessment / performance improvement program in place that used patient care and other relevant quality indicators in 1 of 1 hospice reviewed (See L 563); failed to ensure it had a quality assessment / performance improvement program in place that monitored the safety and</p>	L000559	<p>three months.</p> <p>The QAPI committee will monitor signature compliance quarterly.</p> <p><b>“This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law”</b></p> <p>Tag</p> <p>Statement of Correction</p>	06/13/2014			

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	<p>effectiveness of patient care activities and identified opportunities and priorities for improvement in 1 of 1 hospice reviewed (See L 564); failed to ensure it had a performance improvement program in place that focused on high risk, high volume, or problem-prone areas in 1 of 1 hospice reviewed (See L 566); failed to ensure it had in place performance improvement activities that considered incidence, prevalence, and severity of problems in 1 of 1 hospice reviewed (See L 567); failed to ensure it had implemented performance improvement activities that affected palliative outcomes, patient safety, and quality of care in 1 of 1 hospice reviewed (See L 568); failed to ensure it had developed, implemented, and evaluated performance improvement projects in 1 of 1 hospice reviewed (See L 570); failed to evidence a performance improvement program for 1 of 1 hospice (See L 572 and 573); and failed to ensure the governing body had established hospice-wide quality assessment and performance improvement efforts that addressed priorities for improved quality of care and patient safety and all improvement actions are evaluated for effectiveness in 1 of 1 hospice reviewed (See L 575).</p> <p>The cumulative effect of these systemic problems resulted in the hospice's</p>		<p>Plan</p> <p>Monitoring</p> <p><u>L559</u></p> <p><i>418.58 Quality Assessment &amp; Performance Improvement</i></p> <p>ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement program to ensure improved quality of care and all</p>	

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	inability to be in compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement.		<p>improvement actions.</p> <p>The 2014 Quality Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p> <p>The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem score color zones.</p> <p>Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care—Pain Screening; NQF#1637: Hospice and Palliative Care—Pain Assessment; NQF#1639: Hospice and Palliative Care—Dyspnea Screening; NQF#1638—Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641—Hospice and Palliative Care—Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient)</p>		

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			<p>Quarterly QAPI meeting minutes will be submitted and reviewed by Governing Body which shall include but not limited to Length of Stay&gt;180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit (Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC, ALOS, exception reports and trends, physician survey results, HIPPA/Corporate Compliance, and Performance Improvement Project Meeting notes and initiatives.</p> <p>The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports"</p> <p>During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed</p>	

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			<p>a trend below the benchmark for the past two quarters. No other trends were identified quarter over quarter.</p> <p>The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the 2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results.</p> <p>The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects.</p> <p>The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety.</p>	

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L000560	418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The hospice must develop, implement, and		<p>The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis.</p> <p>The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater.</p> <p>All Hospice staff will complete Relias course training entitled "Adverse Events &amp; Incident Reporting" with a passing percentage of 80% or greater.</p> <p>The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement</p>		

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	<p>maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.</p> <p>Based on administrative record and policy review and interview, the hospice failed to ensure it had developed, implemented, and maintained an effective, on - going, hospice -wide data driven quality assessment and performance improvement (QAPI) program in 1 of 1 hospice reviewed with the potential to affect all of the hospice's current 314 patients.</p> <p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable</p>	L000560	<p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law"</b></p> <p>Tag</p>	06/13/2014

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	<p>dying measures, fall prevention, bowel regimen, pain assessment, length of stay, clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p> <p>2. On 5/13/14 at 3:00 PM, the administrator indicated there had been no performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these initiatives in place, and these initiatives had not been removed. She indicated that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced</p>		<p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p> <p><u>L560</u></p> <p><i>418.58 Quality Assessment &amp; Performance Improvement</i></p> <p>ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement</p>	

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	<p>the use of this data.</p> <p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to patients / families, business operations, quality assurance, regulatory compliance, and corporate compliance. This process is conducted agency wide, integrated into operations, and is data driven and outcome driven. Scope: All clinic and business operations of the hospice ... 1. to collect data regarding clinical outcomes, clinical processes and procedures and business operations. 2. To analyze the data collected, based on established benchmarks, to assess the quality of hospice services and identify opportunities for improvement 3. To conduct performance improvement projects to meet or exceed established benchmarks 4. To implement initiatives to achieve and sustain improvement, 5. To evaluate outcome for sustained performance improvement 6. To ensure the established policies and standard procedures are followed in the provision of hospice services 7. To ensure that regulatory compliance is achieved / maintained in the provision of hospice</p>		<p>program to ensure improved quality of care and all improvement actions.</p> <p>The 2014 Quality Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p> <p>The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem score color zones.</p> <p>Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care—Pain Screening; NQF#1637: Hospice and Palliative Care—Pain Assessment; NQF#1639: Hospice and Palliative Care—Dyspnea Screening; NQF#1638—Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641—Hospice and Palliative Care—Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient)</p>	

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	<p>services 8. To ensure that corporate compliance standards are achieved / maintained in the provision of hospice services 9. To make recommendations to the governing body as necessary to achieve and sustain desired outcomes. Responsibilities 1. All clinical, administrative, volunteer and management staff will participate in QAPI activities including data collection and evaluation, suggestions for areas of improvement and participation in the performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be developed / implemented based on the results of the data analysis and trending and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."</p>		<p>Quarterly QAPI meeting minutes will be submitted and reviewed by Governing Body which shall include but not limited to Length of Stay&gt;180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit (Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC, ALOS, exception reports and trends, physician survey results, HIPPA/Corporate Compliance, and Performance Improvement Project Meeting notes and initiatives.</p> <p>The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports"</p> <p>During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed</p>	

