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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151590 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/03/2013 |
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| NAME OF PROVIDER OR SUPPLIER ASERACARE HOSPICE | STREET ADDRESS, CITY, STATE, ZIP CODE 3775 HALEY DR STE B NEWBURGH, IN 47630 |
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| S000000 | <p>This visit was a State re-licensure survey.</p> <p>Survey Dates: 10-1-13, 10-2-13, 10-3-13, and 10-8-13</p> <p>Facility #: 004386</p> <p>Medicaid Vendor #: 200519300</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Aseracare Hospice was found to be out of compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services; 42 CFR 418.58 Quality Assessment and Performance Improvement; and 42 CFR 418.76 Hospice Aide and Homemaker.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 25, 2013</p> | S000000 | "Preparation and/or execution of this Plan of Correction does not constitute admission or Agreement by the Provider of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state laws". The plan of Correction should be considered as a credible allegation of compliance. | |

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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| S000523 | <p>418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT</p> <p>The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure the interdisciplinary group (IDG) had consulted with the attending physicians to complete the comprehensive assessments in 9 (#s 1, 2, 4, 6, 7, 8, 10, 11, & 12) of 9 records reviewed of patients with attending physicians other than the hospice medical director creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a comprehensive assessment completed by the IDG on 9-24-13. The record failed to evidence the IDG had consulted with the patient's attending physician to complete the comprehensive assessment. 2. Clinical record number 2 included a comprehensive assessment completed by the IDG on 9-17-13. The record failed to evidence the IDG had consulted with the patient's attending physician to complete the comprehensive assessment. | S000523 | <ol style="list-style-type: none"> 1. The Hospice Executive Director (ED) will ensure that the interdisciplinary group has consulted with the attending physician to complete the the comprehensive assessments no later than 5 calendar days after the election of hospice care. 2. RN Case Managers will consult with the attending physician within 5 calendar days after the election of hospice care and information obtained during this collaboration will be documented in the Electronic Medical Record (EMR). 3. RN Case Manager in-service regarding CoP requirements completed on 11/4/2013. RN Case Managers will be in-serviced on how to document the discussion with the attending physician in the Electronic Medical Record (EMR) by 11/7/13. All clinical professional staff will be inserviced on the Admission Process by 11/7/13.4. DOCS and/or designee will audit 100% of all admission notes to ensure that the attending physician has been consulted within 5 days of admission. 100% admission audits will be | 11/07/2013 | | | |

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| | <p>3. Clinical record number 4 included a comprehensive assessment completed by the IDG on 9-20-13. The record failed to evidence the IDG had consulted with the patient's attending physician to complete the comprehensive assessment.</p> <p>4. Clinical record number 6 included a comprehensive assessment completed by the IDG on 8-13-13. The record failed to evidence the IDG had consulted with the patient's attending physician to complete the comprehensive assessment.</p> <p>5. Clinical record number 7 included a comprehensive assessment completed by the IDG on 8-14-13. The record failed to evidence the IDG had consulted with the patient's attending physician to complete the comprehensive assessment.</p> <p>6. Clinical record number 8 included a comprehensive assessment completed by the IDG on 8-15-13. The record failed to evidence the IDG had consulted with the patient's attending physician to complete the comprehensive assessment.</p> <p>7. Clinical record number 10 included a comprehensive assessment completed by the IDG on 8-30-13. The record failed to evidence the IDG had consulted with the patient's attending physician to complete</p> | | <p>conducted until 100% compliance is sustained for 3 months. Thereafter, 5% random sample of admissions (at least 5 records) will be audited monthly for three months.5. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | |

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| | <p>the comprehensive assessment.</p> <p>8. Clinical record number 11 included a comprehensive assessment completed by the IDG on 8-2-13. The record failed to evidence the IDG had consulted with the patient's attending physician to complete the comprehensive assessment.</p> <p>9. Clinical record number 12 included a comprehensive assessment completed by the IDG on 9-3-13. The record failed to evidence the IDG had consulted with the patient's attending physician to complete the comprehensive assessment.</p> <p>10. The Executive Director, employee B, and the Director of Clinical Services, employee C, were unable to provide any additional documentation and/or information when asked on 10-8-13 at 12:25 PM.</p> <p>11. The hospice's undated "Assessment - Comprehensive Assessment of the Patient" policy number PC.A80 states, "The comprehensive assessment of the patient is completed by members of the interdisciplinary team in consultation with the patient's attending physician no later than five (5) calendar days after the patient elects the hospice benefit."</p> | | | | |

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| S000533 | <p>418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT</p> <p>The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure comprehensive assessments reflected updates specific to all members of the interdisciplinary group (IDG) in 10 (#s 1, 2, 3, 5, 6, 7, 8, 9, 11, and 12) of 11 records reviewed of patients on service for longer than 14 days creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 evidenced the comprehensive assessment had been updated on 10-8-13. The update failed to evidence an evaluation of the patient's current spiritual status. 2. Clinical record number 2 evidenced | S000533 | <p>S533 418.54 (d) UPDATE OF COMPREHENSIVE ASSESSMENT 1. The Hospice Executive Director will ensure the update of the comprehensive assessment will be accomplished by the hospice interdisciplinary group (in collaboration with attending physician if any) and it will consider changes that have taken place since the initial assessment. It will include information on the patient's progress toward desired outcomes, as well as a reassessment of the patients response to care. The assessment update will be accomplished as frequently as the condition of the patient requires but no less frequently than every 15 days. 2. All RNCM's, were in-serviced on 10/24/13 and all psych/social, bereavement, volunteer and</p> | 11/07/2013 |

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| | <p>the comprehensive assessment had been updated on 10-8-13. The update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>3. Clinical record number 3 evidenced the comprehensive assessment had been updated on 8-20-13, 9-3-13, 9-17-13, and 10-1-13.</p> <p>A. The 8-20-13 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>B. The 9-3-13 update failed to evidence an evaluation of the patient's current spiritual status.</p> <p>4. Clinical record number 5 evidenced the comprehensive assessment had been updated on 9-24-13. The update failed to evidence an evaluation of the patient's current psychosocial status.</p> <p>5. Clinical record number 6 evidenced the comprehensive assessment had been updated on 8-13-13, 8-27-13, 9-10-13, 9-24-13, and 10-1-13.</p> <p>The 8-13-13 and 8-27-13 updates failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> | | <p>chaplains were in-serviced on 10/28/13 on CoP requirements and on completion of IDG content, goals and 14 day re-assessment. Above mentioned staff will complete IDG notes in the office and under the direct supervision or 1:1 assistance by DOCS or designee for the next two weeks. Above mentioned staff will be in-serviced on how to document above requirements in the EMR by 11/7/13. 3. DOCS and/or designee will monitor the completion of hospice comprehensive assessment updates by necessary members of the interdisciplinary group. During scheduled Interdisciplinary Group weekly meetings, 100% of the comprehensive assessment updates for patients scheduled to be reviewed will be audited for four weeks. After first four weeks, 50% of scheduled IDG comprehensive assessment updates will be audited for four weeks. Thereafter, 5% random sample of scheduled comprehensive assessment updates (at least 5 records) will be audited monthly for three months. 4. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | |

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| | <p>6. Clinical record number 7 evidenced the comprehensive assessment had been updated on 8-13-13, 8-27-13, 9-10-13, and 9-24-13.</p> <p>A. The 8-13-13 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>B. The 8-27-13 and 9-10-13 updates failed to evidence an evaluation of the patient's current psychosocial status.</p> <p>7. Clinical record number 8 evidenced the comprehensive assessment had been updated on 8-13-13, 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The updates failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>8. Clinical record number 9 evidenced the comprehensive assessment had been updated on 8-27-13, 9-10-13, and 9-24-13.</p> <p>The 8-27-13 and 9-24-13 updates failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>9. Clinical record number 11 evidenced the comprehensive assessment had been updated on 8-20-13, 9-3-13, 9-17-13, and 10-1-13.</p> | | | |

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| | <p>A. The 8-20-13 update failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>B. The 9-3-13 update failed to evidence an evaluation of the patient's current spiritual status.</p> <p>C. The 9-17-13 and 10-1-13 updates failed to evidence an evaluation of the patient's current psychosocial status.</p> <p>10. Clinical record number 12 evidenced the comprehensive assessment had been updated on 9-17-13 and 10-1-13. The updates failed to evidence an evaluation of the patient's current psychosocial and spiritual status.</p> <p>11. The Executive Director, employee B, and the Director of Clinical Services, employee C, were unable to provide any additional documentation and/or information when asked on 10-8-13 at 12:25 PM.</p> <p>12. The hospice's undated "Assessment - Comprehensive Assessment of the Patient" policy number PC.A80 states, "Each member of the interdisciplinary team provides input into the comprehensive assessment within the scope of his/her practice and in</p> | | | |

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| | <p>accordance with the needs and desires of the patient . . . The patient's comprehensive assessment is updated at a minimum every 14 days or more frequently if needed by the patient."</p> <p>13. The hospice's undated "Assessment - Updates to the Comprehensive Assessment" policy number PC.A100 states, "A patient's progress toward desired outcomes and response to care is reassessed as often as required by the patient's condition but no less frequently than every 14 days . . . Documentation of the interdisciplinary team's care planning meetings reflects the ongoing reassessment of the patient/caregiver's status and needs."</p> | | | | |

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| S000536 | <p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES</p> <p>Based on clinical record and hospice policy review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure services had been provided in accordance with the written plan of care in 12 of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients (See S 543); by failing to ensure plans of care provided for patient and/or caregiver education and training in 13 of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients (See S 544); by failing to ensure plans of care were individualized and included patient specific interventions to address identified problems in 11 of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients (See S 545); by failing to ensure plans of care included detailed, patient-specific interventions to address identified problems in 11 of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients (See S 547); by failing to ensure plans of care included measurable goals and outcomes in 13 of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients (See S 548); by failing to ensure clinical records</p> | S000536 | (S543)1. The Hospice Executive Director will ensure all hospice care and services furnished to patients and their families will follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. 2. On 10/14/13 ED, DOCS and interim PCC trained in accurate calculation of frequency orders and scheduling. All records requiring frequency orders and schedules are completed accurately from 10/14/13. All charts will be reviewed and corrected, if required, by 11/7/13. 3. DOCS and/or designee will monitor the accuracy of the frequency orders in relation to actual scheduled visits in accordance to care plan. The frequency order accuracy will be reviewed during each patients scheduled IDG meeting. 4. The DOCS and/or designee will audit visit frequencies for all disciplines are completed according to the plan of care on 100% of all patients for one month. 5. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the | 11/07/2013 | | | |

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| | <p>included documentation of the patient and/or caregivers involvement, understanding, and agreement with the plan of care in 13 of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients (See S 551);and by failing to ensure the interdisciplinary group (IDG) collaborated with the attending physicians to update the plans of care in 9 of 9 records reviewed of patients with attending physicians other than the hospice medical director creating the potential to affect all patients of the hospice with attending physicians other than the hospice medical director (See S 552).</p> <p>The cumulative effect of these systemic problems resulted in this hospice being found out of compliance with this condition, 42 CRC 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services.</p> | | <p>QAPI Committee if compliance has not been met or sustained. (S544)1. The Hospice Executive Director will ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. 2. RN Case Manager in-service completed regarding CoP requirements completed on 11/4/2013. RN Case Managers have been in-serviced on how to document provided patient and primary care giver education and training in the EMR. 3. DOCS and/or designee will audit 100% of admission visits, 100% of recert visits and 10% of subsequent visits to ensure that the patient and primary care giver has received education and training until compliance is sustained for 3 months. Thereafter 5% of all RN Case Managers visits will be reviewed for three months. 4. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S545) 1. The Hospice Executive Director will ensure that the hospice agency has developed an individualized written plan of care. The plan of care will reflect patient and family goals and interventions based on</p> | | |

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| | | | <p>the problems identified in the initial, comprehensive and updated comprehensive assessments. The plan of care will include all services necessary for the palliation and management of the terminal illness and related conditions. 2. All RNCM's, were in-serviced on 10/24/13 and all psych/social, bereavement, volunteer and chaplains were in-serviced on 10/28/13 regarding CoP requirements and the completion of patient specific care plans based on problems and family and patient goals. Beginning 10/30/13 and thru 11/7/13, the aforementioned staff, will receive direct supervision and 1:1 assistance completing care plans by the DOCS and/or designee. All care plans will be reviewed, updated and goals set to meet the family goals and interventions based on the problems identified by 11/7/13. 3. DOCS and/or designee will audit 100% of the care plans of patient's being reviewing in the weekly IDG meeting for the completion and individualization of care plans until compliance is sustained for 3 months. Thereafter 5% random sample of care plans (at least 5 records) will be monitored for three months. 4. Audit finds will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance</p> | | |

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| | | | <p>has not been met or sustained. (S545)(S547) 1. The Hospice Executive Director will ensure the plan of care will include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. 2. All RNCM's were in-serviced on 10/24/13 and all psych/social, bereavement, volunteer and chaplains were in-serviced on 10/28/13 regarding CoP requirements and on completion of patient specific care plans based on problems and family and patient goals. Beginning 10/30/13 and thru 11/7/13, the aforementioned staff, will receive direct supervision and 1:1 assistance completing care plans by the DOCS and/or designee. All care plans will be reviewed, updated and goals set to meet the specific patient and family needs by 11/7/13. 3. DOCS and/or designee will audit 100% of the care plans of patient's being reviewed in the weekly IDG meeting for a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs until compliance is sustained for 3 months. Thereafter 5% random sample of care plans (at least 5 records) will be monitored for three months.</p> | |

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| | | | <p>4. Audit finds will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S548) 1. The Hospice Executive Director will ensure the plan of care will include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Measurable outcomes anticipated from implementing and coordinating the plan of care. 2. All RNCM's were in-serviced on 10/24/13 and all psych/social, bereavement, volunteer and chaplains were in-serviced on 10/28/13 regarding CoP requirements and on completion of patient specific care plans based on problems and family and patient goals. Beginning 10/28/13 thru 11/7/13, the aforementioned staff will receive direct supervision and 1:1 assistance completing care plans by the DOCS and/or designee. All care plans will be reviewed, updated and goals set by using measurable outcomes by 11/7/13. 3. DOCS and/or designee will audit 100% of the care plans of patient's being reviewed in the weekly IDG meeting for goals set by using measurable outcomes until compliance is sustained for 3 months. There after 5% random sample of care plans (at least 5 records) will be monitored for 3</p> | | |

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| | | | <p>months. 4. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S551) 1. The Hospice Executive Director will ensure that the plan of care will include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: The interdisciplinary group's documentation of the patients or representative's level of understanding, involvement and agreement with the plan of care in accordance with the hospice's own policies in the clinical record. 2. All RNCM's were in-serviced on 10/24/13 and all psych/social, bereavement, volunteer and chaplains were in-serviced on 10/28/13 regarding the CoP requirement and on completion of patient specific care plans based on problems and family and patient goals. Beginning 10/28/13 thru 11/7/13, the aforementioned staff will receive direct supervision and 1:1 assistance completing care plans by the DOCS and/or designee. All care plans will be reviewed and/or updated for documentation of the patient's or representative's level of understanding, involvement and agreement with the plan of care in accordance with the hospice care plan. 3. DOCS and/or designee</p> | |

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| | | | will audit 100% of the care plans of patient's being reviewed in the weekly IDG meeting for documentation of the patient's or representative's level of understanding, involvement and agreement with the plan of care in accordance with the hospice's own policies in the clinical record until compliance is sustained for 3 months. Thereafter 5% random sample of care plans (at least 5 records) will be monitored for three months. 4. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S552) 1. The Hospice Executive Director will ensure the hospice interdisciplinary group in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan of care as frequently as the patient's condition requires but no less than frequently than 15 days. 2. Following each IDG meeting, the hospice agency will send to the attending physician, a copy of the updated Hospice IDG Comprehensive Assessment and Plan of Care Update for his review. Business office personnel, ED, DOCS and/or designee were in-serviced on this procedure on 11/1/13. 3. BOS and/or designee will audit 100% | |

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| | | | of all Hospice IDG Comprehensive Assessment and Plan of Care Updates sent to attending physicians after each IDG for confirmation of delivery and receipt. 4. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. | | |

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| S000543 | <p>418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. Based on clinical record and hospice policy review and interview, the hospice failed to ensure services had been provided in accordance with the written plan of care in 12 (#s 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, and 13) of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the interdisciplinary group (IDG) on 9-20-13. The plan of care identified skilled nursing (SN) visits were to be provided 3 times per week for 1 week, 5 times per week for 1 week, 4 times per week for 9 weeks, 2 times per week for 2 weeks, and 1 time per week for 1 week.</p> <p>A. The record evidenced only 2 SN visits the week of 9-22-13 (week 2).</p> <p>B. The plan of care identified medical</p> | S000543 | S543 418.56(b) PLAN OF CARE 1. The Hospice Executive Director will ensure all hospice care and services furnished to patients and their families will follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. 2. It was discovered on 10/8/2013 that the frequency orders and completed visits did not match in the EMR. Upon further investigation, it was determined the electronic medical record software used by our hospice auto-calculated prn visits in the frequency schedule. On 10/14/13 ED, DOCS and interim PCC trained in accurate calculation of frequency orders and scheduling. All records requiring frequency orders and schedules are completed accurately from 10/14/13. All charts will be reviewed and corrected, if required, by 11/7/13. | 11/07/2013 |

