

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  12/10/2014
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NAME OF PROVIDER OR SUPPLIER  UNITY HOSPICE OF NORTHWEST INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8407 VIRGINIA ST MERRILLVILLE, IN 46410
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L000000	<p>This visit was for a Hospice federal and state complaint survey.</p> <p>Survey date: December 8 - 10, 2014</p> <p>Complaint #: IN00151123 - Substantiated: Federal and state deficiencies related to the allegations are cited. Unrelated deficiencies are also cited.</p> <p>Facility #: 002379</p> <p>Medicaid Vendor #: 200461590</p> <p>Surveyors: Ingrid Miller, RN, PHNS Tameka Warren, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 18, 2014</p>	L000000	<p>This plan of correction and compliance constitutes Unity Hospice's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was correctly cited. This plan of correction is submitted to comply with State and Federal laws.</p>	
L000514	<p>418.52(c)(3) RIGHTS OF THE PATIENT [The patient has a right to the following:] (3) Refuse care or treatment;</p>	L000514	<b>How will you correct each</b>	01/09/2015

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>Based on document review, policy review, clinical record review, and interview, the hospice failed to ensure the patient was able to refuse spiritual services for 3 of 7 records reviewed (#3, #4, #5) with the potential to affect any of the 59 active patients currently under the hospice's care.</p> <p>Findings</p> <p>1. Clinical record #3, election date and start of care 5/13/14 and a diagnosis of Alzheimer's disease, evidenced a plan of care for the certification period of 5/13/14 - 8/10/14. The patient's death occurred on 6/12/14. The spiritual assessment was completed by the nurse on 5/16/14. This assessment stated, "No Chaplain requested ... [patient #3's informal caregiver] does not have a religion. Atheists." The clinical record evidenced a chaplain visit occurred on 5/19/14. This visit was not ordered on the plan of care or desired by the patient or informal caregivers. The patient rights were signed on 5/13/14.</p> <p>On 12/9/14 at 3:25 PM, the director of clinical services indicated the visit should not have occurred.</p> <p>2. Clinical record #4, election date and</p>		<p><b>deficiency?</b> All IDG team members will receive in-service training on the protection and promotion of Patient Rights, including the right to refuse care or treatment. <b>How will you prevent the deficiency from recurring in the future?</b> Medical Records staff will audit and review patient medical records to ensure that Patient Rights, including the right to refuse care or treatment, are respected and adhered to. Medical records personnel will be responsible for auditing 10% of all open clinical records every month to ensure that patient directives to refuse a specific treatment or category of care is honored. Any deficiencies will be reported to the Director of Clinical Services who will be responsible for ensuring Patient Rights, including refusal of care or treatment is followed to ensure compliance. <b>Who will be responsible for ensuring the Plan of Correction is implemented?</b> The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively instituted and that this deficiency does not occur in the future.</p>		

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	<p>start of care 12/23/14 and diagnosis of lung cancer, evidenced a plan of care for the certification period of 12/23/13 - 3/22/14. The patient's death occurred on 12/31/14. The spiritual assessment was completed by the social worker on 12/27/14. This assessment stated, "Chaplain services declined at this time." A chaplain visit was made on 12/31/14. Patient rights were signed by the patient on 12/23/13.</p> <p>On 12/9/14 at 2:10 PM, Employee E, registered nurse, indicated patient #4 had declined spiritual services and she had called the chaplain, Employee I, to visit when the patient's death occurred.</p> <p>3. Clinical record #5, election date and start of care 4/14/14 and diagnosis of congestive heart failure evidenced a plan of care for the certification period of 4/14/14 - 7/12/14. The patient's death occurred on 6/14/14. The spiritual assessment was completed by the Social Worker on 4/14/14. This assessment stated, "No chaplain requested." A chaplain visit was made on 5/20/14. Patient Rights were signed on 4/14/14 by the power of attorney.</p> <p>On 12/9/14 at 3:10 PM, Employee A, the director of clinical services, indicated a visit should be ordered by the physician</p>			

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	<p>and discussed with the IDG.</p> <p>4. The document titled "Patient Rights" with a date of 9/1/11 stated, "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 patient had the right - 1. to exercise his or her rights as a patient of hospice ... to be involved in developing his or her hospice plan of care 7. To refuse care or treatment ... 10. To be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse ... 11. To receive information about the services covered under the hospice benefit. 12. To receive information about the scope of services that the hospice will provide and specific limitations on those services ... the hospice must ensure all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source ... are reported immediately by hospice employees and contracted staff to the hospice administrator 2. Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further violations ... ensure that verified violations are reported to the State."</p>			
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	<p>5. The policy titled "Patient Plan of Care" with a date of May 2002 / December 2008 stated, "A written plan of care shall be established and maintained for each patient admitted to the hospice program and the care provided to a patient shall be in accordance with the plan."</p> <p>6. The policy titled "Patient Rights Policy" with a date of December 2008 stated, "Each rights include, but are not limited to 1. The patient and family right's for respect of ... person ... the right to be informed in advance about the care to be furnished ... the right to be informed in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished ... the right to be informed in advance of any change in the plan of care before the change is made ... 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 patient has the right to exercise his or her rights has a patient of the hospice. 2. To have his or her property and person treated with respect ... to be involved in developing his or her hospice plan of care 7. to refuse care or treatment ... 10. To be free of mistreatment, neglect ... 12. To receive information about he scope of services that the hospice will provide."</p>			

