

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2013
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NAME OF PROVIDER OR SUPPLIER LIVING WATERS HOSPICE CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 HWY 41 N STE 130 EVANSVILLE, IN 47711
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L000000	<p>This was a hospice federal recertification & state re-licensure survey.</p> <p>Survey Dates: 5-7-13, 5-8-13, 5-9-13, 5-13-13, and 5-14-13</p> <p>Facility #: 009557</p> <p>Medicaid Vendor #: 2003184204</p> <p>Surveyors: Vicki Harmon, RN, PHNS Team Leader Dawn Snider, RN, PHNS</p> <p>Living Waters Hospice Care, LLC, was found to be out of compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 21, 2013</p>	L000000		

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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L000531	<p>418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care. Based on clinical record and hospice policy review and interview, the hospice failed to ensure the initial bereavement assessment identified the level of risk for complicated grief reactions in 11 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11) of 11 records reviewed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 evidenced an initial bereavement assessment had been completed on 4-16-12 as a part of the initial comprehensive assessment. The bereavement assessment failed to evidence the level of risk for complicated grief reactions had been identified. 2. Clinical record number 2 evidenced an initial bereavement assessment had been completed on 4-18-13 as a part of the 	L000531	L 531 The Hospice Administrator, Susan Willis RN, has in-serviced and educated the Living Waters Hospice Staff regarding the federal regulations regarding the initial bereavement assessment identifies the level of risk for complicated grief reactions and that the level is documented appropriately. Additional in-services done on 5/29/2013 were provided to ensure that all staff responsible for completion of the initial bereavement assessment were made aware of the procedure for identifying the level of risk for complicated grief reaction in the electronic documentation system being utilized by Living Waters Hospice Care. Staff are now documenting level of risk for bereavement per policy. Also the policy was revised and approved by the Governing Body and the IDG to read as the questions are written in the documentation system on the	06/14/2013	

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	<p>initial comprehensive assessment. The bereavement assessment failed to evidence the level of risk for complicated grief reactions had been identified.</p> <p>3. Clinical record number 3 evidenced an initial bereavement assessment had been completed on 3-14-13 as a part of the initial comprehensive assessment. The bereavement assessment failed to evidence the level of risk for complicated grief reactions had been identified.</p> <p>4. Clinical record number 4 evidenced an initial bereavement assessment had been completed on 12-12-12 as a part of the initial comprehensive assessment. The bereavement assessment failed to evidence the level of risk for complicated grief had been identified.</p> <p>5. Clinical record number 5 evidenced an initial bereavement assessment had been completed on 4-17-13 as a part of the initial comprehensive assessment. The bereavement assessment failed to evidence the level of risk for complicated grief reactions had been identified.</p> <p>6. Clinical record number 6 evidenced an initial bereavement assessment had been completed on 6-1-12 as a part of the initial comprehensive assessment. The bereavement assessment failed to</p>		<p>bereavement assessment as upon audit it was noted that there was an inconsistency between the electronic levels of risk classification and the policy REG B15. The wording in our policy and procedure manual has now been updated and approved by IDG to read as follows: Well-indicates low risk Fair-indicates low risk Doubtful-indicates moderate risk Badly-indicates high risk Very badly- indicates high risk A minimum of 10 patients or 10% of current charts are audited quarterly to ensure that the initial bereavement assessment includes the level of risk for complicated grief reaction. The administrator, Susan Willis, RN is responsible to ensure that this sited deficiency does not recur.</p>		

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	<p>evidence the level of risk for complicated grief reactions had been identified.</p> <p>7. Clinical record number 7 evidenced an initial bereavement assessment had been completed on 4-11-13 as a part of the initial comprehensive assessment. The bereavement assessment failed to evidence the level of risk for complicated grief reactions had been identified.</p> <p>8. Clinical record number 8 evidenced an initial bereavement assessment had been completed on 4-24-13 as a part of the initial comprehensive assessment. The bereavement assessment failed to evidence the level of risk for complicated grief reactions had been identified.</p> <p>9. Clinical record number 9 evidenced an initial bereavement assessment had been completed on 3-8-13 as a part of the initial comprehensive assessment. The bereavement assessment failed to evidence the level of risk for complicated grief reactions had been identified.</p> <p>10. Clinical record number 10 evidenced an initial bereavement assessment had been completed on 3-18-13 as a part of the initial comprehensive assessment. The bereavement assessment failed to evidence the level of risk for complicated grief reactions had been identified.</p>			

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	<p>11. Clinical record number 11 evidenced an initial bereavement assessment had been completed on 10-13-11 as a part of the initial comprehensive assessment. The bereavement assessment failed to evidence the level of risk for complicated grief reactions had been identified.</p> <p>12. The spiritual care counselor, employee C, indicated, on 5-14-13 at 1:40 PM, the initial bereavement assessments found in records numbered 1 through 11 did not identify the level of risk for complicated grief reactions. The employee stated, "Our computer words it differently."</p> <p>13. The hospice's undated "Bereavement Risk Assessment" policy number REG.B15 states, "Each person designated to receive bereavement services is categorized according to level of risk for complicated grief reactions and receives appropriate interventions according to identified need. The interventions associated with the three levels of risk as follows: Low risk . . . Moderate risk . . . High risk."</p>			

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L000533	<p>418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure comprehensive assessments had been updated to reflect the patients' current conditions in 3 (#s 1, 3, & 7) of 11 records reviewed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included updated comprehensive assessments dated 3-19-13, 4-2-13, 4-16-13, and 4-30-13. The updates failed to evidence the pastoral counselor or the medical social worker had assessed the patient's progress towards the desired outcome of "Continued spiritual comfort, acceptance of death, and utilization of spiritual</p>	L000533	L533 The hospice administrator, Susan Willis, RN in-serviced/educated the IDG members on 5/29/2013 regarding the updating of the comprehensive assessment to consider any changes that have taken place since the initial assessment, to reflect patients' current conditions, to include the patient's progress toward desired outcomes, as well as reassessment of the patient's response to care, with the potential to affect all hospice patients. The administrator, Susan Willis ensured that IDG members were educated that the assessment update must be accomplished as frequently as the condition of the patient requires, but no less than every 15 days, to reflect patients' current condition, and changes are reflected in the patient's	06/14/2013			

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	<p>resources" and "Patient will demonstrate normal grief." The updates failed to evidence a reassessment of the patient's condition after learning the adult child did not want any further contact with the patient.</p> <p>A. The chaplain's portion of the 3-19-13 updated comprehensive assessment states, "Pt's caregiver indicated that [the caregiver] didn't have a prior relationship with pt [patient]. [The caregiver] felt there would be helped by our added support. 12/3/12 Pastoral to F/U [follow-up] on pursuing if pt would like to contact/connect with [adult child] as preparation for end of life." The medical social services (MSS) portion of the updated comprehensive assessment states, "Hospice pastor assisted pt to write letter to [adult child] previously - [adult child] informed hospice not to contact [the adult child] again and stated does not want contact with pt."</p> <p>B. The chaplain's portion of the 4-2-13 updated comprehensive assessment states, "Pt's caregiver indicated that [the caregiver] didn't have a prior relationship with pt [patient]. [The caregiver] felt there would be helped by our added support. 12/3/12 Pastoral to F/U [follow-up] on pursuing if pt would like to contact/connect with [adult child]</p>		<p>updated plan of care. All disciplines are now updating the comprehensive assessment to reflect the patients current condition. To ensure that the updates are accomplished on all patients, an audit of a minimum of 10 patients or 10% of current charts will be done during each quarter with specific attention to the spiritual and social worker areas of the comprehensive assessment being updated to reflect the patient's current condition. Staff has also been in-serviced on policy C-65 Administrator, Susan Willis,RN will over see the audits to ensure that this cited deficiency will not recur.</p>		

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	<p>as preparation for end of life." The medical social services (MSS) portion of the updated comprehensive assessment states, "Hospice pastor assisted pt to write letter to [adult child] previously - [adult child] informed hospice not to contact [the adult child] again and stated does not want contact with pt."</p> <p>C. The chaplain's portion of the 4-16-13 updated comprehensive assessment states, "Pt's caregiver indicated that [the caregiver] didn't have a prior relationship with pt [patient]. [The caregiver] felt there would be helped by our added support. 12/3/12 Pastoral to F/U [follow-up] on pursuing if pt would like to contact/connect with [adult child] as preparation for end of life." The medical social services (MSS) portion of the updated comprehensive assessment states, "Hospice pastor assisted pt to write letter to [adult child] previously - [adult child] informed hospice not to contact [the adult child] again and stated does not want contact with pt."</p> <p>D. The chaplain's portion of the 4-30-13 updated comprehensive assessment states, "Pt's caregiver indicated that [the caregiver] didn't have a prior relationship with pt [patient]. [The caregiver] felt there would be helped by our added support. 12/3/12 Pastoral to</p>						