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			<p>a trend below the benchmark for the past two quarters. No other trends were identified quarter over quarter.</p> <p>The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the 2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results.</p> <p>The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects.</p> <p>The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety.</p>	

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L000561	418.58(a)(1) PROGRAM SCOPE (1) The program must at least be capable of		<p>The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis.</p> <p>The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater.</p> <p>All Hospice staff will complete Relias course training entitled "Adverse Events &amp; Incident Reporting" with a passing percentage of 80% or greater.</p> <p>The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement</p>		

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	<p>showing measurable improvement in indicators related to improved palliative outcomes and hospice services.</p> <p>Based on administrative record and policy review and interview, the hospice failed to ensure a quality assessment/performance improvement program had been implemented that was capable of showing improvement in palliative outcomes in 1 of 1 hospice reviewed with the potential to affect all the hospice's patients.</p> <p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable dying measures, fall prevention, bowel regimen, pain assessment, length of stay, clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p> <p>2. On 5/13/14 at 3:00 PM, the</p>	L000561	<p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law"</b></p> <p>Tag</p> <p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p> <p><u>L561</u></p> <p>418.58(a)(1) Program Scope</p>	06/13/2014

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	<p>administrator indicated there had been no performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these initiatives in place, and these initiatives had not been removed. She indicated that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced the use of this data.</p> <p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to patients / families, business operations, quality assurance, regulatory compliance,</p>		<p>ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement program to ensure improved quality of care and all improvement actions.</p> <p>The 2014 Quality Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p>	

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	and corporate compliance. This process is conducted agency wide, integrated into operations, and is data driven and outcome driven. Scope: All clinic and business operations of the hospice ... 1. to collect data regarding clinical outcomes, clinical processes and procedures and business operations. 2. To analyze the data collected, based on established benchmarks, to assess the quality of hospice services and identify opportunities for improvement 3. To conduct performance improvement projects to meet or exceed established benchmarks 4. To implement initiatives to achieve and sustain improvement, 5. To evaluate outcome for sustained performance improvement 6. To ensure the established policies and standard procedures are followed in the provision of hospice services 7. To ensure that regulatory compliance is achieved / maintained in the provision of hospice services 8. To ensure that corporate compliance standards are achieved / maintained in the provision of hospice services 9. To make recommendations to the governing body as necessary to achieve and sustain desired outcomes. Responsibilities 1. All clinical, administrative, volunteer and management staff will participate in QAPI activities including data collection and evaluation, suggestions for areas of		The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem score color zones.  Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care--Pain Screening; NQF#1637: Hospice and Palliative Care--Pain Assessment; NQF#1639: Hospice and Palliative Care--Dyspnea Screening; NQF#1638--Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641--Hospice and Palliative Care--Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient)  Quarterly QAPI meeting minutes will be submitted and reviewed by Governing Body which shall include but not limited to Length of Stay>180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit	

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	improvement and participation in the performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be developed / implemented based on the results of the data analysis and trending and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."		(Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC, ALOS, exception reports and trends, physician survey results, HIPPA/Corporate Compliance, and Performance Improvement Project Meeting notes and initiatives.  The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports"  During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed a trend below the benchmark for the past two quarters. No other trends were identified quarter over quarter.  The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the	

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			<p>2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results.</p> <p>The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects.</p> <p>The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety.</p> <p>The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis.</p> <p>The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater.</p>		

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L000563	<p>418.58(b)(1) PROGRAM DATA (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program. Based on administrative record and policy review and interview, the hospice failed to ensure it had a quality assessment / performance improvement program in place that used patient care and other relevant quality indicators in 1 of 1 hospice reviewed with the potential to affect all of the hospice's current 314</p>	L000563	<p>All Hospice staff will complete Relias course training entitled "Adverse Events &amp; Incident Reporting" with a passing percentage of 80% or greater.</p> <p>The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement</p> <p><b>"This Plan of Correction constitutes Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of</b></p>	06/13/2014

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	<p>patients.</p> <p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable dying measures, fall prevention, bowel regimen, pain assessment, length of stay, clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p> <p>2. On 5/13/14 at 3:00 PM, the administrator indicated there had been no performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these</p>		<p><b>Correction is submitted to meet requirements established by State and Federal Law"</b> Tag Statement of Correction Plan Monitoring</p> <p><u>L563</u></p> <p><i>418.58(b)(1) Program Data</i> ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement program to ensure improved quality of care and all improvement actions. The 2014 Quality Assessment/Performance</p>				

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	<p>initiatives in place, and these initiatives had not been removed. She indicated that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced the use of this data.</p> <p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to patients / families, business operations, quality assurance, regulatory compliance, and corporate compliance. This process is conducted agency wide, integrated into operations, and is data driven and outcome driven. Scope: All clinic and business operations of the hospice ... 1. to collect data regarding clinical outcomes, clinical processes and procedures and business operations. 2. To analyze the data collected, based on established benchmarks, to assess the quality of hospice services and identify opportunities for improvement 3. To</p>		<p>Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p> <p>The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem score color zones. Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care—Pain Screening; NQF#1637: Hospice and Palliative Care—Pain Assessment; NQF#1639: Hospice and Palliative Care—Dyspnea Screening; NQF#1638—Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641—Hospice and Palliative Care—Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient) Quarterly QAPI meeting minutes will be submitted and reviewed by Governing Body which shall include but not limited to Length of Stay&gt;180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit (Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC,</p>	