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| | <p>social services (MSS) were to be provided 1 time per week for 1 week for an evaluation. A verbal order dated 9-24-13 identified MSS visits were to be provided 2 times per week for 1 week, 1 time per week for 2 weeks, 1 every 2 weeks for 2 weeks, 1 time per week for 2 weeks, 1 every 2 weeks for 2 weeks, 2 every 2 weeks for 2 weeks and 1 every 2 weeks for 2 weeks. The record evidenced only 1 MSS visit the week of 9-22-13 (week 2).</p> <p>2. Clinical record number 2 (start of care 9-13-13) included physician verbal orders dated 9-20-13 that identified effective 9-15-13 SN visits were to be provided 7 times per week for 1 week, 2 times per week for 11 weeks, and 1 time per week for 1 week. The record included a physician verbal order dated 9-26-13 that identified that effective 9-22-13 SN visits were to be provided 5 times per week for 1 week, 2 times per week for 10 weeks, and 1 time per week for 1 week.</p> <p>A. The record evidenced only 5 SN visits the week of 9-15-13 and only 3 SN visits the week of 9-22-13.</p> <p>B. The record included a physician verbal order dated 9-17-13 that identified effective 9-15-13 MSS visits were to be provided 2 times per week for 1 week, 2 every 3 weeks for 3 weeks, and 2 every 2</p> | | <p>3. DOCS and/or designee will monitor the accuracy of the frequency orders in relation to actual scheduled visits in accordance to care plan. The frequency order accuracy will be reviewed during each patients scheduled IDG meeting.4. The DOCS and/or designee will audit visit frequencies for all disciplines are completed according to the plan of care on 100% of all patients for one month.5. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | |

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| | <p>weeks for 6 weeks. The record evidenced only 1 MSS visit the week of 9-15-13.</p> <p>3. Clinical record number 3 (start of care 5-3-13) included an update to the plan of care dated 10-1-13 that identified effective 8-2-13 SN visits were to be provided 4 times per week for 1 week, 2 times per week for 3 weeks, and 1 time per week for 9 weeks.</p> <p>A. The record evidenced only 2 SN visits the week of 8-4-13 (week 2), only 1 SN visit the week of 8-11-13 (week 3), and only 1 SN visit the week of 8-18-13 (week 4).</p> <p>B. The 10-1-13 update to the plan of care identified that effective 8-4-13 MSS visits were to be provided 1 time per week for 1 week and 1 every 2 weeks for 10 weeks. The record evidenced a MSS visit had been completed on 8-23-13 and not again until 9-12-13, a period of 3 weeks between MSS visits</p> <p>C. The 10-1-13 update to the plan of care identified that effective 8-11-13 spiritual care counseling (SCC) visits were to be provided 1 time per week for 1 week and 1 every 2 weeks for 10 weeks. The record evidenced a SCC visit on 8-17-13 and not again until 9-11-13, a period of 3 weeks and 3 days between</p> | | | | | | |

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| | <p>SCC visits.</p> <p>D. The record included a physician verbal order dated 7-30-13 that identified 2 volunteer visits were to be provided in August, September, and October. The record evidenced 3 volunteer visits had been provided in September 2013, on 9-4-13, 9-5-13, and 9-19-13.</p> <p>4. Clinical record number 4 (start of care 9-17-13) included a plan of care established by the IDG on 9-17-13. The plan of care identifies SN visits were to be provided 4 times per week for 1 week, 3 times per week for 3 weeks, 2 times per week for 2 weeks, 3 times per week for 2 weeks, 2 times per week for 3 weeks, and 3 times per week for 2 weeks.</p> <p>A. The record evidenced only 3 SN visits the week of 9-17-13 (week 1).</p> <p>B. The record evidenced only 2 SN visits the week of 9-23-13 (week 2).</p> <p>5. Clinical record number 5 (start of care 9-7-13) included a plan of care dated 9-7-13 that identified SN visits were to be provided 2 times per week for 1 week, 4 times per week for 1 week, and 3 times per week for 12 weeks. An update to the plan of care dated 9-24-13 identified that effective 9-11-13 SN visits were to be</p> | | | | |

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| | <p>provided 5 times per week for 1 week, 4 times per week for 3 weeks, and 3 times per week for 9 weeks.</p> <p>A. The record evidenced only 3 SN visits the week of 9-8-13 (week 1) and only 2 SN visits the weeks of 9-15-13 and 9-22-13 (weeks 2 and 3).</p> <p>B. The 9-24-13 update to the plan of care identified that effective 9-8-13 hospice aide visits were to be provided 5 times per week for 12 weeks and 4 times per week for 1 week. The record evidenced only 4 aide visits the weeks of 9-8-13 and 9-22-13 and only 3 aide visits the week of 9-15-13.</p> <p>C. The 9-24-13 update to the plan of care identified that effective 9-9-13 MSS visits were to be provided 1 time per week for 3 weeks, 1 every 2 weeks for 2 weeks, 1 time per week for 2 weeks, 1 every 2 weeks for 2 weeks and 1 every week for 2 weeks. The record failed to evidence any MSS visits had been provided the week of 9-15-13 (week 2).</p> <p>6. Clinical record number 6 (start of care 8-10-13) included an update to the plan of care dated 9-24-13 that identified SN visits were to be provided 1 time per week for 1 week, 4 times per week for 1 week, 3 times per week for 2 weeks, and</p> | | | | | | |

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| | <p>2 times per week for 5 weeks.</p> <p>A. The record evidenced only 3 SN visits the week of 8-11-13 (week 2).</p> <p>B. The 9-24-13 update identified that effective 8-12-13 MSS visits were to be provided 2 times per week for 1 week, 1 time per week for 4 weeks, 1 every 2 weeks for 2 weeks, and 1 time per week for 2 week. The record evidenced only 1 MSS visit the week of 8-11-13 (week 1) and failed to evidence any MSS visits had been provided the week of 9-1-13 (week 4).</p> <p>7. Clinical record number 7 (start of care 8-12-13) included an update to the plan of care dated 9-24-13 that identified SN visits were to be provided 4 times per week for 1 week, 3 times per week for 1 week, 2 times per week for 1 week, 3 times per week for 2 weeks, 2 times per week for 2 weeks, 3 times per week for 2 weeks, and 2 times per week for 4 weeks.</p> <p>A. The record evidenced only 3 SN visits had been provided the week of 8-12-13 (week 1), only 2 SN visits the weeks of 8-18-13 (week 2), 9-1-13 (week 4), and 9-8-13 (week 5).</p> <p>B. The 9-24-13 update to the plan of care identified hospice aide visits were to</p> | | | | | | |

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| | <p>be provided 2 times per week for 1 week and 3 times per week for 12 weeks. The record evidenced only 2 hospice aide visits had been provided the weeks of 8-25-13, 9-15-13, and 9-22-13.</p> <p>C. The 9-24-13 update identified that effective 8-14-13 MSS visits were to be provided 2 times per week for 1 week, 1 time per week for 1 week, 2 every 2 weeks for 2 weeks, and 1 every 2 weeks for 2 weeks. The record evidenced only 1 MSS visit the week of 8-14-13 (week 1) and failed to evidence any MSS visits had been provided the weeks of 8-25-13 and 9-8-13.</p> <p>8. Clinical record number 8 (start of care 8-11-13) included an update to the plan of care dated 9-17-13 that identified effective 8-11-13 SN visits were to be provided 3 times per week for 1 week, 2 times per week for 11 weeks, and 1 time per week for 1 week.</p> <p>A. The record evidenced only 1 SN visit had been provided the week of 9-1-13.</p> <p>B. The update identified effective 8-15-13 hospice aide services were to be provided 3 times per week for 6 weeks and 1 time per week for 6 weeks. The record evidenced only 2 aide visits the</p> | | | | |

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| | <p>weeks of 8-25-13, 9-1-13, and 9-8-13 (weeks 3, 4, and 5)</p> <p>C. The update identified effective 8-11-13 SCC visits were to be provided 4 times per week for 1 week and 1 time per week for 12 weeks. The record evidenced only 1 SCC visit the week of 8-11-13 (week 1) and failed to evidence any SCC visits had been provided the week of 8-25-13 (week 3).</p> <p>D. The update identified effective 8-15-13 MSS visits were to be provided 2 times per week for 1 week, 1 time per week for 4 weeks, 1 every 2 weeks for 2 weeks, 1 time per week for 2 weeks, 1 every 2 weeks for 2 weeks, and 1 time per week for 2 weeks. The record evidenced only 1 MSS visit the week of 8-11-13 (week 1) and failed to evidence any MSS visits had been provided the weeks of 9-1-13 and 9-22-13 (weeks 4 and 7).</p> <p>9. Clinical record number 10 (start of care 8-28-13) included an update to the plan of care dated 8-17-13 that identified SN visits were to be provided 4 times per week for 5 weeks and 3 times per week for 1 week.</p> <p>A. The record evidenced only 2 SN visits had been provided the weeks of 8-28-13, 9-1-13, 9-8-13, 9-15-13, and</p> | | | | | | |

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| | <p>9-22-13 (weeks 1 - 5).</p> <p>B. The update identified that effective 8-30-13 SCC visits were to be provided 1 time per week for 1 week, 4 times per week for 1 week, 1 every 2 weeks for 6 weeks, 1 every 3 weeks for 3 weeks, and 1 every 2 weeks for 2 weeks. The record evidenced only 1 SCC visit had been provided the week of 9-1-13 (week 2).</p> <p>C. The update identified that effective 8-29-13 MSS visits were to be provided 2 times per week for 1 week, 1 time per week for 1 week, 1 every 2 weeks for 6 weeks, 1 every 3 weeks for 2 weeks, and 1 every 2 weeks for 2 weeks. The record evidenced only 1 MSS visit had been provided the week of 8-28-13 (week 1) and failed to evidence any MSS visits had been provided the weeks of 9-1-13 and 9-15-13 (weeks 2 and 4).</p> <p>10. Clinical record number 11 included an update to the plan of care dated 10-1-13 that identified that effective 8-2-13 SN visits were to be provided 3 times per week for 1 week, 2 times per week for 4 weeks, 1 time per week for 9 weeks, 1 time per week for 1 week, and 1 every 2 weeks for 2 weeks.</p> <p>A. The record evidenced only 1 SN visit the weeks of 8-18-13 and 8-25-13</p> | | | | |

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| | <p>(weeks 4 and 5).</p> <p>B. The 10-1-13 update identified that effective 9-4-13 hospice aide services were to be provided 1 time per week for 1 week and 2 times per week for 7 weeks. The record evidenced only 1 hospice aide visit had been provided the week of 9-22-13 (week 9).</p> <p>11. Clinical record number 12 (start of care 8-29-13) included an update to the plan of care dated 10-1-13 that identified effective 8-29-13 SN visits were to be provided 4 times per week for 6 weeks.</p> <p>A. The record evidenced only 2 SN visits had been provided the weeks of 9-1-13 and 9-8-13 (weeks 2 and 3), and that only 3 SN visits had been provided the weeks of 9-15-13 and 9-22-13 (weeks 4 and 5).</p> <p>B. The 10-1-13 update evidenced that effective 9-9-13 hospice aide services were to be provided 5 days per week for 4 weeks and 4 times per week for 1 week. The record evidenced only 3 hospice aide visits had been provided the weeks of 9-9-13 and 9-15-13 and that only 4 aide visits had been provided the week of 9-22-13.</p> <p>12. Clinical record number 13 (start of</p> | | | | |

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| | <p>care 9-15-13) included a plan of care established by the IDG on 9-15-13. The plan of care identified MSS visits were to be provided 2 times per week for 1 week and 1 every 3 weeks for 3 weeks, 1 time per week for 2 weeks.</p> <p>A. The record evidenced only 1 MSS visit the week of 9-15-13.</p> <p>B. The plan of care identified SCC visits were to be provided 2 times per week for 1 week and 1 every 2 weeks for 12 weeks. The record evidenced only 1 SCC visit the week of 9-15-13.</p> <p>13. The Executive Director, employee B, and the Director of Clinical Services, employee C, were unable to provide any additional documentation and/or information when asked on 10-8-13 at 12:25 PM. The Executive Director indicated the visit frequencies "must include the prn visits. There is a computer issue. We write the visit frequencies like that so that we don't have to call the doctor every time we need an extra visit."</p> <p>14. The hospice's May 2009 "Plan of Care" policy number PC.P40 states, "Hospice care and services provided to patients and their families are in accordance with an individualized,</p> | | | | |

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| | written plan of care established by the hospice IDG in collaboration with the patient's attending physician (if any), and, if appropriate, the patient or representative and the primary caregiver." | | | |

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| S000544 | <p>418.56(b) PLAN OF CARE</p> <p>The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care provided for patient and/or caregiver education and training in 13 (#s 1 through) 13 records reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 (start of care 9-20-13) included a plan of care established by the interdisciplinary group (IDG) on 9-24-13 and updated on 10-8-13. The plan of care failed to provide for the education and training of the patient and/or caregiver regarding their responsibilities. 2. Clinical record number 2 (start of care 9-13-13) included a plan of care dated 9-13-13 and updated on 10-8-13. The plan of care failed to provide for the education and training of the patient and/or caregiver regarding their responsibilities. | S000544 | <p>S544 418.56(b) PLAN OF CARE</p> <p>1. The Hospice Executive Director will ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. 2. RN Case Manager in-service completed regarding CoP requirements completed on 11/4/2013. RN Case Managers have been in-serviced on how to document provided patient and primary care giver education and training in the EMR.3. DOCS and/or designee will audit 100% of admission visits, 100% of recert visits and 10% of subsequent visits to ensure that the patient and primary care giver has received education and training until compliance is sustained for 3 months. Thereafter 5% of all RN Case Managers visits will be reviewed for three months.4. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | 11/07/2013 |

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| | <p>3. Clinical record number 3 (start of care 5-3-13) included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The updates failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> <p>4. Clinical record number 4 (start of care 9-17-13) included a plan of care established by the IDG on 9-17-13. The plan of care failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> <p>5. Clinical record number 5 (start of care 9-7-13) included a plan of care established by the IDG on 9-10-13 and updated on 9-24-13. The plan of care and the update failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> <p>6. Clinical record number 6 (start of care 8-10-13) included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, 9-24-13, and 10-1-13. The plan of care and the updates failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> | | | | | | |

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| | <p>7. Clinical record number 7 (start of care 8-12-13) included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, and 9-24-13. The plan of care and the updates failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> <p>8. Clinical record number 8 (start of care 8-11-13) included a plan of care established on 8-13-13 and updated on 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The plan of care and the updates failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> <p>9. Clinical record number 9 (start of care 5-6-13) included updates to the plan of care dated 8-27-13, 9-10-13, and 9-24-13. The updates failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> <p>10. Clinical record number 10 (start of care 8-28-13) included a plan of care established on 9-3-13 and updated on 9-17-13 and 10-1-13. The plan of care and the updates failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> | | | |

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| | <p>11. Clinical record number 11 (start of care 7-31-13) included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The updates failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> <p>12. Clinical record number 12 (start of care 8-29-13) included a plan of care established on 9-3-13 and updated on 9-17-13 and 10-1-13. The plan of care and the updates failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> <p>13. Clinical record number 13 (start of care 9-15-13) included a plan of care established on 9-15-13. The plan of care failed to provide for the education and training of the patient and/or caregivers regarding their responsibilities.</p> <p>14. The Executive Director, employee B, and the Director of Clinical Services, employee C, were unable to provide any additional documentation and/or information when asked on 10-8-13 at 12:25 PM.</p> <p>15. The hospice's May 2009 "Plan of Care" policy number PC.P40 states,</p> | | | |

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| | "Each patient and his or her primary caregiver(s) receive education and training from the hospice as appropriate to their responsibilities for the care and services provided in the plan of care. | | | |

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| S000545 | <p>418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care were individualized and included patient specific interventions to address identified problems in 11 (#s 1, 2, 4, 5, 6, 7, 9, 10, 11, 12, and 13) of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical records numbered 1 through 13 included computer generated plans of care established by the interdisciplinary group (IDG). The plans of care all included the same generic problem lists with generalized, non-specific interventions. Clinical record number 1 included an initial comprehensive assessment completed by the registered nurse (RN), | S000545 | <p>S545 418.56 (c) CONTENT OF PLAN OF CARE 1. The Hospice Executive Director will ensure that the hospice agency has developed an individualized written plan of care. The plan of care will reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive and updated comprehensive assessments. The plan of care will include all services necessary for the palliation and management of the terminal illness and related conditions. 2. All RNCM's, were in-serviced on 10/24/13 and all psych/social, bereavement, volunteer and chaplains were in-serviced on 10/28/13 regarding CoP requirements and the completion of patient specific care plans based on problems and family and patient goals. Beginning 10/30/13 and thru 11/7/13, the aforementioned staff, will receive direct supervision and 1:1 assistance completing care</p> | 11/07/2013 | | | |

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| | <p>employee N, on 9-20-13. The assessment identifies the patient is unable to communicate discomfort, has difficulty swallowing, is unable to perform activities of daily living (ADLs), has difficulty swallowing, and sometimes chokes. The spiritual portion of the assessment, completed by the spiritual care counselor, employee O, on 9-23-13, identifies the family is sometimes overwhelmed with the patient's care. The plan of care, established by the interdisciplinary group (IDG) on 9-24-13, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>3. Clinical record number 2 included an initial comprehensive assessment completed by the RN, employee P, on 9-13-13. The assessment identifies the patient has had recurrent infections, has a left side chest tube, has decreased nutritional intake, and needs assistance with ambulation. The psychosocial portion of the initial comprehensive assessment, completed by the medical social worker (MSW) on 9-17-13, identifies the patient is "grieving loss of independence" and is "still shocked over diagnosis." The assessment states, "Diagnosis is still new, pt [patient] states it feels like a bad dream." The plan of care, established by the IDG on 9-13-13,</p> | | <p>plans by the DOCS and/or designee. All care plans will be reviewed, updated and goals set to meet the family goals and interventions based on the problems identified by 11/7/13.</p> <p>3. DOCS and/or designee will audit 100% of the care plans of patient's being reviewing in the weekly IDG meeting for the completion and individualization of care plans until compliance is sustained for 3 months. Thereafter 5% random sample of care plans (at least 5 records) will be monitored for three months.4. Audit finds will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | | | |

