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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>151609 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/18/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>VITAS HEALTHCARE CORPORATION MIDWEST | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1605 ADLER CIRCLE, SUITE E<br>PORTAGE, IN 46368 |
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| L 0000<br><br>Bldg. 00 | <p>This was a federal hospice validation, state licensure, and complaint survey</p> <p>Complaint ID # IN00182541/<br/>unsubstantiated</p> <p>Survey Dates 9/14/2015 through<br/>9/17/2015</p> <p>Medicaid ID # 201136860</p> <p>Census 257</p> <p>Vitas Healthcare Corporation was found to be in compliance with 42 CFR 418.52, 418.54 and 418.56 as related to the above listed complaint.</p>  | L 0000        |   |                      |
| L 0545<br><br>Bldg. 00 | <p>418.56(c)<br/>CONTENT OF PLAN OF CARE</p> <p>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:<br/>Based on record review, the hospice</p> | L 0545        | Immediate response: The program's staff have been   | 09/30/2015           |

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>failed to ensure plans of care were individualized and included patient specific interventions to address identified problems from the updated comprehensive assessments for 2 of 13 (#s 1 and 7) records reviewed.</p> <p>Findings:</p> <p>1. Record #1 evidenced a start of care and hospice benefit election date, 2/21/2015. The initial comprehensive assessment and plan of care both completed at admission noted the patient had a wound vac dressing to the left lower abdomen. An updated nursing comprehensive assessment dated 4/6/2015 indicated the patient had a 4x4 dressing applied to the left lower abdomen. The record failed to evidence an updated plan of care to reflect the change in wound care.</p> <p>2. Record #7 evidenced a start of care and hospice benefit election date 7/1/2015. The initial comprehensive assessment and plan of care completed at admission documented " no report or indication of skin breakdown." An updated nursing comprehensive assessment dated 7/2/2015 indicated "fragile skin" and a 1 cm skin tear to the right wrist. The record failed to evidence and updated plan of care to address the</p> |               | <p>reeducated on the process for developing, coordinating and updating the plan of care based on the individualized needs of each patient. Records of all currently active patients were reviewed to ensure plans of care were updated based on the individual's plan of care needs. Title of person responsible for the corrective action: Patient Care Administrator Monitoring and Compliance Process: During the 3 months folloing the survey the program will audit 4 patient records each week according to the Standard program review using questions from the Comprehensive Assessment and Plan of Care Core Review to verify the plan of care was individualized and includes patient specific interventions based on their comprehensive assessment. The number of reviews conducted after the initial 3 month period will be based on the initial auditing results.</p> |                      |

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| L 0552<br>Bldg. 00 | <p>issues with the patient's skin.</p> <p>3. The agency's 12/09/2009 policy titled Interdisciplinary Team Policies, Interdisciplinary Team states, " A registered nurse in consultation with patient/family, attending physician and team members will develop and revise as necessary the Plan of Care."</p> <p>418.56(d)<br/>REVIEW OF THE PLAN OF CARE<br/>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.<br/>Based on record review, the hospice interdisciplinary group ( IDG) failed to review, and document the individualized plan of care no less that every 15 days for 3 ( #1, 5 and 8) of 13 records reviewed.<br/><br/>Findings include:<br/><br/>1 Record # 1 start if care and hospice benefit election date 2/24/2015, failed to evidence the plan of care was reviewed by the IDG from 4/22/2015 through</p> | L 0552        | <p>Immediate Response: In an effort to ensure the IDG reviews and documents the individualized plan of care no less than every 15 days, <b>The program's staff have been reeducated on the process for developing, coordinating, updating and discontinuing plans of care as necessary based on the Program Standard for Plan of Care. The Program's IDG reviewed all the currently active patients to ensure continuity of care. Records</b></p> | 09/30/2015           |

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| L 0629   | <p>6/22/2105.</p> <p>2. Record #5, start of care and hospice benefit election date 7/24/2015, failed to evidence the plan of care was reviewed by the IDG from 8/5/2015 through 8/26/2015.</p> <p>3. Record #8, start of care and hospice benefit election date 7/16/2015, failed to evidence the plan of care was reviewed by the IDG from 8/5/2015 through 8/26/2015.</p> <p>4. The Agency's 7/9/2015 policy titled Plan of Care Review states " The hospice interdisciplinary group...must review the individualized plan ...no less frequently than every 15 calender days."</p> <p>418.76(h)(1)(i)<br/>SUPERVISION OF HOSPICE AIDES</p> |   | <p><b>were reviewed on currently active patients for a comprehensive assessment and service coordination by the IDG and verified the plans of care have been updated at least every 15 days. A Patient Care Secretary tracking system and tool has been implemented to ensure the IDG documentation is received timely (withing the15 day requirement) and is accurate. A process for reporting results to management weekly has been implemented. Title of the person responsible for corrective action: Patient Care Administrator Monitoring and Compliance Process:</b></p> <p><b>To ensure ongoing compliance, during the 3 month period following the survey, Program will audit a mininum of 4 patient records per week according to the Standard program review using questions from the Comprehensive Assessment and Plan of Care Core Review to verify coordination of plan of care by the IDG and updates are done at least every 15 days with a compliance of 90% or greater. The number of reviews conducted after the initial 3 month period will be based on the initial auditing results.</b></p> |                      |   |