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	conduct performance improvement projects to meet or exceed established benchmarks 4. To implement initiates to achieve and sustain improvement, 5. To evaluate outcome for sustained performance improvement 6. To ensure the established policies and standard procedures are followed in the provision of hospice services 7. To ensure that regulatory compliance is achieved / maintained in the provision of hospice services 8. To ensure that corporate compliance standards are achieved / maintained in the provision of hospice services 9. To make recommendations to the governing body as necessary to achieve and sustain desired outcomes. Responsibilities 1. All clinical, administrative, volunteer and management staff will participate in QAPI activities including data collection and evaluation, suggestions for areas of improvement and participation in the performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be		ALOS, exception reports and trends, physician survey results, HIPPA/Corporate Compliance, and Performance Improvement Project Meeting notes and initiatives. The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports" During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed a trend below the benchmark for the past two quarters. No other trends were identified quarter over quarter. The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the 2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results. The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance		

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L000564	<p>developed / implemented based on the results of the data analysis and trending and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."</p> <p>418.58(b)(2) PROGRAM DATA (2) The hospice must use the data collected to do the following: (i) Monitor the effectiveness and safety of services and quality of care. (ii) Identify opportunities and priorities for</p>		<p>Improvement Projects. The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety. The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis. The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater. All Hospice staff will complete Relias course training entitled "Adverse Events &amp; Incident Reporting" with a passing percentage of 80% or greater. The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement</p>	

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	<p>improvement.</p> <p>Based on administrative record and policy review and interview, the hospice failed to ensure it had a quality assessment / performance improvement program in place that monitored the safety and effectiveness of patient care activities and identified opportunities and priorities for improvement in 1 of 1 hospice reviewed with the potential to affect all the hospice's patients.</p> <p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable dying measures, fall prevention, bowel regimen, pain assessment, length of stay, clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p> <p>2. On 5/13/14 at 3:00 PM, the administrator indicated there had been no</p>	L000564	<p><b>"This Plan of Correction constitutes Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law"</b></p> <p>Tag Statement of Correction Plan Monitoring</p> <p><u>L564</u></p> <p><i>418.58(b)(2) Program Data</i> ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement</p>	06/13/2014

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	<p>performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these initiatives in place, and these initiatives had not been removed. She indicated that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced the use of this data.</p> <p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to patients / families, business operations, quality assurance, regulatory compliance, and corporate compliance. This process</p>		<p>projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement program to ensure improved quality of care and all improvement actions. The 2014 Quality Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee. The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem score color zones. Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge-</p> <p>Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care—Pain Screening; NQF#1637: Hospice and Palliative Care—Pain Assessment; NQF#1639: Hospice and Palliative Care—Dyspnea Screening; NQF#1638—Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641—Hospice and Palliative Care—Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient) Quarterly QAPI meeting minutes will be</p>				

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	performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be developed / implemented based on the results of the data analysis and trending and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."		Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results. The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects. The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety. The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis. The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater. All Hospice staff will complete Relias course training entitled "Adverse Events & Incident Reporting" with a passing percentage of 80% or greater. The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58	

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L000566	<p>418.58(c)(1)(i) PROGRAM ACTIVITIES (1) The hospice's performance improvement activities must: (i) Focus on high risk, high volume, or problem-prone areas.</p> <p>Based on administrative record and policy review and interview, the hospice failed to ensure it had a performance improvement program in place that focused on high risk, high volume, or problem-prone areas in 1 of 1 hospice reviewed with the potential to affect all the hospice's patients.</p> <p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable dying measures, fall prevention, bowel regimen, pain assessment, length of stay, clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The</p>	L000566	<p>Quality Assessment and Performance Improvement</p> <p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law"</b></p> <p>Tag</p> <p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p>	06/13/2014

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NAME OF PROVIDER OR SUPPLIER  HARBOR LIGHT HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1841 E SUMMIT ST CROWN POINT, IN 46307			
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	<p>quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p> <p>2. On 5/13/14 at 3:00 PM, the administrator indicated there had been no performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these initiatives in place, and these initiatives had not been removed. She indicated that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced the use of this data.</p> <p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the</p>		<p><u>L566</u></p> <p>418.58(c)(1)(i) Program Activities</p> <p>ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement program to ensure improved quality of care and all improvement actions.</p> <p>The 2014 Quality</p>				

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	<p>hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to patients / families, business operations, quality assurance, regulatory compliance, and corporate compliance. This process is conducted agency wide, integrated into operations, and is data driven and outcome driven. Scope: All clinic and business operations of the hospice ... 1. to collect data regarding clinical outcomes, clinical processes and procedures and business operations. 2. To analyze the data collected, based on established benchmarks, to assess the quality of hospice services and identify opportunities for improvement 3. To conduct performance improvement projects to meet or exceed established benchmarks 4. To implement initiatives to achieve and sustain improvement, 5. To evaluate outcome for sustained performance improvement 6. To ensure the established policies and standard procedures are followed in the provision of hospice services 7. To ensure that regulatory compliance is achieved / maintained in the provision of hospice services 8. To ensure that corporate compliance standards are achieved / maintained in the provision of hospice services 9. To make recommendations to the governing body as necessary to achieve and sustain desired outcomes.</p>		<p>Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p> <p>The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem score color zones.</p> <p>Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care--Pain Screening; NQF#1637: Hospice and Palliative Care--Pain Assessment; NQF#1639: Hospice and Palliative Care--Dyspnea Screening; NQF#1638--Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641--Hospice and Palliative Care--Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient)</p> <p>Quarterly QAPI meeting minutes will be submitted and reviewed by</p>	

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	Responsibilities 1. All clinical, administrative, volunteer and management staff will participate in QAPI activities including data collection and evaluation, suggestions for areas of improvement and participation in the performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be developed / implemented based on the results of the data analysis and trending and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."		Governing Body which shall include but not limited to Length of Stay>180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit (Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC, ALOS, exception reports and trends, physician survey results, HIPPA/Corporate Compliance, and Performance Improvement Project Meeting notes and initiatives.  The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports"  During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed a trend below the benchmark for the past two quarters. No other trends were identified quarter over quarter.		