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	<p>F/U [follow-up] on pursuing if pt would like to contact/connect with [adult child] as preparation for end of life." The medical social services (MSS) portion of the updated comprehensive assessment states, "Hospice pastor assisted pt to write letter to [adult child] previously - [adult child] informed hospice not to contact [the adult child] again and stated does not want contact with pt."</p> <p>2. Clinical record number 3 evidenced an initial spiritual assessment dated 3-14-13 that states, "Spiritual Issues to Address: added support to provide strength to the pt and [the patient's] family throughout the dying process. Comments: Pt is strong in faith yet desired added support and fellowship. [The patient] does have pastors come to visit in [the patient's] home."</p> <p>A. The record included updated comprehensive assessments dated 3-19-13, 4-2-13, 4-16-13, and 4-30-13. The updates failed to evidence the pastoral counselor had re-assessed the patient's spiritual needs or had ascertained the patient's progress towards the desired goal of "Continued spiritual comfort, acceptance of death, and utilization of spiritual resources."</p> <p>B. The spiritual care counselor,</p>						

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	<p>employee C, was unable to provide any additional documentation and/or information when asked on 5-14-13 at 1:40 PM. The spiritual care counselor indicated any updates to the assessment would be documented in the interventions that were listed in the updated comprehensive assessment.</p> <p>3. Clinical record number 7 evidenced an initial spiritual assessment dated 4-15-13 that states "Spiritual Issues to Address: Added spiritual support due to pt lack of attending her church. Comments: Pt's [adult child] said [the patient] may not allow a visit, yet [adult child] request an attempt."</p> <p>A. The record included updated comprehensive assessments dated 4-16-13 and 4-30-13. The updates failed to evidence the pastoral counselor had re-assessed the spiritual needs or had ascertained the patient's progress towards the desired goal of "Continued spiritual comfort, acceptance of death, and utilization of spiritual resources."</p> <p>B. The spiritual care counselor, employee C, was unable to provide any additional documentation and/or information when asked on 5-14-13 at 1:40 PM. The spiritual care counselor indicated any updates to the assessment</p>						

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	<p>would be documented in the interventions that were listed in the updated comprehensive assessment.</p> <p>4. The hospice's undated "Comprehensive Assessment - Updates" policy number REG.C65 states, "A patient's progress toward desired outcomes and response to care is reassessed as often as required by the patient's condition but no less frequently than every 15 days."</p> <p>5. The hospice's undated "Spiritual Care Services" policy number REG.S20 states, "The patient/caregiver's spiritual needs are reassessed every 15 days and changes are reflected in the patient's updated plan of care."</p>			

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L000534	<p>418.54(e)(1) PATIENT OUTCOME MEASURES (1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation. Based on clinical record and hospice policy review and interview, the hospice failed to ensure comprehensive assessments included data elements to be collected and measured in the same way for all patients in 11 (#s 1 through 11) of 11 records reviewed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 evidenced an initial comprehensive assessment had been completed on 4-16-12. The assessment failed to evidence identifiable data elements had been incorporated into the assessment. 2. Clinical record number 2 evidenced an initial comprehensive assessment had been completed on 4-18-13. The assessment failed to evidence identifiable data elements had been incorporated into the assessment. 	L000534	L534 The Hospice Administrator, Susan Willis, RN, has in-serviced IDG members and staff on 5/29/2013, educating IDG members and staff on identifying and retrieving specific data elements for selected outcome measures to ensure initial comprehensive assessments and subsequent comprehensive assessments include individual data elements that are collected and measured in the same way for all patients; with education to include but not limited to use of documenting system. Staff educated to utilize data areas in the same way in documenting system. These data elements will then be incorporated into the comprehensive assessment and used to provide individualized care planning, coordination of care for each patient and to be used in the QAPI program. Policy number REG C 55 and REG C 65, Initial Comprehensive Assessment and Comprehensive Assessment Updates policies have been updated, revised, and approved by the governing board and IDG team to identify the	06/14/2013			

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	<p>3. Clinical record number 3 evidenced an initial comprehensive assessment had been completed on 3-14-13. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>4. Clinical record number 4 evidenced an initial comprehensive assessment had been completed on 12-12-12. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>5. Clinical record number 5 evidenced an initial comprehensive assessment had been completed on 4-17-13. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>6. Clinical record number 6 evidenced an initial comprehensive assessment had been completed on 6-1-12. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>7. Clinical record number 7 evidenced an initial compressive assessment had been completed on 4-11-13. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p>		<p>method by which hospice RN and IDG will document appropriately to ensure collection of this data in the same way through an initial comprehensive assessment and ongoing reassessment of patients needs. All staff are now documenting in such a way that data can be identified and retrieved in a consistent manner for all patients for selected outcome measures, to be incorporated into patient's initial comprehensive assessment to be completed on admission with full assessment of body systems. Based on patient's needs and findings from the initial assessment, the hospice RN coordinates and designates disciplines that must participate in the comprehensive assessment of the patient. Ongoing reassessments to include a full body assessment will be done at a minimum of once weekly to address patient/caregiver's status, needs, response to care, and to direct the care plan. The care plan to address and identify any new problems and ongoing assessments. A minimum of 10 or 10% of current patient charts will be audited during each quarter to ensure that identifiable data elements are retrieved and measured in a systematic way and incorporated into assessments for all patients. Administrator, Susan Willis, RN, is responsible for overseeing the monitoring of chart audits to</p>				

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	<p>8. Clinical record number 8 evidenced an initial comprehensive assessment had been completed on 4-24-13. The assessment failed to evidence identifiable data had been incorporated into the assessment.</p> <p>9. Clinical record number 9 evidenced an initial comprehensive assessment had been completed on 3-8-13. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>10. Clinical record number 10 evidenced an initial comprehensive assessment had been completed on 3-18-13. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>11. Clinical record number 11 evidenced an initial comprehensive assessment had been completed on 10-13-11. The assessment failed to evidence identifiable data elements had been incorporated into the assessment.</p> <p>12. The administrator, employee L, was unable to provide any additional documentation and/or information when asked on 5-14-13 at 10:30 AM.</p>		ensure that this deficiency does not recur.		

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	13. The hospice's undated "Comprehensive Assessment - Patient Outcome Measures" policy number REG.C60 states, "The comprehensive assessment includes data elements that allow for the measurement of patient outcomes. Members of the IDG document data elements that measure patient outcomes in the same manner for each patient . . . The data elements related to selected outcome measures are an integral part of the comprehensive assessment and reassessment tools and are documented in a systematic and retrievable manner for each patient."			

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L000535	<p>418.54(e)(2) PATIENT OUTCOME MEASURES (2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure comprehensive assessments included data elements that had been documented in a systematic and retrievable way for all patients in 11 (#s 1 through 11) of 11 records reviewed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 evidenced an initial comprehensive assessment had been completed on 4-16-12. The assessment failed to evidence identifiable and retrievable data elements had been incorporated into the assessment. 2. Clinical record number 2 evidenced an initial comprehensive assessment had been completed on 4-18-13. The assessment failed to evidence identifiable and retrievable data elements had been 	L000535	<p>L535 The Hospice Administrator, Susan Willis, RN, has in-serviced IDG members and staff on 5/29/2013, educating IDG members and staff on identifying and retrieving specific data elements for selected outcome measures to ensure initial comprehensive assessments and subsequent comprehensive assessments include individual data elements that are collected and measured in the same way for all patients; with education to use of documenting system. Staff educated to utilize data areas in the same way in documenting system. These data elements will then be incorporated into the comprehensive assessment and used to provide individualized care planning, coordination of care for each patient and to be used in the QAPI program. Policy number REG C 55 and REG C 65, Initial Comprehensive Assessment and Comprehensive Assessment Updates policies have been updated, revised, and</p>	06/14/2013	

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	<p>incorporated into the assessment.</p> <p>3. Clinical record number 3 evidenced an initial comprehensive assessment had been completed on 3-14-13. The assessment failed to evidence identifiable and retrievable data elements had been incorporated into the assessment.</p> <p>4. Clinical record number 4 evidenced an initial comprehensive assessment had been completed on 12-12-12. The assessment failed to evidence identifiable and retrievable data elements had been incorporated into the assessment.</p> <p>5. Clinical record number 5 evidenced an initial comprehensive assessment had been completed on 4-17-13. The assessment failed to evidence identifiable and retrievable data elements had been incorporated into the assessment.</p> <p>6. Clinical record number 6 evidenced an initial comprehensive assessment had been completed on 6-1-12. The assessment failed to evidence identifiable retrievable data elements had been incorporated into the assessment.</p> <p>7. Clinical record number 7 evidenced an initial compressive assessment had been completed on 4-11-13. The assessment failed to evidence identifiable and</p>		<p>approved by the governing board and IDG team to identify the method by which hospice RN and IDG will document appropriately to ensure collection of this data in the same way through an initial comprehensive assessment and ongoing reassessment of patients needs. All staff are now documenting in such a way that data can be identified and retrieved in a consistent manner for all patients for selected outcome measures to be incorporated for each patient's initial comprehensive assessment to be completed on admission with full assessment of body systems. Based on patient's needs and findings from the initial assessment, the hospice RN coordinates and designates disciplines that must participate in the comprehensive assessment of the patient. Ongoing reassessments to include a full body assessment will be done at a minimum of once weekly to address patient/caregiver's status, needs, response to care, and to direct the care plan. The care plan to address and identify any new problems and ongoing assessments. A minimum of 10 or 10% of current patient charts will be audited during each quarter to ensure that identifiable data elements are retrieved and measured in a systematic way and incorporated into assessments for all patients. Administrator, Susan Willis,RN, is</p>	

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	<p>retrievable data elements had been incorporated into the assessment.</p> <p>8. Clinical record number 8 evidenced an initial comprehensive assessment had been completed on 4-24-13. The assessment failed to evidence identifiable and retrievable data elements had been incorporated into the assessment.</p> <p>9. Clinical record number 9 evidenced an initial comprehensive assessment had been completed on 3-8-13. The assessment failed to evidence identifiable and retrievable data elements had been incorporated into the assessment.</p> <p>10. Clinical record number 10 evidenced an initial comprehensive assessment had been completed on 3-18-13. The assessment failed to evidence identifiable and retrievable data elements had been incorporated into the assessment.</p> <p>11. Clinical record number 11 evidenced an initial comprehensive assessment had been completed on 10-13-11. The assessment failed to evidence identifiable and retrievable data elements had been incorporated into the assessment.</p> <p>12. The administrator, employee L, was unable to provide any additional documentation and/or information when</p>		responsible for overseeing the monitoring chart audits to ensure that this deficiency does not recur.	