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| | <p>failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>4. Clinical record number 4 included an initial comprehensive assessment completed by the RN, employee D, on 9-17-13. The assessment identifies the patient is cognitively impaired, is bedfast, has an indwelling suprapubic catheter, is anemic, is unable to communicate, and is at high risk for falls. The psychosocial portion of the comprehensive assessment, dated 9-20-13, identifies the patient has a memory deficit and is unable to recognize familiar persons or places. The plan of care dated 9-24-13 failed to evidence individualized, patient-specific interventions to address the identified problems.</p> <p>5. Clinical record number 5 included an initial comprehensive assessment completed by the RN, employee N, on 9-7-13. The assessment identifies the patient cannot always communicate discomfort, is forgetful and has hallucinations, has anxiety, is chairbound, and requires maximum assist to transfer. The psychosocial portion of the assessment dated 9-9-13 identifies the patient is confused and "sees no need for assistance gets angry and upset by additional caregivers" and that the family</p> | | | |

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| | <p>is "overwhelmed at times." The plan of care dated 9-10-13 failed to include individualized, patient-specific interventions to address the identifies problems.</p> <p>6. Clinical record number 6 included an initial comprehensive assessment completed by the RN, employee N, on 8-10-13. The assessment identifies the patient is "still cough had choking issues . . . multiple narcotics pt [patient] still in pain." The assessment identifies communication issues and is unable to recall recent events. The psychosocial portion of the comprehensive assessment dated 8-12-13 identifies the patient has "depressive type psychosis, depressive D/O [disorder] and unspecified psychosis" and that the facility staff reports the patient "makes periodic statements of feeling down/sad." The spiritual portion of the assessment dated 8-13-13 identifies the patient has "limited family members / friends available or supportive." The plan of care dated 8-13-13 failed to evidence individualized, patient-specific interventions to address the identified problems.</p> <p>7. Clinical record number 7 included an initial comprehensive assessment completed by the RN, employee D, on 8-12-13. The assessment identifies the</p> | | | | |

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| | <p>patient has bilateral lower extremity edema and wears "ted" hose, requires a maximum assist of 2 people to transfer, has communication issues, is chairfast, has urinary incontinence and dysphasia, and has altered memory. The psychosocial portion of the assessment dated 8-14-13 identifies the patient has a history of a depressive disorder, has a memory deficit, and has impaired decision making processes. The spiritual portion of the assessment identifies the patient has "limited family members / friends available or supportive." The plan of care dated 8-13-13 failed to evidence individualized, patient-specific interventions to address the identified problems.</p> <p>8. Clinical record number 8 included an initial comprehensive assessment completed by the RN, employee P, on 8-11-13. The assessment identified the patient has edema with a poor response to diuretics, has cardiac arrhythmia, has a functional decline in mobility, and has abdominal distention. The psychosocial portion of the assessment dated 8-15-13 identifies the patient is "grieving loss of independence" and "has some denial regarding disease prognosis" and needs some assistance with legal documents. The spiritual portion of the comprehensive assessment dated 8-13-13</p> | | | |

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| | <p>identifies "there is some estrangement between [the patient] and [adult child]" and that there is "tension involved with family relationship." The plan of care dated 8-13-13 failed to evidence individualized, patient-specific interventions to address the identified problems.</p> <p>9. Clinical record number 9 evidenced the plan of care had been reviewed and updated on 8-27-13, 9-10-13, and 9-24-13. The updates failed to include patient-specific interventions to address an identified safety problem.</p> <p>A. The 8-27-13 update states, "being true to [the patient's self] - still smoking." The 9-10-13 update states, "increased confusion, increased fatigue, smoke with O2 on." The 9-24-13 update notes the patient is "O2 dependent" but does not specify if the patient is still smoking with the O2 on.</p> <p>B. A "Client Coordination Note Report" dated 9-26-13 states, "Small house fire at 3 AM. Fell asleep thought cig [cigarette] was out. Smelled burning. It fell beside [the patient's] chair caught carpet / Kleenex / paper plate on fire. [The patient] threw water on it put it out. Gave [the patient] a pretty good scare."</p> | | | |

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| | <p>C. The RN, employee N, stated, on 10-8-13 at 12:45 PM, "We tried to re-educate the patient and remind the patient not to smoke with the O2 on."</p> <p>10. Clinical record number 10 included an initial comprehensive assessment completed by the RN, employee N, on 8-28-13. The assessment identified the patient has a history of psychosis, "increase in hallucinations", "talks to dead [spouse]", is resistive to care, is immobile, has had nausea and vomiting and communication issues, is disoriented, and is unable to perform own ADLs. The psychosocial portion of the assessment dated 8-29-13 identified the patient has a history of past psychosis and a current diagnosis of depressive disorder and anxiety. The plan of care established by the IDG on 9-3-13 failed to evidence individualized, patient-specific interventions to address the identified needs.</p> <p>11. Clinical record number 11 included an initial comprehensive assessment completed by the RN, employee Q, on 7-31-13. The assessment identifies the patient has had increased falls, is incontinent of urine, is dependent for ADLs, has communication issues, and is disoriented times three at all times. The spiritual portion of the assessment dated</p> | | | | | | |

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| | <p>8-2-13 identifies the patient "feels somewhat abandoned by family and old friends who have already died" and that the patient would like to have more independence, the patient "feels people are rude", the patient "feels most of the caregivers are inadequate", and has a history of being difficult and combative at times. The psychosocial portion of the assessment dated 8-1-13 identifies the patient is "grieving loss of independence", has a history of depression and anxiety, "acting out toward staff."</p> <p>A. The plan of care dated 7-31-13 failed to evidence individualized, patient-specific interventions to address the identified needs.</p> <p>B. Updates to the plan of care, dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13, failed to evidence the plan of care had been updated with individualized, patient-specific interventions to address the patient's pain after a fall and measures to prevent further injury to the patient.</p> <p>1.) A "Client Coordination Note Report", signed and dated by the RN, employee R, on 8-19-13 states, "Pt had fall of 8-17-13 @ 6:15 PM when [the patient] was ambulating in room and missed WC [wheelchair] . . . Pt fell on buttocks resulting in no injuries. Facility</p> | | | | |

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| | <p>did not report fall until today."</p> <p>2.) A "Client Coordination Note Report", signed and dated by the medical social worker (MSW), employee F, on 8-30-13, states, "Pt stated has less pain today in hip."</p> <p>3.) A "Client Coordination Note Report", signed and dated by the MSW, employee F, on 9-13-13, states, "Pt continues with complaints of pain from [the patient's] recent fall."</p> <p>4.) A "Client Coordination Note Report", signed and dated by the MSW, employee F, on 9-20-13, states "Pt continues to complain of hip pain and leg discomfort."</p> <p>12. Clinical record number 12 included an initial comprehensive assessment completed by the RN, employee N, on 8-29-13. The assessment identifies the patient has dysphasia (difficulty swallowing), a decline in mobility, dyspnea (shortness of breath) at rest, is nonverbal, has had hallucinations, is irritable and restless. The psychosocial portion of the assessment dated 9-2-13 identifies the patient has had a significant memory loss, and is forgetful and confused. The spiritual portion of the assessment notes "patient grieving loss of</p> | | | |

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| | <p>independence", is withdrawn and shows no interest in anything, and that the "family is overwhelmed at times." The plan of care, established by the IDG on 9-3-13 failed to evidence individualized, patient-specific interventions to address the identified needs.</p> <p>13. Clinical record number 13 included an initial comprehensive assessment completed by the RN, employee P, on 9-15-13. The assessment identifies the patient has had a decline in mobility, a change in orientation and cognitive status, is chairfast, and is incontinent of urine. The psychosocial portion of the assessment identifies the patient has limited communication, has periods of agitation and is restless while sitting in a chair and that "family visits but staff feels family not realistic about how bad pt really is." The plan of care dated -15-13 failed to evidence individualized, patient-specific interventions to address the identified problems.</p> <p>14. The Executive Director, employee B, and the Director of Clinical Services, employee C, were unable to provide any additional documentation and/or information when asked on 10-8-13 at 12:25 PM.</p> <p>15. The hospice's May 2009 "Plan of</p> | | | | | | |

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| | Care - Content" policy number PC.P45 states, "The plan of care reflects patient and family goals and interventions that are based on the problems identified in the initial, comprehensive, and updated assessment." | | | |

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| S000547 | <p>418.56(c)(2) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care included detailed, patient-specific interventions to address identified problems in 11 (#s 1, 2, 4, 5, 6, 7, 9, 10, 11, 12, and 13) of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical records numbered 1 through 13 included computer generated plans of care established by the interdisciplinary group (IDG). The plans of care all included the same generic problem lists with generalized, non-specific interventions. 2. Clinical record number 1 included an initial comprehensive assessment completed by the registered nurse (RN), employee N, on 9-20-13. The assessment identifies the patient is unable to communicate discomfort, has difficulty swallowing, is unable to perform | S000547 | <p>S547 418.56 (c) (2) CONTENT OF PLAN OF CARE 1. The Hospice Executive Director will ensure the plan of care will include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. 2. All RNCM's were in-serviced on 10/24/13 and all psych/social, bereavement, volunteer and chaplains were in-serviced on 10/28/13 regarding CoP requirements and on completion of patient specific care plans based on problems and family and patient goals. Beginning 10/30/13 and thru 11/7/13, the aforementioned staff, will receive direct supervision and 1:1 assistance completing care plans by the DOCS and/or designee. All care plans will be reviewed, updated and goals set to meet the specific patient and family needs by 11/7/13. 3. DOCS and/or designee will audit 100% of the care plans of patient's being reviewed in the</p> | 11/07/2013 | |

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| | <p>activities of daily living (ADLs), has difficulty swallowing, and sometimes chokes. The spiritual portion of the assessment, completed by the spiritual care counselor, employee O, on 9-23-13, identifies the family is sometimes overwhelmed with the patient's care. The plan of care, established by the interdisciplinary group (IDG) on 9-24-13, failed to include individualized, patient-specific interventions to address the identified problems.</p> <p>3. Clinical record number 2 included an initial comprehensive assessment completed by the RN, employee P, on 9-13-13. The assessment identifies the patient has had recurrent infections, has a left side chest tube, has decreased nutritional intake, and needs assistance with ambulation. The psychosocial portion of the initial comprehensive assessment, completed by the medical social worker (MSW) on 9-17-13, identifies the patient is "grieving loss of independence" and is "still shocked over diagnosis." The assessment states, "Diagnosis is still new, pt [patient] states it feels like a bad dream." The plan of care, established by the IDG on 9-13-13, failed to include individualized, patient-specific interventions to address the identified problems.</p> | | <p>weekly IDG meeting for a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs until compliance is sustained for 3 months. Thereafter 5% random sample of care plans (at least 5 records) will be monitored for three months.4. Audit finds will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | | | |

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| | <p>4. Clinical record number 4 included an initial comprehensive assessment completed by the RN, employee D, on 9-17-13. The assessment identifies the patient is cognitively impaired, is bedfast, has an indwelling suprapubic catheter, is anemic, is unable to communicate, and is at high risk for falls. The psychosocial portion of the comprehensive assessment, dated 9-20-13, identifies the patient has a memory deficit and is unable to recognize familiar persons or places. The plan of care dated 9-24-13 failed to evidence individualized, patient-specific interventions to address the identified problems.</p> <p>5. Clinical record number 5 included an initial comprehensive assessment completed by the RN, employee N, on 9-7-13. The assessment identifies the patient cannot always communicate discomfort, is forgetful and has hallucinations, has anxiety, is chairbound, and requires maximum assist to transfer. The psychosocial portion of the assessment dated 9-9-13 identifies the patient is confused and "sees no need for assistance gets angry and upset by additional caregivers" and that the family is "overwhelmed at times." The plan of care dated 9-10-13 failed to include individualized, patient-specific interventions to address the identifies</p> | | | | | | |

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| | <p>problems.</p> <p>6. Clinical record number 6 included an initial comprehensive assessment completed by the RN, employee N, on 8-10-13. The assessment identifies the patient is "still cough had choking issues . . . multiple narcotics pt [patient] still in pain." The assessment identifies communication issues and is unable to recall recent events. The psychosocial portion of the comprehensive assessment dated 8-12-13 identifies the patient has "depressive type psychosis, depressive D/O [disorder] and unspecified psychosis" and that the facility staff reports the patient "makes periodic statements of feeling down/sad." The spiritual portion of the assessment dated 8-13-13 identifies the patient has "limited family members / friends available or supportive." The plan of care dated 8-13-13 failed to evidence individualized, patient-specific interventions to address the identified problems.</p> <p>7. Clinical record number 7 included an initial comprehensive assessment completed by the RN, employee D, on 8-12-13. The assessment identifies the patient has bilateral lower extremity edema and wears "ted" hose, requires a maximum assist of 2 people to transfer, has communication issues, is chairfast,</p> | | | |

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| | <p>has urinary incontinence and dysphasia, and has altered memory. The psychosocial portion of the assessment dated 8-14-13 identifies the patient has a history of a depressive disorder, has a memory deficit, and has impaired decision making processes. The spiritual portion of the assessment identifies the patient has "limited family members / friends available or supportive." The plan of care dated 8-13-13 failed to evidence individualized, patient-specific interventions to address the identified problems.</p> <p>8. Clinical record number 8 included an initial comprehensive assessment completed by the RN, employee P, on 8-11-13. The assessment identified the patient has edema with a poor response to diuretics, has cardiac arrhythmia, has a functional decline in mobility, and has abdominal distention. The psychosocial portion of the assessment dated 8-15-13 identifies the patient is "grieving loss of independence" and "has some denial regarding disease prognosis" and needs some assistance with legal documents. The spiritual portion of the comprehensive assessment dated 8-13-13 identifies "there is some estrangement between [the patient] and [adult child]" and that there is "tension involved with family relationship." The plan of care</p> | | | |

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| | <p>dated 8-13-13 failed to evidence individualized, patient-specific interventions to address the identified problems.</p> <p>9. Clinical record number 9 evidenced the plan of care had been reviewed and updated on 8-27-13, 9-10-13, and 9-24-13. The updates failed to include patient-specific interventions to address an identified safety problem.</p> <p>A. The 8-27-13 update states, "being true to [the patient's self] - still smoking." The 9-10-13 update states, "increased confusion, increased fatigue, smoke with O2 on." The 9-24-13 update notes the patient is "O2 dependent" but does not specify if the patient is still smoking with the O2 on.</p> <p>B. A "Client Coordination Note Report" dated 9-26-13 states, "Small house fire at 3 AM. Fell asleep thought cig [cigarette] was out. Smelled burning. It fell beside [the patient's] chair caught carpet / Kleenex / paper plate on fire. [The patient] threw water on it put it out. Gave [the patient] a pretty good scare."</p> <p>C. The RN, employee N, stated, on 10-8-13 at 12:45 PM, "We tried to re-educate the patient and remind the patient not to smoke with the O2 on."</p> | | | | | | |

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| | <p>10. Clinical record number 10 included an initial comprehensive assessment completed by the RN, employee N, on 8-28-13. The assessment identified the patient has a history of psychosis, "increase in hallucinations", "talks to dead [spouse]", is resistive to care, is immobile, has had nausea and vomiting and communication issues, is disoriented, and is unable to perform own ADLs. The psychosocial portion of the assessment dated 8-29-13 identified the patient has a history of past psychosis and a current diagnosis of depressive disorder and anxiety. The plan of care established by the IDG on 9-3-13 failed to evidence individualized, patient-specific interventions to address the identified needs.</p> <p>11. Clinical record number 11 included an initial comprehensive assessment completed by the RN, employee Q, on 7-31-13. The assessment identifies the patient has had increased falls, is incontinent of urine, is dependent for ADLs, has communication issues, and is disoriented times three at all times. The spiritual portion of the assessment dated 8-2-13 identifies the patient "feels somewhat abandoned by family and old friends who have already died" and that the patient would like to have more</p> | | | |

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| | <p>independence, the patient "feels people are rude", the patient "feels most of the caregivers are inadequate", and has a history of being difficult and combative at times. The psychosocial portion of the assessment dated 8-1-13 identifies the patient is "grieving loss of independence", has a history of depression and anxiety, "acting out toward staff."</p> <p>A. The plan of care dated 7-31-13 failed to evidence individualized, patient-specific interventions to address the identified needs.</p> <p>B. Updates to the plan of care, dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13, failed to evidence the plan of care had been updated with individualized, patient-specific interventions to address the patient's pain after a fall and measures to prevent further injury to the patient.</p> <p>1.) A "Client Coordination Note Report", signed and dated by the RN, employee R, on 8-19-13 states, "Pt had fall of 8-17-13 @ 6:15 PM when [the patient] was ambulating in room and missed WC [wheelchair] . . . Pt fell on buttocks resulting in no injuries. Facility did not report fall until today."</p> <p>2.) A "Client Coordination Note Report", signed and dated by the medical</p> | | | | | | |

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| | <p>social worker (MSW), employee F, on 8-30-13, states, "Pt stated has less pain today in hip."</p> <p>3.) A "Client Coordination Note Report", signed and dated by the MSW, employee F, on 9-13-13, states, "Pt continues with complaints of pain from [the patient's] recent fall."</p> <p>4.) A "Client Coordination Note Report", signed and dated by the MSW, employee F, on 9-20-13, states "Pt continues to complain of hip pain and leg discomfort."</p> <p>12. Clinical record number 12 included an initial comprehensive assessment completed by the RN, employee N, on 8-29-13. The assessment identifies the patient has dysphasia (difficulty swallowing), a decline in mobility, dyspnea (shortness of breath) at rest, is nonverbal, has had hallucinations, is irritable and restless. The psychosocial portion of the assessment dated 9-2-13 identifies the patient has had a significant memory loss, and is forgetful and confused. The spiritual portion of the assessment notes "patient grieving loss of independence", is withdrawn and shows no interest in anything, and that the "family is overwhelmed at times." The plan of care, established by the IDG on</p> | | | | | | |

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| | <p>9-3-13 failed to evidence individualized, patient-specific interventions to address the identified needs.</p> <p>13. Clinical record number 13 included an initial comprehensive assessment completed by the RN, employee P, on 9-15-13. The assessment identifies the patient has had a decline in mobility, a change in orientation and cognitive status, is chairfast, and is incontinent of urine. The psychosocial portion of the assessment identifies the patient has limited communication, has periods of agitation and is restless while sitting in a chair and that "family visits but staff feels family not realistic about how bad pt really is." The plan of care dated -15-13 failed to evidence individualized, patient-specific interventions to address the identified problems.</p> <p>14. The Executive Director, employee B, and the Director of Clinical Services, employee C, were unable to provide any additional documentation and/or information when asked on 10-8-13 at 12:25 PM.</p> <p>15. The hospice's May 2009 "Plan of Care - Content" policy number PC.P45 states, "The plan of care reflects patient and family goals and interventions that are based on the problems identified in</p> | | | |