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			<p>The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the 2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results.</p> <p>The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects.</p> <p>The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety.</p> <p>The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis.</p>		

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L000567	418.58(c)(1)(ii) PROGRAM ACTIVITIES [The hospice's performance improvement activities must:] (ii) Consider incidence, prevalence, and severity of problems in those areas.	L000567	The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater.  All Hospice staff will complete Relias course training entitled "Adverse Events & Incident Reporting" with a passing percentage of 80% or greater.  The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement	06/13/2014

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	<p>Based on administrative record and policy review and interview, the hospice failed to ensure it had performance improvement activities in place that considered incidence, prevalence, and severity of problems in 1 of 1 hospice reviewed with the potential to affect all the hospice's patients.</p> <p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable dying measures, fall prevention, bowel regimen, pain assessment, length of stay, clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p> <p>2. On 5/13/14 at 3:00 PM, the administrator indicated there had been no performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the</p>		<p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law"</b></p> <p>Tag</p> <p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p> <p><u>L567</u></p> <p><i>418.58(c)(1)(ii) Program Activities</i></p> <p>ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide</p>				

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	<p>performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these initiatives in place, and these initiatives had not been removed. She indicated that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced the use of this data.</p> <p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to patients / families, business operations, quality assurance, regulatory compliance, and corporate compliance. This process is conducted agency wide, integrated into operations, and is data driven and outcome driven. Scope: All clinic and business operations of the hospice ... 1. to</p>		<p>data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement program to ensure improved quality of care and all improvement actions.</p> <p>The 2014 Quality Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p> <p>The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three</p>	

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	<p>collect data regarding clinical outcomes, clinical processes and procedures and business operations. 2. To analyze the data collected, based on established benchmarks, to assess the quality of hospice services and identify opportunities for improvement 3. To conduct performance improvement projects to meet or exceed established benchmarks 4. To implement initiatives to achieve and sustain improvement, 5. To evaluate outcome for sustained performance improvement 6. To ensure the established policies and standard procedures are followed in the provision of hospice services 7. To ensure that regulatory compliance is achieved / maintained in the provision of hospice services 8. To ensure that corporate compliance standards are achieved / maintained in the provision of hospice services 9. To make recommendations to the governing body as necessary to achieve and sustain desired outcomes.</p> <p>Responsibilities 1. All clinical, administrative, volunteer and management staff will participate in QAPI activities including data collection and evaluation, suggestions for areas of improvement and participation in the performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve</p>		<p>(3) opportunities for improvement, domain performance, problem score color zones.</p> <p>Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care—Pain Screening; NQF#1637: Hospice and Palliative Care—Pain Assessment; NQF#1639: Hospice and Palliative Care—Dyspnea Screening; NQF#1638—Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641—Hospice and Palliative Care—Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient)</p> <p>Quarterly QAPI meeting minutes will be submitted and reviewed by Governing Body which shall include but not limited to Length of Stay&gt;180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit (Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC, ALOS, exception reports and trends, physician survey results,</p>	

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	palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be developed / implemented based on the results of the data analysis and trending and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."		<p>HIPPA/Corporate Compliance, and Performance Improvement Project Meeting notes and initiatives.</p> <p>The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports"</p> <p>During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed a trend below the benchmark for the past two quarters. No other trends were identified quarter over quarter.</p> <p>The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the 2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results.</p>	

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			<p>The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects.</p> <p>The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety.</p> <p>The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis.</p> <p>The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater.</p> <p>All Hospice staff will complete Relias course training entitled</p>	

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L000568	<p>418.58(c)(1)(iii) PROGRAM ACTIVITIES [The hospice's performance improvement activities must:] (iii) Affect palliative outcomes, patient safety, and quality of care.</p> <p>Based on administrative record and policy review and interview, the hospice failed to ensure it had implemented performance improvement activities that affected palliative outcomes, patient safety, and quality of care in 1 of 1 hospice reviewed with the potential to affect all the hospice's patients.</p>	L000568	<p>"Adverse Events &amp; Incident Reporting" with a passing percentage of 80% or greater.</p> <p>The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement</p> <p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to</b></p>	06/13/2014

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	<p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable dying measures, fall prevention, bowel regimen, pain assessment, length of stay, clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p> <p>2. On 5/13/14 at 3:00 PM, the administrator indicated there had been no performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these initiatives in place, and these initiatives had not been removed. She indicated</p>		<p><b>meet requirements established by State and Federal Law"</b></p> <p>Tag</p> <p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p> <p><u>L568</u></p> <p><i>418.58(c)(1)(iii) Program Activities</i></p> <p>ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance</p>				

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	<p>that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced the use of this data.</p> <p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to patients / families, business operations, quality assurance, regulatory compliance, and corporate compliance. This process is conducted agency wide, integrated into operations, and is data driven and outcome driven. Scope: All clinic and business operations of the hospice ... 1. to collect data regarding clinical outcomes, clinical processes and procedures and business operations. 2. To analyze the data collected, based on established benchmarks, to assess the quality of hospice services and identify opportunities for improvement 3. To conduct performance improvement projects to meet or exceed established</p>		<p>improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement program to ensure improved quality of care and all improvement actions.</p> <p>The 2014 Quality Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p> <p>The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem score color zones.</p> <p>Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and</p>		

