

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151583	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2012
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NAME OF PROVIDER OR SUPPLIER UNITY HOSPICE OF NORTHWEST INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7020 BROADWAY MERRILLVILLE, IN 46410
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L0000	<p>This visit was for a Hospice federal and state complaint survey.</p> <p>Survey date: 11/13/12 - 11/19/12</p> <p>Complaint #: IN00118037 - Substantiated: Federal and state deficiencies related to the allegations are cited.</p> <p>Facility #: 002379</p> <p>Medicaid Vendor #: 200461590</p> <p>Surveyors: Ingrid Miller, RN, PHNS</p> <p>Unity Hospice of Northwest Indiana was found out of compliance with IC 16-25-3 and the Conditions of Participation 418.76: Hospice Aide and Homemaker services and 418.100 Organization and administration of Services.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 29, 2012</p>	L0000	<p><u>Credible Allegation of Correction and Compliance:</u> For purposes of any allegation that Unity Hospice of Northwest Indiana, LLC ("Hospice") is not in compliance with theregulations as set forth in this statement of deficiencies, this Plan ofCorrection constitutes Hospice's credible allegation of correction andcompliance.</p> <p>The preparation and execution of this Response and Plan ofCorrection do not constitute an admission or agreement by the provider of thetruth of the facts alleged or conclusions set forth in the statement ofdeficiencies. This Plan of Correction isprepared and/or executed solely because it is required by the provisions offederal and state law.</p>	

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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L0513	<p>418.52(c)(2) RIGHTS OF THE PATIENT [The patient has a right to the following:] (2) Be involved in developing his or her hospice plan of care;</p> <p>Based on clinical record review, policy review, and interview, the hospice failed to inform the patient representatives who requested to be involved in the plan of care development were invited to interdisciplinary group meetings for planning the care of 1 of 4 patient records reviewed (patient #10) with the potential to affect all the facility's patients.</p> <p>Findings</p> <p>1. The agency policy titled "Patient Rights Policy" with an effective date of January 2001, March 2002, and December 2008 stated, "As set forth in the attached Notice of the Hospice Patient Rights and Responsibilities, each patient rights include, but are not limited to ... the right to review and to participate in the development of the plan of care and planning changes in the care ... the patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights ... the hospice must maintained documentation showing it has complied with the above requirements and that the patient or representative has demonstrated an</p>	L0513	<p>How will you correct each deficiency? All open clinical records were reviewed to ensure notification of Patient Rights, including right to attend IDG meetings and participate in development of plan of care, has been provided to all current patients/primary caregivers. Current patients were provided advance written notification of date, time and location of IDG meetings to be held on to Nov.28 and Dec 12, 2012. (See attachment 513 #1). A notice of scheduled upcoming IDG meetings(including date, time, and place) will be delivered to all current patients/primary caregivers. (See attachment 513 #2) A copy of the signed notice will be kept in patient medical record. The PCG for 2 patients attended the Nov 28, 2012 IDG meeting. (See attachment 513 #3). How will you prevent the deficiency from recurring in the future? All IDG members, including, but not limited to, the registered nurse, chaplain, medical social worker, have been in-serviced on the rights of the patient/primary caregiver to participate in the development of the patient's plan of care, including the right to attend IDG meetings. (See attachment 513</p>	12/18/2012	

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	<p>understanding of these rights."</p> <p>2. The agency policy titled "Hospice Interdisciplinary Group" with an effective date of May 2002 and December 2008 stated, "The Hospice Interdisciplinary Group represents a working unit composed of those staff providing hospice services to an individual and his family. This team will be interdisciplinary in nature and consist of, but not limited to, a doctor of medicine or osteopathy, a registered professional nurse, a social worker and a pastoral or other counselor. Other participants who may be part of the Hospice Interdisciplinary Group include, but are not limited to ... The patient, the patient's physician and the patient's family are considered members of the Hospice Interdisciplinary Group when development or revision of the patient's plan of care takes place ... The hospice interdisciplinary group will work together to meet the physical, emotional, and spiritual needs of hospice patients and their family facing terminal illness and bereavement ... the interdisciplinary group will maintain a system of communication to ensure that patient care and services are provided in accordance with the plan of care and are based on assessments of the patient and family needs."</p> <p>3. Clinical record #10, start of care</p>		<p>#4 for copies of the in-services.) A schedule of upcoming IDG meetings (including date, time, and place) will be provided to each patient/primary caregiver during the admission process. (See attachment 513 # 2). Medical record staff will audit patient records after admission to ensure each patient/primary caregiver has received a copy of Patient Rights and schedule of IDG meetings. If no verification is found, the nurse case manager will be responsible for ensuring the information is provided. Results of the audits will be submitted to the Director of Clinical Services who will be responsible for ensuring compliance. Who will be responsible for ensuring the Plan of Correction is implemented? The Director of Clinical Services is responsible for ensuring the Plan of Correction identified above is effectively implemented.</p>				