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| | the initial, comprehensive, and updated assessment." | | | | |

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| S000548 | <p>418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.</p> <p>Based on clinical record review and interview, the hospice failed to ensure plans of care included measurable goals and outcomes in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical records numbered 1 through 13 included computer generated plans of care established by the interdisciplinary group (IDG). The plans of care included the same non-specific goals and outcomes for each identified problem. The plans of care failed to evidence the outcomes were specific enough to be measured. Clinical record number 1 (start of care 9-20-13) included a plan of care established by the interdisciplinary group (IDG) on 9-24-13 and reviewed and updated on 10-8-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes | S000548 | <p>S548 418.56 (c) (3) CONTENT OF PLAN OF CARE 1. The Hospice Executive Director will ensure the plan of care will include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Measurable outcomes anticipated from implementing and coordinating the plan of care. 2. All RNCM's were in-serviced on 10/24/13 and all psych/social, bereavement, volunteer and chaplains were in-serviced on 10/28/13 regarding CoP requirements and on completion of patient specific care plans based on problems and family and patient goals. Beginning 10/28/13 thru 11/7/13, the aforementioned staff will receive direct supervision and 1:1 assistance completing care plans by the DOCS and/or designee. All care plans will be reviewed, updated and goals set by using measurable outcomes by 11/7/13.3. DOCS and/or designee will audit 100% of the care plans of patient's being reviewed in the weekly IDG meeting for goals set by using</p> | 11/07/2013 | | | |

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| | <p>included the following:</p> <p>A. "Need for observation and assessment of altered comfort . . . G [goal]: patient/caregiver will understand the pain scale, how to manage pain and report changes to hospice."</p> <p>B. "Need for observation and assessment of cardiac/circulatory system . . . G: Cardiac exacerbations are identified promptly and interventions initiated quickly to minimize associated risks."</p> <p>C. "Need for O/A [observation and assessment] of sensory / neurological status . . .G: Patient tolerates assessment of sensory / neurological status."</p> <p>D. "Need of O/A respiratory status . . . G: patient's respiratory status is stabilized to comfort within realm of disease."</p> <p>E. "Need for O/A genitourinary status . . . G: Patient is free from exacerbations of genitourinary disease since last visit."</p> <p>F. "Need for observation and assessment of skin . . . G: patient is free from exacerbations of integument status since last visit."</p> <p>3. Clinical record number 2 (start of care 9-13-13) included a plan of care dated</p> | | <p>measurable outcomes until compliance is sustained for 3 months. There after 5% random sample of care plans (at least 5 records) will be monitored for 3 months.4. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | |

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| | <p>9-13-13 and a review and update dated 10-8-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>A. "Need for observation and assessment of altered comfort . . . G [goal]: patient / caregiver will understand the pain scale, how to manage pain and report changes to hospice."</p> <p>B. "Need for observation and assessment of cardiac / circulatory system . . . G: Cardiac exacerbations are identified promptly and interventions initiated quickly to minimize associated risks."</p> <p>C. "Altered respiratory status . . . G: Patient has minimal problems with respiratory comfort, patient has minimal problems with secretions."</p> <p>D. "Need for home health aide services to assist with personal care needs." No goals specified.</p> <p>4. Clinical record number 3 (start of care 5-3-13) included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13.</p> | | | | | | |

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| | <p>A. The 8-20-13 update included goals for "comfort, safety, dignity . . . provide socialization and support . . . decrease [the patient's] sense of isolation and loneliness." There were no goals documented for the volunteer services.</p> <p>B. The 9-3-13 update included goals for "comfort, safety, dignity." There were no goals documented for the social services, spiritual care, or volunteer services."</p> <p>C. The 9-17-13 update included goals for "hospice services to take over managing patient care you [sic] to patients inability to tolerate the beauty shop." There were no goals documented for social services, spiritual care counseling, or volunteer services.</p> <p>D. The 10-1-13 update failed to include any measurable goals or outcomes for nursing, social services, spiritual care counseling, or volunteer services.</p> <p>5. Clinical record number 4 (start of care 9-17-13) included a plan of care established by the IDG on 9-17-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> | | | | |

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| | <p>A. "Altered sensory / neurological status . . . G: patient tolerates assessment of sensory / neurological status."</p> <p>B. "Altered respiratory status . . . Patient's respiratory status is stabilized to comfort within realms of disease."</p> <p>C. Altered Genitourinary . . . G: Patient is free from exacerbations of genitourinary disease since last visit."</p> <p>D. "Altered skin integrity . . . G: Patient is free from exacerbations of integument status since last visit."</p> <p>E. "Need for home health aide services to assist with person care needs." No goals documented.</p> <p>F. "Self care deficits." No goals documented.</p> <p>G. "Need for volunteer for companionship, support and activities . . . G: Patient has optimal companionship support throughout the declining process."</p> <p>6. Clinical record number 5 (start of care 9-7-13) included a plan of care established by the IDG on 9-10-13 and updated on 9-24-13. The plan of care identified multiple problems to be</p> | | | | | | |

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| | <p>addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>A. "Altered comfort . . . G: Patient/caregiver(s) understand need to report changes in pain level to hospice RN . . . understands the cause(s) of pain . . . verbalizes understanding of the administration and side effect of pain medication."</p> <p>B. "Altered cardiac/circulatory system." No goals documented.</p> <p>C. "Altered sensory/neurological status." No goals documented.</p> <p>D. "Altered respiratory status . . . G: Patient has minimal problems with respiratory comfort . . . secretions."</p> <p>E. "Potential for constipation related to opioid use and/or other GI problem." No goal documented.</p> <p>F. "Need for home health aide services." No goals documented.</p> <p>G. "Altered skin integrity." No goals documented.</p> <p>H. "Need for volunteer services" No goals documented.</p> | | | |

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| | <p>7. Clinical record number 6 (start of care 8-10-13) included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, 9-24-13, and 10-1-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>A. "Altered comfort . . . G: Patient/caregiver will understand the pain scale, how to manage pain and report changes to hospice."</p> <p>B. "Altered sensory/neurological status." No goals documented.</p> <p>C. "Need for home health aide services to assist with personal care needs." No goals documented.</p> <p>D. "Self care deficits." No goals documented.</p> <p>E. "Need for O/A sensory / neurological status . . . G. Patient tolerates assessment of sensory / neurological status."</p> <p>F. "Need for volunteer for companionship, support, and activities . . . G: Patient has optimal companionship support throughout the declining</p> | | | | | | |

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| | <p>process."</p> <p>8. Clinical record number 7 (start of care 8-12-13) included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, and 9-24-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>A. "Altered cardiac / circulatory system . . . G: Cardiac exacerbations are identified promptly and intervention initiated quickly to minimize associated risks."</p> <p>B. "Altered sensory / neurological status . . . G: Patient tolerates assessment of sensory/neurological status."</p> <p>C. "Potential for constipation related to opioid use and/or other GI problem." No goals documented.</p> <p>D. "Need for home health aide services to assist with personal care needs." No goals documented.</p> <p>E. "Need for volunteer services." No goals documented.</p> <p>9. Clinical record number 8 (start of care 8-11-13) included a plan of care</p> | | | | | | |

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| | <p>established on 8-13-13 and updated on 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>A. "Altered skin integrity . . . G: Patient is free from exacerbations of integument status since last visit."</p> <p>B. "Self care deficits." No goals documented.</p> <p>C. "Need for observation and assessment of cardiac/circulatory system . . . G: Cardiac exacerbations are identified promptly and interventions initiated quickly to minimize associated risks."</p> <p>D. "Altered respiratory status . . . G: Patient has minimal problems with respiratory comfort . . . secretions."</p> <p>10. Clinical record number 9 (start of care 5-6-13) included updates to the plan of care dated 8-27-13, 9-10-13, and 9-24-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>A. "Altered cardiac/circulatory system</p> | | | | |

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| | <p>. . . G: Cardiac exacerbations are identified promptly and interventions initiated quickly to minimize associated risks."</p> <p>B. "Altered nutrition/hydration" No goals documented.</p> <p>C. "Altered respiratory status . . . G: Patient's respiratory status is stabilized to comfort within realms of disease . . . Patient has minimal problems with respiratory comfort . . . secretions."</p> <p>D. "Self care deficits." No goals documented.</p> <p>E. "Need for home health aide services to assist with personal care needs." No goals documented.</p> <p>F. "Need for volunteer services." No goals documented.</p> <p>G. "Altered sensory / neurological status . . . G: Patient tolerates assessment of sensory/neurological status."</p> <p>11. Clinical record number 10 (start of care 8-28-13) included a plan of care established on 9-3-13 and updated on 9-17-13 and 10-1-13. The plan of care identified multiple problems to be addressed by the IDG. The identified</p> | | | |

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| | <p>problems and expected outcomes included the following:</p> <p>A. "Altered comfort" No goals documented.</p> <p>B. "Altered sensory / neurological status." No goals documented.</p> <p>C. "Altered nutrition / hydration." No goals documented.</p> <p>D. "Altered respiratory status . . . G: Patient has minimal problems with respiratory comfort . . . secretions."</p> <p>E. "Altered genitourinary." No goals documented.</p> <p>F. "Altered skin integrity . . . G: Patient is free from exacerbations of integument status since last visit."</p> <p>G. "Altered gastrointestinal." No goals documented.</p> <p>H. "Potential for constipation related to opioid use and/or other GI problem." No goals documented.</p> <p>12. Clinical record number 11 (start of care 7-31-13) included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The plan of care identified</p> | | | | | | |

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| | <p>multiple problems to be addressed by the IDG. The updates failed to evidence any updated goals.</p> <p>13. Clinical record number 12 (start of care 8-29-13) included a plan of care established on 9-3-13 and updated on 9-17-13, and 10-1-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>A. "Altered comfort." No goals documented.</p> <p>B. "Altered sensory / neurological status." No goals documented.</p> <p>C. "Altered nutrition / hydration." No goals documented.</p> <p>D. "Altered respiratory status." No goals documented.</p> <p>E. "Need for skilled teaching of respiratory status . . . G: Patient has minimal problems with respiratory comfort . . . secretions."</p> <p>F. "Altered genitourinary." No goals documented.</p> <p>G. "Altered gastrointestinal." No</p> | | | |

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| | <p>goals documented.</p> <p>14. Clinical record number 13 (start of care 9-15-13) included a plan of care established on 9-15-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>A. "Altered comfort." No goals documented.</p> <p>B. "Altered nutrition/hydration." No goals documented.</p> <p>C. "Self care deficit." No goals documented.</p> <p>D. "Need for home health aide services to assist with personal care needs." No goals documented.</p> <p>E. "Need for volunteer services." No goals documented.</p> <p>15. The Executive Director, employee B, and the Director of Clinical Services, employee C, were unable to provide any additional documentation and/or information when asked on 10-8-13 at 12:25 PM.</p> | | | | | | |

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| S000551 | <p>418.56(c)(6) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure clinical records included documentation of the patient and/or caregivers involvement, understanding, and agreement with the plan of care in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 (start of care 9-20-13) included a plan of care established by the interdisciplinary group (IDG) on 9-24-13 and reviewed and updated on 10-8-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> | S000551 | <p>S551 418.56 (c) (6) CONTENT OF PLAN OF CARE 1. The Hospice Executive Director will ensure that the plan of care will include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: The interdisciplinary group's documentation of the patients or representative's level of understanding, involvement and agreement with the plan of care in accordance with the hospice's own policies in the clinical record. 2. All RNCM's were in-serviced on 10/24/13 and all psych/social, bereavement, volunteer and chaplains were in-serviced on 10/28/13 regarding the CoP requirement and on completion of patient specific care plans based on problems and family and patient goals. Beginning 10/28/13 thru 11/7/13, the aforementioned staff will receive direct supervision and 1:1 assistance completing care plans by the DOCS and/or designee. All care plans will be reviewed and/or</p> | 11/07/2013 | | | |

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| | <p>2. Clinical record number 2 (start of care 9-13-13) included a plan of care dated 9-13-13 and a review and update dated 10-8-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>3. Clinical record number 3 (start of care 5-3-13) included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>4. Clinical record number 4 (start of care 9-17-13) included a plan of care established by the IDG on 9-17-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>5. Clinical record number 5 (start of care 9-7-13) included a plan of care</p> | | <p>updated for documentation of the patient's or representative's level of understanding, involvement and agreement with the plan of care in accordance with the hospice care plan. 3. DOCS and/or designee will audit 100% of the care plans of patient's being reviewed in the weekly IDG meeting for documentation of the patient's or representative's level of understanding, involvement and agreement with the plan of care in accordance with the hospice's own policies in the clinical record until compliance is sustained for 3 months. Thereafter 5% random sample of care plans (at least 5 records) will be monitored for three months.4. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | | | |

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| | <p>established by the IDG on 9-10-13 and updated on 9-24-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>6. Clinical record number 6 (start of care 8-10-13) included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, 9-24-13, and 10-1-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>7. Clinical record number 7 (start of care 8-12-13) included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, and 9-24-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>8. Clinical record number 8 (start of care 8-11-13) included a plan of care established on 8-13-13 and updated on</p> | | | |

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| | <p>8-20-13, 9-3-13, 9-17-13, and 10-1-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>9. Clinical record number 9 (start of care 5-6-13) included updates to the plan of care dated 8-27-13, 9-10-13, and 9-24-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>10. Clinical record number 10 (start of care 8-28-13) included a plan of care established on 9-3-13 and updated on 9-17-13 and 10-1-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>11. Clinical record number 11 (start of care 7-31-13) included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The record failed to evidence the IDG's documentation of the</p> | | | | |

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| | <p>patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>12. Clinical record number 12 (start of care 8-29-13) included a plan of care established on 9-3-13 and updated on 9-17-13, and 10-1-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>13. Clinical record number 13 (start of care 9-15-13) included a plan of care established on 9-15-13. The record failed to evidence the IDG's documentation of the patient and/or the caregivers' level of understanding of the planned care, involvement in the development of the plan, and the agreement with the plan of care.</p> <p>14. The Executive Director, employee B, and the Director of Clinical Services, employee C, were unable to provide any additional documentation and/or information when asked on 10-8-13 at 12:25 PM.</p> | | | | | | |

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| | 15. The hospice's May 2009 "Plan of Care - Content" policy number PC.P45 states, "The plan of care includes, but is not limited to: . . . documentation from the IDG of the patient or representative's level of understanding, involvement and agreement with the plan of care." | | | |

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| S000552 | <p>418.56(d) REVIEW OF THE PLAN OF CARE The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. Based on clinical record and hospice policy review and interview, the hospice failed to ensure the interdisciplinary group (IDG) collaborated with the attending physicians to update the plans of care in 9 (#s 1, 2, 4, 6, 7, 8, 10, 11, and 12) of 9 records reviewed of patients with attending physicians other than the hospice medical director creating the potential to affect all patients of the hospice with attending physicians other than the hospice medical director.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 1 (start of care 9-20-13) evidenced the plan of care had been reviewed and updated on 10-8-13. The record failed to evidence collaboration with the attending physician for the review and update. Clinical record number 2 (start of care 9-13-13) evidenced the plan of care had been reviewed and updated on 10-8-13. The record failed to evidence collaboration with the attending physician | S000552 | <p>S552 418.56(d) REVIEW OF THE PLAN OF CARE 1. The Hospice Executive Director will ensure the hospice interdisciplinary group in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan of care as frequently as the patient's condition requires but no less than frequently than 15 days.2. Following each IDG meeting, the hospice agency will send to the attending physician, a copy of the updated Hospice IDG Comprehensive Assessment and Plan of Care Update for his review. Business office personnel, ED, DOCS and/or designee were in-serviced on this procedure on 11/1/13.3. BOS and/or designee will audit 100% of all Hospice IDG Comprehensive Assessment and Plan of Care Updates sent to attending physicians after each IDG for confirmation of delivery and receipt.4. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the</p> | 11/07/2013 | | | |

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| | <p>for the review and update.</p> <p>3. Clinical record number 4 (start of care 9-17-13) evidenced the plan of care had been reviewed and updated on 9-24-13. The record failed to evidence collaboration with the attending physician for the review and update.</p> <p>4. Clinical record number 6 (start of care 8-10-13) evidenced the plan of care had been reviewed and updated on 8-27-13, 9-10-13, 9-24-13, and 10-1-13. The record failed to evidence collaboration with the attending physician for the review and update.</p> <p>5. Clinical record number 7 (start of care 8-12-13) evidenced the plan of care had been reviewed and updated on 8-27-13, 9-10-13, and 9-24-13. The record failed to evidence collaboration with the attending physician for the review and update.</p> <p>6. Clinical record number 8 (start of care 8-11-13) evidenced the plan of care had been reviewed and updated on 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The record failed to evidence collaboration with the attending physician for the review and update.</p> <p>7. Clinical record number 10 (start of</p> | | QAPI Committee if compliance has not been met or sustained. | | | | |

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| | <p>care 8-28-13) evidenced the plan of care had been reviewed and updated on 9-17-13 and 10-1-13. The record failed to evidence collaboration with the attending physician for the review and update.</p> <p>8. Clinical record number 11 (start of care 7-31-13) evidenced the plan of care had been reviewed and updated on 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The record failed to evidence collaboration with the attending physician for the review and update.</p> <p>9. Clinical record number 12 (start of care 8-29-13) evidenced the plan of care had been reviewed and updated on 9-17-13, and 10-1-13. The record failed to evidence collaboration with the attending physician for the review and update.</p> <p>10. The Executive Director, employee B, stated, on 10-1-13 at 2:15 PM, "The IDG meeting minutes are faxed to the attendings after the IDG meeting. We do not get anything back from them to let us know they have received or read them."</p> <p>11. The hospice's May 2009 "Plan of Care" policy number PC.P40 states, "Efforts to involve the patient's attending physician (if there is one) in the development and updating of the hospice</p> | | | | |

