

Standard	Action	Date Of Compliance	Responsible Party	Process to Prevent Recurrence	Notes & Surveyor Findings
Standard: Hospice aide assignment and duties LTAGS: (L625) (L626) (L627) (L628) ACHC HSP4-13A CHAP HCDT 15.I HCDT 16.I HCDT 17.I HCDT 18.I Frequency of citation: 52%	<p>Staff will be in-serviced on how to document a complete and individualized plan of care that specifies the care and services necessary to meet the patient's needs.</p> <p>Ensure that aides communicate with the RN whenever there is a deviation from the written instructions/plan of care, as when a patient declines a service or when there is a change in the patient's condition.</p> <p>Ensure the written instructions are specific to the aide's tasks and their frequency</p> <p>Aides may only complete tasks that are:</p> <ul style="list-style-type: none"> – Ordered by the physician and included in the plan of care. – Permitted under state law to be performed by a hospice aide and consistent with aide training. <p>Re-educate aides on the importance of complete and accurate documentation of services provided and communication regarding services not delivered and/or changes in the patient's condition.</p> <p>Audit patient records to ensure compliance.</p>		Clinical Educator Case Manager Clinical Manager Case Manager Clinical Educator Clinical Manager	<p>Audit 10% of all active patients to ensure the plan of care is individualized, and complete and address the care and services necessary to meet the needs of the patient for at least 5 weeks. Target threshold is 95%.</p> <p>Once the threshold is met, will continue to audit 10% of all patient records quarterly.</p> <p>Findings will be reported to the QAPI Committee.</p>	<ul style="list-style-type: none"> • Aide care plans specified that assigned tasks were to be completed at every visit. On several occasions, the aide documented "no, not needed this visit" for specific tasks. There was no evidence of notification to the RN or change of plan by RN. • The interdisciplinary plan of care calls for aide visits three times a week. In several weeks, there were only two aide visits and no evidence of a missed visit notification. • Patient with a diagnosis of Parkinson's and dysphagia. No evidence of aspiration precautions on aide care plans. • Patients identified as high fall risk. No evidence of fall risk precautions on aide care plans. • Care plan included aide visits twice weekly. There was no evidence of visits by the aide. • Aide documented a change (decline) in the patient's mental state but no evidence to indicate that the aide informed the RN.

Comprehensive Assessment					
<p>Standard: The hospice must develop an individualized, patient-specific plan of care that reflects patient/family goals and interventions based on the initial and updated comprehensive assessment.</p> <p>LTAGS (L536), (L537), (L538), (L543), (L545), (L546), (L547), (L548), (L549), (L550)</p> <p>ACHC HSP5-4A</p> <p>CHAP HCPC 1.I HCPC 18.I HCPC 19.I HCPC 21.I</p> <p>Frequency of citation: 71%</p>	<p>Reeducate staff to ensure all patients have an individualized written plan of care that addresses the issues identified in the comprehensive assessment.</p> <p>Ensure the written plan of care includes:</p> <ul style="list-style-type: none"> – The principal diagnosis and other pertinent diagnoses. – Goals and interventions, including all services necessary for the palliation and management of terminal illness and related conditions. – A detailed statement of the scope and frequency of services necessary. – Measurable outcomes. – Medications. – Equipment and supply needs. – Start of care date and certification period. – Patient demographics. – Allergies. – Family needs including bereavement needs. – Spiritual needs. – End-of-life care preferences. – Functional limitations. – Diet and nutritional needs. – Safety measures. – Evidence of collaboration with the attending physician, if applicable. <p>100% of patient records will be reviewed to ensure there is evidence the plan of care includes all services necessary for the palliation and management of the</p>		<p>Clinical Manager And Case Manager</p> <p>Clinical Manager</p> <p>Clinical Manager And Case Manager</p> <p>Director of Clinical Services</p>	<p>Hospice will audit 10% of care plans monthly x3 months to ensure the plan of care addresses the care and services individualized to the patient's needs.</p> <p>Hospice will audit 100% of new admissions for 6 weeks or until a threshold of 95% compliance is met.</p> <p>Audit areas to include: CTI, plan of care, oxygen, nebulizers, medication profiles are current and match the orders and the medications in the home, frequencies.</p> <p>Clinicians will be in-serviced on ensuring that the care and services are provided in accordance with the hospice plan of care. To include reviewing visit frequency orders in the patient record prior to visiting a patient or scheduling a visit.</p> <p>Findings will be reported</p>	<ul style="list-style-type: none"> ● The patient was admitted 7/8, the plan of care was not signed by the attending physician until 8/27 and the certification of terminal illness was signed on 9/14. ● Both of these authorizations are out of compliance with hospice policy. ● The plan of care did not address the scope and frequency of services to meet specific patient and family needs. ● The medical record indicated the patient was on oxygen 4L/min continuously. ● There was no reference to O2 equipment or supplies on the plan of care. ● Observed at a home visit, the patient has a nebulizer for the albuterol treatments. ● The plan of care does not contain a nebulizer. ● The medical record contained information that the patient was on aspirin daily. The plan of care did not include bleeding precautions necessary for the care and management of the patient. ● The standard was cited for incomplete plans of care.

	terminal illness and related conditions, including specific orders for all medications and treatments.			to the QAPI Committee.	
Standard: Hospice services are delivered in accordance with the plan of care. LTAG (L555) ACHC HSP5-4B CHAP HCPC 23.D Frequency of citation: 44%	<p>Re Educate staff on documenting visits to validate care was provided in accordance with the plan of care, including how to appropriately document patient refusals.</p> <p>Ensure the frequencies of visits match the plan of care and there is a clear process for missed visits and frequency changes.</p> <p>100% of patient records will be reviewed to ensure hospice services are delivered in accordance with the hospice plan of care.</p> <p>Ensure that facility patients have a delineation of duties associated that clearly shows who is responsible for the delivery of care and interventions.</p>		<p>Clinical Manager And Case Manager</p> <p>Clinical Manager</p> <p>Clinical Educator</p> <p>Director of Clinical Services</p>	<p>Hospice will audit 10% of all active patient records monthly x3 months to ensure the care and services are provided in accordance with the hospice plan of care until 95% compliance is met.</p> <p>Hospice will audit the frequency order and visit compliance for 100% of new admissions for 6 weeks or until a threshold of 95% compliance is met.</p> <p>Clinicians will be in-serviced on ensuring that the care and services are provided in accordance with the hospice plan of care. To include reviewing visit frequency orders in the patient record prior to visiting a patient or scheduling a visit.</p> <p>Findings will be reported to the QAPI Committee.</p>	<ul style="list-style-type: none"> Deficiencies were cited when the provision of care differed from the documented plan of care. Issues of visit frequency by the appropriate discipline were prevalent. Spiritual care and social work visit frequency did not match the plan of care. There was no evidence of missed visit documentation or change to the order for frequency. An order was received for wound care for a patient living in a group home. The order was not clear as to whether the hospice RN or in-home caregiver was to perform the dressing change. Initial plan of care includes an order for social work evaluation. No evidence of a visit or refusal of a visit made by the social worker.