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	<p>(SOC) 5/17/12, had a signed copy of the patient rights signed by the power of attorney on 5/17/12. This document titled "Hospice Patient Rights and Responsibilities" stated, "This patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights ... to be involved in developing his or her hospice plan of care ... if the patient has been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to State law to act on the patient's behalf."</p> <p>4. On 11/13/12 at 11:10 AM, the director of nursing indicated the interdisciplinary group (IDG) meeting was held every other Wednesday at 8:30 AM and the staff involved included the medical director, the social worker, the chaplain, the director of nursing, the case managers, the administrator, and the administrative assistant. The next meeting of the IDG was to be 11/14/12 at 8:30 AM. Family attendance was very rare.</p> <p>5. On 11/14/12 at 10:30 AM, the medical director indicated he was not aware the family or caregivers were aware of the IDG meetings or involved in developing the plan of care.</p>						

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	<p>6. On 11/15/12 at 12 PM, a family member of patient #10 indicated not being involved in the development of the plan of care or being invited or aware of the bi-weekly meetings of the IDG. The family member was the patient's power of attorney and wanted to have an involvement in this process.</p> <p>7. On 11/16/12 at 8:05 AM, a family member of patient #10 indicated not being involved in the development of the plan of care or invited to any IDG meetings. The family member was not being shown the plan of care even after requesting it and also had requested to be a part of the care planning process.</p> <p>8. On 11/16/12 at 12:50 PM, Employee C, Case Manager and Registered Nurse, stated, "It is not the hospice's policy to invite the patient's families to the interdisciplinary group meetings."</p>			

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L0540	<p>418.56(a)(1) APPROACH TO SERVICE DELIVERY The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. Based on interview, hospice policy review, personnel record review, and clinical record review, the hospice failed to ensure the registered nurse assessed the patient's needs when the patient had a change in condition for 1 of 4 patient records reviewed with the potential to affect all the agency's patients. (patient #10).</p> <p>The findings include</p> <ol style="list-style-type: none"> 1. Clinical record #10, start of care 5/17/12, failed to evidence the registered nurse assessed the patient when Employee F, hospice aide, reported the patient had foul smelling, blood-tinged urine. Employee C, Registered Nurse (RN), called the patient's physician without making a visit or assessing the patient and received an order for the antibiotic Cipro. 2. Personnel file C, date of hire 10/19/11, evidenced a document titled, "RN Case Manager." This document was signed by the Employee C on 10/19/11. This document stated, "The RN case manager 	L0540	<p>How will you correct each deficiency? All open clinical records will be reviewed to ensure that the RN has assessed the current needs of each patient/family member and that they are appropriately addressed in the patient's Plan of Care.</p> <p>How will you prevent the deficiency from recurring in the future? All IDG team members, including all RNs, have received in-service training on the requirement that the RN assess and re-assess the needs of the patient and family, including any needs stemming from a change in condition, so that those needs may be appropriately addressed in the patient's plan of care. (See attachment 540 #1 for copies of the in-service.) Changes in condition will be shared with IDG members, reported at IDG and reflected in the medical record. Medical record staff will review patient records after IDG meetings to ensure all changes in condition have been assessed, discussed and documented. The RN case manager is responsible for ensuring all needs are appropriately assessed and areas</p>	12/18/2012	

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	<p>... assesses and evaluates patient's status by ... regularly re-evaluating patient / family / caregiver needs ... uses health assessment data to determine nursing diagnosis and nursing interventions."</p> <p>3. On 11/19/12 at 12:45 PM, Employee B, director of clinical services, indicated the registered nurse had not made an as needed nursing visit for symptom management.</p> <p>4. The agency policy titled "Ongoing assessment" with an effective date of May 2002 / December 2008 stated, "Reassessment all clinicians should focus on A. patient's response to care B. Changes in patient condition ... Based on the reassessments, the plan of care, including problems, needs, goals and outcomes will be reviewed and revised accordingly, by the Hospice RN Case Manager in collaboration with all hospice interdisciplinary group members responsible for the case."</p>		<p>of documentation are completed. Medical records personnel will be responsible for auditing 10% of all open clinical records every other month to verify that this reassessment has been documented. Any deficiencies will be reported to the Director of Clinical Services who will be responsible for tracking the deficiencies and ensuring the RN reassesses the patient for any changes in condition, and provides continuing education as necessary. Who will be responsible for ensuring the Plan of Correction is implemented? The Director of Clinical Services is responsible for overseeing the ongoing compliance efforts are effectively instituted and that this deficiency does not recur.</p>		