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| | plan of care and the results of those efforts are documented in the patient's clinical record." | | | |

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| S000559 | <p>418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT</p> <p>Based on administrative record and hospice policy review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure its quality assessment and performance improvement (QAPI) program included all aspects of the hospice program in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 560); by failing to ensure its QAPI program analyzed and tracked adverse events in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 562); by failing to ensure its QAPI program included performance improvement projects based on identified problem areas in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 566); by failing to ensure its QAPI program included performance improvement projects that considered incidence, prevalence, and severity of identified problem areas in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 567); by failing to ensure its QAPI program included performance improvement projects had</p> | S000559 | <p>(S560)1. The Hospice Executive Director will ensure the hospice agency's QAPI program will include all aspects of the hospice program according to CoPs and policy. 2. The CoP's and agency policies and procedures were reviewed on 10/25/13 by the hospice Executive Director and the hospice Director of Clinical Services. 3. All hospice staff will complete inservice training on QAPI by 11/7/13. 4. The hospice agency's QAPI committee will meet weekly for 8 weeks, then bi-weekly for 4 weeks, then monthly ongoing. All aspects of the hospice program will be reviewed by the QAPI Committee monthly. 5. ED and/or designee will audit all QAPI minutes to ensure all aspects of the hospice program have been addressed monthly. 6. All Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained (S562) 1. The Hospice Executive Director will ensure that the hospice agency's QAPI program will measure, analyze and track quality indicators including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care hospice services and operations. The</p> | 11/07/2013 |

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| | <p>been implemented to affect palliative outcomes, patient safety, and quality of care in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 568); by failing to ensure its QAPI program included performance improvement activities to reduce patient falls and injury in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 569); by failing to ensure its QAPI program included performance improvement projects to measure and track performance to ensure sustained improvement in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 570); by failing to ensure its QAPI program included performance improvement projects in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 571); by failing to ensure its QAPI program included performance improvement projects based on the needs of the hospice program patients and reflected the scope of the hospice's services in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 572); by failing to ensure its QAPI program included documentation of performance</p> | | <p>hospice agency's QAPI program will track and analyze patient adverse events.2. The CoP's and agency policies and procedures were reviewed on 10/25/13 by the hospice Executive Director and the hospice Director of Clinical Services. 3. The agency staff will be inserviced on measuring, analyzing and tracking quality indicators including adverse events by 11/7/13. 3. The agency will analyze the root cause of adverse events and implement a plan to reduce the occurrences through the QAPI Committee or PIP team. 4. ED and/or designee will audit 100% of QAPI and PIP team minutes to ensure the hospice is measuring, analyzing and tracking quality indicators. 5. All Audit findings will be presented to the QAPI Committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S566)1. The Hospice Executive Director will ensure the hospice agency's QAPI program and activities focus on high risk, high volume or problem prone areas. The Hospice Executive Director will ensure the agency's QAPI program includes performance improvement projects based on identified problem areas. 2. The agency staff will be inserviced on QAPI CoPs to include performance improvement</p> | | | | |

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| | <p>improvement projects in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 573); and by failing to ensure the the governing body had fully implemented the hospice's QAPI program in 4 of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients (See S 574).</p> <p>The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with this condition, 42 CFR 418.58 Quality Assessment and Performance Improvement.</p> | | <p>projects by 11/7/13. 3. ED and/or designee will audit all QAPI minutes to ensure performance improvement projects are based on identified problem areas and QAPI activities focus on high risk, high volume or problem prone areas. 4. All Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S567)1. The Hospice Executive Director will ensure the hospice agency's QAPI program will include performance improvement projects that consider incidence, prevalence, and severity of identified problem areas to include patient falls, missed visits, and patient infection control. 2. Problem areas based on incidence, prevalence and severity will be identified thru the QAPI program and referred for an agency performance improvement activity. 3. ED and/or designee will audit all QAPI minutes to ensure the QAPI program includes performance improvement projects that consider incidence, prevalence, and severity of identified problem areas including patient safety and infection control as necessary. 4. All audit findings will be presented to the QAPI copmmittee and documented in the minutes.</p> | | |

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| | | | Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S568) 1. The Hospice Executive Director will ensure that it's QAPI program will include performance improvement projects that affect palliative outcomes, patient safety, and quality of care to include issues with patient falls, missed visits and quality of care. 2. The agency staff will be inserviced on QAPI CoP including performance improvement projects by 11/7/13. 3. Areas that affect palliative outcomes, patient safety and quality of care will be identified thru the QAPI program and referred for an agency performance improvement activity. 4. ED and/or designee will audit all QAPI minutes to ensure the QAPI program includes performance improvement projects that affect palliative outcomes, patient safety, and quality of care to include issues with patient falls, missed visits and quality of care. 4. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S569) 1. The Hospice Executive Director will ensure that it's QAPI program will include performance improvement activities that track adverse patient events, analyze | |

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| | | | <p>their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the agency to include reducing patient falls and injury. 2. The hospice staff will be inserviced on QAPI CoPs that includes tracking of patient events by 11/7/13. 3. All Adverse events identified will be tracked, analyzed and actions taken to prevent or reduce falls and injury thru the QAPI Committee and Performance Improvement Project team as indicated. 4. ED and/or designee will audit all QAPI minutes to ensure the QAPI program includes performance improvement activities that track adverse patient events, causes and implementation of actions. 5. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S570) 1. The Hospice Executive Director will ensure that it's QAPI program will include and establish performance improvement projects as necessary to measure and track performance to ensure sustained improvement in quality measures which include patient falls, missed visits and patient infection control. 2. The hospice staff will be inserviced on the QAPI CoPs to include performance improvement</p> | |

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| | | | <p>projects by 11/7/13. 3. The QAPI Committee will establish a performance improvement project as necessary when a problem area or opportunity to improve is identified in order to ensure sustained improvment. 4. ED and/or designee will audit all QAPI minutes to ensure performance improvement projects are established as necessary to sustain improvement in quality measures. 5. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S571) 1. The Hospice Executive Director will ensure that the hospice agency's QAPI Program develops, implements and evaluates performance improvement projects in an ongoing manner. 2. The hospice staff will be inserviced on the QAPI CoPs which includes performance improvement projects by 11/7/13. 3. The hospice agency QAPI Committee will review the need for a performance improvement projects at during their QAPI meeting based on the findings of quality measures and outcomes. 4. Performance improvement activities and projects will be reviewed by the QAPI committee on a monthly basis. 5. The Executive Director and/or designee will audit</p> | |

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| | | | <p>QAPI Committee meetings to ensure performance improvement projects are identified and implemented. (S572) 1. The Hospice Executive Director will ensure that it's QAPI program will include performance improvement projects based on the needs of the hospice program patients and reflect the scope of the hospices services. 2. The Hospice Executive Director will ensure the number and scope of distinct performance improvement projects conducted annually, is based on the needs of the hospice's population and internal organizational needs, and reflects the scope, complexity and past performance of the hospice's services and operations. 3. The hospice staff will be inserviced on the QAPI CoPs by 11/7/13. 4. The hospice's QAPI Committee will review the results of the quality monitoring and other quality information monthly and establish performance improvement projects when necessary to improve performance. 5. ED and/or designee will audit the QAPI minutes to ensure performance improvement projects have been identified and implemented. 6. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S573)1. The Hospice</p> | |

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| | | | Executive Director will ensure that documentation of their Performance Improvement Projects are being conducted, the reasons for conducting these projects, and the measureable progress achieved on these projects. 2. The Hospice Executive Director will ensure the performance improvement projects are documented and reported to the QAPI Committee.3. Performance improvement project documentation will be reviewed by the QAPI committee on a monthly basis. 4. The hospice staff will be inserviced on the QAPI CoPs including performance improvement projects by 11/7/13. 5. ED and/or designee will audit the QAPI minutes ongoing to ensure documentation of performance improvement projects are documented. 6. Audit findings and performance improvement projects will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S574)1. The Hospice's Governing Body will ensure that the agency has implemented and maintained an ongoing program for quality improvement and patient safety. 2. The Hospice's Governing Body has appointed the Executive Director to be responsible for the day to day operation of the | |

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| | | | agency's quality improvement program. 3. The Executive Director will ensure the agency's QAPI program has been implemented and maintained to include all aspects of the hospice program. 4. The Executive Director will ensure the QAPI Committee meets on a monthly basis and includes the review of all aspects of hospice care and services provided. 5. The hospice staff will be inserviced on the QAPI CoPs by 11/7/13. 6. ED and/or designee will audit the QAPI minutes ongoing to ensure the minutes include the review of all aspects of hospice care and services provided. 7. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. | |

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| S000560 | <p>418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The hospice must develop, implement, and 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 hospice policy review, the hospice failed to ensure its quality assessment and performance improvement (QAPI) program included all aspects of the hospice program in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <p>1. The hospice's QAPI meeting minutes, dated 2-8-13, 4-8-13, 5-3-13, and 9-27-13, failed to evidence the hospice's QAPI program included all aspects of hospice care and services. The meeting</p> | S000560 | S560 418.58 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT1. The Hospice Executive Director will ensure the hospice agency's QAPI program will include all aspects of the hospice program according to CoPs and policy.2. The CoP's and agency policies and procedures were reviewed on 10/25/13 by the hospice Executive Director and the hospice Director of Clinical Services.3. All hospice staff will complete inservice training on QAPI by 11/7/13.4. The hospice agency's QAPI committee will meet weekly for 8 weeks, then bi-weekly for 4 weeks, then monthly ongoing. All aspects of the hospice program will be | 11/07/2013 | | | |

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| | <p>minutes failed to evidence quality indicators regarding contracted therapy services, durable medical equipment services, pharmaceutical services, coordination of care with skilled nursing facilities, physician services, medical social services, and spiritual care counseling services had been tracked and analyzed.</p> <p>The meeting minutes failed to evidence the median length of stay data had been gathered and discussed, referral patterns and delays in admission or provision of services had been tracked and analyzed, and the financial performance of the hospice had been tracked and analyzed per the hospice's own policy.</p> <p>2. Employee B, the Executive Director, indicated, on 10-8-13 at 1:15 PM, the hospice's QAPI program did not address all aspects of care and services provided by this hospice.</p> <p>3. The hospice's undated "QAPI - Program Data" policy number AD.Q25 states, "Data collection includes, but is not limited to: average and median lengths of stay . . . referral patterns and delays in admission and or provision of services . . . The Executive Director is responsible for reviewing reports from the</p> | | <p>reviewed by the QAPI Committee monthly.5. ED and/or designee will audit all QAPI minutes to ensure all aspects of the hospice program have been addressed monthly.6. All Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | | | |

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| | QAPI Committee and analyzing data collected related to the financial performance of the hospice, including but not limited to: staff productivity and services provided, patient costs per day, additional cost report related data, accounts receivable and payable, and status of the annual operating budget." | | | |

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| S000562 | <p>418.58(a)(2) PROGRAM SCOPE (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations. Based on administrative record and hospice policy review and interview, the hospice failed to ensure its quality assessment and performance improvement (QAPI) program analyzed and tracked adverse events in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <p>1. The hospice's QAPI meeting minutes dated 2-8-13 evidenced 3 patient falls had been identified with 2 patients injured. The meeting minutes state, "3 patients were residing in SNF at time of fall. Fall prevention plans in place which were coordinated with facility. All patients have fall mats, alarms and low beds." The hospice's QAPI program documentation failed to evidence an analysis of the root cause(s) of patient falls had been completed and a plan to reduce the occurrence had been implemented</p> | S000562 | <p>S562 418.58(a)(2) PROGRAM SCOPE1. The Hospice Executive Director will ensure that the hospice agency's QAPI program will measure, analyze and track quality indicators including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care hospice services and operations. The hospice agency's QAPI program will track and analyze patient adverse events.2. The CoP's and agency policies and procedures were reviewed on 10/25/13 by the hospice Executive Director and the hospice Director of Clinical Services.3. The agency staff will be inserviced on measuring, analyzing and tracking quality indicators including adverse events by 11/7/13. 3. The agency will analyze the root cause of adverse events and implement a plan to reduce the occurrences through the QAPI Committee or PIP team.4. ED and/or designee will audit 100% of QAPI and PIP team minutes to ensure the hospice is measuring, analyzing and tracking quality indicators.5. All Audit findings will</p> | 11/07/2013 | | | |

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| | <p>2. QAPI meeting minutes dated 4-8-13 evidenced 6 patient falls had been identified with 2 patients being transported to the hospital by ambulance following the falls. The meeting minutes stated, "Both revoked hospice for aggressive treatment . . . 3 patients were residing in SNF at time of fall. Fall prevention plans in place which were coordinated with facility. All patients have fall mats, alarms and low beds. 3 pts [patients] were home patients. 1 pt had 24 hr caregivers in home. Fall safety discussed and implemented." The hospice's QAPI program documentation failed to evidence an analysis of the root cause(s) of patient falls had been completed and a plan to reduce the occurrence had been implemented</p> <p>3. QAPI meeting minutes dated 5-3-13 evidenced 14 patient falls had been identified with 3 patient injuries. The meeting minutes state, "11 patients were residing in SNF at time of fall. Fall prevention plans in place which were coordinated with facilities. All patients have fall mats, alarms and low beds. 1 pt was a home patient. This patient fell twice. Education on safety was given to caregivers and alarms placed in the home to alert the family / caregivers when the patient was attempting to ambulate</p> | | be presented to the QAPI Committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. | | |

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| | <p>without assist." The hospice's QAPI program documentation failed to evidence an analysis of the root cause(s) of patient falls had been completed and a plan to reduce the occurrence had been implemented</p> <p>4. QAPI meeting minutes dated 9-27-13 evidenced 4 patient falls with no patient injury. The meeting minutes state, "2 patients were residing in SNF at time of fall. Fall prevention plans in place which were coordinated with facility. All patients have fall mats, alarms and low beds. 2 pt were home patients. 1 patient was assisted to floor, by non staff caregiver. Caregiver education regarding use of hoier lift. 1 patient ambulating without assistance. Did not realize was in a weakened state." The hospice's QAPI program documentation failed to evidence an analysis of the root cause(s) of patient falls had been completed and a plan to reduce the occurrence had been implemented</p> <p>5. The Executive Director, employee B, was unable to provide any additional documentation and/or information when asked on 10-8-13 at 1:25 PM.</p> <p>6. The hospice's May 2009 "Adverse Events" policy number AD.A20 states, "Any employee who is involved in,</p> | | | |

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| | witnesses or discovers any event that is not consistent with routine operations and/or has resulted in or has the potential to result in injury or harm is required to complete a written incident report . . . Examples of reportable incidents include, but are not limited to: . . . employee, volunteer, patient or family injury or endangerment including falls . . . A root cause analysis is conducted when an adverse event occurs in order to determine causes and prevent future occurrences . . . The Director of Clinical Services, in collaboration with the QAPI Committee, tracks and trends all reports of adverse events in order to analyze their causes, implement preventive actions and mechanisms that include feedback and learning throughout the hospice." | | | | |

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| S000566 | <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. Based on administrative record and hospice policy review and interview, the hospice failed to ensure its quality assessment and performance improvement (QAPI) program included performance improvement projects based on identified problem areas in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <p>1. The hospice's QAPI meeting minutes, dated 2-8-13, 4-8-13, 5-3-13, and 9-27-13, failed to evidence the hospice's QAPI program included any performance improvement projects. The meeting minutes identified issues with patient falls, missed visits, and patient infection control.</p> <p>2. The Executive Director, employee B, stated, on 10-8-13 at 1:25 PM, "We had one performance improvement project. It was resolved in November 2012. We do not have any currently."</p> | S000566 | <p>S566 418.58(c)(1)(i) PROGRAM ACTIVITIES 1. The Hospice Executive Director will ensure the hospice agency's QAPI program and activities focus on high risk, high volume or problem prone areas. The Hospice Executive Director will ensure the agency's QAPI program includes performance improvement projects based on identified problem areas.2. The agency staff will be inserved on QAPI CoPs to include performance improvement projects by 11/7/13. 3. ED and/or designee will audit all QAPI minutes to ensure performance improvement projects are based on identified problem areas and QAPI activities focus on high risk, high volume or problem prone areas. 4. All Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | 11/07/2013 | |

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| | 3. The hospice's May 2009 "QAPI - Performance Improvement Activities and Projects" policy number AD.Q15 states, "Performance improvement activities and projects are consistent with and reflective of the size, complexity and past performance of the hospice's services and operations. Procedures: The planning, development and implementation of performance improvement activities and projects is comprehensive and collaborative. The QAPI Committee makes recommendations for potential performance improvement activities and projects based on a analysis of the hospice's program data, areas for improvement through analysis, input by staff, volunteers, hospice's leaders and the needs of the organization." | | | | |

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| S000567 | <p>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. Based on administrative record and hospice policy review, and interview, the hospice failed to ensure its quality assessment and performance improvement (QAPI) program included performance improvement projects that considered incidence, prevalence, and severity of identified problem areas in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice's QAPI meeting minutes, dated 2-8-13, 4-8-13, 5-3-13, and 9-27-13, failed to evidence the hospice's QAPI program included any performance improvement projects. The meeting minutes identified issues with patient falls, missed visits, and patient infection control. The Executive Director, employee B, stated, on 10-8-13 at 1:25 PM, "We had one performance improvement project. It was resolved in November 2012. We do not have any currently." | S000567 | <p>S567 418.58(c)(1)(ii) PROGRAM ACTIVITIES1. The Hospice Executive Director will ensure the hospice agency's QAPI program will include performance improvement projects that consider incidence, prevalence, and severity of identified problem areas to include patient falls, missed visits, and patient infection control. 2. Problem areas based on incidence, prevalence and severity will be identified thru the QAPI program and referred for an agency performance improvement activity.3. ED and/or designee will audit all QAPI minutes to ensure the QAPI program includes performance improvement projects that consider incidence, prevalence, and severity of identified problem areas including patient safety and infection control as necessary 4. All audit findings will be presented to the QAPI copmmittee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | 11/07/2013 |