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	<p>benchmarks 4. To implement initiates to achieve and sustain improvement, 5. To evaluate outcome for sustained performance improvement 6. To ensure the established policies and standard procedures are followed in the provision of hospice services 7. To ensure that regulatory compliance is achieved / maintained in the provision of hospice services 8. To ensure that corporate compliance standards are achieved / maintained in the provision of hospice services 9. To make recommendations to the governing body as necessary to achieve and sustain desired outcomes.</p> <p>Responsibilities 1. All clinical, administrative, volunteer and management staff will participate in QAPI activities including data collection and evaluation, suggestions for areas of improvement and participation in the performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be developed / implemented based on the results of the data analysis and trending</p>		<p>Palliative Care—Pain Screening; NQF#1637: Hospice and Palliative Care—Pain Assessment; NQF#1639: Hospice and Palliative Care—Dyspnea Screening; NQF#1638—Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641—Hospice and Palliative Care—Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient)</p> <p>Quarterly QAPI meeting minutes will be submitted and reviewed by Governing Body which shall include but not limited to Length of Stay&gt;180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit (Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC, ALOS, exception reports and trends, physician survey results, HIPPA/Corporate Compliance, and Performance Improvement Project Meeting notes and initiatives.</p> <p>The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance</p>	

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	and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."		<p>Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports"</p> <p>During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed a trend below the benchmark for the past two quarters. No other trends were identified quarter over quarter.</p> <p>The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the 2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results.</p> <p>The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects.</p>	

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			<p>The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety.</p> <p>The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis.</p> <p>The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater.</p> <p>All Hospice staff will complete Relias course training entitled "Adverse Events &amp; Incident Reporting" with a passing percentage of 80% or greater.</p> <p>The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three</p>	

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L000570	<p>418.58(c)(3) PROGRAM ACTIVITIES (3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.</p> <p>Based on administrative record and policy review and interview, the hospice failed to ensure it had developed, implemented, and evaluated any performance improvement projects in 1 of 1 hospice reviewed with the potential to affect all the hospice's patients.</p> <p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable dying measures, fall prevention, bowel regimen, pain assessment, length of stay,</p>	L000570	<p>months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement</p> <p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law"</b></p>	06/13/2014

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	<p>clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p> <p>2. On 5/13/14 at 3:00 PM, the administrator indicated there had been no performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these initiatives in place, and these initiatives had not been removed. She indicated that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced the use of this data.</p>		<p>Tag</p> <p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p> <p><u>L570</u></p> <p>418.58(c)((3) Program Activities</p> <p>ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will</p>	

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	<p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to patients / families, business operations, quality assurance, regulatory compliance, and corporate compliance. This process is conducted agency wide, integrated into operations, and is data driven and outcome driven. Scope: All clinic and business operations of the hospice ... 1. to collect data regarding clinical outcomes, clinical processes and procedures and business operations. 2. To analyze the data collected, based on established benchmarks, to assess the quality of hospice services and identify opportunities for improvement 3. To conduct performance improvement projects to meet or exceed established benchmarks 4. To implement initiatives to achieve and sustain improvement, 5. To evaluate outcome for sustained performance improvement 6. To ensure the established policies and standard procedures are followed in the provision of hospice services 7. To ensure that regulatory compliance is achieved / maintained in the provision of hospice services 8. To ensure that corporate compliance standards are achieved /</p>		<p>review the Hospice quality assessment and improvement program to ensure improved quality of care and all improvement actions.</p> <p>The 2014 Quality Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p> <p>The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem score color zones.</p> <p>Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care—Pain Screening; NQF#1637: Hospice and Palliative Care—Pain Assessment; NQF#1639: Hospice and Palliative Care—Dyspnea Screening; NQF#1638—Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641—Hospice</p>	

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	<p>maintained in the provision of hospice services 9. To make recommendations to the governing body as necessary to achieve and sustain desired outcomes.</p> <p>Responsibilities 1. All clinical, administrative, volunteer and management staff will participate in QAPI activities including data collection and evaluation, suggestions for areas of improvement and participation in the performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be developed / implemented based on the results of the data analysis and trending and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."</p>		<p>and Palliative Care—Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient)</p> <p>Quarterly QAPI meeting minutes will be submitted and reviewed by Governing Body which shall include but not limited to Length of Stay&gt;180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit (Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC, ALOS, exception reports and trends, physician survey results, HIPPA/Corporate Compliance, and Performance Improvement Project Meeting notes and initiatives.</p> <p>The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports"</p> <p>During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and</p>	

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			<p>documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed a trend below the benchmark for the past two quarters. No other trends were identified quarter over quarter.</p> <p>The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the 2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results.</p> <p>The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects.</p> <p>The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient</p>		

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			<p>safety.</p> <p>The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis.</p> <p>The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater.</p> <p>All Hospice staff will complete Relias course training entitled "Adverse Events &amp; Incident Reporting" with a passing percentage of 80% or greater.</p> <p>The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement</p>		

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L000572	<p>418.58(d)(1) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.</p> <p>Based on administrative record and policy review and interview, the hospice failed to evidence a performance improvement program for 1 of 1 hospice with the potential to affect all of the hospice's current 314 patients.</p> <p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable dying measures, fall prevention, bowel regimen, pain assessment, length of stay, clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p>	L000572	<p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law"</b></p> <p>Tag</p> <p>Statement of Correction</p> <p>Plan</p>	06/13/2014			

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	<p>2. On 5/13/14 at 3:00 PM, the administrator indicated there had been no performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these initiatives in place, and these initiatives had not been removed. She indicated that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced the use of this data.</p> <p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to</p>		<p>Monitoring</p> <p><u>L572</u></p> <p><i>418.58(d)(1) Performance Improvement Projects</i></p> <p>ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement program to ensure improved quality of care and all improvement actions.</p>	