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	asked on 5-14-13 at 10:30 AM. 13. The hospice's undated "Comprehensive Assessment - Patient Outcome Measures" policy number REG.C60 states, "The comprehensive assessment includes data elements that allow for the measurement of patient outcomes. Members of the IDG document data elements that measure patient outcomes in the same manner for each patient . . . The data elements related to selected outcome measures are an integral part of the comprehensive assessment and reassessment tools and are documented in a systematic and retrievable manner for each patient."						

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L000548	<p>418.56(c)(3) 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:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure plans of care included measurable goals and outcomes in 11 (#s 1 through 11) of 11 records reviewed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <p>1. Clinical records numbered 1 through 11 included computer generated plans of care established by the interdisciplinary group (IDG). The plans of care included the same non-specific goals and outcomes for each identified problem. The plans of care failed to evidence the outcomes were individualized to the patient and were specific enough to be measured.</p> <p>A. Clinical record number 1 included a plan of care established by the IDG for the benefit period 4-11-13 to 6-9-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p>	L000548	L548 The hospice administrator, Susan Willis RN, in-serviced the IDG team on 5/29/2013 regarding plans of care to include all services necessary for the palliation and management of the terminal illness and related conditions-that the outcomes must be measurable and anticipated from implementation and coordination of the plan of care. The plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions including the following : measurable outcomes anticipated from implementing and coordinating the plan of care. All current patient charts have been reviewed, and plans of care have been appropriately updated by IDG team to ensure that current plans of care include measurable goals and outcomes specific to each pt. The plans of care were individualized to each pt and goals/outcomes were made to be specific enough to be measurable. To ensure continued compliance at a minimum 10 patient 10% of charts will be audited each	06/14/2013			

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	<p>1.) "Adjustment to Long-Term Care" with the expected outcome of "Patient will adjust to long term care facility to extent possible."</p> <p>2.) "Affirmation of Present Spiritual Comfort, Acceptance of Death, and Utilization of Spiritual Resources" with the expected outcome "Continued spiritual comfort, acceptance of death, and utilization of spiritual resources."</p> <p>3.) incontinence, laxative use to prevent constipation with the expected outcome "Patient will achieve and maintain regular bowel elimination and skin integrity."</p> <p>4.) cardiac and circulatory function and fluid volume alteration with the expected outcome "Patient will maintain adequate cardiac/circulatory and fluid volume as long as possible."</p> <p>5.) confusion/disorientation with the expected outcome "Promote optimal patient orientation."</p> <p>6.) normal grief process with the expected outcome "Patient will demonstrate normal grief process."</p> <p>7.) risk for dehydration and weight</p>		<p>quarter so that deficiency does not recur. The administrator, Susan Willis, RN is responsible for over-site that this cited deficiency does not recur.</p>	

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	<p>loss with the expected outcome "Patient will maintain optimal nutrition and hydration."</p> <p>8.) decline in activities of daily living with the expected outcome "PCG [patient's caregiver] / Family will understand and deliver care needed to maintain patient safety and comfortably at home."</p> <p>9.) patient unable to live independently with the expected outcome "SNF STAFF/PCG will understand and deliver care needed to maintain patient safely and comfortable at home."</p> <p>10.) occasional episodes of pain to lower extremities per patient with the expected outcome "Patient will achieve and maintain optimal physical comfort."</p> <p>11.) skin integrity with the expected outcome "Patient will achieve and maintain optimal skin integrity as disease progresses."</p> <p>12.) history of UTI, incontinence with the expected outcome "Patient will maintain optimal urinary elimination patterns and comfort."</p> <p>B. Clinical record number 2 included a plan of care established by the IDG for</p>						

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	<p>the benefit period 4-18-13 to 7-16-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) history of interstitial lung disease with the expected outcome "Patient will achieve optimal breathing patterns, airway patency, and comfort."</p> <p>2.) history of constipation, incontinence with the expected outcome "Patient will achieve and maintain regular bowel elimination and skin integrity."</p> <p>3.) cardiac and acute renal failure with the expected outcome "Patient will maintain adequate cardiac/circulatory function and fluid volume as long as possible."</p> <p>4.) confusion and disorientation with the expected outcome "Promote optimal patient orientation."</p> <p>5.) recent weight loss with aspiration risk and poor appetite with the expected outcome "Patient will maintain optimal nutrition and hydration."</p> <p>6.) physical comfort alteration with the expected outcome "Patient will achieve and maintain optimal physical</p>			

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	<p>comfort."</p> <p>7.) skin/membrane integrity with the expected outcome "Patient will achieve and maintain optimal skin integrity as disease progresses."</p> <p>8.) urinary elimination and incontinence with the expected outcome "Patient will maintain optimal urinary elimination patterns and comfort."</p> <p>C. Clinical record number 3 included a plan of care established by the IDG for the benefit period 3-14-13 to 6-11-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) risk for injury related to falls with the expected outcome "Promote optimal patient safety and prevention of injury."</p> <p>2.) confusion and disorientation with the expected outcome "Promote optimal patient orientation."</p> <p>3.) nutrition/hydration with the expected outcome "Patient will maintain optimal nutrition and hydration."</p> <p>4.) patient activity mobility with</p>			

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	<p>the expected outcome "PCG/Family will understand and deliver care needed to maintain patient safety and comfortably at home."</p> <p>5.) physical comfort alteration-pain in knees with the expected outcome "Patient will achieve and maintain optimal physical comfort."</p> <p>6.) sleep patterns with the expected outcome "Patient and PCG will achieve optimal sleep/rest patterns."</p> <p>7.) urinary elimination with the expected outcome "Patient will maintain optimal urinary elimination patterns and comfort."</p> <p>D. Clinical record # 4 included a plan of care established by the IDG for the benefit period 3/12/13 to 6/9/13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) Airway and Breathing with the expected outcome "Patient will achieve optimal breathing patterns."</p> <p>2.) Anxiety with the expected outcome "Patient will have no anxiety r/t end of life issues."</p>			

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	<p>3.) At risk for injury R/T Falls with the expected outcome "Promote optimal patient safety and prevention injury."</p> <p>4.) Infection with the expected outcome "Patients [sic] infection process will be contained. Comfort will be promoted. Further infection prevented."</p> <p>5.) Normal Grief Process with the expected outcome "facilitate [sic] normal grief process."</p> <p>6.) Nutrition and Hydration with the expected outcome "Patient will maintain optimal nutrition and hydration."</p> <p>7.) Patient Activity Mobility with the expected outcome "coordination [sic] declining of upper extremities, declining activity tolerance, fatigue. PCG/Family will understand and deliver care need to maintain patient safety."</p> <p>8.) Physical Comfort Alteration with the expected outcome "Patient will achieve and maintain optimal physical comfort."</p> <p>E. Clinical record number 5 included a plan of care established by the IDG for the benefit period 4-17-13 to 7-15-13.</p>				

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	<p>The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) airway and breathing patterns related to COPD with the expected outcome "Patient will achieve optimal breathing patterns, airway patency, and comfort."</p> <p>2.) at risk for injury related to falls with the expected outcome "Promote optimal patient safety and prevention of injury."</p> <p>3.) history of constipation, poor hydration/nutrition with the expected outcome "Patient will achieve and maintain regular bowel elimination and skin integrity."</p> <p>4.) history of atrial fibrillation, hypertension, and valve disease with the expected outcome "Patient will maintain adequate cardiac/circulatory function and fluid volume as long as possible."</p> <p>5.) confusion/disorientation with the expected outcome "Promote optimal patient orientation."</p> <p>6.) risk for infection with the expected outcome "Patients [sic] infection</p>			