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L0544	<p>418.56(b) PLAN OF CARE 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 agency failed to ensure plans of care identified the care and services the patient would be responsible for and failed to include plan for education and training related to the patient and / or caregiver responsibilities in 1 of 4 records reviewed (patient #10) with the potential to affect all the hospice's patients.</p> <p>The findings include:</p> <p>1. The hospice's policy titled "Patient Plan of Care" with dates of May 2002 / December 2008 stated, "The hospice must ensure that each patient and the primary caregiver receive education and training provided by the hospice as appropriate to their responsibilities of the care and services identified in the plan of care ... the hospice interdisciplinary group members will develop an individualized written plan of care for each patient ... The plan of care will include all services</p>	L0544	<p>How will you correct each deficiency? All open clinical records will be reviewed to ensure that each patient/primary caregiver has received education and training as appropriate to their responsibilities for the care and services identified in the plan of care. Confirmation will be received from all current patients/primary caregivers that they have received training on the proper use of all medical equipment supplied by or on behalf of hospice, and placed in the medical record. Additional training will be provided if needed or requested. How will you prevent the deficiency from recurring in the future? All appropriate staff members will receive in-service training on the requirement to ensure that each patient/primary caregiver receives education and training as appropriate to their responsibilities for the care and services identified in the plan of care, with specific reference to the use of medical equipment. (See attachment 544 #1 for copies of the in-services) Each patient/primary caregiver will be given education and training as</p>	12/18/2012	

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	<p>necessary for the palliation and management of the terminal illness and related conditions, including the following: medical supplies and appliances necessary to meet the needs of the patient."</p> <p>2. Clinical record #10 included a plan of care dated 5/17/12. The plan of care failed to identify patient and / or caregiver responsibilities related to use of side rails and failed to provide for the education and training of the patient / caregivers related to the side rail use.</p> <p>3. On 11/15/12 at 12 PM, a video of patient #10 showed Employee F, Hospice Aide, caring for patient #10 on four different dates of 7/16/12, 7/30/12, 8/21/12, and 9/6/12. At each of these visits, the patient had full side rails up on the bed and the aide lowered these side rails prior to giving care to the patient.</p> <p>4. On 11/16/12 at 8:05 AM, the family of patient #10 indicated receiving no education on side rail use.</p> <p>5. On 11/19/12 at 12:40 PM, Employee H, durable medical equipment technician, indicated patient #10 had full siderails on the bed he delivered to the patient on 5/22/12.</p>		<p>appropriate to their responsibilities for the care and services identified in the plan of care, with specific reference to the use of medical equipment. Education on the use of medical equipment will be provided when the equipment is delivered, in the form of written instructions and/or demonstration. Confirmation that education was provided will be noted in the medical record. Medical records personnel will be responsible for auditing 10% of all open clinical records every other month for documentation that the patient/primary caregiver has received education and training on the use of medical equipment hospice has provided. Any deficiencies will be reported to the Director of Clinical Services who will be responsible for implementing appropriate staff education and training to ensure patient/primary caregiver education and training is provided. Who will be responsible for ensuring the Plan of Correction is implemented? The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively instituted and that this deficiency does not recur.</p>		

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	6. On 11/19/12 at 12:45 PM, Employee C, Registered Nurse, indicated the patient or family was not educated on side rail use and the care plan had not been updated to include side rail use.			