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L000537	<p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES</p> <p>The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.</p> <p>Based on clinical record review, policy review, and interview, the hospice failed to ensure all members of the IDG (Interdisciplinary Group) attended the IDG meeting and completed the written plan of care for 3 of 7 records reviewed (#1, #2, and #5) .</p> <p>Findings</p> <p>Regarding Active Records #1 and #2</p> <p>1. The IDG meeting document titled "Unity Hospice Of Northwest Indiana LLC" with a meeting date of 11/12/14 failed to evidence the social worker was present or participated in the IDG meeting that is held every 2 weeks. There were meeting notes on active clinical records #1 and #2. The sign in sheet did not evidence the social worker had been present.</p> <p>a. Via phone call, on 12/9/14 at 1:45</p>	L000537	<p><b>How will you correct each deficiency?</b> All IDG team members will be in-serviced on the requirement to participate with other members of the team in the preparation of a Plan of Care for each patient. Participation in development of Plan of Care shall generally take place via attendance at scheduled IDG meetings and/or participation in IDG meetings via phone where physical attendance is not possible. <b>How will you prevent the deficiency from recurring in the future?</b> A sign-in sheet will be maintained for all IDG meetings. Medical Records personnel will be responsible for auditing <b>100%</b> of all IDG meeting sign-in sheets to ensure the participation of all required IDG team members. It shall be noted in the team records if an IDG team member participates via phone. Any questions or omissions shall be reported to the Director of Clinical Services. <b>Who will be responsible for ensuring the Plan of Correction</b></p>	01/09/2015
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	<p>PM, Employee D, social worker, indicated not attending any IDG meetings since January 2014. She indicated not attending these meetings in person or by phone conference.</p> <p>b. A email document from Employee A, director of clinical services, to Employee D on Friday, November 14, 2014, stated, "Find attached handwritten notes from our last IDG this past Wednesday [notes were from 11/12/14 IDG meeting.]"</p> <p>c. Clinical record #1, election date and start of care 5/5/14, evidenced a plan of care for certification period from 11/1/14 - 12/30/14. The IDG update, dated 11/12/14, included the electronic signature of Employee D, social worker, who had not attended the IDG meeting.</p> <p>d. Clinical record #2, election date and start of care 11/8/14, evidenced a plan of care for the certification period from 11/8/14 - 2/5/15. The IDG failed to show a social worker had updated the plan of care. The IDG update, dated 11/12/14, included an electronic signature of Employee D, social worker, who had not attended the IDG meeting.</p> <p>Regarding closed record #5</p>		<b>is implemented?</b> The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively maintained and that this deficiency does not occur in the future.		

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	<p>2. Clinical record #5, start of care 4/14/14, with a plan of care for the certification period of 4/14/14 - 7/12/14 evidenced an initial plan of care dated 4/14/14, prior to the chaplain's hire date. This initial plan of care included an electronic signature for Employee H, chaplain, date of hire 6/2/14. This patient died on 6/14/14.</p> <p>On 12/9/14 at 1:55 PM, Employee H, Chaplain, indicated he had been hired in June of 2014. He had moved here from Florida for this job. The director of clinical services had introduced him to patients in the mid part of June. He indicated that he did not recall details about patient #5's care.</p> <p>3. The policy titled "Patient Plan of Care" with a date of May 2002 / December 2008 stated, "Unity Hospice recognizes that in order to provide continuity of care, it is necessary to designate an interdisciplinary group which in consultation with the patient's attending physician, shall prepare a written plan of care for each patient ... the hospice care team will complete an assessment of the patient's care needs, and establish an individualized plan of care in collaboration with the attending physician [if any], the patient /</p>			