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	<p>patients / families, business operations, quality assurance, regulatory compliance, and corporate compliance. This process is conducted agency wide, integrated into operations, and is data driven and outcome driven. Scope: All clinic and business operations of the hospice ... 1. to collect data regarding clinical outcomes, clinical processes and procedures and business operations. 2. To analyze the data collected, based on established benchmarks, to assess the quality of hospice services and identify opportunities for improvement 3. To conduct performance improvement projects to meet or exceed established benchmarks 4. To implement initiatives to achieve and sustain improvement, 5. To evaluate outcome for sustained performance improvement 6. To ensure the established policies and standard procedures are followed in the provision of hospice services 7. To ensure that regulatory compliance is achieved / maintained in the provision of hospice services 8. To ensure that corporate compliance standards are achieved / maintained in the provision of hospice services 9. To make recommendations to the governing body as necessary to achieve and sustain desired outcomes. Responsibilities 1. All clinical, administrative, volunteer and management staff will participate in</p>		<p>The 2014 Quality Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p> <p>The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem score color zones.</p> <p>Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care—Pain Screening; NQF#1637: Hospice and Palliative Care—Pain Assessment; NQF#1639: Hospice and Palliative Care—Dyspnea Screening; NQF#1638—Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641—Hospice and Palliative Care—Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient)</p>	

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	<p>QAPI activities including data collection and evaluation, suggestions for areas of improvement and participation in the performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be developed / implemented based on the results of the data analysis and trending and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."</p>		<p>Quarterly QAPI meeting minutes will be submitted and reviewed by Governing Body which shall include but not limited to Length of Stay&gt;180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit (Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC, ALOS, exception reports and trends, physician survey results, HIPPA/Corporate Compliance, and Performance Improvement Project Meeting notes and initiatives.</p> <p>The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports"</p> <p>During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed a trend below the benchmark for the past two quarters. No other trends were identified quarter</p>		

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			<p>over quarter.</p> <p>The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the 2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results.</p> <p>The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects.</p> <p>The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety.</p> <p>The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on</p>	

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L000573	418.58(d)(2) PERFORMANCE IMPROVEMENT PROJECTS (2)The hospice must document what performance improvement projects are being conducted, the reasons for conducting		a quarterly basis.  The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater.  All Hospice staff will complete Relias course training entitled "Adverse Events & Incident Reporting" with a passing percentage of 80% or greater.  The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement		

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	<p>these projects, and the measurable progress achieved on these projects. Based on administrative record and policy review and interview, the hospice failed to evidence a performance improvement program for 1 of 1 hospice with the potential to affect all of the hospice's current 314 patients.</p> <p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable dying measures, fall prevention, bowel regimen, pain assessment, length of stay, clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p> <p>2. On 5/13/14 at 3:00 PM, the administrator indicated there had been no performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the</p>	L000573	<p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law"</b></p> <p>Tag</p> <p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p> <p><u>L573</u></p> <p><i>418.58(d)(2) Performance Improvement Projects</i></p>	06/13/2014			

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	<p>performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these initiatives in place, and these initiatives had not been removed. She indicated that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced the use of this data.</p> <p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to patients / families, business operations, quality assurance, regulatory compliance, and corporate compliance. This process is conducted agency wide, integrated into operations, and is data driven and outcome driven. Scope: All clinic and business operations of the hospice ... 1. to</p>		<p>ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement program to ensure improved quality of care and all improvement actions.</p> <p>The 2014 Quality Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p>	

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	<p>collect data regarding clinical outcomes, clinical processes and procedures and business operations. 2. To analyze the data collected, based on established benchmarks, to assess the quality of hospice services and identify opportunities for improvement 3. To conduct performance improvement projects to meet or exceed established benchmarks 4. To implement initiatives to achieve and sustain improvement, 5. To evaluate outcome for sustained performance improvement 6. To ensure the established policies and standard procedures are followed in the provision of hospice services 7. To ensure that regulatory compliance is achieved / maintained in the provision of hospice services 8. To ensure that corporate compliance standards are achieved / maintained in the provision of hospice services 9. To make recommendations to the governing body as necessary to achieve and sustain desired outcomes.</p> <p>Responsibilities 1. All clinical, administrative, volunteer and management staff will participate in QAPI activities including data collection and evaluation, suggestions for areas of improvement and participation in the performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve</p>		<p>The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem score color zones.</p> <p>Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care--Pain Screening; NQF#1637: Hospice and Palliative Care--Pain Assessment; NQF#1639: Hospice and Palliative Care--Dyspnea Screening; NQF#1638--Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641--Hospice and Palliative Care--Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient)</p> <p>Quarterly QAPI meeting minutes will be submitted and reviewed by Governing Body which shall include but not limited to Length of Stay&gt;180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit</p>	

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	palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be developed / implemented based on the results of the data analysis and trending and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."		(Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC, ALOS, exception reports and trends, physician survey results, HIPPA/Corporate Compliance, and Performance Improvement Project Meeting notes and initiatives.  The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports"  During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed a trend below the benchmark for the past two quarters. No other trends were identified quarter over quarter.  The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the	

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			<p>2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results.</p> <p>The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects.</p> <p>The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety.</p> <p>The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis.</p> <p>The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater.</p>	

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L000575	<p>418.58(e)(2) EXECUTIVE RESPONSIBILITIES [The hospice's governing body is responsible for ensuring the following:] (2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness. Based on administrative record and policy review and interview, the hospice failed to ensure the governing body had established a hospice-wide quality</p>	L000575	<p>All Hospice staff will complete Relias course training entitled "Adverse Events &amp; Incident Reporting" with a passing percentage of 80% or greater.</p> <p>The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement</p> <p><b>"This Plan of Correction constitutes</b></p>	06/13/2014