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L0547	<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.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure each patient had a Plan of Care that included an acceptable range of visits that was a specific frequency necessary to meet the patient and family's needs for 2 of 4 (#10, #11) records reviewed with the potential to affect all patients of the hospice.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record #10 had documentation on the "IDG Update" from 8/8/12 - 8/21/12 that the hospice aide was to visit 10 - 20 times in 15 days to assist with personal care. The range of 10 to 20 is too great and not a specific frequency. Clinical record #11 had documentation on the "IDG Update" from 11/14/12 - 11/27/12 that the hospice aide was to visit 5 - 10 times in 15 days to assist with personal care. The range of 10 to 20 is too great and not a specific frequency. 	L0547	<p>How will you correct each deficiency? All open clinical records, including those patients identified in the survey, will be reviewed to ensure each individualized Plan of Care includes a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. The frequency of hospice aid visits in the Plans of Care of those current patient's identified in the survey will be updated to be more detailed and specific and do not contain frequency ranges greater than two (2) visits per 15 day period. How will you prevent the deficiency from recurring in the future? All IDG members have received in-service training on requirement to ensure that each individualized Plan of Care includes a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. And specifically that any visit frequency ranges are not to span a range greater than two (2) visits per 15 day period. (See attachment 547 #1 for copies of the in-services) Medical record</p>	12/18/2012			

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	<p>3. On 11/15/12 at 12:15 PM, the director of clinical indicated the frequency of visits for the hospice aide for #10 and #11 was too great a range and could lead to a lack of continuity of care for agency patients receiving hospice aide services.</p> <p>4. The agency policy titled "Patient Plan of Care" with an effective date of May 2002 / December 2008 stated, "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."</p>		<p>staff will review Plan of Care records after IDG meetings to ensure visit frequencies are detailed and specific and do not contain a range spanning greater than two(2) visits per 15 day period. If a deficiency is found, the RN case manager is responsible for ensuring the Care Plan is corrected. Medical records personnel will be responsible for auditing 10% of all open clinical records every other month to ensure visit frequencies are compliant. Any deficiencies will be reported to the Director of Clinical Services who will be responsible for ensuring the Plan of Care is specific and implementing appropriate staff education and training to ensure compliance. Who will be responsible for ensuring the Plan of Correction is implemented? The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively instituted and that this deficiency does not recur.</p>		

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L0579	<p>418.60(a) PREVENTION</p> <p>The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.</p> <p>Based on interview and review of personnel file, policy, document, and video, the hospice failed to ensure the hospice aide who provided care followed standard infection control policies including handwashing while providing direct patient care in 1 of 1 video observation of a patient (patient #10) with the potential to affect all the agency's patients who receive services from employee F.</p> <p>Findings</p> <p>1. On 11/15/12 at 12 PM, a video of patient #10 showed Employee F, Hospice Aide, caring for patient #10. The aide was observed to give the patient a cup which fell to the floor, spilling the contents. The aide was observed to get a dishcloth to mop up the spill from the patient, the chair, her own legs, and the floor. The aide was not observed to wash her hands after cleaning up the spill of the floor and continued caring for patient #10.</p> <p>2. On 11/16/12 at 1 PM, Employee C, Case Manager and Registered Nurse,</p>	L0579	<p>How will you correct each deficiency? Hospice will ensure that hospice staff adhere to and follow its policies and procedures regarding accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. How will you prevent the deficiency from recurring in the future? All caregiver staff have received in-service training on requirement to follow policies and procedures regarding accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions and hand washing technique when providing direct patient care. Competency exams have been given. (See attachment 579 #1 for copies of the in-services) The Director of Clinical Services will perform an in-person supervisory visit on all hospice aides providing direct patient care to verify compliance with hand washing requirements. Subsequent in-person supervisory visits with all hospice aides providing direct patient care will be performed by the DCS or RN once per month for the next 2</p>	12/18/2012	

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	<p>indicated the aide should always wash hands after cleaning up a spill from the floor.</p> <p>3. The agency policy titled "Infection control" with a date of January 2001 / March 2002 / December 2008 stated, "The nursing supervisor will be responsible for implementing and monitoring the infection control program and will coordinate / oversee the following ... the provision of appropriate infection control techniques including standard precautions by staff delivering direct patient care ... Policies and procedures shall conform with the Centers for Disease Control ... Guidelines for Isolations Precautions: Preventing Transmission of Infectious Agents in Healthcare settings 2007, Occupational Safety and Health administration."</p> <p>4. Personnel file F, date of hire 1/12/10, evidenced a yearly on site supervisory visit documentation completed by Employee C on 1/27/12. This visit documentation evidenced the aide was competent in handwashing.</p> <p>5. A document titled "February 29, 2012 Staff Meeting" included a sign in sheet with the signature of Employee F, Hospice Aide. Several documents were included in this inservice packet including</p>		<p>months. These supervisory visits will be documented in the employee file. Any deficiency will require the staff member to be re-in serviced and pass a competency exam before he/she will be allowed to make any patient visits. Human resource personnel will audit the employee file of each current hospice aide to verify this supervision. Who will be responsible for ensuring the Plan of Correction is implemented? The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively instituted and that this deficiency does not recur.</p>		

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	a document titled "World Health Organization Patient Safety Save Lives Clean your Hands" with a revised date of August 2009. This document stated, "Your 5 Moments for Hand Hygiene ... After touching patient surroundings ... Clean your hands after touching any object or furniture."			