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| Bldg. 00   | <p>(l) A registered nurse must make an on-site visit to the patient's home:<br/>(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.<br/>Based on record review, the hospice failed to ensure a registered nurse (RN) assessed the care and quality of services provided by the hospice aide no less frequently than every 14 days for 4 ( records #6, 8, 9 and 12) of 13 records reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Record #6 start of care and hospice benefit election date 4/15/2014, contained orders for the hospice aide to visit two times weekly during the review period of 7/17/15 through 9/12/2015. The record failed to evidence RN supervisory visits were made from the dates of 7/21/2015 through 8/23/2015.</li> <li>Record #8, start of care and hospice benefit election date 7/16/2015, contained orders for the hospice aide to visit two times weekly during the review period of 7/17/15 through 9/12/2015. The record failed to evidence RN supervisory visits were made from the</li> </ol> | L 0629  | <p>Immediate Response: To ensure the RN is assessing the care and quality of services provided by the hospice aide no less than ever 14 days the program reeducated the RN staff on the Vitas Standard Supervision, Delegation and Coordination as well as the documentation procedure for supervision of the hospice aide. The program reviewed all the active patient's charts to ensure all supervision of hospice aide by the RN was evident. Title of person responsible for corrective action: Patient Care Administrator Monitoring and Compliance Process: During the 3 month period following the survey the program will audit 4 patient records per week according to the Vitas Standard program review using the Team Manager Supervision Focus Review to ensure the RN supersion of hospice aides is 90% compliant or greater. The number of reviews conducted after the initial 3 month period will be based on the initial auditing results.</p> | 09/30/2015   |  |   |  |

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| L 0683<br>Bldg. 00 | <p>dates of 7/24/2015 through 9/12/2015.</p> <p>3. Record #9, start of care and hospice benefit election date 8/27/2015, contained orders for the hospice aide to visit twice weekly. The record failed to evidence that RN supervisory visits were made from 8/27/2015 through 9/17/2015.</p> <p>4. Record #12, start of care and hospice benefit election date 6/22/2014, contained orders for the hospice aide to see the patient three times weekly. The record failed to evidence RN supervisory visits from May 15, 2015 through June 8, 2015.</p> <p>5. The agency's 12/02/2008 policy titled, Interdisciplinary team policies hospice aide services 5:18 states " Documentation supervision of the hospice aide will be performed and documented by a registered nurse at least every 14 days"</p> <p>418.104(e)(2)<br/>DISCHARGE OR TRANSFER OF CARE<br/>(2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with §418.26, the hospice must forward to the patient's attending physician, a copy of-<br/>(i) The hospice discharge summary; and<br/>(ii) The patient's clinical record, if requested.<br/>Based on record review and interview,</p> | L 0683        | Immediate Response: The   | 09/30/2015           |

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|                    | <p>the hospice failed to ensure that a discharge summary was prepared and forwarded to the patients attending physician for 1 of 2 (#10) discharged records reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Record # 10, evidenced a start of care and election of hospice benefit on 7/28/2015. The patient revoked hospice services on 7/31/2015. The record failed to evidence that a discharge summary was prepared and sent to the patient's attending physician.</li> <li>The agency's 01/18/2006 policy titled Interdisciplinary Team Policies: Discharge of Patients states " A discharge summary will be completed and filed in the medical record no later than 30 days after the patient is discharged.</li> <li>In an interview on 9/17/2015 15 1130 AM, the agency's clinical manager stated that no discharge summary had been prepared.</li> </ol> |               | <p>program staff were reeducated on the process of completing a discharge summary on all discharged patients to include all alive, transferred, revoked, general inpatient discharges and patients who have died. Title of person responsible for corrective action: Patient Care Administrator Monitoring and Compliance Process: During the 3 months following the survey the program will review 100% of discharge charts to ensure that discharge summaries are completed and provided to the attending physician on all discharges including alive, transfers revocations, inpatient stays and deaths. The number of reviews conducted after the initial 3 month period will be based on the initial auditing results.</p> |                      |