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	<p>process will be contained; comfort will be promoted; further infection prevented."</p> <p>7.) nutrition/hydration with the expected outcome "Patient will maintain optimal nutrition and hydration."</p> <p>8.) unsteady gait, frequent falls, declining self care deficit with the expected outcome "PCG/Family will understand and deliver care needed to maintain patient safety and comfortably at home."</p> <p>9.) skin/membrane integrity with the expected outcome "Patient will achieve and maintain optimal skin integrity as disease progresses."</p> <p>F. Clinical record number 6 included a plan of care established by the IDG for the benefit period 3-27-13 to 6-4-12 The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) Affirmation of Present Spiritual Comfort, Acceptance of Death, and Utilization of Spiritual Resources"with the expected outcome "Continued spiritual comfort, acceptance of death, and utilization of spiritual resources."</p>			

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	<p>2.) altered airway and breathing patterns related to shortness of breath with speech, increased respiratory secretions with the expected outcome "Patient will achieve optimal breathing patterns, airway patency, and comfort."</p> <p>3.) at risk for injury related to falls with the expected outcome "Promote optimal patient safety and prevention of injury."</p> <p>4.) bowel elimination with the expected outcome "Patient will achieve and maintain regular bowel elimination and skin integrity."</p> <p>5.) altered cardiac and circulatory function and fluid volume alteration with the expected outcome "Patient will maintain adequate cardiac/circulatory function and fluid volume as long as possible."</p> <p>6.) difficulty with finances with the expected outcome "Explore community resources available to patient."</p> <p>7.) infection with the expected outcome "Comfort will be promoted. Further infection will be prevented."</p> <p>8.) nutrition/hydration related to dysphasia, loss of muscle mass with the</p>			

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	<p>expected outcome "patient will maintain optimal nutrition/hydration."</p> <p>9.) immobility, history of falls, caregiver unable to provide all personal care with the expected outcome "PCG/Family will understand and deliver care needed to maintain patient safety and comfortably at home."</p> <p>10.) muscle cramping, twitching, tingling with the expected outcome "Patient will achieve and maintain optimal physical comfort."</p> <p>11.) potential for caregiver problem with the expected outcome "Caregiver will provide care to extent possible."</p> <p>12.) refusal of hospice chaplain visits with the expected outcome "Patient knows chaplain is available for spiritual care."</p> <p>13.) risk for potential deficit due to immobility, decreased sensation to extremities with the expected outcome "Patient will achieve and maintain optimal skin integrity as disease progresses."</p> <p>G. Clinical record number 7 included a plan of care established by the IDG for</p>						

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	<p>the benefit period 4-11-13 to 7-9-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) at risk for injury related to falls with the expected outcome "Promote optimal patient safety and prevention of injury."</p> <p>2.) history of arrhythmia, syncope, pacemaker placement, hypertension with the expected outcome "Patient will maintain adequate cardiac/circulatory function and fluid volume as long as possible."</p> <p>3.) confusion/disorientation with the expected outcome "Promote optimal patient orientation."</p> <p>4.) infection related to potential for urinary tract infection related to incontinence with the expected outcome "Patients [sic] infection process will be contained; Comfort will be promoted: Further infection prevented."</p> <p>5.) patient living independently with progressing dementia with the expected outcome "Patient will remain safe and free of any injuries."</p>			

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	<p>6.) nutrition/hydration related to very poor appetite, poor nutritional intake with the expected outcome "Patient will maintain optimal nutrition and hydration."</p> <p>7.) declining activity tolerance, fatigue, self care deficit with the expected outcome "PCG/Family will understand and deliver care needed to maintain patient safety and comfortably at home."</p> <p>8.) chronic pain to right hip, new onset pain to right shoulder with the expected outcome "Patient will achieve and maintain optimal physical comfort."</p> <p>9.) urinary elimination with the expected outcome "Patient will maintain optimal urinary elimination patterns and comfort."</p> <p>H. Clinical record number 8 included a plan of care established by the IDG for the benefit period 4-24-13 to 7-22-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>The plan of care identified cardiac/circulatory function and fluid volume alteration, communication/sensory functioning, dying process, knowledge deficit,</p>			
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	<p>nutrition/hydration, patient activity mobility, physical comfort alteration, skin/membrane integrity, and urinary elimination as problems to be addressed. The plan failed to evidence any expected outcome for these identified problems.</p> <p>I. Clinical record number 9 included a plan of care established by the IDG for the benefit period 3-8-13 to 6-5-13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) airway and breathing patterns with the expected outcome "Patient will achieve optimal breathing patterns, airway patency, and comfort."</p> <p>2.) at risk for injury related to falls with the expected outcome "Promote optimal safety and prevention of injury."</p> <p>3.) cardiac/circulatory function and fluid volume alteration with the expected outcome "Patient will maintain adequate cardiac/circulatory function and fluid volume as long as possible."</p> <p>4.) confusion/disorientation related to forgetfulness, occasional episodes of confusion with the expected outcome "Promote optimal patient orientation."</p>				

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	<p>5.) knowledge deficit related to patient/caregiver unaware of safety needs, overestimation of patient abilities to care for self with the expected outcome "Patient/PCG will have sufficient knowledge to safely provide care."</p> <p>6.) impaired gait, decline in mobility with the expected outcome "PCG/Family will understand and deliver care needed to maintain patient safety and comfortably at home."</p> <p>7.) physical comfort alteration related to chronic back pain with the expected outcome "Patient will achieve and maintain optimal physical comfort."</p> <p>8.) urinary elimination with the expected outcome "Patient will maintain optimal urinary elimination patterns and comfort."</p> <p>J. Clinical record # 10 included a plan of care established by the IDG for the benefit period 3/18/13 to 5/16/13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) Affirmation of Present Spiritual Comfort, Acceptance of Death, and</p>						

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	<p>Utilization of Spiritual Resources with the expected outcome of "Continues spiritual comfort, acceptance of death, and utilization of spiritual resources."</p> <p>2.) Airway and Breathing with the expected outcome "Patient will achieve optimal breathing patterns, airway potency, and comfort."</p> <p>3.) Bowel Elimination with the expected outcome " Patient will achieve and maintain regular bowel elimination and skin integrity."</p> <p>4.) Cardiac/Circulatory Function and Fluid Volume Alteration with the expected outcome "Patient will maintain adequate cardiac/circulatory function and fluid volume as long as possible."</p> <p>5.) Nutrition / Hydration with the expected outcome "Patient will maintain optimal nutrition and hydration."</p> <p>6.) Patient Activity Mobility with the expected outcome "PCG/Family will understand deliver care needed to maintain patient safety and comfortably at home."</p> <p>7.) Physical Comfort Alteration with the expected outcome "Patient will achieve and maintain optimal physical</p>			

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	<p>comfort."</p> <p>8.) Skin/ Membrane Integrity with the expected outcome "Patient will achieve and maintain optimal skin integrity as disease progresses."</p> <p>K. Clinical record # 11 included a plan of care established by the IDG for the benefit period 4/5/13 to 6/3/13. The plan of care identified multiple problems to be addressed by the IDG. The identified problems and expected outcomes included the following:</p> <p>1.) Affirmation of Present Spiritual Comfort, Acceptance of Death, and Utilization of Spiritual Resources with the expected outcome "Continued spiritual comfort, acceptance of death, and utilization of spiritual resources."</p> <p>2.) Airway and Breathing Patterns with the expected outcome "patient[sic] will achieve optimal breathing patterns, airway potency and comfort."</p> <p>3.) At Risk for injury R/T Falls with the expected outcome " Promote optimal patient safety and prevention of injury."</p> <p>4.) Bowel elimination with the expected outcome "Patient will achieve</p>				

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	<p>and maintain regular bowel elimination and skin integrity."</p> <p>5.) Cardiac/Circulatory Function and Fluid Volume Alteration with the expected outcome ""Patient will maintain adequate cardiac/circulatory function and fluid volume as long as possible."</p> <p>6.) Communication/Sensory Functioning with the expected outcome "Promote optimal patient orientation and communication abilities."</p> <p>7.) Infection with the expected outcome "Pt's infection process will be contained, comfort promoted."</p> <p>8.) Nutrition/Hydration with the expected outcome "Patient will maintain optimal nutrition and hydration."</p> <p>9.) Patient Activity Mobility with the expected outcome "PCG/Family will understand and deliver care needed to maintain patient safety and comfortably at home."</p> <p>10.) Physical Comfort Alteration with the expected outcome "Patient will achieve and maintain optimal physical comfort."</p> <p>11.) Skin/Membrane Integrity with</p>				

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	<p>the expected outcome "Patient will achieve and maintain optimal skin integrity as disease progresses."</p> <p>12.) Urinary Elimination with the expected outcome "Patient will maintain optimal urinary elimination patterns and comfort."</p> <p>2. The administrator, employee L, indicated, on 5-14-13 at 10:00 AM, the expected outcomes found on the plans of care in records numbered 1 through 11 were not measurable and had not been individualized for each patient.</p> <p>3. The hospice's undated "Plan of Care - Content" policy number REG.P30 states, "The plan of care includes, but is not limited to: . . . measurable outcomes anticipated from implementing and coordinating the plan of care."</p>			