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L0591	<p>418.64(b)(1) NURSING SERVICES</p> <p>(1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.</p> <p>Based on policy review, clinical record review, and interview, the hospice failed to ensure that 1 of 4 clinical records reviewed (patient #10) had a nursing visit for assessment made after symptoms of urinary tract infection were reported by the hospice home health aide with the potential to affect all the hospice's patients.</p> <p>Findings</p> <p>1. Clinical record #10, start of care 5/17/12, evidenced a progress note written by Employee C, Registered Nurse (RN), on 8/21/12. This progress note indicated the patient's urine had a strong foul odor and was blood tinged as reported by Employee F, Hospice Aide. The nurse called the physician for an antibiotic order and obtained an order for Cipro without making an on-site visit to assess the patient and despite orders on the plan of care for as needed visits for symptom management.</p>	L0591	<p>How will you correct each deficiency? All open clinical records will be reviewed to ensure that nursing services are provided by or under the supervision of a registered nurse, and nursing services meet the needs of the patient as identified in the patient's initial, comprehensive and updated assessments. How will you prevent the deficiency from recurring in the future? All IDG team members, including all RNs, have received in-service training on the requirement that the RN assess and re-assess the needs of the patient and family, including any needs stemming from a change in condition, so that those nursing services meet the assessed needs of the patient and are appropriately addressed in the patient's plan of care. (See attachment 540 #1 for copies of the in-service.) Changes in condition will be shared with IDG members, reported at IDG and reflected in the medical record. Medical record staff will review patient records after IDG meetings to ensure all changes in condition have been assessed,</p>	12/18/2012			

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	<p>2. On 11/15/12 at 12:50 PM, Employee C, RN, indicated not visiting patient #10 after Employee F, Hospice Aide, reported patient had symptoms of a urinary tract infection that included a strong foul odor and blood tinged urine before contacting the physician.</p> <p>3. The agency policy titled "Ongoing Assessment" - Unity Hospice dated May 2002/Dec 2008 states, "The scope and intensity of ongoing hospice assessments will be determined by the patient's prognosis, diagnoses, condition, desire for care, response to previous care and the care setting ... Reassessments all clinicians should focus on ... Changes in patient condition, level of deterioration ... Based upon findings of the reassessment, change / verbal orders will be generated and forwarded to the physician as needed."</p>		<p>discussed and documented. The RN case manager is responsible for ensuring all needs are appropriately assessed and areas of documentation are completed. Medical records personnel will be responsible for auditing 10% of all open clinical records every other month to verify that this assessment and reassessment, as appropriate, have been documented. Any deficiencies will be reported to the Director of Clinical Services who will be responsible for tracking the deficiencies and ensuring the RN reassesses the patient's needs based upon any changes in condition, and provides continuing education as necessary. Who will be responsible for ensuring the Plan of Correction is implemented? The Director of Clinical Services is responsible for overseeing the ongoing compliance efforts are effectively instituted and that this deficiency does not recur.</p>		

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L0607	<p>418.76 HOSPICE AIDE AND HOME MAKER SERVICES</p> <p>Based on clinical record, document, video, and policy review and interview, it was determined the hospice failed to ensure the aide care plan was followed for 2 of 4 records reviewed putting the patient's safety at risk with the potential to affect all the patients the hospice aides provide care for (See L 626).</p> <p>The cumulative effect of this problem resulted in the hospice's inability to provide safe hospice aide care as required by the Condition of Participation 418.76: Hospice Aide and Homemaker services.</p>	L0607	Hospice will implement a Plan of Correction for each of the deficiencies related to tag L626 to ensure the provision of safe hospice aide care. Hospice will ensure that hospice staff adhere to and follow its policies and procedures to ensure the provision of safe hospice aide care. The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively instituted and that this deficiency does not recur.	12/18/2012	