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| | 3. The hospice's May 2009 "QAPI - Performance Improvement Activities and Projects" policy number AD.Q15 states, "Performance improvement activities and projects are consistent with and reflective of the size, complexity and past performance of the hospice's services and operations. Procedures: The planning, development and implementation of performance improvement activities and projects is comprehensive and collaborative. The QAPI Committee makes recommendations for potential performance improvement activities and projects based on a analysis of the hospice's program data, areas for improvement through analysis, input by staff, volunteers, hospice's leaders and the needs of the organization." | | | | |

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| S000568 | <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 hospice policy review, and interview, the hospice failed to ensure its quality assessment and performance improvement (QAPI) program included performance improvement projects had been implemented to affect palliative outcomes, patient safety, and quality of care in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's QAPI meeting minutes, dated 2-8-13, 4-8-13, 5-3-13, and 9-27-13, failed to evidence the hospice's QAPI program included any performance improvement projects. The meeting minutes identified issues with patient falls, missed visits, and patient infection control. 2. The Executive Director, employee B, stated, on 10-8-13 at 1:25 PM, "We had one performance improvement project. It was resolved in November 2012. We do | S000568 | <p>S568 418.58 (c)(1)(iii) PROGRAM ACTIVITIES 1. The Hospice Executive Director will ensure that it's QAPI program will include performance improvement projects that affect palliative outcomes, patient safety, and quality of care to include issues with patient falls, missed visits and quality of care. 2. The agency staff will be inserviced on QAPI CoP including performance improvement projects by 11/7/13. 3. Areas that affect palliative outcomes, patient safety and quality of care will be identified thru the QAPI program and referred for an agency performance improvement activity. 4. ED and/or designee will audit all QAPI minutes to ensure the QAPI program includes performance improvement projects that affect palliative outcomes, patient safety, and quality of care to include issues with patient falls, missed visits and quality of care. 4. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | 11/07/2013 |

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| | <p>not have any currently."</p> <p>3. The hospice's May 2009 "QAPI - Performance Improvement Activities and Projects" policy number AD.Q15 states, "Performance improvement activities and projects are consistent with and reflective of the size, complexity and past performance of the hospice's services and operations. Procedures: The planning, development and implementation of performance improvement activities and projects is comprehensive and collaborative. The QAPI Committee makes recommendations for potential performance improvement activities and projects based on a analysis of the hospice's program data, areas for improvement through analysis, input by staff, volunteers, hospice's leaders and the needs of the organization."</p> | | | | |

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| S000569 | <p>418.58(c)(2) PROGRAM ACTIVITIES (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.</p> <p>Based on administrative record and hospice policy review and interview, the hospice failed to ensure its quality assessment and performance improvement (QAPI) program included performance improvement activities to reduce patient falls and injury in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <p>1. The hospice's QAPI meeting minutes dated 2-8-13 evidenced 3 patient falls had been identified with 2 patients injured. The meeting minutes state, "3 patients were residing in SNF at time of fall. Fall prevention plans in place which were coordinated with facility. All patients have fall mats, alarms and low beds." The hospice's QAPI program documentation failed to evidence performance improvement activities had been implemented to analyze the cause of falls and to reduce their occurrence to</p> | S000569 | <p>S569 418.58 (c)(2) PROGRAM ACTIVITIES 1. The Hospice Executive Director will ensure that it's QAPI program will include performance improvement activities that track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the agency to include reducing patient falls and injury. 2. The hospice staff will be inserviced on QAPI CoPs that includes tracking of patient events by 11/7/13.3. All Adverse events identified will be tracked, analyzed and actions taken to prevent or reduce falls and injury thru the QAPI Committee and Performance Improvement Project team as indicated. 4. ED and/or designee will audit all QAPI minutes to ensure the QAPI program includes performance improvement activities that track adverse patient events, causes and implementation of actions. 5. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance</p> | 11/07/2013 | | | |

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| | <p>prevent patient injury.</p> <p>2. QAPI meeting minutes dated 4-8-13 evidenced 6 patient falls had been identified with 2 patients being transported to the hospital by ambulance following the falls. The meeting minutes stated, "Both revoked hospice for aggressive treatment . . . 3 patients were residing in SNF at time of fall. Fall prevention plans in place which were coordinated with facility. All patients have fall mats, alarms and low beds. 3 pts [patients] were home patients. 1 pt had 24 hr caregivers in home. Fall safety discussed and implemented." The hospice's QAPI program documentation failed to evidence performance improvement activities had been implemented to analyze the cause of falls and to reduce their occurrence to prevent patient injury.</p> <p>3. QAPI meeting minutes dated 5-3-13 evidenced 14 patient falls had been identified with 3 patient injuries. The meeting minutes state, "11 patients were residing in SNF at time of fall. Fall prevention plans in place which were coordinated with facilities. All patients have fall mats, alarms and low beds. 1 pt was a home patient. This patient fell twice. Education on safety was given to caregivers and alarms placed in the home</p> | | has not been met or sustained. | | |

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| | <p>to alert the family/caregivers when the patient was attempting to ambulate without assist." The hospice's QAPI program documentation failed to evidence performance improvement activities had been implemented to analyze the cause of falls and to reduce their occurrence to prevent patient injury.</p> <p>4. QAPI meeting minutes dated 9-27-13 evidenced 4 patient falls with no patient injury. The meeting minutes state, "2 patients were residing in SNF at time of fall. Fall prevention plans in place which were coordinated with facility. All patients have fall mats, alarms and low beds. 2 pt were home patients. 1 patient was assisted to floor, by non staff caregiver. Caregiver education regarding use of hoier lift. 1 patient ambulating without assistance. Did not realize was in a weakened state." The hospice's QAPI program documentation failed to evidence performance improvement activities had been implemented to analyze the cause of falls and to reduce their occurrence to prevent patient injury.</p> <p>3. The Executive Director, employee B, was unable to provide any additional documentation and/or information when asked on 10-8-13 at 1:25 PM.</p> <p>4. The hospice's May 2009 "Adverse</p> | | | | | | |

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| | <p>Events" policy number AD.A20 states, "Any employee who is involved in, witnesses or discovers any event that is not consistent with routine operations and/or has resulted in or has the potential to result in injury or harm is required to complete a written incident report . . . Examples of reportable incidents include, but are not limited to: . . . employee, volunteer, patient or family injury or endangerment including falls . . . A root cause analysis is conducted when an adverse event occurs in order to determine causes and prevent future occurrences . . . The Director of Clinical Services, in collaboration with the QAPI Committee, tracks and trends all reports of adverse events in order to analyze their causes, implement preventive actions and mechanisms that include feedback and learning throughout the hospice."</p> | | | | |

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| S000570 | <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 hospice policy review and interview, the hospice failed to ensure its quality assessment and performance improvement (QAPI) program included performance improvement projects to measure and track performance to ensure sustained improvement in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's QAPI meeting minutes, dated 2-8-13, 4-8-13, 5-3-13, and 9-27-13, failed to evidence the hospice's QAPI program included any performance improvement projects. The meeting minutes identified issues with patient falls, missed visits, and patient infection control. 2. The Executive Director, employee B, stated, on 10-8-13 at 1:25 PM, "We had one performance improvement project. It | S000570 | <p>S570 418.58 (c)(3) PROGRAM ACTIVITIES1. The Hospice Executive Director will ensure that it's QAPI program will include and establish performance improvement projects as necessary to measure and track performance to ensure sustained improvement in quality measures which include patient falls, missed visits and patient infection control.2. The hospice staff will be inserviced on the QAPI CoPs to include performance improvement projects by 11/7/133. The QAPI Committee will establish a performance improvement project as necessary when a problem area or opportunity to improve is identified in order to ensure sustained improvment.4. ED and/or designee will audit all QAPI minutes to ensure performance improvement projects are established as necessary to sustain improvement in quality measures. 5. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or</p> | 11/07/2013 | | | |

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| | <p>was resolved in November 2012. We do not have any currently."</p> <p>3. The hospice's May 2009 "QAPI - Performance Improvement Activities and Projects" policy number AD.Q15 states, "Performance improvement activities and projects are consistent with and reflective of the size, complexity and past performance of the hospice's services and operations. Procedures: The planning, development and implementation of performance improvement activities and projects is comprehensive and collaborative. The QAPI Committee makes recommendations for potential performance improvement activities and projects based on a analysis of the hospice's program data, areas for improvement through analysis, input by staff, volunteers, hospice's leaders and the needs of the organization."</p> | | sustained. | | |

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| S000571 | <p>418.58(d) PERFORMANCE IMPROVEMENT PROJECTS Beginning February 2, 2009, hospices must develop, implement and evaluate performance improvement projects. Based on administrative record and hospice policy review and interview, the hospice failed to ensure its quality assessment and performance improvement (QAPI) program included performance improvement projects in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's QAPI meeting minutes, dated 2-8-13, 4-8-13, 5-3-13, and 9-27-13, failed to evidence the hospice's QAPI program included any performance improvement projects. The meeting minutes identified issues with patient falls, missed visits, and patient infection control. 2. The Executive Director, employee B, stated, on 10-8-13 at 1:25 PM, "We had one performance improvement project. It was resolved in November 2012. We do not have any currently." 3. The hospice's May 2009 "QAPI - | S000571 | <p>S571 418.58 (d) PERFORMANCE IMPROVEMENT PROJECTS+1. The Hospice Executive Director will ensure that the hospice agency's QAPI Program develops, implements and evaluates performance improvement projects in an ongoing manner.2. The hospice staff will be inserviced on the QAPI CoPs which includes performance improvement projects by 11/7/13.3. The hospice agency QAPI Committee will review the need for a performance improvement projects at during their QAPI meeting based on the findings of quality measures and outcomes.4. Performance improvement activities and projects will be reviewed by the QAPI committee on a monthly basis.5. The Executive Director and/or designee will audit QAPI Committee meetings to ensure performance improvement projects are identified and implemented.</p> | 11/07/2013 | | | |

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| | Performance Improvement Activities and Projects" policy number AD.Q15 states, "Performance improvement activities and projects are consistent with and reflective of the size, complexity and past performance of the hospice's services and operations. Procedures: The planning, development and implementation of performance improvement activities and projects is comprehensive and collaborative. The QAPI Committee makes recommendations for potential performance improvement activities and projects based on a analysis of the hospice's program data, areas for improvement through analysis, input by staff, volunteers, hospice's leaders and the needs of the organization." | | | |

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| S000572 | <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. Based on administrative record and hospice policy review and interview, the hospice failed to ensure its quality assessment and performance improvement (QAPI) program included performance improvement projects based on the needs of the hospice program patients and reflected the scope of the hospice's services in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's QAPI meeting minutes, dated 2-8-13, 4-8-13, 5-3-13, and 9-27-13, failed to evidence the hospice's QAPI program included any performance improvement projects. The meeting minutes identified issues with patient falls, missed visits, and patient infection control. 2. The Executive Director, employee B, | S000572 | <p>S572 418.58(d)(1) PERFORMANCE IMPROVEMENT PROJECTS 1. The Hospice Executive Director will ensure that it's QAPI program will include performance improvement projects based on the needs of the hospice program patients and reflect the scope of the hospices services.2. The Hospice Executive Director will ensure the number and scope of distinct performance improvement projects conducted annually, is based on the needs of the hospice's population and internal organizational needs, and reflects the scope, complexity and past performance of the hospice's services and operations.3. The hospice staff will be inserviced on the QAPI CoPs by 11/7/13.4. The hospice's QAPI Committee will review the results of the quality monitoring and other quality information monthly and establish performance improvement projects when necessary to improve performance.5. ED and/or designee will audit the QAPI minutes to ensure performance</p> | 11/07/2013 | | | |

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| | <p>stated, on 10-8-13 at 1:25 PM, "We had one performance improvement project. It was resolved in November 2012. We do not have any currently."</p> <p>3. The hospice's May 2009 "QAPI - Performance Improvement Activities and Projects" policy number AD.Q15 states, "Performance improvement activities and projects are consistent with and reflective of the size, complexity and past performance of the hospice's services and operations. Procedures: The planning, development and implementation of performance improvement activities and projects is comprehensive and collaborative. The QAPI Committee makes recommendations for potential performance improvement activities and projects based on a analysis of the hospice's program data, areas for improvement through analysis, input by staff, volunteers, hospice's leaders and the needs of the organization."</p> | | <p>improvement projects have been identified and implemented. 4. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | |

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| S000573 | <p>418.58(d)(2) PERFORMANCE IMPROVEMENT PROJECTS (2)The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on administrative record and hospice policy review and interview, the hospice failed to ensure its quality assessment and performance improvement (QAPI) program included documentation of performance improvement projects in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice's QAPI meeting minutes, dated 2-8-13, 4-8-13, 5-3-13, and 9-27-13, failed to evidence the hospice's QAPI program included any performance improvement projects. The meeting minutes identified issues with patient falls, missed visits, and patient infection control. 2. The Executive Director, employee B, stated, on 10-8-13 at 1:25 PM, "We had one performance improvement project. It was resolved in November 2012. We do | S000573 | <p>S573 418.58(d)(2) PERFORMANCE IMPROVEMENT PROJECTS 1. The Hospice Executive Director will ensure that documentation of their Performance Improvement Projects are being conducted, the reasons for conducting these projects, and the measureable progress achieved on these projects.2. The Hospice Executive Director will ensure the performance improvement projects are documented and reported to the QAPI Committee.3. Performance improvement project documentation will be reviewed by the QAPI committee on a monthly basis. 4. The hospice staff will be inserviced on the QAPI CoPs including performance improvement projects by 11/7/13. 5. ED and/or designee will audit the QAPI minutes ongoing to ensure documentation of performance improvement projects are documented.6. Audit findings and performance improvement projects will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance</p> | 11/07/2013 | |

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| | not have any currently." 3. The hospice's May 2009 "QAPI - Performance Improvement Activities and Projects" policy number AD.Q15 states, "Performance improvement activities and projects are consistent with and reflective of the size, complexity and past performance of the hospice's services and operations. Procedures: The planning, development and implementation of performance improvement activities and projects is comprehensive and collaborative. The QAPI Committee makes recommendations for potential performance improvement activities and projects based on a analysis of the hospice's program data, areas for improvement through analysis, input by staff, volunteers, hospice's leaders and the needs of the organization." | | has not been met or sustained. | | |

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| S000574 | <p>418.58(e)(1) EXECUTIVE RESPONSIBILITIES</p> <p>The hospice's governing body is responsible for ensuring the following: (1)That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.</p> <p>Based on administrative record and hospice policy review, the governing body failed to ensure the hospice's quality assessment and performance improvement (QAPI) program had been implemented and included all aspects of the hospice program in 4 (February, April, May, and September 2013) of 4 QAPI meeting minutes reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <p>1. The hospice's QAPI meeting minutes, dated 2-8-13, 4-8-13, 5-3-13, and 9-27-13, failed to evidence the hospice's QAPI program included all aspects of hospice care and services. The meeting minutes failed to evidence quality indicators regarding contracted therapy services, durable medical equipment services, pharmaceutical services, coordination of care with skilled nursing facilities, physician services, medical social services, and spiritual care counseling services had been tracked and</p> | S000574 | S574 418.58(e)(1) EXECUTIVE RESPONSIBILITIES1. The Hospice's Governing Body will ensure that the agency has implemented and maintained an ongoing program for quality improvement and patient safety.2. The Hospice's Governing Body has appointed the Executive Director to be responsible for the day to day operation of the agency's quality improvement program.3. The Executive Director will ensure the agency's QAPI program has been implemented and maintained to include all aspects of the hospice program.4. The Executive Director will ensure the QAPI Committee meets on a monthly basis and includes the review of all aspects of hospice care and services provided.5. The hospice staff will be inserviced on the QAPI CoPs by 11/7/13. 6. ED and/or designee will audit the QAPI minutes ongoing to ensure the minutes include the review of all aspects of hospice care and services provided. 7. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will | 11/07/2013 |

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| | <p>analyzed.</p> <p>The meeting minutes failed to evidence the median length of stay data had been gathered and discussed, referral patterns and delays in admission or provision of services had been tracked and analyzed, and the financial performance of the hospice had been tracked and analyzed per the hospice's own policy.</p> <p>2. Employee B, the Executive Director, indicated, on 10-8-13 at 1:15 PM, the hospice's QAPI program did not address all aspects of care and services provided by this hospice.</p> <p>3. The hospice's undated "QAPI - Program Data" policy number AD.Q25 states, "Data collection includes, but is not limited to: average and median lengths of stay . . . referral patterns and delays in admission and or provision of services . . . The Executive Director is responsible for reviewing reports from the QAPI Committee and analyzing data collected related to the financial performance of the hospice, including but not limited to: staff productivity and services provided, patient costs per day, additional cost report related data, accounts receivable and payable, and status of the annual operating budget."</p> | | <p>be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | | | |

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| S000607 | <p>418.76 HOSPICE AIDE AND HOME MAKER SERVICES</p> <p>Based on clinical record and hospice policy review and interview, it was determined the hospice failed to maintain compliance with this condition by failing to ensure individuals that provided hospice aide services on its behalf had completed a training and competency evaluation or competency evaluation program as required in 2 of 3 hospice aide files reviewed creating the potential to affect all of the hospice's 42 current patients that receive hospice aide services (See S 609); by failing to ensure individuals that provided hospice aide services on its behalf had completed a competency evaluation as required in 2 of 3 hospice aide files reviewed creating the potential to affect all of the hospice's 42 current patients that receive hospice aide services (See S 615); by failing to ensure documentation had been maintained that demonstrated that individuals that provided hospice aide services on its behalf had completed a competency evaluation as required in 2 creating the potential to affect all of the hospice's 42 current patients that receive hospice aide services (See S 619); by failing to ensure hospice aides had received at least 12 hours of inservice training in 1 of 1 aide file reviewed of aides that had been</p> | S000607 | (S609)1. The Hospice Executive Director will ensure that individuals that provide hospice aide services on its behalf have completed a training and competency evaluation or competency evaluation program to include the reading and recording of temperature, pulse, and respiration, recognizing emergencies and the knowledge of emergency procedures and their application, appropriate and safe techniques in performing personal hygiene and grooming tasks, including bed bath, sponge, tub, and shower bath, hair shampoo (sink, tub, and bed), nail and skin care, oral hygiene, and toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning and adequate nutrition and fluid intake, as well as communication skills. 2. The DOCS or designee will inservice all current hospice aides on the CoPs regarding Hospice Aide Services by 11/7/13. 3. All hospice aides currently providing care and services have completed the most current competency evaluation checklist which includes information as described above completed by 11/7/13. This competency evaluation checklist will be repeated annually. 4. BOS or | 11/07/2013 | |