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L000545	<p>representative, and the primary caregiver in accordance with the primary caregiver in accordance with the patient's needs ... the hospice interdisciplinary group members will develop an individualized written plan of care for each patient."</p> <p>4. The policy titled "Standards of Conduct / Ethical Behavior" with a date of June 2005 and December 2008 stated, "All paperwork is to be completed in a timely, accurate manner. Any falsification of documentation or altered documentation in the clinical record and billing record may result in disciplinary action, including termination."</p> <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:</p>	L000545	<i>How will you correct each</i>	01/09/2015
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	<p>Based on clinical record review, interview, and policy review, the hospice failed to develop an individualized written plan of care that included the patient's Foley for 1 of 2 active records reviewed (#2).</p> <p>The findings</p> <ol style="list-style-type: none"> <li>The policy titled "Patient Plan of Care" with a date of May 2002 and December 2008 stated, "The hospice interdisciplinary group members will develop and individualized written plan of care for each patient ... treatment necessary to meet the needs of the patient."</li> <li>Clinical record #2 contained a progress note completed by the skilled nurse that evidenced the Foley catheter was changed on 11/18/14 with a 16 French catheter and inflated with a 30 CC (cubic centimeter) bulb. A progress note completed by the skilled nurse evidenced the Foley catheter was changed on 11/22/14 with 16 French 10 CC bulb. The admission orders on 11/8/14 evidenced the hospice protocol was to anchor a Foley catheter and change / irrigate prn (as needed) per hospice protocol.</li> <li>On 12/10/14 at 10:55 AM, the</li> </ol>		<p><b>deficiency?</b> All nurses will receive in-service training on the requirement to develop an individualized written plan of care for each patient, including the use of Foley catheters. 100% of all open clinical records for patients that utilize a Foley catheter will be reviewed to ensure that proper protocols are followed. <b>How will you prevent the deficiency from recurring in the future?</b> Medical records personnel will audit 10% of all open clinical records every month to verify the individualized plan of care is followed, including the protocol for the care of Foley catheters. 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. <b>Who will be responsible for ensuring the Plan of Correction is implemented?</b> The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively instituted and that this deficiency does not occur in the future.</p>	

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L000671	<p>administrator indicated that a specific protocol would be developed for Foley catheter procedures. This would take some time.</p> <p>418.104 CLINICAL RECORDS A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. Based on clinical record review, policy review, and interview, the hospice failed to ensure that electronic signatures were accurate for 3 of 7 records reviewed (#1 and #2 and #5)</p> <p>Findings Regarding Active Records #1 and #2</p> <p>1. The IDG meeting document titled "Unity Hospice Of Northwest Indiana</p>	L000671	<p><b>How will you correct each deficiency?</b> All IDG team members and medical record personnel will be in-serviced on the requirement for each clinical record to contain correct information, including accurate electronic signatures. <b>How will you prevent the deficiency from recurring in the future?</b> Medical records personnel will audit 10% of all open clinical records every month to ensure that all signatures, including electronic signatures, are</p>	01/09/2015

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	<p>LLC" with a meeting date of 11/12/14 failed to evidence the social worker was present or participated in the IDG meeting that is held every 2 weeks. There were meeting notes on active clinical records #1 and #2. The sign in sheet did not evidence the social worker had been present.</p> <p>a. Via phone call, on 12/9/14 at 1:45 PM, Employee D, social worker, indicated not attending any IDG meetings since January 2014. She indicated not attending these meetings in person or by phone conference.</p> <p>b. A email document from Employee A, director of clinical services, to Employee D on Friday, November 14, 2014, stated, "Find attached handwritten notes from our last IDG this past Wednesday [notes were from 11/12/14 IDG meeting.]"</p> <p>c. Clinical record #1, election date and start of care 5/5/14, evidenced a plan of care for certification period from 11/1/14 - 12/30/14. The IDG update, dated 11/12/14, included the electronic signature of Employee D, social worker, who had not attended the IDG meeting.</p> <p>d. Clinical record #2, election date and start of care 11/8/14, evidenced a</p>		<p>accurate and correct. They will be responsible for reporting any questions or omissions to the Director of Clinical Services.</p> <p><b>Who will be responsible for ensuring the Plan of Correction is implemented?</b> The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively maintained and that this deficiency does not occur in the future.</p>				

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	<p>plan of care for the certification period from 11/8/14 - 2/5/15. The IDG failed to show a social worker had updated the plan of care. The IDG update, dated 11/12/14, included an electronic signature of Employee D, social worker, who had not attended the IDG meeting.</p> <p>Regarding closed record #5</p> <p>2. Clinical record #5, start of care 4/14/14, with a plan of care for the certification period of 4/14/14 - 7/12/14 evidenced an initial plan of care dated 4/14/14, prior to the chaplain's hire date. This initial plan of care included an electronic signature for Employee H, chaplain, date of hire 6/2/14. This patient died on 6/14/14.</p> <p>On 12/9/14 at 1:55 PM, Employee H, Chaplain, indicated he had been hired in June of 2014. He had moved here from Florida for this job. The director of clinical services had introduced him to patients in the mid part of June. He indicated that he did not recall details about patient #5's care.</p> <p>3. The policy titled "Patient Plan of Care" with a date of May 2002 / December 2008 stated, "Unity Hospice recognizes that in order to provide</p>			