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L0626	<p>418.76(g)(2) HOSPICE AIDE ASSIGNMENTS AND DUTIES (2) A hospice aide provides services that are:</p> <ul style="list-style-type: none"> (i) Ordered by the interdisciplinary group. (ii) Included in the plan of care. (iii) Permitted to be performed under State law by such hospice aide. (iv) Consistent with the hospice aide training. <p>Based on clinical record, document, video, and policy review and interview, the hospice failed to ensure the aide care plan was followed for 2 of 4 records (7 and 10) reviewed putting the patient's safety at risk and with the potential to affect all the patients the hospice aides provide care for.</p> <p>Findings include</p> <p>1. Clinical record #7 contained a plan of care dated 10/16/12 - 10/30/12 with orders for Hospice Aide services. The Hospice Aide notes dated 10/16/12, 10/17/12, 10/18/12, 10/19/12, 10/20/12, 10/21/12, 10/22/12, 10/23/12, 10/24/12 10/25/12, 10/26/12, 10/27/12, and 10/28/12 failed to evidence the aide had completed the skin sheet, combed and brushed hair, recorded most recent bowel movements, inspected mouth, assisted with brushing teeth, offer foods and fluids, cleaned patient's room and area, and assisted with gentle range of motion exercise per visit as ordered on the plan of</p>	L0626	<p>How will you correct each deficiency? Hospice will ensure that all hospice aide services are as (i) ordered by the interdisciplinary group, (ii) included in the plan of care, (iii) permitted to be performed understate law, and (iv) consistent with the hospice aide training. Hospice will ensure that hospice aides adhere to and follow its policies and procedures to ensure the provision of safe hospice aide care by following the hospice aide assignment sheet.</p> <p>How will you prevent the deficiency from recurring in the future? . All caregiver staff,including IDG team members, nurses and hospice aides, have received in-service training on the requirement that aide services be in accordance with instructions detailed in the hospice aide assignment sheet for each specific patient. (See attachment 650 #1 for copies of the in-services) Hospice is in process of revising its hospice aide assignment sheet and corresponding hospice aide flow sheet to more accurately track</p>	12/18/2012			

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	<p>care.</p> <p>On 11/14/12 at 4:10 PM, Employee B, the director of clinical services, indicated aide assignments do not correspond with the aide care plan.</p> <p>2. Clinical record #10 contained plans of care dated 7/11/12 - 7/24/12 7/25/12 - 8/7/12, 8/8/12 - 8/21/12, 8/22/12 - 9/4/12, and 9/5/12 - 9/18/12. The Hospice Aide notes dated 8/8/12, 8/9/12, 8/13/12, 8/14/12, 8/15/12, 8/16/12, 8/17/12, 8/20/12, and 8/21/12 failed to evidence the aide had recorded the most recent bowel movement in the clinical record. Review of a video which recorded visits which occurred 7/16/12, 7/30/12, 8/21/12, and 9/6/12 failed to show the Hospice Aide assisted the patient in feeding and keeping the patient's room / area clean as ordered on the plan of care.</p> <p>A. The clinical document titled "Safety Precaution Assignments" with a date of 5/23/12 and signed by Employee C, Registered Nurse (RN), stated, "Aspiration Precautions ... Follow the prescribed diet and / or specific feeding strategies designed by therapist: nectar thick ... allow enough time for the meal ... feed slowly and sit within the patient's field of vision, offer small amounts (1/2 to 1 tsp. [teaspoon] at a time). Alternate</p>		<p>compliance with this requirement. All hospice aide assignment sheets for current patients will be reviewed by the RN and discussed with the hospice aide to ensure the aide understands the specific care he/she is to perform. The Director of Clinical Services or RN will perform an in-person supervisory visit on all hospice aides to confirm aide services are in accordance with the hospice aide assignment sheet for that patient. Subsequent in-person supervisory visits with all direct patient care staff will be performed by the DCS or RN once per month for the next 2 months. These supervisory visits will be documented in the employee file. Human resource personnel will audit the employee file of each current caregiver staff member to verify this supervision. In addition, medical records personnel will be responsible for auditing 10% of all open clinical records every other month to ensure that visit notes submitted by hospice aides indicate care that is consistent with services required in the corresponding assignment sheet. The hospice RN case manager is responsible for ensuring the aide services provided to their patient is consistent with the aide assignment sheet. Any deficiencies will be reported to the Director of Clinical Services who will be responsible for implementing appropriate staff</p>				