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L000559	<p>418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT Based on document review and interview, the hospice failed to maintain compliance with the quality assessment and performance improvement requirements creating the potential to affect all hospice patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice failed to ensure the quality assessment and performance improvement (QAPI) program involved all hospice services, focused on indicators related to improved palliative outcomes, and took actions to demonstrate improvement in hospice performance with the potential to affect all hospice patients. (See L 560). 2. The hospice failed to ensure the QAPI program showed measurable improvement in indicators with the potential to affect all hospice patients. (See L 561). 3. The hospice failed to ensure the QAPI program analyzed quality indicators and included adverse patient events with the potential to affect all hospice patients. (See L 562). 	L000559	L559 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice governing body directed the QAPI team to conduct a PIP centered around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and	06/14/2013	

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	<p>4. The hospice failed to ensure the QAPI data collected monitored the effectiveness and safety of services and quality of care and identified opportunities and priorities for improvement with the potential to affect all hospice patients. (See L 564).</p> <p>5. The hospice failed to ensure the QAPI program activities focused on high risk, high volume, or problem prone areas with the potential to affect all hospice patients. (See L 566).</p> <p>6. The hospice failed to ensure the program activities considered incidence, prevalence, and severity of high risk, high volume, or problem prone areas with the potential to affect all hospice patients. (See L 567).</p> <p>7. The hospice failed to ensure the QAPI program activities affected palliative outcomes, patient safety, and quality of care with the potential to affect all hospice patients. (See L 568).</p> <p>8. The hospice failed to ensure the QAPI program tracked adverse events, analyzed their causes, and implemented preventative actions and mechanisms that included feedback and learning throughout the hospice with the potential to affect all hospice patients. (See L 569).</p>		<p>found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and implementing those actions to ensure improvements are sustained. The QAPI team will evaluate performance improvement projects, document</p>		

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	<p>9. The hospice failed to ensure the QAPI program included taking actions for improvement and implementing those actions to ensure improvements are sustained with the potential to affect all hospice patients. (See L 570).</p> <p>10. The hospice failed to ensure the QAPI program evaluated performance improvement projects with the potential to affect all hospice patients. (See L 571).</p> <p>11. The hospice failed to document the reason for conducting the QAPI projects and the measurable progress achieved on these projects with the potential to affect all hospice patients. (See L 573).</p> <p>12. The hospice failed to ensure the governing body evaluated the QAPI program annually with the potential to affect all hospice patients. (See L 574).</p> <p>13. The governing body failed to ensure the QAPI program included improvement actions, and they were evaluated for effectiveness with the potential to affect all hospice patients. (See L 575).</p> <p>The cumulative effect of these systemic problems resulted in the hospice being found out of compliance with this Condition of Participation 42 CFR 418.58</p>		<p>the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.</p>		

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	Quality Assessment and Performance Improvement.				

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L000560	<p>418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.</p> <p>Based on document review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program involved all hospice services, focused on indicators related to improved palliative outcomes, and took actions to demonstrate improvement in hospice performance with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the program involved all hospice services, focused on indicators related to improved palliative outcomes,</p>	L000560	L560 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team	06/14/2013	

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	<p>and took actions to demonstrate improvement in hospice performance.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (Upper Respiratory Infection), UTIs (Urinary Tract (Infection) related to catheter, Contact with family/patient care giver done routinely, IDG (Interdisciplinary Group) invitation/update sent and received prior to IDG, IDG Notes sent and received within 2 days, Number of referrals to admissions, and Chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. None of the indicators included a plan or any actions to demonstrate improvement in hospice performance. There was no documentation regarding how these indicators were chosen nor was there any documentation that the goal was reached.</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to evidence improvement in the hospice performance.</p>		<p>conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice governing body directed the QAPI team to conduct a PIP centered around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and</p>		

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			severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and implementing those actions to ensure improvements are sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.	

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L000561	<p>418.58(a)(1) PROGRAM SCOPE (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.</p> <p>Based on document review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program showed measurable improvement in indicators with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the program involved all hospice services, focused on indicators related to improved palliative outcomes, and took actions to demonstrate improvement in hospice performance.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections) related to catheter, Contact with family/patient care giver done routinely, IDG (interdisciplinary group) invitation/update sent and received prior</p>	L000561	L561 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice governing body directed the QAPI team to conduct a PIP centered	06/14/2013
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	<p>to IDG, IDG Notes sent and received within 2 days, Number of referrals to admissions, and Chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. None of the indicators included a plan or any actions to demonstrate improvement in hospice performance. There was no documentation of improvement in any of the indicators.</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to evidence improvement in the hospice performance.</p>		<p>around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and implementing those actions to ensure improvements are</p>		

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			sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.		

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L000562	<p>418.58(a)(2) PROGRAM SCOPE (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.</p> <p>Based on document review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program analyzed quality indicators and included adverse patient events with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the program analyzed quality indicators and included adverse patient events.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections) related to catheter, Contact with family/patient care giver done routinely, IDG (interdisciplinary group) invitation/update sent and received prior</p>	L000562	L562 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice	06/14/2013

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	<p>to IDG, IDG Notes sent and received within 2 days, Number of referrals to admissions, and Chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. None of the indicators included a plan or any actions to demonstrate improvement in hospice performance. There was no documentation of how these indicators were analyzed and there was no indicator that included adverse patient events.</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to evidence improvement in the hospice performance.</p>		<p>governing body directed the QAPI team to conduct a PIP centered around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and</p>		

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			implementing those actions to ensure improvements are sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.		

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L000564	<p>418.58(b)(2) PROGRAM DATA (2) The hospice must use the data collected to do the following: (i) Monitor the effectiveness and safety of services and quality of care. (ii) Identify opportunities and priorities for improvement.</p> <p>Based on document review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) data collected monitored the effectiveness and safety of services and quality of care and identified opportunities and priorities for improvement with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the program collected monitored the effectiveness and safety of services and quality of care and identified opportunities and priorities for improvement.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections)</p>	L000564	L564 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice	06/14/2013			

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	<p>related to catheter, Contact with family/patient care giver done routinely, IDG (interdisciplinary group) invitation/update sent and received prior to IDG, IDG Notes sent and received within 2 days, Number of referrals to admissions, and Chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. None of the indicators included a plan or any actions to demonstrate improvement in hospice performance. There was no documentation regarding how the hospice monitored the effectiveness and safety of services and quality of care and identified opportunities and priorities for improvement.</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to indicate improvement in the hospice program.</p>		<p>governing body directed the QAPI team to conduct a PIP centered around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and</p>		

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L000566	<p>418.58(c)(1)(i) PROGRAM ACTIVITIES (1) The hospice's performance improvement activities must: (i) Focus on high risk, high volume, or problem-prone areas.</p> <p>Based on document review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program activities focused on high risk, high volume, or problem prone areas with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the program focused on high risk, high volume, or problem prone areas.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections) related to catheter, Contact with family/patient care giver done routinely, IDG (interdisciplinary group) invitation/update sent and received prior to IDG, IDG Notes sent and received within 2 days, Number of referrals to</p>	L000566	L566 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPKO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPKO Quality Program and Standards of Practice for Hospice Care and NHPKO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPKO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice governing body directed the QAPI team to conduct a PIP centered	06/14/2013
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	<p>admissions, and Chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. There was no documentation regarding how these indicators were chosen or that they were high risk, high volume, or problem prone areas.</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to indicate improvement in the hospice program.</p>		<p>around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and implementing those actions to ensure improvements are</p>		

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L000567	<p>418.58(c)(1)(ii) PROGRAM ACTIVITIES [The hospice's performance improvement activities must:] (ii) Consider incidence, prevalence, and severity of problems in those areas.</p> <p>Based on document review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program activities considered incidence, prevalence, and severity of high risk, high volume, or problem prone areas with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the program considered incidence, prevalence, and severity of high risk, high volume, or problem prone areas.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections) related to catheter, Contact with family/patient care giver done routinely, IDG (interdisciplinary group) invitation/update sent and received prior</p>	L000567	L567 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice governing body directed the QAPI team to conduct a PIP centered	06/14/2013	

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	<p>to IDG, IDG Notes sent and received within 2 days, Number of referrals to admissions, and Chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. There was no documentation regarding how these indicators were chosen or considered incidence, prevalence, and severity of high risk, high volume, or problem prone areas.</p> <p>2. On 5/8/13 at 4:45 PM employee F, the QAPI nurse, indicated there was no documentation as to how indicators were chosen.</p>		<p>around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and implementing those actions to ensure improvements are</p>		

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			sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.		

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L000568	<p>418.58(c)(1)(iii) PROGRAM ACTIVITIES [The hospice's performance improvement activities must:] (iii) Affect palliative outcomes, patient safety, and quality of care.</p> <p>Based on document review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program activities affected palliative outcomes, patient safety, and quality of care with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the program activities affected palliative outcomes, patient safety, and quality of care.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections) related to catheter, Contact with family/patient care giver done routinely, IDG (interdisciplinary group) invitation/update sent and received prior to IDG, IDG Notes sent and received within 2 days, Number of referrals to</p>	L000568	L568 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPKO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPKO Quality Program and Standards of Practice for Hospice Care and NHPKO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPKO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice governing body directed the QAPI team to conduct a PIP centered	06/14/2013
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	<p>admissions, and Chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. None of the indicators included a plan or any actions to demonstrate improvement in hospice performance. There was no documentation regarding how these activities affected palliative outcomes, patient safety, and quality of care .</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to evidence improvement in the hospice performance.</p>		<p>around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and implementing those actions to ensure improvements are</p>		

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			sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.		