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	<p>assessment and performance improvement program that addressed priorities for improved quality of care and patient safety and all improvement actions were evaluated for effectiveness in 1 of 1 hospice reviewed with the potential to affect all the hospice's patients.</p> <p>The findings include</p> <p>1. A facility document titled "Quality Assurance / Process Improvement Agenda first quarter 2014" with the signatures of the administrator dated 4/15/14 and the president of the hospice on 4/17/14 evidenced that the quality assurance projects were comfortable dying measures, fall prevention, bowel regimen, pain assessment, length of stay, clinical documentation, and state specific initiatives including Part D Medical management, IDG flow and process, billing, and plan of treatment. The quality assurance program failed to evidence that data was collected and analyzed in accordance with the policy.</p> <p>2. On 5/13/14 at 3:00 PM, the administrator indicated there had been no performance improvement team in place and the members of this team had not been identified yet. The quality assurance program was separate from the</p>		<p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law"</b></p> <p>Tag</p> <p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p> <p><u>L575</u></p> <p><i>418.58(e)(2) Executive Responsibilities</i></p> <p>ED or designee will ensure that the Hospice has and develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement</p>	

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	<p>performance improvement program. The administrator indicated some of the quality assurance initiatives evidenced on the document in finding #1 were no longer in place including the pain assessment data and comfortable dying measure. The template still had these initiatives in place, and these initiatives had not been removed. She indicated that clinical record review was done by each case manager for their own case load of patients and that this data was not found in the quality assurance program although she was aware of the data. She indicated there was no form or other analysis that showed the use of clinical record review data after it was compiled and that no written documents evidenced the use of this data.</p> <p>3. The agency policy titled "Quality Assessment / Performance Improvement / Corporate Compliance Plan with a date of 2014 stated, "It is the policy of the hospice to provide a systematic processes to evaluate and monitor the effectiveness, safety, and quality of hospice services to patients / families, business operations, quality assurance, regulatory compliance, and corporate compliance. This process is conducted agency wide, integrated into operations, and is data driven and outcome driven. Scope: All clinic and business operations of the hospice ... 1. to</p>		<p>program that shows improvement of quality outcomes, that uses patient care and other relevant quality indicators to monitor the safety and effectiveness of patient care activities and will identify opportunities and priorities for improvement and develop performance improvement activities that considers incidence, prevalence, and severity of problems that affect palliative outcomes, patient safety, and quality of care. Performance improvement projects will be developed, implemented, evaluated based on relevant quality indicators. The Hospice Governing Body will review the Hospice quality assessment and improvement program to ensure improved quality of care and all improvement actions.</p> <p>The 2014 Quality Assessment/Performance Improvement Plan will be reviewed with the Harbor Light Hospice 2014 QAPI committee.</p> <p>The QAPI committee will review the Hospice FEHC results on quarterly basis and monitor family satisfaction, overall Hospice rating, composite score, top three (3) opportunities for improvement, domain performance, problem</p>	

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	<p>collect data regarding clinical outcomes, clinical processes and procedures and business operations. 2. To analyze the data collected, based on established benchmarks, to assess the quality of hospice services and identify opportunities for improvement 3. To conduct performance improvement projects to meet or exceed established benchmarks 4. To implement initiatives to achieve and sustain improvement, 5. To evaluate outcome for sustained performance improvement 6. To ensure the established policies and standard procedures are followed in the provision of hospice services 7. To ensure that regulatory compliance is achieved / maintained in the provision of hospice services 8. To ensure that corporate compliance standards are achieved / maintained in the provision of hospice services 9. To make recommendations to the governing body as necessary to achieve and sustain desired outcomes. Responsibilities 1. All clinical, administrative, volunteer and management staff will participate in QAPI activities including data collection and evaluation, suggestions for areas of improvement and participation in the performance improvement projects ... activities ... the hospice performance improvement will be focused on the following ... activities that will improve</p>		<p>score color zones.</p> <p>Beginning July 1, 2014, the required CMS quality measures will be reported on admission and discharge--Hospice Item Set (HIS): NQF#1634: Hospice and Palliative Care--Pain Screening; NQF#1637: Hospice and Palliative Care--Pain Assessment; NQF#1639: Hospice and Palliative Care--Dyspnea Screening; NQF#1638--Dyspnea Treatment; NQF#1617: Patients Treated with an Opioid who are Given a Bowel Regimen; NQF#1641--Hospice and Palliative Care--Treatment Preferences; NQF#1647: Beliefs/Values Addressed (if desired by patient)</p> <p>Quarterly QAPI meeting minutes will be submitted and reviewed by Governing Body which shall include but not limited to Length of Stay&gt;180 audit, Clinical Appropriateness Audit, Evaluation of Bereavement Services Audit, Opioid Use and Bowel Regimen Audit, Discharge Audit (Discharged Live), GIP/CC Level of Care Audit, Supervisory Visit Audit, volunteer hours, ADC, ALOS, exception reports and trends, physician survey results, HIPPA/Corporate Compliance, and Performance Improvement</p>	

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	palliative outcomes, patient safety, and quality of care ... tracking adverse patient events, performing a root cause analysis, and implementing preventative measures that include feedback and education throughout the hospice organization ... A performance improvement plan will be developed / implemented based on the results of the data analysis and trending and include ... reason and indicators for plan, goals / benchmarks to be achieved, plan for success / responsible party, progress and findings, barriers identified, outcomes and / or achievements of desired results."		<p>Project Meeting notes and initiatives.</p> <p>The 2014 QAPI committee will review Harbor Light Hospice Policy #3A entitled "Quality Assessment/Performance Improvement Program" and Harbor Light Hospice Policy #3b entitled "Exception Reports"</p> <p>During April 28th, 2014, QAPI meeting a need for a Performance Improvement Project was identified and documented in the 2014 First Quarter notes regarding Overall Satisfaction scores taken from FEHC survey results that showed a trend below the benchmark for the past two quarters. No other trends were identified quarter over quarter.</p> <p>The Performance Improvement Project meetings will be held bimonthly with meeting notes and initiatives to improve overall quality submitted monthly to the 2014 QAPI committee for review. Outcome of initiatives will be monitored and evaluated based on the 2nd quarter FEHC survey results.</p>		