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(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
L000679	<p>continuity of care, it is necessary to designate an interdisciplinary group which in consultation with the patient's attending physician, shall prepare a written plan of care for each patient ... the hospice care team will complete an assessment of the patient's care needs, and establish an individualized plan of care in collaboration with the attending physician [if any], the patient / representative, and the primary caregiver in accordance with the primary caregiver in accordance with the patient's needs ... the hospice interdisciplinary group members will develop an individualized written plan of care for each patient."</p> <p>4. The policy titled "Standards of Conduct / Ethical Behavior" with a date of June 2005 and December 2008 stated, "All paperwork is to be completed in a timely, accurate manner. Any falsification of documentation or altered documentation in the clinical record and billing record may result in disciplinary action, including termination."</p> <p>418.104(b) AUTHENTICATION All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.</p>			

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  12/10/2014
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	<p>Based on clinical record review, policy review, and interview, the hospice failed to ensure that electronic signatures were accurate for 3 of 7 records reviewed (#1 and #2 and #5)</p> <p>Findings</p> <p>Regarding Active Records #1 and #2</p> <p>1. The IDG meeting document titled "Unity Hospice Of Northwest Indiana LLC" with a meeting date of 11/12/14 failed to evidence the social worker was present or participated in the IDG meeting that is held every 2 weeks. There were meeting notes on active clinical records #1 and #2. The sign in sheet did not evidence the social worker had been present.</p> <p>a. Via phone call, on 12/9/14 at 1:45 PM, Employee D, social worker, indicated not attending any IDG meetings since January 2014. She indicated not attending these meetings in person or by phone conference.</p> <p>b. A email document from Employee A, director of clinical services, to Employee D on Friday, November 14, 2014, stated, "Find attached handwritten notes from our last IDG this past Wednesday [notes were from 11/12/14</p>	L000679	<p><b>How will you correct each deficiency?</b> All IDG team members and medical record personnel will be in-serviced on the requirement for each entry in the clinical record, including electronic signatures, to be legible, clear, complete, and appropriately authenticated and dated. <b>How will you prevent the deficiency from recurring in the future?</b> Medical records personnel will audit 10% of all open clinical records every month to ensure that entries in the clinical record, including electronic signatures, are legible, clear, complete and appropriately authenticated and dated. They will be responsible for reporting any questions or omissions to the Director of Clinical Services. <b>Who will be responsible for ensuring the Plan of Correction is implemented?</b> The Director of Clinical Services is responsible for ensuring ongoing compliance efforts are effectively maintained and that this deficiency does not occur in the future.</p>	01/09/2015

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	<p>IDG meeting.]"</p> <p>c. Clinical record #1, election date and start of care 5/5/14, evidenced a plan of care for certification period from 11/1/14 - 12/30/14. The IDG update, dated 11/12/14, included the electronic signature of Employee D, social worker, who had not attended the IDG meeting.</p> <p>d. Clinical record #2, election date and start of care 11/8/14, evidenced a plan of care for the certification period from 11/8/14 - 2/5/15. The IDG failed to show a social worker had updated the plan of care. The IDG update, dated 11/12/14, included an electronic signature of Employee D, social worker, who had not attended the IDG meeting.</p> <p>Regarding closed record #5</p> <p>2. Clinical record #5, start of care 4/14/14, with a plan of care for the certification period of 4/14/14 - 7/12/14 evidenced an initial plan of care dated 4/14/14, prior to the chaplain's hire date. This initial plan of care included an electronic signature for Employee H, chaplain, date of hire 6/2/14. This patient died on 6/14/14.</p> <p>On 12/9/14 at 1:55 PM, Employee H,</p>			

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	<p>Chaplain, indicated he had been hired in June of 2014. He had moved here from Florida for this job. The director of clinical services had introduced him to patients in the mid part of June. He indicated that he did not recall details about patient #5's care.</p> <p>3. The policy titled "Patient Plan of Care" with a date of May 2002 / December 2008 stated, "Unity Hospice recognizes that in order to provide continuity of care, it is necessary to designate an interdisciplinary group which in consultation with the patient's attending physician, shall prepare a written plan of care for each patient ... the hospice care team will complete an assessment of the patient's care needs, and establish an individualized plan of care in collaboration with the attending physician [if any], the patient / representative, and the primary caregiver in accordance with the primary caregiver in accordance with the patient's needs ... the hospice interdisciplinary group members will develop an individualized written plan of care for each patient."</p> <p>4. The policy titled "Standards of Conduct / Ethical Behavior" with a date of June 2005 and December 2008 stated, "All paperwork is to be completed in a timely, accurate manner. Any</p>			

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	falsification of documentation or altered documentation in the clinical record and billing record may result in disciplinary action, including termination."				