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	<p>solids and liquids."</p> <p>B. The video taken of the care of patient #10 showed Employee F, Hospice Aide, caring for patient #10 for morning care which included getting the patient out of bed and into the bathroom, showered, dressed, and fed breakfast. After the patient was bathed and dressed, the patient walked self with a walker to a recliner in the living room area. The aide handed the patient a container of food while the patient fed her / himself at these four observations of breakfast feeding. The aide never gave the patient any bites of food or any sips of liquid in any of days of care recorded on the video.</p> <p>1.) On 7/16/12 at 8:35 AM, Employee F was observed calling on a cell phone and texting on the phone three times while the patient fed self breakfast.</p> <p>2.) On 8/21/12 at 9:00 AM, Employee F was talking on a cell phone and was off at 9:02 AM. At 9:05 AM, Employee F was observed talking on the cell phone as the patient was feeding her / himself with a spoon out of a Styrofoam container.</p> <p>C. On 11/16/12 at 8:05 AM, patient #10's family indicated Employee C, RN, had discussed how the aide would assist</p>		<p>education and training, and discipline if appropriate, to ensure continued compliance. Who will be responsible for ensuring the Plan of Correction is implemented? The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively instituted and that this deficiency does not recur.</p>				

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	<p>the patient with eating and drinking with the morning care. The family indicated disappointment with the care provided by Employee F and how the bathroom was cleaned up after most showers. The family indicated soiled towels were left on the bathroom floor and not cleaned up after the aide had completed care.</p> <p>3. The policy provided titled "Plan of Care" with review dates of May 2002 / May 2008 stated, "The hospice interdisciplinary group members will develop an individualized written plan of care for each patient ... the plan of care will include all services necessary for the palliation and management of the terminal illness and related conditions."</p> <p>4. The agency policy titled "Hospice Aide and Homemaker services" with an effective date of January 2001 / March 2002 / December 2008 stated, "Hospice Aide and Homemaker service shall be available to meet the needs of the patients. All hospice aide services must be provided by individuals who meet the personnel requirements specified in Medicare Conditions of Participation 418.76 9(a) ... a hospice aide provides services that are ordered by the interdisciplinary group, included in the plan of care, permitted under state law by such hospice aide, and consistent with the</p>				

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	hospice aide training."			

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L0648	<p>Based on personnel file, clinical record, video, and policy review and interview, it was determined the hospice failed to ensure the hospice aide provided care that was consistent with the patient's need for safety for 1 of 1 video record of patient care by a hospice aide with the potential to affect all the patients of the hospice who receive aide services (See L 650).</p> <p>The cumulative effect of this problem resulted in the hospice's inability to provide safe hospice aide services as required by the Condition of Participation 418.100 Organization and administration of Services.</p>	L0648	Hospice will implement a Plan of Correction for each of the deficiencies related to tag L650 to ensure the provision of safe hospice aide care. Hospice will ensure that hospice staff adhere to and follow its policies and procedures to ensure the provision of safe hospice aide care. The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively instituted and that this deficiency does not recur.	12/18/2012	

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L0650	<p>418.100(a) SERVING THE HOSPICE PATIENT AND FAMILY</p> <p>The hospice must provide hospice care that-</p> <p>(1) Optimizes comfort and dignity; and</p> <p>(2) Is consistent with patient and family needs and goals, with patient needs and goals as priority.</p> <p>Based on personnel file, clinical record, video, and policy review and interview, the hospice failed to ensure the hospice aide provided care that was consistent with the patient's need for safety for 1 of 1 video record of patient care by a hospice aide (patient #10) with the potential to affect all the patients of the hospice who receive aide services.</p> <p>Findings</p> <p>1. The clinical document for patient #10 titled "Safety Precaution Assignments" with a date of 5/23/12 and signed by Employee C, Registered Nurse (RN), stated, "Aspiration Precautions ... Follow the prescribed diet and / or specific feeding strategies designed by therapist: nectar thick ... allow enough time for the meal ... feed slowly and sit within the patient's field of vision, offer small amounts (1/2 to 1 tsp. [teaspoon] at a time). Alternate solids and liquids."</p> <p>2. A video record of the care provided patient #10 on 7/16/12, 7/30/12, 8/21/12,</p>	L0650	<p>How will you correct each deficiency? Hospice will ensure that all hospice aide services (i) optimize comfort and dignity, and (ii) is consistent with patient and family needs and goals, with patient needs and goals as the priority. Hospice will ensure that hospice aides adhere to and follow its policies and procedures to ensure the provision of safe hospice aide care by following the hospice aide assignment sheet, adhering to policies and procedures restricting the use of a cell phone or texting while providing patient care, and following standard precautions including proper hand washing technique. How will you prevent the deficiency from recurring in the future? . All caregiver staff, including IDG team members, nurses and hospice aides, has received in-service training on the requirement that aide services be in accordance with instructions detailed in the hospice aide assignment sheet for each specific patient. Hospice is in process of revising its hospice aide assignment sheet and corresponding hospice aide flow</p>	12/18/2012			