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			<p>The 2014 QAPI Committee will continue to meet monthly to review high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity of problems in order to develop specific Performance Improvement Projects.</p> <p>The Hospice Governing Body will meet quarterly to review hospice wide program data submitted by individual agencies to evaluate all improvement action effectiveness, priorities for improved quality care and patient safety.</p> <p>The Hospice Governing Body will provide feedback and direction to the specific hospice agencies on a quarterly basis.</p> <p>The 2014 QAPI Committee will complete Relias QAPI courses numbered 827 and 828 with a passing percentage of 80% or greater.</p> <p>All Hospice staff will complete Relias course training entitled "Adverse Events &amp; Incident Reporting" with a passing</p>	

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NAME OF PROVIDER OR SUPPLIER  HARBOR LIGHT HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1841 E SUMMIT ST CROWN POINT, IN 46307
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L000579	<p>418.60(a) PREVENTION</p> <p>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 observation, interview, and review of procedures, the hospice failed to ensure that 1 of 1 registered nurse (I) observed at a skilled nursing facility visit with a patient (4) with a Foley catheter followed the hospice procedure with a Foley catheter with the potential to affect all patients with Foley catheters in place.</p> <p>Findings</p> <p>1. On 5/8/14 at 9:15 AM, Employee I, Registered Nurse, was observed at a</p>	L000579	<p>percentage of 80% or greater.</p> <p>The Hospice Governing Body will review monthly QAPI meeting minutes, Performance Improvement Project meeting minutes and initiatives until three months of consecutive benchmark achieved to ensure compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement</p> <p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p>	06/13/2014

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	<p>nurse visit to patient #4 in a skilled nurse facility. The patient was observed to have a patent Foley catheter draining into a closed urinary drainage bag. The urine was hindered in its downward flow by the bolsters on the air mattress bumpers which impeded the flow of the urine to the drainage bag. The nurse did not alter the path of the urine flow until after the visit was ended.</p> <p>2. The procedure book titled "Lippincott Manual of Nursing Practice" with a copyright date of 2014 and written by Sandra Nettina stated, "Management of the Patient with an indwelling catheter and closed drainage system ... Maintain unobstructed urine flow ... Keep the drainage bag in a dependent position below the level of the bladder."</p> <p>3. On 5/8/14 at 3:15 PM, Employee C, Registered Nurse, indicated the tubing was not in a dependent position below the bladder.</p>		<p><b>by State and Federal Law"</b></p> <p>Tag</p> <p>Statement of Correction</p> <p>Plan</p> <p>Monitoring</p> <p><u>L579</u></p> <p>418.60(a) Prevention</p> <p>-</p> <p>ED or designee will ensure that all Hospice personnel follow the accepted standards of practice to prevent the transmission of infections and communicable diseases, including standard precautions.</p> <p>All Hospice staff will be inserviced on infection control practices and proper positioning of indwelling catheter bags including review of Lippincott Manual of Nursing Practice related to management of and indwelling catheter and closed drainage system, Harbor</p>	

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			<p>Light Hospice Policy #2A "Infection Control/Exposure Plan", and Harbor Light Hospice Policy #2B "Infection Control Policy"</p> <p>All Hospice staff will complete Relias Training entitled "Infection Control" completing with an 80% or greater</p> <p>All employees will be inserviced on the infection control practices upon hire and annually thereafter with skill check off.</p> <p>ED or designee will ensure skills checklist completed for employees on hire and annually to review infection control prevention.</p> <p>ED or designee will complete exception reports to track infections as indicated and report to QAPI monthly.</p> <p>The QAPI committee will review exception reports quarterly.</p>	

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L000782	<p>418.112(f) ORIENTATION AND TRAINING OF STAFF Hospice staff must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.</p> <p>Based on interview and review of hospice administrative documents, the hospice failed to ensure it had provided orientation regarding hospice care and services to skilled nursing facility (SNF) staff to 1 of 2 SNFs visited with the potential to affect all the SNFs where the hospice patients resided.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>On 5/18/14 at 3:15 PM, Employee C, Registered Nurse, indicated that training records for the skilled nursing facility were not available to show the hospice had provided orientation to SNF staff.</li> <li>The administrative document titled "Residential Hospice Care Agreement for Services to Residents of Nursing Facilities" with a date of 2/8/13 and signature of Employee C and skilled nursing facility administrator stated, "Hospice training. Facility shall provide</li> </ol>	L000782	<p><b>"This Plan of Correction constitutes</b></p> <p><b>Harbor Light Hospice written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established</b></p> <p><b>by State and Federal Law"</b></p> <p>Tag Statement of Correction Plan</p>	06/13/2014
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	Hospice with a list of Facility personnel who will be providing care to Hospice Patients, indicating where each person has already been provided with hospice training. For personnel who have already received training, Facility shall provide hospice with the names of the individuals who gave the training and a description of the training."		<p>Monitoring</p> <p><u>L782</u></p> <p><i>418.112(f) Orientation and Training of Staff</i></p> <p>ED or designee will ensure all contracted facilities have been educated on Hospice philosophy, including Hospice policies &amp; procedures regarding methods of comfort, pain control, symptom management, death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.</p> <p>All current SNF/NF and ICF/MR contracts will be reviewed to ensure Hospice training within the past twelve months. Immediate training will be provided to SNF/NF and ICF/MR facilities that have no documented training.</p> <p>Upon completion of contract, initial orientation to Hospice will be arranged for facility staff education within one week of receiving signed agreement.</p> <p>Annual review of SNF/NF and ICF/MR contracts will be done by</p>	

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			ED or designee to ensure ongoing education.  The QAPI committee will review orientation and training of staff monthly for three months or until 100% compliance.		