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L000569	<p>418.58(c)(2) PROGRAM ACTIVITIES (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.</p> <p>Based on document review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program tracked adverse events, analyzed their causes, and implemented preventative actions and mechanisms that included feedback and learning throughout the hospice with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the program tracked adverse events, analyzed their causes, and implemented preventative actions and mechanisms that included feedback and learning throughout the hospice.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections)</p>	L000569	L569 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice	06/14/2013	

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	<p>related to catheter, Contact with family/patient care giver done routinely, IDG (interdisciplinary group) invitation/update sent and received prior to IDG, IDG Notes sent and received within 2 days, Number of referrals to admissions, and Chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. None of the indicators included a plan or any actions to demonstrate improvement in hospice performance. There was no indicator that tracked adverse events, analyzed their causes, and implemented preventative actions and mechanisms.</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to indicate improvement in the hospice program.</p>		<p>governing body directed the QAPI team to conduct a PIP centered around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and</p>		

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			implementing those actions to ensure improvements are sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, will be responsible to ensure that this deficiency is corrected and will not recur.		

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L000570	<p>418.58(c)(3) PROGRAM ACTIVITIES (3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.</p> <p>Based on document review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program included taking actions for improvement and implementing those actions to ensure improvements are sustained with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the program included taking actions for improvement and implementing those actions to ensure improvements are sustained.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections) related to catheter, Contact with family/patient care giver done</p>	L000570	L570 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice	06/14/2013			

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	<p>routinely, IDG (interdisciplinary group) invitation/update sent and received prior to IDG, IDG Notes sent and received within 2 days, Number of referrals to admissions, and chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. None of the indicators included a plan or any actions to demonstrate improvement in hospice performance.</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to indicate improvement in the hospice program.</p>		<p>governing body directed the QAPI team to conduct a PIP centered around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and</p>		

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			implementing those actions to ensure improvements are sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.	

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L000571	<p>418.58(d) PERFORMANCE IMPROVEMENT PROJECTS Beginning February 2, 2009, hospices must develop, implement and evaluate performance improvement projects.</p> <p>Based on document review and interview, the hospice failed to ensure the quality assessment and performance improvement (QAPI) program evaluated performance improvement projects with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the program evaluated quality improvement projects.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections) related to catheter, Contact with family/patient care giver done routinely, IDG (interdisciplinary group) invitation/update sent and received prior to IDG, IDG Notes sent and received within 2 days, Number of referrals to admissions, and chaplain needs provided. None of these indicators were monitored</p>	L000571	L571 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPKO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPKO Quality Program and Standards of Practice for Hospice Care and NHPKO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPKO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice governing body directed the QAPI team to conduct a PIP centered	06/14/2013

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	<p>for more than 6 months; 8 of them were only monitored for 3 months. None of the indicators included a plan or any actions to demonstrate improvement in hospice performance. There was no documentation regarding an evaluation of any quality improvement project.</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to indicate improvement in the hospice program.</p>		<p>around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and implementing those actions to ensure improvements are</p>		

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			sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.		

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L000573	<p>418.58(d)(2) PERFORMANCE IMPROVEMENT PROJECTS (2)The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.</p> <p>Based on document review and interview, the hospice failed to document the reason for conducting the quality assessment and performance improvement (QAPI) projects and the measurable progress achieved on these projects with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the hospice documented the reason for conducting the qapi projects and the measurable progress achieved on these projects.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections) related to catheter, Contact with family/patient care giver done routinely, IDG (interdisciplinary group)</p>	L000573	L573 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice	06/14/2013

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	<p>invitation/update sent and received prior to IDG, IDG Notes sent and received within 2 days, Number of referrals to admissions, and Chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. None of the indicators included a plan or any actions to demonstrate improvement in hospice performance. There was no documentation regarding how these indicators were chosen nor was there any documentation of measurable progress.</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to indicate improvement in the hospice program.</p>		<p>governing body directed the QAPI team to conduct a PIP centered around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and</p>		

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			implementing those actions to ensure improvements are sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.		

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L000574	<p>418.58(e)(1) EXECUTIVE RESPONSIBILITIES The hospice's governing body is responsible for ensuring the following: (1)That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.</p> <p>Based on document review and interview, the hospice failed to ensure the governing body evaluated the quality assessment and performance improvement (QAPI) program annually with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's QAPI program failed to evidence the governing body evaluated the QAPI program annually.</p> <p>The indicators identified for 2012 included monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections) related to catheter, Contact with family/patient care giver done routinely, IDG (interdisciplinary group) invitation/update sent and received prior to IDG, IDG Notes sent and received within 2 days, Number of referrals to</p>	L000574	L574 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been implemented that involves all hospice services. The hospice	06/14/2013			

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	<p>admissions, and chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. There was no documentation that the governing body evaluated the QAPI program annually.</p> <p>2. On 5/14/13 at 2:50 PM the administrator indicated there was no further documentation available.</p>		<p>governing body directed the QAPI team to conduct a PIP centered around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout the hospice, including taking actions for improvement and</p>		

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			implementing those actions to ensure improvements are sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.		

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L000575	<p>418.58(e)(2) EXECUTIVE RESPONSIBILITIES [The hospice's governing body is responsible for ensuring the following:] (2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.</p> <p>Based on document review and interview, the governing body failed to ensure the quality assessment and performance improvement (QAPI) program included improvement actions, and they were evaluated for effectiveness with the potential to affect all hospice patients.</p> <p>Findings:</p> <p>1. Review of the hospice's documents failed to evidence the governing body ensured the QAPI program included improvement actions, and they were evaluated for effectiveness.</p> <p>The indicators in the hospice's QAPI program identified for 2012 included Monitoring of weight and MAC (acronym meaning unknown) done monthly, Home health aide care plan followed, Comfortable dying assessment, Infection control URIs (upper respiratory infections), UTIs (urinary tract infections) related to catheter, Contact with</p>	L000575	L575 The hospice administrator, Susan Willis RN, and President, Steven Claspell reviewed our QAPI program with NHPCO Vice President of Resources/QAPI, Carol Spence, who provided valuable training and insight about our program, we utilized that insight to reorganize our QAPI program to better implement and maintain an effective, ongoing, hospice-wide, data driven quality assessment and performance improvement program. The governing body, IDG team, and QAPI team were in-serviced on 05/29/13 regarding NHPCO Quality Program and Standards of Practice for Hospice Care and NHPCO Quick Guide to Quality Assessment/Performance Improvement. The QAPI team conducted a 360 self assessment from the NHPCO website to help identify hospice wide areas potential for improvement focused on indicators related to improved palliative outcomes to demonstrate improvement in hospice performance that would affect all hospice patients. An agency wide program has been	06/14/2013	

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	<p>family/patient care giver done routinely, IDG (interdisciplinary group) invitation/update sent and received prior to IDG, IDG Notes sent and received within 2 days, Number of referrals to admissions, and Chaplain needs provided. None of these indicators were monitored for more than 6 months; 8 of them were only monitored for 3 months. None of the indicators included a plan or any actions to demonstrate improvement in hospice performance.</p> <p>2. On 5/8/13 at 5:10 PM, employee F, the QAPI nurse, indicated there was no further documentation to indicate improvement in the hospice program.</p>		<p>implemented that involves all hospice services. The hospice governing body directed the QAPI team to conduct a PIP centered around patient and family care by monitoring the Family Evaluation of Hospice Care Surveys and found opportunities for improvement. The QAPI team has implemented a new format of PIP's which now includes an AIM statement which will delineate goals to be reached, documentation regarding how indicator was chosen, and plan for action after PIP timeline completed that would show measurable improvements that has the potential affect all hospice patients. In addition, the QAPI program will analyze quality indicators and include adverse patient events, with data collected to be monitored for the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement. The program activities will focus on high risk, high volume, or problem prone areas and will consider incidence, prevalence, and severity of high risk, high volume, or problem prone areas, affected palliative outcomes, patient safety, quality of care and tracked adverse events. These adverse events will be analyzed for their causes and preventative actions will be implemented with mechanisms that include feedback and learning throughout</p>		

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			the hospice, including taking actions for improvement and implementing those actions to ensure improvements are sustained. The QAPI team will evaluate performance improvement projects, document the reason for conducting the QAPI projects and measurable progress achieved on these projects. The governing body will evaluate the QAPI program including improvement action, and will evaluate for effectiveness annually, at a minimum or more often as warranted, as required by the QAPI project with the potential to affect all hospice patients. Susan Willis, Administrator, RN, Steven Claspell, President, and the governing body, will be responsible to ensure that this deficiency is corrected and will not recur.		