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	<p>and 9/6/12 evidenced Employee F, Hospice Aide (HA), did not feed the patient per safety precautions and as identified on the aide care plan. The video recorded the aide getting the patient out of bed and into the bathroom, showered, dressed, and fed breakfast. After the patient was bathed and dressed, the patient walked self with a walker to a recliner in the living room area. The aide was observed to hand the patient a container of food while the patient fed her / himself at these four observations of breakfast feeding. The aide never gave the patient any bites of food or any sips of liquid at any of these video observations.</p> <p>A. On 7/16/12 at 8:35 AM, Employee F was observed calling on a cell phone and texting on the phone three times while the patient fed self breakfast.</p> <p>B. On 8/21/12 at 9:00 AM, Employee F was talking on a cell phone and was off at 9:02 AM. At 9:05 AM, Employee F was observed talking on the cell phone as the patient was feeding her / himself with a spoon out of a Styrofoam container.</p> <p>C. On 9/6/12 at 9:09 AM, Employee F was observed to clean up a spill from a Styrofoam cup that spilled its contents onto the aide, the patient, the patient's chair, and the floor. The patient fed self</p>		<p>sheet to more accurately track compliance with this requirement. All hospice aide assignment sheets for current patients will be reviewed by the RN and discussed with the hospice aide to ensure the aide understands the specific care he/she is to perform. . (See attachment 650 #1 , for copies of the in-services). Caregiver staff have also been in serviced on standard precautions, including proper hand washing technique. Caregiver staff, including aides, have also been in-serviced on restrictions on the use of cell phones for phone calls and texting while providing patient care. (See attachments 579 #1 and 650 #1 for copies of the in-services). They have also been given instruction on the Policy Related to the Use of Cell Phones. (See attachment 650 #2). Confirmation of their receipt of this policy will be maintained in the employee file. The Director of Clinical Services or RN will perform an in-person supervisory visit on all hospice aides providing direct patient care to confirm the aide is providing services in accordance with the hospice aide assignment sheet, and that proper hand washing technique is being followed. Subsequent in-person supervisory visits with all hospice aides providing direct patient care will be performed by the DCS or RN once per month for the next 2 months. These supervisory visits will be</p>		

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	<p>while Employee F walked around the room cleaning up the spill and simultaneously talking on a cell phone. The patient was not in the aide's field of vision during parts of this care encounter while the aide walked around the living and kitchen area. After cleaning the spill, the aide continued to talk on the cell phone before removing the patient's food container from the patient's lap.</p> <p>3. The clinical document titled "Hospice Aide Assignment and Plan of Care" with a signature of Employee C, RN, on 6/25/12, 7/11/12, 7/25/12, 8/8/12, 8/22/12, and 9/5/12 indicated the patient was to be on regular diet with pureed food and nectar thick liquid with the aide feeding the patient at every hospice aide visit.</p> <p>4. On 11/16/12 at 8:05 AM, patient #10's family indicated Employee C, RN, had discussed how the home health aide would assist the patient with eating and drinking with the morning care. The family indicated disappointment with the care provided by Employee F.</p> <p>5. On 11/16/12 at 12:50 PM, Employee C indicated an aide should not care for a patient while talking on a cell phone and aspiration precautions for patient #10 were included in the clinical record.</p>		<p>documented in the employee file. Human resource personnel will audit the employee file of each current aide providing patient care to verify this supervision and to verify their receipt of the Policy Related to the Use of Cell Phones. In addition, medical records personnel will be responsible for auditing 10% of all open clinical records every other month to ensure that visit notes submitted by hospice aides indicate care that is consistent with services required in the corresponding assignment sheet. The hospice RN case manager is responsible for ensuring the aide services provided to their patient is consistent with the aide assignment sheet. Any deficiencies will be reported to the Director of Clinical Services who will be responsible for implementing appropriate staff education and training, and discipline if appropriate, to ensure continued compliance. Who will be responsible for ensuring the Plan of Correction is implemented? The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively instituted and that this deficiency does not recur.</p>		

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