STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151592	A. BUILDING 00 B. WING	03/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HOSPICE	3401 S 4TH ST TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0000 Bldg. 00		L 0000		
	This was a follow up Federal and State hospice recertification and relicensure survey. Survey dates: March 20 and 21, 2017 Medicaid ID: 200141370c Provider ID: 151592 Facility ID: 004763 Census: 74 Kindred Hospice was found to be back in compliance with 42 CFR 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services.			
L 0553 Bldg. 00	418.56(d) REVIEW OF THE PLAN OF CARE A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. Based on observation, record review and interview, the hospice failed to ensure that the IDG (Interdisciplinary Group),	L 0553	Patient #9: The patient and family by choice reside in a memory	04/17/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	in collaboration with the individual's attending physician, updated the initial plan of care to include interventions and measureable goals with information included in the updated comprehensive assessments in 1 out of 6 patient records reviewed. (#9) Findings include: 1. The clinical record for patient # 9 was reviewed and indicated the following: A. The patient resides in a locked dementia unit at an Assisted Living Facility with limited caretakers. B. A facility nursing note, dated 02/25/17, indicated the patient had fallen. A skilled nurse visit on 3/1/17 included a neurological assessment that indicated patient was oriented to person only. A musculoskeletal assessment indicated patient forgets to use his walker in his room. A nurse narrative indicated patient up to bathroom, didn't have walker and was forgetful. C. Review of the Interdisciplinary Plan of Care update, dated 03/01/17 and 03/15/17, included a psychosocial assessment which indicated the patient was "disoriented, unwilling to		care unit as this was his home prior to the area becoming a memory care unit. The fall identified was the only occurrence in over a year. Education was provided to the patient/staff after the fall, and no further falls were identified. The patient, the daughter who is a retired RN and the entire IDG team believe this patient's choice of home is appropriate for him. The POC was updated and the fall was discussed in IDG as mentioned by the state surveyor. This information was provided to the surveyor prior to exit. Education: 1) The administrator/designee will educate IDG team that the POC should be	

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	communicate when problems arise, becomes agitated by change". The Safety/Falls assessment indicated the patient is at risk for falls and that patient would be instructed on safety, instructed to use walker. The IDG failed to update and revise the plan of care to include interventions and measurable goals to prevent patient falls. D. The Manager of Clinical Practice was unable to provide additional information of action taken prior to the correction deadline of 3/9/17 by the end of the Exit Conference on 3/21/17 at 3:00 pm.		updated and revised to include interventions and measurable goals to prevent falls. **Monitor:** 1) The administrator/designee will review 10 IDG weekly x 4 weeks; then 5 IDG weekly x 2 weeks then 10 monthly x 2 months for evidence of the IDG POC being updated with interventions and goals. Ongoing Monitoring will be performed via quarterly clinical record review and incorporated into QAPI.	
L 0782 Bldg. 00	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,			

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	symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements. Based on record review and interview, the agency failed to ensure orientation of skilled nursing facilities / retirement community 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 in 12 out of 30 facilities . Findings include: 1. Review of the Plan of Correction provided to the Indiana State Department of Health by the hospice agency, the plan of correction indicated the deficiencies would be corrected by 3/9/17. 2. On 03/21/17 at 10:15 AM, the Administrator provided a copy of an in-service that had been provided at a facility on 03/20/17. The Administrator also provided a copy of "TITLE OF	L 0782	Education: 1) The administrator/designee will provide education to the administrative staff including sales support staff that 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	04/17/2017

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	FORM" forms which indicated skilled nursing and assisted living facilities that needed an in-service with the hospice agency. The form indicated the following: A. Facility #1, scheduled for training 3/31/17 B. Facility #2, scheduled for training: "to be scheduled" C. Facility #3, scheduled for training 3/22/17 D. Facility #4, scheduled for training 3/20/17 (2 nurses trained on 3/20/17) E. Facility #5, scheduled for training 3/21/17 F. Facility #6, scheduled for training 3/21/17 G. Facility #7, scheduled for self study 3/16/17 H. Facility #8, scheduled for training 3/21/17 I. Facility #9, scheduled for training April 2017 J. Facility #10, scheduled for		rights, appropriate forms, and record keeping requirements. Monitor: 1) The administrator/designee will establish quarterly dates to review the schedule for providing education to facilities on the hospice philosophy on an on-going basis.	

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	training: "to be scheduled" K. Facility #11, scheduled for training: "to be scheduled" L. Facility #12, scheduled for training: 4/19/17 3. On 03/21/17 at 10:15 AM, the Administrator indicated that it was not feasible to have all the facilities in-serviced by 03/09/17 plan of correction date.			