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L000579	<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. Based on observation, hospice policy review and Centers for Disease Control (CDC) document review, the hospice failed to ensure its staff provided care in accordance with Standard Precautions in 2 (#s 1 and 2) of 3 home visit observations completed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <p>1. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or</p>	L000579	<p>L579 The Administrator, Susan Willis, RN, will assure compliance with the Standards of Precautions and Hand Hygiene. The hospice upon being informed of a break in infection control during the survey process, provided individual counseling/in-servicing with the specific staff observed to be non-compliant. On site supervisory visits will be completed annually for all staff to assure compliance after education provided. Supervisory visits were completed on other staff providing direct care to assure compliance with standard precautions. On site supervisory visits completed on staff yearly. Individual education will be provided to any non-compliant staff and/ or follow up supervisory visits will be completed. In-servicing of other staff will be completed based on supervisory visit results, to educate staff regarding potential sources of non-compliance. Susan Willis, RN Administrator will be responsible for staff compliance with standard precautions. Ongoing compliance will be tracked by maintaining yearly in-service materials on hand washing, infection control, and standard precaution. Annual</p>	06/14/2013
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	<p>blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>2. The hospice's undated "Infection Control - Standard Precautions" policy number REG.I30 states, "Hospice staff follows accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions in the care of all hospice patients, regardless of diagnosis or presumed infection status . . . Handwashing: Wash hands after touching</p>		<p>supervisory visits will continue to completed on 100% of staff providing direct patient care. Annual staff in-servicing education reviewed and updated to include standards of precautions upon hire as well as annually. Admission packets updated to include current acceptable standards of practice. Reminder of hand hygiene practices posted in office. The Administrator, Susan Willis, RN, is responsible to ensure that this cited deficiency does not recur.</p>	

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	<p>blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn: Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer to microorganisms to other patients or environments; Wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites . . . Gloves . . . Put on clean gloves just before touching mucous membranes and nonintact skin; Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms; and Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another patient, and wash hands immediately to avoid transfer of microorganisms to other patients or environments."</p> <p>3. A home visit was made to patient number 1 on 5-8-13 at 10:45 AM with employee I, a registered nurse (RN). The RN was observed to perform dressing changes to the patient's bilateral lower extremities. The RN removed equipment from her nursing bag to take the patient's vital signs. She took the patient's blood pressure, listened to bowel sounds, and</p>			

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	<p>took a radial pulse. Without cleansing her hands, the nurse then reached into her nursing bag and retrieved a thermometer and took the patient's axillary temperature.</p> <p>A. The nurse requested dressing supplies from the skilled nursing facility (SNF) nurse and retrieved the supplies from the top of the medicine cart. The RN washed her hands and placed an open trash bag on the floor at the foot of the bed. Without cleansing her hands, the RN reached into her nursing bag and obtained a bag of gloves. The RN then donned clean gloves without cleansing her hands. The RN removed the patient's socks and compression stockings from the right leg and checked the pedal pulses and for the presence of edema in the lower legs. The RN again reached into her bag wearing the same gloves she had on while touching the patient's lower extremities and obtained a paper ruler to measure the wounds. The nurse then removed the glove from her right hand and wrote on her note with a pen. The RN then put the same glove back onto her right hand and measured an open area on the right shin. The RN again removed the glove from her right hand and wrote on her note. The RN donned the same glove on her right hand and removed the sock and compression stocking from the left leg</p>			

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	<p>and checked for edema. The RN then removed the Bandaid from the left shin and measured the wound. The RN removed the glove from her right hand and wrote on her note. The RN then measured the wound on the right second toe, removed the glove from her right hand, wrote on her note, and placed the same glove back onto her right hand. The RN then removed both gloves and cleansed her hands.</p> <p>B. After cleansing her hands, the RN donned clean gloves. She prepared the dressing supplies, cleansed the wound on the left shin with normal saline, cleansed the wound on the right shin with normal saline and then cleansed the right 2nd toe with normal saline. Using an applicator, the RN applied ointment to the left 2nd toe and then applied a cream to right and left shin. The RN then applied a dry non-stick dressing to the left shin and then the right shin and a Bandaid to the left 2nd toe wound. The RN re-applied the patient's socks and compressions stocking to the patient's bilateral lower extremities.</p> <p>C. The RN pushed the patient's wheelchair into the bathroom to check the patient's buttocks and gluteal fold for open areas. The RN pulled the Depends down and assisted the patient to the</p>				

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	<p>commode and, with the assistance of a SNF aide, stood the patient and touched the patient's buttocks and gluteal fold. The RN measured a small, red area in the patient's gluteal fold. The RN removed the glove from her right hand and donned a clean glove without cleansing her hand. The RN applied a cream to the patient's buttocks. The RN then pulled up the patient's Depends and assisted the patient to sit in the wheelchair.</p> <p>D. After placing the patient's wheelchair out in the lobby in order for the patient to watch TV, the RN re-entered the patient's room and placed her equipment (blood pressure cuff, stethoscope, pulse oximetry meter, thermometer) back into her bag. The RN was not observed to clean the equipment prior to placing it into her nursing bag.</p> <p>4. A home visit was made to patient number 2 on 5-8-13 at 1:00 PM with employee H, a home health aide. The aide was observed to provide a total bed bath. The patient was observed to have a urinary catheter. The aide was observed to complete the bath, except for the front perineal area, and placed the patient on the patient's back. The aide performed perineal care, to include catheter care, to the front perineal area. Without changing her gloves or cleansing her hands, the aide</p>			
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	<p>turned the patient, with the assistance of the patient's adult child, onto the right side and applied cream to the patient's buttocks. The aide then applied a clean adult diaper and nightgown and put away the supplies. The aide then removed her gloves and cleansed her hands.</p> <p>5. The hospice administrator, employee L, indicated, on 5-14-13 at 10:00 AM, employees H and I had not followed the hospice's standard precautions policies and procedures.</p>			

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L000580	<p>418.60(b)(1) CONTROL</p> <p>The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that-</p> <p>(1) Is an integral part of the hospice's quality assessment and performance improvement program; and</p> <p>Based on document and policy review and interview, the agency failed to ensure the quality assessment and performance improvement (QAPI) program included prevention, control, and investigation of infectious and communicable diseases for 1 of 1 hospice with the potential to affect all the employees and patients of the agency.</p> <p>Findings include:</p> <p>1. Review of documentation failed to evidence a coordinated agency-wide program for the prevention, control, and investigation of infectious and communicable diseases that was an integral part of the hospice's quality assessment and performance improvement program.</p> <p>2. The undated policy # REG.125 titled "INFECTION CONTROL - PROGRAM" states, "3. A summary of all infection control activities performed as well as</p>	L000580	L580 Living Waters Hospice Care developed an agency-wide coordinated infection control program for the prevention, control, and investigation of infection and communicable diseases that is an intregral part of our newly revised QAPI program that has been approved by our governing body, and our IDG. Susan Willis, RN, Administrator in-serviced the governing body, IDG team, and QAPI team on 5/29/13 regarding the agency-wide coordinated infection control program for the prevention, control, and investigation of infection and communicable diseases that is an integral part of our newly revised QAPI program. Data collection tools are now in place to collect this data for monitoring purposes. To ensure that this cited deficiency does not recur, the Administrator, Susan Willis, RN, is responsible for over sight of the data collection tools to ensure this data is collected, analyzed, with findings to be reported to the governing body, with appropriate action to be taken to result in	06/14/2013			

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	<p>results of aggregated surveillance data analysis is provided by the QAPI Committee and included in reports to hospice leaders."</p> <p>3. On 5/8/13 at 4:30 PM, employee F, the QAPI nurse, indicated there was no further documentation to evidence reports of infection control for performance improvement of the hospice program.</p>		<p>improvement and disease prevention that may have the potential to affect all employees, and/or patients of the agency. The Administrator, Susan Willis, RN, Steven Claspell, and the governing body are responsible to ensure that this cited deficiency does not recur.</p>		

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L000581	<p>418.60(b)(2) CONTROL</p> <p>[The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that-]</p> <p>(2) Includes the following:</p> <p>(i) A method of identifying infectious and communicable disease problems; and</p> <p>(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.</p> <p>Based on document and policy review and interview, the agency failed to ensure the hospice coordinated an agency-wide program for the prevention, control, and investigation of infectious and communicable diseases and a plan for implementing the appropriate actions that were expected to result in improvement and disease prevention for 1 of 1 hospice with the potential to affect all the employees and patients of the agency.</p> <p>Findings include:</p> <p>1. Review of documentation failed to evidence a coordinated agency-wide program for the prevention, control, and investigation of infectious and communicable diseases and a plan for implementing appropriate actions to result in improvement and disease prevention.</p>	L000581	L581 Living Waters Hospice Care developed an agency-wide coordinated infection control program for the surveillance, prevention, control, and investigation of infection and communicable diseases that is an integral part of our newly revised QAPI program that has been approved by our governing body, IDG team, and the QAPI team. This infection control program includes a method for identifying infectious and communicable disease problems and a plan for implementing the appropriate actions that are expected to result in improvement and disease prevention. Susan Willis, RN, Administrator in-serviced the governing body, IDG team, and QAPI team on 5/29/13 regarding the agency-wide coordinated infection control program for the prevention, control, and investigation of infection and communicable diseases that is an integral part of our newly revised QAPI program. Methods for	06/14/2013			

