

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2014
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NAME OF PROVIDER OR SUPPLIER VIAQUEST HOSPICE OF INDIANA, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5 N 10TH STREET LAFAYETTE, IN 47901
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L000000	<p>This was a hospice Federal recertification and State relicensure survey.</p> <p>Survey Dates: October 30 - 31 and November 3 and 5, 2014</p> <p>Facility Number: 003308</p> <p>Medicaid Number: 201056830FW</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 6, 2014</p>	L000000		
L000543	<p>418.56(b) PLAN OF CARE</p> <p>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.</p> <p>Based on clinical record review, policy review, and interview, the hospice failed to ensure all hospice care and services furnished to patients followed an individualized written plan of care established by the hospice interdisciplinary group in 3 of 9 active</p>	L000543	L 0543 On 11/10/2014 the Administrator in-serviced each RN Case Manager regarding an enhanced communication system to ensure care and services are provided in accordance with each individualized patient plan of care. Each plan of care is created from discipline specific	11/14/2014

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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	<p>patient records reviewed creating the potential to affect all patients of the agency. (#2, 3, and 7)</p> <p>Findings include:</p> <p>1. Clinical record #2, election date and start of care 1/27/12, evidenced a plan of care for certification period 9/13 to 11/11/14 with orders for volunteer services 1 time per week for 8 weeks. The record failed to evidence a volunteer visit was conducted for weeks 3, 4, 5, and 7.</p> <p>On 11/3/14 at 2:30 PM, employee A (administrator) indicated being unable to locate documentation to support visits were conducted during those weeks.</p> <p>2. Clinical record #3, election date and start of care 5/30/13, evidenced a plan of care for certification period 9/22 to 11/20/14 with orders for volunteer services 1 time per week for 8 weeks. The record failed to evidence a volunteer visit was conducted for week 1.</p> <p>On 11/3/14 at 2:35 PM, employee A indicated being unable to locate documentation to support a visit was conducted during week 1.</p> <p>3. Clinical record #7, election date and</p>		<p>initial assessments.</p> <p>On 11/13/2014 every discipline was in-serviced regarding the importance of ongoing communication, collaboration of care, related policy and securing a physician order to reflect visit frequency for each discipline. Each discipline visit will be documented immediately upon completion of the visit. 100% of the current patient population volunteer and clergy care plans were reviewed and updated to ensure physician orders and frequency of visits are aligned. Discipline specific care plan binders were created for easy access and cross reference. 100% of active patient volunteer and clergy care plans will be audited by the QAPI RN monthly to ensure this standard is adhered to.</p>				

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	<p>start of care 9/5/14, evidenced a plan of care for certification period 9/5 to 12/3/14 with orders for spiritual care services one time for week one.</p> <p>A. The record evidenced a physician's order dated 9/12/14 to increase spiritual care services to one time per week for 12 weeks was electronically signed by the registered nurse, employee G.</p> <p>B. On 11/5/14 at 1:55 PM, employee A indicated being unable to locate documentation to support visits were conducted for weeks 6 and 7.</p> <p>4. The agency policy with a revision date of January 2012 titled "Coordination of Patient Care" states, "POLICY Hospice staff members regularly communicate to ensure that their efforts are coordinated effectively and ultimately support the objectives outlined in the IDG [interdisciplinary group] plan of care. ... PROCEDURE 1. The clinical director has developed and maintains a system of communication and integration to: ... Ensure that care and services are provided in accordance with the plan of care and are based on all assessments of the patient and family needs."</p>						

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L000625	<p>418.76(g)(1) HOSPICE AIDE ASSIGNMENTS AND DUTIES (1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.</p> <p>Based on clinical record review, policy review, and interview, the hospice failed to ensure written patient care instructions for a hospice aide were reviewed by the registered nurse every 60 days in 2 of 9 active patient records reviewed of patients receiving hospice aide services creating the potential to affect all patients of the hospice receiving aide services. (#3 and 4)</p> <p>Findings include:</p> <p>1. Clinical record #3, election date and start of care 5/30/13, contained a plan of care for certification period 9/22 to 11/20/14 with orders for hospice aide services 1 time a week for 1 week, 2 times per week for 8 weeks, and 1 time a week for 1 week.</p> <p>The record evidenced a document titled "Aide / Homemaker Care Plan" with an initial signature and date of</p>	L000625	L0625 An Aide Plan of Care Worksheet was developed to capture individualized patient care plan instructions as outlined in the McKesson computerized documentation system. The Administrator and Patient Care Manager reviewed the worksheet, company policy regarding written patient care plan instructions and the importance of a physician order to reflect the frequency of the Aide visits with each RN Case Manager on 11/10/2014. The Aide will document each visit immediately upon completion of the visit. 100% of the current patient population will have an updated Aide Plan of Care Worksheet completed by the assigned RN Case Manger by 11/26/2014. According to company policy the Aide Plan of Care Worksheet will be updated by the assigned RN Case Manager immediately as changes occur but never to exceed every 60 days. Each active patient file will be audited by the QAPI RN monthly to	11/26/2014			

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	<p>5/31/13 by the registered nurse and review dates of 6/3/13 and 7/23/14. The record failed to evidence the aide care plan was reviewed after 7/23/14 and every 60 days by the registered nurse.</p> <p>2. Clinical record #4, election date and start of care 4/8/14, contained a plan of care for certification period 10/5 to 12/3/14 to include orders for hospice aide services 5 times a month for 2 months. The record contained a physicians order dated 10/5/14 to increase hospice aide services to 2 times per week for 9 weeks.</p> <p>The record evidenced a document titled "Aide / Homemaker Care Plan" with an initial signature and date of 4/8/14 by the registered nurse and review dates of 7/23/14 and 10/1/14. The record failed to evidence the aide care plan was reviewed every 60 days by the registered nurse.</p> <p>3. On 11/3/14 at 3:05 PM, employee A (administrator) indicated the registered nurse should review the aide care plans at least every 60 days.</p> <p>4. The agency policy with a revised date of August 2013 titled "Aide Care Plan" states, "POLICY A complete and appropriate care plan, identifying duties to be performed by the aide, shall be</p>		ensure this standard is adhered to.		

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	developed by the registered nurse or therapist. ... PROCEDURE ... 6. The aide care plan shall be reviewed and updated by the registered nurse minimally every sixty (60) days."				