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| | <p>employed the entire year of 2012 creating the potential to affect all of the hospice's 42 current patients that receive hospice aide services (See S 620); by failing to ensure documentation had been maintained that demonstrated the hospice aide had received at least 12 hours of inservice training in 1 of 1 aide file reviewed of aides that had been employed the entire year of 2012 creating the potential to affect all of the hospice's 42 current patients that receive hospice aide services (See S 622); and by failing to ensure the registered nurse (RN) had completed an on-site supervisory visit to the patient's home at least every fourteen (14) days in 7 of 10 records reviewed of patients that received hospice aide services and had been on service for longer than 2 weeks creating the potential to affect all of the hospice's 42 current patients that receive aide services (See S 629).</p> <p>The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with this condition, 42 CFR 418.76 Hospice Aide and Homemaker Services.</p> | | <p>designee will audit all current hospice aide files to ensure completion of competency by 11/7/13. 5. BOS and/or designee will audit all newly hired hospice aides and all other aides annually to ensure that this standard is met. (Ongoing) 6. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S615) 1. The Hospice Executive Director will ensure that all hospice aides successfully complete the required competency evaluation program to include subject areas cited in this deficiency. All hospice aides will be required to complete this competency evaluation. 2. The agency will utilize the updated competency evaluation checklist form which include subject areas cited in this deficiency for all future newly hired hospice aides as well as be certain that all current aides have completed the appropriate checklist by 11/7/13. 3. The DOCS and/or designee will inservice all hospice aides on the CoPs regarding Hospice Aide Services by 11/7/13. 4. BOS or her designee will audit all new hire personnel files for the required competency evaluation. (Ongoing)5. The BOS or designee will audit all current hospice aide personnel files for</p> | | | | |

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| | | | <p>the required competency evaluation by 11/7/13. 6. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S619) 1. The Hospice Executive Director will ensure that the hospice agency maintains documentation that all hospice aides have completed a competency evaluation as required. 2. The current hospice aides cited in deficiency will complete a current competency evaluation by 11/7/13. 3. The DOCS or designee will inservice all current hospice aides on the CoPs regarding Hospice Aide Services by 11/7/13. 4. Effective immediately, hospice aides will complete the required competency evaluation checklist during new hire orientation prior to providing patient care to agency patients. The checklist will be done annually, following hire. This competency evaluation must be performed and documented by a registered nurse. 5. BOS and/or her designee will audit all new hire personel files for the appropriate required competency evaluation. (ongoing) 6. BOS and/or designee will audit all current hospice aide files for the required competency evaluation by 11/7/13. 7. Audit findings will be presented to the QAPI committee</p> | | |

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| | | | and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S620) 1. The Hospice Executive Director will ensure all hospice aides receive 12 hours of in-service during each 12-month period (on a calendar year basis, an employment anniversary basis or a rolling 12 month basis.) 2. All Hospice Aides cited in this deficiency will complete 8 hours of in-services from 2012 and be current with 2013 by 11/7/2013. 3. Effective immediately, all hospice aides will be required to complete monthly in-services by the last working day of the month. (ongoing) 4. DOCS and/or designee will audit and maintain documentation through the "in-service completion report" on a monthly basis. (ongoing) 5. Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (S622)1. The Hospice Executive Director will ensure that the hospice agency maintains documentation that all hospice aides have completed the required in-service training. 2. All Hospice Aides cited will complete 8 hours in-service from 2012 and be current with 2013 by 11/7/13. Documentation of completion will be verified by | | |

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| | | | <p>registered nurse. 3. Effective immediately, all hospice aides will be required to complete monthly in-services by the last working day of the month. Documentation of completion will be reviewed/audited by a registered nurse. (ongoing) 4. In-service completion report will be audited on a monthly basis by the DOCS and/or designee to ensure that agency has documentation of completion. (ongoing) 5. Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (ongoing) (S629) 1. The Hospice Executive Director will ensure that an agency hospice RN completes a hospice aide supervisory visit every 14 days to assess quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. 2. Agency RN Case Managers will complete their patients' supervisory visit during their scheduled nursing visit. All supervisory visits for current patients will be completed by 11/7/13. 3. The DOCS or designee inserviced all Hospice RNs on October 24, 2013 regarding supervisory visits. 4. Hospice Aide supervisory visits will be reviewed during the bi-weekly IDG meetings by the</p> | |

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| NAME OF PROVIDER OR SUPPLIER ASERACARE HOSPICE | STREET ADDRESS, CITY, STATE, ZIP CODE 3775 HALEY DR STE B NEWBURGH, IN 47630 |
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| | | | RNCM or designee (ongoing) 5. The DOCS and/or designee will audit 100% of current patients with Hospice Aide to ensure that all Hospice Aide supervisory visits are completed per regulation by 11/7/13. 6. The DOCS and/or designee will audit 100% patients with hospice aides for 3 months or until compliance is sustained. 7. Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. | |

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| S000609 | <p>418.76(a)(1) HOSPICE AIDE QUALIFICATIONS (1) A qualified hospice aide is a person who has successfully completed one of the following: (i) A training program and competency evaluation as specified in paragraphs (b) and (c) of this section respectively. (ii) A competency evaluation program that meets the requirements of paragraph (c) of this section. (iii) A nurse aide training and competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry. (iv) A State licensure program that meets the requirements of paragraphs (b) and (c) of this section.</p> <p>Based on personnel file and hospice policy review and interview, the hospice failed to ensure individuals that provided hospice aide services on its behalf had completed a training and competency evaluation or competency evaluation program as required in 2 (files H and I) of 3 hospice aide files reviewed creating the potential to affect all of the hospice's 42 current patients that receive hospice aide services.</p> <p>The findings include:</p> <p>1. Personnel file H evidenced the individual had been hired on 7-15-13 to provide aide services on behalf of the hospice. The file failed to evidence the</p> | S000609 | S609 418.76(a)(1) HOSPICE AIDE QUALIFICATIONS1. The Hospice Executive Director will ensure that individuals that provide hospice aide services on its behalf have completed a training and competency evaluation or competency evaluation program to include the reading and recording of temperature, pulse, and respiration, recognizing emergencies and the knowledge of emergency procedures and their application, appropriate and safe techniques in performing personal hygiene and grooming tasks, including bed bath, sponge, tub, and shower bath, hair shampoo (sink, tub, and bed), nail and skin care, oral hygiene, and toileting and | 11/07/2013 | |

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| | <p>individual had completed a competency evaluation that addressed reading and recording of temperature, pulse, and respiration as required by 418.76(b)(3) (iii); recognizing emergencies and the knowledge of emergency procedures and their application [418.76(b)(3)(vii)]; appropriate and safe techniques in performing personal hygiene and grooming tasks, including . . . bed bath, sponge, tub, and shower bath, hair shampoo (sink, tub, and bed), nail and skin care oral hygiene, and toileting and elimination [418.76(B)(3)(ix)(A), (B), (C), (D), (E), and (F)]; safe transfer techniques and ambulation [418.76(b)(3) (x)]; normal range of motion and positioning [418.76(b)(3)(xi)]; and adequate nutrition and fluid intake [418.76(b)(3)(xii)].</p> <p>2. Personnel file I evidenced the individual had been hired on 10-17-12 to provide aide services on behalf of the hospice. The file failed to evidence the individual had completed a competency evaluation that addressed communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff as required by 418.76(b)(3)(i).</p> <p>3. Employee C, the Executive Director, was unable to provide any additional</p> | | <p>elimination, safe transfer techniques and ambulation, normal range of motion and positioning and adequate nutrition and fluid intake, as well as communication skills. 2. The DOCS or designee will inservice all current hospice aides on the CoPs regarding Hospice Aide Services by 11/7/13.3. All hospice aides currently providing care and services have completed the most current competency evaluation checklist which includes information as described above completed by 11/7/13. This competency evaluation checklist will be repeated annually. 4. BOS or designee will audit all current hospice aide files to ensure completion of competency by 11/7/13. 5. BOS and/or designee will audit all newly hired hospice aides and all other aides annually to ensure that this standard is met. (Ongoing)6. Audit findings will be presented to the QAPI Committee monthly and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | | | |

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| | <p>documentation and/or information regarding the competency evaluations administered to employees H and I when asked on 10-8-13 at 12:40 PM.</p> <p>4. The hospice's May 2009 "Hospice Aide Services" policy number PC.H.25 states, "Hospice aide services are provided under the supervision of a registered nurse by individuals who meet training requirements and who have successfully completed a competency evaluation program as required by regulations."</p> | | | | |

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| S000615 | <p>418.76(c)(1) COMPETENCY EVALUATION An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section.</p> <p>(1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient.</p> <p>Based on personnel file review and interview, the hospice failed to ensure individuals that provided hospice aide services on its behalf had completed a competency evaluation as required in 2 (files H and I) of 3 hospice aide files reviewed creating the potential to affect all of the hospice's 42 current patients that receive hospice aide services.</p> <p>The findings include:</p> <p>1. Personnel file H evidenced the individual had been hired on 7-15-13 to provide aide services on behalf of the hospice. The file failed to evidence the individual had completed a competency evaluation that addressed reading and recording of temperature, pulse, and</p> | S000615 | <p>S615 418.76(c)(1) COMPETENCY EVALUATION 1. The Hospice Executive Director will ensure that all hospice aides successfully complete the required competency evaluation program to include subject areas cited in this deficiency. All hospice aides will be required to complete this competency evaluation. 2. The agency will utilize the updated competency evaluation checklist form which include subject areas cited in this deficiency for all future newly hired hospice aides as well as be certain that all current aides have completed the appropriate checklist by 11/7/13.3. The DOCS and/or designee will inservice all hospice aides on the CoPs regarding Hospice Aide Services by 11/7/13.4. BOS or her designee will audit all new</p> | 11/07/2013 | |

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| | <p>respiration as required by 418.76(b)(3) (iii); recognizing emergencies and the knowledge of emergency procedures and their application [418.76(b)(3)(vii)]; appropriate and safe techniques in performing personal hygiene and grooming tasks, including . . . bed bath, sponge, tub, and shower bath, hair shampoo (sink, tub, and bed), nail and skin care oral hygiene, and toileting and elimination [418.76(B)(3)(ix)(A), (B), (C), (D), (E), and (F)]; safe transfer techniques and ambulation [418.76(b)(3) (x)]; normal range of motion and positioning [418.76(b)(3)(xi)]; and adequate nutrition and fluid intake [418.76(b)(3)(xii)].</p> <p>2. Personnel file I evidenced the individual had been hired on 10-17-12 to provide aide services on behalf of the hospice. The file failed to evidence the individual had completed a competency evaluation that addressed communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff as required by 418.76(b)(3)(i).</p> <p>3. Employee C, the Executive Director, was unable to provide any additional documentation and/or information regarding the competency evaluations administered to employees H and I when</p> | | <p>hire personnel files for the required competency evaluation. (Ongoing)5. The BOS or designee will audit all current hospice aide personnel files for the required competency evaluation by 11/7/13. 6. All audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | |

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| | asked on 10-8-13 at 12:40 PM. 4. The hospice's May 2009 "Hospice Aide Services" policy number PC.H.25 states, "Hospice aide services are provided under the supervision of a registered nurse by individuals who meet training requirements and who have successfully completed a competency evaluation program as required by regulations." | | | |

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| S000619 | <p>418.76(c)(5) COMPETENCY EVALUATION (5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met. Based on personnel file and hospice policy review and interview, the hospice failed maintain documentation that demonstrated that individuals that provided hospice aide services on its behalf had completed a competency evaluation as required in 2 (files H and I) of 3 hospice aide files reviewed creating the potential to affect all of the hospice's 42 current patients that receive hospice aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file H evidenced the individual had been hired on 7-15-13 to provide aide services on behalf of the hospice. The file failed to evidence the individual had completed a competency evaluation as required. (See L 615). 2. Personnel file I evidenced the individual had been hired on 10-17-12 to provide aide services on behalf of the hospice. The file failed to evidence the individual had completed a competency evaluation as required. (See L 615). 3. Employee C, the Executive Director, was unable to provide any additional | S000619 | <p>S619 418.76 (c)(5) COMPETENCY EVALUATION 1. The Hospice Executive Director will ensure that the hospice agency maintains documentation that all hospice aides have completed a competency evaluation as required. 2. The current hospice aides cited in deficiency will complete a current competency evaluation by 11/7/13.3. The DOCS or designee will inservice all current hospice aides on the CoPs regarding Hospice Aide Services by 11/7/13. 4. Effective immediately, hospice aides will complete the required competency evaluation checklist during new hire orientation prior to providing patient care to agency patients. The checklist will be done annually, following hire. This competency evaluation must be performed and documented by a registered nurse. 5. BOS and/or her designee will audit all new hire personel files for the appropriate required competency evaluation. (ongoing)6. BOS and/or designee will audit all current hospice aide files for the required competency evaluation by 11/7/13.7. Audit findings will be presented to the QAPI committee and documented in the minutes.</p> | 11/07/2013 | |

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| | documentation and/or information regarding the competency evaluations administered to employees H and I when asked on 10-8-13 at 12:40 PM. 4. The hospice's May 22, 2009, "Inservice Education and Competency Evaluation" policy number QM.20 states, "The Executive Director will enforce adherence to the competency program and maintain records." | | Further action will be taken by the QAPI Committee if compliance has not been met or sustained. | | | | |

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| S000620 | <p>418.76(d) IN-SERVICE TRAINING A hospice aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient.</p> <p>Based on personnel file, inservice record review, and hospice policy review and interview, the hospice failed to ensure the hospice aide had received at least 12 hours of inservice training in 1 (file G) of 1 aide file reviewed of aides that had been employed the entire year of 2012 creating the potential to affect all of the hospice's 42 current patients that receive hospice aide services.</p> <p>The findings include:</p> <p>1. Personnel file G evidenced the individual had been hired on 8-11-11 to provide aide services on behalf of the hospice. The hospice's "Course Completion Report" for 1-1-12 to 12-31-12 failed to evidence employee G had completed at least 12 hours of inservice training during 2012. The report evidenced the aide had completed only 4 hours of inservice training during 2012.</p> <p>2. Employee N, a registered nurse, indicated, on 10-8-13 at 12:45 PM, the hospice's "Course Completion Report"</p> | S000620 | S620 418.76 (d) IN-SERVICE TRAINING 1. The Hospice Executive Director will ensure all hospice aides receive 12 hours of in-service during each 12-month period (on a calendar year basis, an employment anniversary basis or a rolling 12 month basis.) 2. All Hospice Aides cited in this deficiency will complete 8 hours of in-services from 2012 and be current with 2013 by 11/7/2013 3. Effective immediately, all hospice aides will be required to complete monthly in-services by the last working day of the month. (ongoing) 4. DOCS and/or designee will audit and maintain documentation through the "in-service completion report" on a monthly basis. (ongoing)5. Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. | 11/07/2013 | | | |

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| | <p>did not evidence employee G had completed at least 12 hours of inservice training during 2012.</p> <p>3. The hospice's May 2009 "Hospice Aide Services" policy number PC.H25 states, "Hospice aides receive twelve hours of in-service training every twelve months."</p> | | | |

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| S000622 | <p>418.76(d)(2) IN-SERVICE TRAINING (2) The hospice must maintain documentation that demonstrates the requirements of this standard are met. Based on personnel file and hospice inservice record review and interview, the hospice failed to maintain documentation that demonstrated the hospice aide had received at least 12 hours of inservice training in 1 (file G) of 1 aide file reviewed of aides that had been employed the entire year of 2012 creating the potential to affect all of the hospice's 42 current patients that receive hospice aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file G evidenced the individual had been hired on 8-11-11 to provide aide services on behalf of the hospice. The hospice's "Course Completion Report" for 1-1-12 to 12-31-12 failed to evidence employee G had completed at least 12 hours of inservice training during 2012. The report evidenced the aide had completed only 4 hours of inservice training during 2012. 2. Employee N, a registered nurse, indicated, on 10-8-13 at 12:45 PM, the hospice's "Course Completion Report" did not evidence employee G had | S000622 | S622 418.76 (d)(2) IN-SERVICE TRAINING1. The Hospice Executive Director will ensure that the hospice agency maintains documentation that all hospice aides have completed the required in-service training. 2. All Hospice Aides cited will complete 8 hours in-service from 2012 and be current with 2013 by 11/7/13. Documentation of completion will be verified by registered nurse. 3. Effective immediately, all hospice aides will be required to complete monthly in-services by the last working day of the month. Documentation of completion will be reviewed/audited by a registered nurse. (ongoing) 4. In-service completion report will be audited on a monthly basis by the DOCS and/or designee to ensure that agency has documentation of completion. (ongoing) 5. Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. (ongoing) | 11/07/2013 | |

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| | completed at least 12 hours of inservice training during 2012. | | | | |