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	<p>2. The undated policy # REG.125 titled "INFECTION CONTROL - PROGRAM" states, "[Hospice] maintains and documents an effective, organization-wide infection control program that includes active monitoring, surveillance, identification, prevention, and control of known or suspected infections among the hospice's patients and employees."</p> <p>3. On 5/8/13 at 4:30 PM, employee F, the QAPI (quality assessment and performance improvement) nurse, indicated there was no further documentation to evidence reports of infection control for performance improvement of the hospice program.</p>		<p>identifying infectious and communicable disease problems include data collection tools that are now in place to collect this data for monitoring purposes. The plan that has been implemented includes the appropriate actions that are expected to result in improvement and disease prevention that may have the potential to affect all employees, and/or patients of the agency. To ensure that this cited deficiency does not recur, the Administrator, Susan Willis, RN, is responsible for over sight of the data collection tools to ensure this data is collected, analyzed, with findings to be reported to the governing body. The Administrator, Susan Willis, RN, Steven Claspell, and the governing body are responsible to ensure that this cited deficiency does not recur.</p>		

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L000684	<p>418.104(e)(3) DISCHARGE OR TRANSFER OF CARE (3) The hospice discharge summary required by (e)(1) and (e)(2) of this section must include-</p> <p>(i) A summary of the patient's stay including treatments, symptoms and pain management;</p> <p>(ii) The patient's current plan of care;</p> <p>(iii) The patient's latest physician orders; and</p> <p>(iv) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.</p> <p>Based on clinical record and hospice policy review and interview, the hospice failed to ensure a discharge summary that included all of the required items had been prepared in 1 (# 6) of 1 discharged record reviewed creating the potential to affect all of the hospice's 11 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6 included a physician order dated 3-22-13 that evidenced the patient had transferred to another hospice provider. The record failed to evidence a discharge summary that included a summary of the patient's treatment, the current plan of care, or the latest physician orders. 2. The administrator, employee L, was unable to provide any additional documentation and/or information when 	L000684	L684 The IDG team and governing body reviewed and approved a new form that will assist staff in transfer/discharge of hospice patients according to Policy number: REG. 10 Transfer of a Hospice Patient with the hospice staff including a written summary is prepared for the receiving provider that includes, at a minimum the reason for transfer, a summary of the patient's stay including treatments, symptoms and pain management, a copy of the patient's current care plan, the patient's latest physician's orders, and any other documentation that will assist in the post-transfer continuity of care that is requested by the Attending Physician or receiving facility. To ensure that all of the needed information is prepared for the receiving provider a transfer/discharge form was reviewed and approved by the IDG team and governing body to	06/14/2013	

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	<p>asked on 5-14-13 at 10:00 AM and on 5-14-13 at 11:00 AM.</p> <p>3. The hospice's undated "Transfer of a Hospice Patient" policy number REG.T10 states, "Transfer procedures are initiated when a patient requests or needs admission to an inpatient facility, skilled nursing facility, assisted living facility, a hospice residence, or another hospice or health care provider. A written discharge summary is prepared for the receiving provider that includes, at a minimum: a. the reason for the transfer; a summary of the patient's stay including treatments, symptoms and pain management; c. a copy of the patient's current plan of care; d. the patient's latest physician orders; e. any other documentation that will assist in post-transfer continuity of care."</p>		<p>assist staff with documentation to ensure continuity of care. Administrator Susan Willis, RN, conducted an in-service on 5/29/2013, educated the staff and IDG on the process of filling out a discharge summary for transfer of a hospice patient, with implementation of a new form that was reviewed and approved by the IDG and governing body. The Administrator, Susan Willis, RN, will monitor the form to ensure that all required items are included on transfer/discharge summaries for hospice patients that are transferred. The Administrator, Susan Willis RN, is responsible to ensure that this deficiency does not recur.</p>		

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L000774	<p>418.112(d)(1) HOSPICE PLAN OF CARE</p> <p>The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.</p> <p>Based on clinical record review and interview, the hospice failed to ensure plans of care specifically identified which provider was responsible for performing care and services in 2 (#s 1 and 5) of 2 records reviewed of patients that were residents of skilled nursing facilities (SNF) creating the potential to affect both of the hospice patients that are residents of SNFs.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 evidenced the patient was a resident of a SNF and included a plan of care established by the interdisciplinary group (IDG) for the benefit period 4-11-13 to 6-9-13. The plan of care states, "Hospice nurse to provide any medications or treatments as indicated during visits." The plan of care failed to specify which medications and/or treatments the hospice nurse would be responsible for administering. 2. Clinical record number 5 evidenced the patient was a resident of a SNF and 	L000774	<p>L774 The Hospice Administrator, Susan Willis, in-serviced the staff was completed on 5/29/2013 regarding documentation and maintenance of an individualized plan of care that delineates responsibilities of hospice and responsibilities of nursing facility. Each hospice patient's that resides in a SNF has a current plan of care that has been updated and reviewed through IDG to identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care. The current plan of care with updated delineation of responsibilities has been placed in the nursing facilities for each skilled nursing facility patient. Living waters hospice care staff have been educated regarding use of the current updated plan of care to identify specific responsibilities for the hospice and SNF provider. 50% patients of the skilled nursing facility charts will be audited quarterly to ensure the identify the care and services that are needed and specifically</p>	06/14/2013	

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	<p>included a plan of care established by the IDG for the benefit period 4-17-13 to 7-15-13. The plan of care states, "Hospice nurse to provide any medications or treatments as indicated during visits." The plan of care failed to specify which medications and/or treatments the hospice nurse would be responsible for administering.</p> <p>3. The administrator, employee L, was unable to provide any additional documentation and/or information when asked on 5-14-13 at 10:00 AM and 11:00 AM.</p>		<p>identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care. Susan Willis, RN Administrator is responsible for over seeing the monitoring of corrective actions to ensure that this deficiency does not recur.</p>		

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L000796	<p>418.114(d)(2) CRIMINAL BACKGROUND CHECKS Criminal background checks must be obtained in accordance with State requirements. In the absence of State requirements, criminal background checks must be obtained within three months of the date of employment for all states that the individual has lived or worked in the past 3 years.</p> <p>Based on state law, personnel file, and policy review and interview, the hospice failed to ensure a limited criminal history was obtained as required by state law in 1 (J) of 5 personnel files reviewed with hire dates later than 2007 with the potential to affect all the Hospice's patients.</p> <p>Findings include:</p> <p>1. State Law IC 16-25-6 states, "Sec. 2. (a) A person who owns or operates a hospice program shall apply, not more than three (3) business days after the date that an employee or volunteer begins to provide hospice services, for a copy of the employee's or volunteer's limited criminal history from the Indiana Central Repository for criminal history information under IC 5-2-5. (b) A hospice program may not employ an individual or allow a volunteer to provide hospice services for more than three business days without applying for</p>	L000796	L 796 The administrator Susan Willis RN, has completed a thorough audit on all employee and volunteer files and criminal back ground checks have been completed on all employees with no identified criminal backgrounds. The hospice will continue using the attestation of Indiana residency and work history form approved by IDG and any employee or volunteer who meets the Indiana Code requirements for out of state residency, also has a current expanded criminal history check on file per state regulation. A new employee checklist has been developed to improve internal processes and the form has been clearly divided into sections that must be completed prior to any new employee providing direct patient care to prevent this deficiency from recurring. The administrative employee hiring policy has been updated to include the new process and has been approved by IDG and governing body. The new form will require initialing by the Hospice Director prior to day 21	06/14/2013	

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	<p>that person's limited criminal history as required by subsection (a).</p> <p>Sec. 3 (b) A hospice program may not employ a person to or allow a volunteer to provide hospice services for more than twenty-one calendar days without receipt of that person's limited criminal history required by section 2 of this chapter, unless the Indiana Central Repository for criminal history information under IC 5-2-5 is solely responsible for failing to provide the person's limited criminal history to the hospice program within the time required under this subsection."</p> <p>2. Personnel file J, date of hire 7/16/10, failed to evidence a criminal history check had been obtained within 21 calendar days of the date of employment. The first patient contact date was not available.</p> <p>3. The undated policy #REG.C90 titled "CRIMINAL BACKGROUND CHECKS" states, "[Hospice] obtains a criminal background check as required by State laws and regulations."</p> <p>4. On 5/14/13 at 2:40 PM, employee L, the administrator, indicated there was no further documentation available.</p>		<p>indicating verification that the limited criminal history checks had been received in the hospice office. If no limited criminal history has been received back in a timely manner then an electronic criminal background check will be obtained on or before day 21 by the administrator or designee. The administrator, Susan Willis, RN in-serviced and educated administrative staff on 5/29/13 regarding the new process for obtaining limited criminal history checks. The hospice administrator, Susan Willis RN, will be responsible for the over site to ensure that this sited deficiency does not recur.</p>		

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NAME OF PROVIDER OR SUPPLIER LIVING WATERS HOSPICE CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 HWY 41 N STE 130 EVANSVILLE, IN 47711
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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