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| S000629 | <p>418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES (l) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit. Based on clinical record and hospice policy review and interview, the hospice failed to ensure the registered nurse (RN) had completed an on-site supervisory visit to the patient's home at least every fourteen (14) days in 7 (#s 3, 8, 9, 10, 11, 12, and 13) of 10 records reviewed of patients that received hospice aide services and had been on service for longer than 2 weeks creating the potential to affect all of the hospice's 42 current patients that receive aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced hospice aide services had been provided 2 times per week during the benefit period beginning 8-1-13. The record failed to evidence the RN had completed any supervisory visits. 2. Clinical record number 8 evidenced hospice aide services had been provided 1 to 3 times per week during the benefit | S000629 | S629 418.76 (h)(1)(i) SUPERVISION OF HOSPICE AIDES 1. The Hospice Executive Director will ensure that an agency hospice RN completes a hospice aide supervisory visit every 14 days to assess quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. 2. Agency RN Case Managers will complete their patients' supervisory visit during their scheduled nursing visit. All supervisory visits for current patients will be completed by 11/7/13. 3. The DOCS or designee inserviced all Hospice RNs on October 24, 2013 regarding supervisory visits. 4. Hospice Aide supervisory visits will be reviewed during the bi-weekly IDG meetings by the RNCM or designee (ongoing) 5. The DOCS and/or designee will audit 100% of current patients with Hospice Aide to ensure that all Hospice Aide supervisory visits are completed per regulation by 11/7/13.6. The DOCS and/or | 11/07/2013 | | | |

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| | <p>period beginning 8-11-13.</p> <p>A. The record evidenced the RN, employee D, had completed a supervisory visit on 9-6-13, 3 weeks and 2 days after the date of the first aide visit, 8-14-13.</p> <p>B. The record evidenced the RN, employee D, had completed a supervisory visit on 9-13-13. The record failed to evidence any further aide supervisory visits had been completed.</p> <p>3. Clinical record number 9 evidenced hospice aide services had been provided 2 to 4 times per week during the benefit period beginning 8-14-13. The record failed to evidence any hospice aide supervisory visits had been completed.</p> <p>4. Clinical record number 10 evidenced hospice aide services had been provided 3 times per week during the benefit period beginning 8-28-13. The record evidenced the RN, employee D, had completed supervisory visits on 9-9-13 and 9-13-13. The record failed to evidence any further supervisory visits had been completed.</p> <p>5. Clinical record number 11 evidenced hospice aide services had been provided 1 to 2 times per week during the benefit period beginning 7-31-13. The record failed to evidence any hospice aide</p> | | <p>designee will audit 100% patients with hospice aides for 3 months or until compliance is sustained.7. Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | |

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| | <p>supervisory visits had been completed.</p> <p>6. Clinical record number 12 evidenced hospice aide services had been provided 2 to 4 times per week during the benefit period beginning 8-29-13. The record failed to evidence any hospice aide supervisory visits had been completed.</p> <p>7. Clinical record number 13 evidenced hospice aide services had been provided 2 times per week during the benefit period beginning 9-15-13. The record failed to evidence any hospice aide supervisory visits had been completed.</p> <p>8. Employee N, a registered nurse, stated, on 10-8-13 at 2:00 PM, "The aide supervisory visits are being done. They are just not being documented in the computer the way they are supposed to be."</p> <p>9. The hospice's May 2009 "Hospice Aide Supervision" policy number PC.H30 states, "A registered nurse makes an on-site visit to the patient's home no less frequently than every 14 days to ensure that the services ordered by the IDG and provided by the aide are meeting the patient's need."</p> | | | | |

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| S000773 | <p>418.112(d) HOSPICE PLAN OF CARE In accordance with §418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care.</p> <p>Based on clinical record review and interview, the hospice failed to ensure plans of care reflected consultation with skilled nursing facility (SNF) staff in 8 (#s 3, 4, 5, 6, 7, 10, 11, & 13) of 8 records reviewed of patients that were residents of SNFs creating the potential to affect all of the hospice's 31 patients that were residents of a SNF.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 (start of care 5-3-13) evidenced the patient was a resident of a SNF. The record included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The updates failed to evidence consultation and collaboration with SNF staff. 2. Clinical record number 4 (start of care 9-17-13) included a plan of care established by the IDG on 9-17-13. The plan of care failed to evidence consultation and collaboration with SNF staff. | S000773 | <p>S773 418.112 (d) HOSPICE PLAN OF CARE 1. The Hospice Executive Director will ensure that the hospice agency establishes and maintains a written hospice plan of care in collaboration and consultation with the SNF/NF/ICF/MR. 2. The hospice agency and the SNF/SN/ICF/MR will meet and consult bi-weekly by sharing the IDG Comprehensive Assessment and Plan of Care in order to establish and maintain a written hospice plan of care. (ongoing) 3. Agency staff and facility staff will consult at their next scheduled bi-weekly collaborative meeting and written hospice plans of care will be maintained. This will be completed by 11/7/13. Future consultative meetings for agency hospice patients will be held bi-weekly during scheduled bi-weekly collaborative meetings. (ongoing)4. DOCS and/or designee will audit 100% of the hospice care plans of the agency's SNF/NF/ICF/MR patients that are scheduled to be reviewed during the bi-weekly IDG meetings until compliance is sustained for 3 months. Thereafter, 5% random sample of</p> | 11/07/2013 |

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| | <p>3. Clinical record number 5 (start of care 9-7-13) included a plan of care established by the IDG on 9-10-13 and updated on 9-24-13. The plan of care and the update failed to evidence consultation and collaboration with SNF staff.</p> <p>4. Clinical record number 6 (start of care 8-10-13) included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, 9-24-13, and 10-1-13. The plan of care and the updates failed to evidence consultation and collaboration with SNF staff.</p> <p>5. Clinical record number 7 (start of care 8-12-13) included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, and 9-24-13. The plan of care and the updates failed to evidence consultation and collaboration with the SNF staff.</p> <p>6. Clinical record number 10 (start of care 8-28-13) included a plan of care established on 9-3-13 and updated on 9-17-13 and 10-1-13. The plan of care and the updates failed to evidence consultation and collaboration with the SNF staff.</p> <p>7. Clinical record number 11 (start of care 7-31-13) included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and</p> | | <p>care plans (at least 5 records) will be monitored for three months. 5. Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | | | |

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| | <p>10-1-13. The updates failed to evidence consultation and collaboration with the SNF staff.</p> <p>8 Clinical record number 13 (start of care 9-15-13) included a plan of care established on 9-15-13. The plan of care failed to evidence consultation and collaboration with the SNF.</p> <p>9 The Executive Director, employee B, and the Director of Clinical Services, employee C, were unable to provide any additional documentation and/or information when asked on 10-2-13 at 2:45 PM and on 10-8-13 at 12:25 PM.</p> | | | | |

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| S000774 | <p>418.112(d)(1) HOSPICE PLAN OF CARE</p> <p>The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care. Based on clinical record review and interview, the hospice failed to ensure plans of care of residents of skilled nursing facilities (SNF) identified all care and services needed by the patient and which provider was responsible for them creating the potential to affect all of the hospice's 31 current patients that are residents of SNFs.</p> <p>The findings include:</p> <p>1. Clinical record number 3 (start of care 5-3-13) evidenced the patient was a resident of a SNF. The record included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The updates failed to evidence coordination between the hospice and SNF, a common problem list, and which provider was responsible for the implementation of interventions included in the plan.</p> <p>2. Clinical record number 4 (start of care 9-17-13) evidenced the patient was a resident of a SNF. The record included a plan of care established by the IDG on</p> | S000774 | <p>S774 418.112(d)(1) HOSPICE PLAN OF CARE 1. The Hospice Exective Director will ensure that the hospice agency and the SNF will identify the care and services needed for their patients and will agree upon which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care. 2. The Agency staff and facility staff will review agency hospice patients at their next scheduled bi-weekly collaborative meeting and plans of care will reflect which provider is responsible for performing the respective functions that have been agreed upon. 3. Effective immediately, the hospice agency admission RN Case Manager and the facility staff responsible for their care plans and/or designee will review and agree which provider is responsible for performing their respective functions and evidence it within the plan of care. 4. DOCS and/or designee will audit 100% of hospice care plans of the agency's SNF/NF/ICF/MR patients that are scheduled to be reviewed during the bi-weekly IDG meetings until compliance is</p> | 11/07/2013 |

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| | <p>9-17-13. The plan of care failed to evidence coordination between the hospice and SNF, a common problem list, and which provider was responsible for the implementation of interventions included in the plan.</p> <p>3. Clinical record number 5 (start of care 9-7-13) evidenced the patient was a resident of a SNF. There record included a plan of care established by the IDG on 9-10-13 and updated on 9-24-13. The plan of care and the update failed to evidence coordination between the hospice and SNF, a common problem list, and which provider was responsible for the implementation of interventions included in the plan.</p> <p>4. Clinical record number 6 (start of care 8-10-13) evidenced the patient was a resident of a SNF. The record included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, 9-24-13, and 10-1-13. The plan of care and the updates failed to evidence coordination between the hospice and SNF, a common problem list, and which provider was responsible for the implementation of interventions included in the plan.</p> <p>5. Clinical record number 7 (start of care 8-12-13) evidenced the patient was a resident of a SNF. The record included a</p> | | <p>sustained for 3 months. Thereafter, 5% random sample of care plans (at least 5 records) will be monitored for three months. 5. Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | | | | |

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| | <p>plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, and 9-24-13. The plan of care and the updates failed to evidence coordination between the hospice and SNF, a common problem list, and which provider was responsible for the implementation of interventions included in the plan.</p> <p>6. Clinical record number 10 (start of care 8-28-13) evidenced the patient was a resident of a SNF. The record included a plan of care established on 9-3-13 and updated on 9-17-13 and 10-1-13. The plan of care and the updates failed to evidence coordination between the hospice and SNF, a common problem list, and which provider was responsible for the implementation of interventions included in the plan.</p> <p>7. Clinical record number 11 (start of care 7-31-13) evidenced the patient was a resident of a SNF. The record included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The updates failed to evidence coordination between the hospice and SNF, a common problem list, and which provider was responsible for the implementation of interventions included in the plan.</p> <p>8 Clinical record number 13 (start of care 9-15-13) evidenced the patient was a</p> | | | |

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| | <p>resident of a SNF. The record included a plan of care established on 9-15-13. The plan of care failed to evidence coordination between the hospice and SNF, a common problem list, and which provider was responsible for the implementation of interventions included in the plan.</p> <p>9 The Executive Director, employee B, stated, on 10-8-13 at 1:55 PM, "We don't put SNF problems on our plans of care. We are not responsible for that."</p> | | | |

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| S000775 | <p>418.112(d)(2) HOSPICE PLAN OF CARE</p> <p>The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible.</p> <p>Based on clinical record review and interview, the hospice failed to ensure plans of care reflected consultation with skilled nursing facility (SNF) staff in 8 (#s 3, 4, 5, 6, 7, 10, 11, & 13) of 8 records reviewed of patients that were residents of SNFs creating the potential to affect all of the hospice's 31 patients that were residents of a SNF.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 (start of care 5-3-13) evidenced the patient was a resident of a SNF. The record included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The updates failed to evidence consultation and collaboration with SNF staff. 2. Clinical record number 4 (start of care 9-17-13) included a plan of care established by the IDG on 9-17-13. The plan of care failed to evidence consultation and collaboration with SNF staff. 3. Clinical record number 5 (start of care 9-7-13) included a plan of care | S000775 | <p>S775 418.112(d)(2) HOSPICE PLAN OF CARE 1. The Hospice Executive Director will ensure that the agency consults and collaborates with SNF/NF/ALF/MR staff and the patient and family (to the extent possible) on a bi-weekly basis. 2. Agency staff and facility staff will consult and update agency care plan during the next scheduled bi-weekly collaborative meeting. Effective immediately, hospice care plan updates and care consulting will be completed during the bi-weekly collaborative meetings that are held at the facilities. (ongoing) 3. DOCS and/or designee will audit 100% of the hospice care plans of the agency's SNF/NF/ICF/MR patients that are scheduled to be reviewed during the bi-weekly IDG meetings until compliance is sustained for 3 months. Thereafter, 5% random sample of care plans (at least 5 records) will be monitored for three months. 4. Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained.</p> | 11/07/2013 | | | |

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| | <p>established by the IDG on 9-10-13 and updated on 9-24-13. The plan of care and the update failed to evidence consultation and collaboration with SNF staff.</p> <p>4. Clinical record number 6 (start of care 8-10-13) included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, 9-24-13, and 10-1-13. The plan of care and the updates failed to evidence consultation and collaboration with SNF staff.</p> <p>5. Clinical record number 7 (start of care 8-12-13) included a plan of care established on 8-13-13 and updated on 8-27-13, 9-10-13, and 9-24-13. The plan of care and the updates failed to evidence consultation and collaboration with the SNF staff.</p> <p>6. Clinical record number 10 (start of care 8-28-13) included a plan of care established on 9-3-13 and updated on 9-17-13 and 10-1-13. The plan of care and the updates failed to evidence consultation and collaboration with the SNF staff.</p> <p>7. Clinical record number 11 (start of care 7-31-13) included updates to the plan of care dated 8-20-13, 9-3-13, 9-17-13, and 10-1-13. The updates failed to evidence consultation and collaboration with the</p> | | | | | | |

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| | <p>SNF staff.</p> <p>8 Clinical record number 13 (start of care 9-15-13) included a plan of care established on 9-15-13. The plan of care failed to evidence consultation and collaboration with the SNF.</p> <p>9 The Executive Director, employee B, and the Director of Clinical Services, employee C, were unable to provide any additional documentation and/or information when asked on 10-2-13 at 2:45 PM and on 10-8-13 at 12:25 PM.</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER ASERACARE HOSPICE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3775 HALEY DR STE B NEWBURGH, IN 47630 | | | |
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| S000782 | <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 administrative record review and interview, the hospice failed to ensure it had provided hospice orientation and training to skilled nursing facility (SNF) staff in 2 (facilities A and B) of 2 SNFs visited creating the potential to affect all of the hospice's 31 current patients that are residents of a SNF.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During a home visit to patient number 4, on 10-2-13 at 8:45 AM, at facility A, an interview was conducted with the SNF administrator. The administrator stated, "This hospice has not provided any hospice training and orientation to any of our employees." 2. During a home visit to patient number 3, on 10-2-13 at 10:25 AM, at facility B, the certified nursing assistant providing care to patient number 3 indicated she had not received any hospice orientation and training from this hospice. | S000782 | <p>S782 418.112(f) ORIENTATION AND TRAINING OF STAFF 1. The Hospice Executive Director will ensure that the agency provides hospice orientation to SNF/NF/ALF/MR staff that provide care to our patients to include the hospice philosophy, hospice policies and procedures regarding 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. 2. SNF/NF/ALF/MR staff caring for our current patients will be in-serviced by agency staff during our next bi-weekly collaborative meeting but no later than 11/7/13. An orientation packet will be provided to each SNF/NF/ALF/MR to be used in their new hire process. 3. On a bi-weekly basis, the DOCS and/or designee will ensure that SNF/NF/ALF/MR orientation packets along with orientation acknowledgement forms are</p> | 11/07/2013 | | | |

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| | 3. The Executive Director, employee B, stated, on 10-2-13 at 2:45 PM, "Our marketing person does inservices every 3 to 4 months at the SNFs." | | available to the appropriate facility staff and that they are being utilized. The hospice will assess and determine how often orientation is needed so as to ensure that facility staff are aware of the hospice philosophy, etc. 4. Findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. | | |

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| S009996 | <p>IC 16-25-7 Disclosure Requirements</p> <p>Sec. 1. Each hospice program licensed or approved under this article shall prepare and update as necessary a disclosure document to be presented to each potential patient of the hospice program.</p> <p>Sec. 2. The disclosure document required under section 1 of this chapter must contain at least the following:</p> <p>(1) A description of all hospice services provided by the hospice program, including the</p> <ul style="list-style-type: none"> (A) types of nursing services; (B) other service; (C) specific services available during the progressive stages of the terminal illness and thereafter; and (D) a statement that the extent of the hospice services and supplies are dispensed based on the hospice program patient's individual needs as determined by the interdisciplinary team. <p>(2) An explanation of the hospice program's internal complaint resolution process.</p> <p>(3) A statement that the hospice program patient has the right to participate in the planning of the patient's care.</p> <p>(4) A statement that a hospice program patient may refuse any component of hospice services offered by the hospice program.</p> <p>(5) A statement that a hospice employee may provide supplies to a:</p> <ul style="list-style-type: none"> (A) hospice program patient; or (B) hospice program patient's family; <p>in addition to the supplies provided by the hospice program, but the employee may only be reimbursed for the supplies by providing a written receipt to the hospice program patient or the hospice program</p> | | | |
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| | <p>patient's family.</p> <p>(6) A statement that the hospice program patient may request the hospice program to provide, on a monthly basis, an itemized statement of services and supplies delivered to the patient, as submitted to the patient's payer</p> <p>(7) The toll free number established by the state department under IC 16-25-5-4 to receive complaints from hospice program patients and the family members of hospice program patients regarding the hospice program.</p> <p>Based on clinical record and hospice admission packet review and interview, the hospice failed to prepare and present a disclosure document to each patient in 13 (#s 1 through 13) of 13 records reviewed creating the potential to affect all of the hospice's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical records numbered 1 through 13 failed to evidence the hospice had presented a disclosure document to the patient at any time. 2. The Executive Director indicated she did not know what a disclosure document was when asked on 10-1-13 at 10:00 AM. The Director stated, "It may be in the admission packet." 3. The admission packet was reviewed on 10-1-13 at 10:00 AM. The admission | S009996 | S9996 IC-16-25-7 DISCLOSURE REQUIREMENTS 1. The Hospice Executive Director will ensure that the agency presents a disclosure document to all potential patients of the hospice program in accordance with IC 16-25-7. 2. The description of all hospice services provided by the hospice program and disclosure requirements are included in the Hospice Care Handbook which is presented to all patients/family/caregiver during the admission process.3. The acknowledgement of receipt of the disclosure requirements and information in the Hospice Care Handbook is included in the Medicare/Medicaid Statement of Consent and Election which is signed upon admission to hospice services. 4. The Business Office Specialist and/or designee will audit 100% of current patients for the disclosure acknowledgement form being signed and scanned into the Electronic Medical | 11/07/2013 | |

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| | packet failed to evidence a disclosure document. | | Record with all other legal documents by 11/7/13. 5. The BOS and/or designee will audit 100% of new admissions to ensure compliance . 6. Audit findings will be presented to the QAPI committee and documented in the minutes. Further action will be taken by the QAPI Committee if compliance has not been met or sustained. | | |