DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/02/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 000000		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) date survey completed 06/23/2016	
	PROVIDER OR SUPPLIER VALLEY HOSPICE SUMMARY ST	TATEMENT OF DEFICIENCIES	1234 M	ADDRESS, CITY, STATE, ZIP CODE Main St. ere, US 77000 PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
L 0543 Bldg. 00	to patients and to an individualized established by the interdisciplinary with the attending patient or representation of the patient's need desire. Based on record the hospice failed care were individuant services processing and services processing and services processing and services processing individual services processing i	and services furnished their families must follow d written plan of care he hospice group in collaboration ng physician (if any), the sentative, and the er in accordance with eds if any of them so d review and interview, ed to ensure plans of dualized and that care byided were in a the plan of care in 11	L 0543	L 543 The Administrator wi instruct all clinical staff that plans of care are individualized and care and services provided are in accordance with the plan of care. 10% of all medical records will be audited monthly to ensure that the plan of care is individualize and care and services are accordance with the plan of care. The Administrator will responsible for monitoring ensure this deficiency is corrected and will not recurred.	ed, in of ll be to

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STATEMEN	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		000000	B. W	ING		06/23/	/2016
			1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L		1234 M			
STONE \	ALLEY HOPSICE			Ληνανδο	ere, US 77000		
(WA) ID	CID O (A DV/ C	TATEMENT OF DEFICIENCIES	1		16, 03 77000		(375)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710				ind	·		DATE
	The findings inc	lude:					
	December of the disc	idea line di constitui di cons					
	•	idualization of care					
	plans:						
	1 Oliniaal	ed number 1 included =					
		rd number 1 included a					
	plan of care esta	-					
		group (IDG) on 5-20-16.					
	•	e identifies "Care Plan					
		on Management" as a					
	•	ddressed. The plan					
	failed to be indiv						
	_	specific concerns					
	associated with						
	medication man	agement problem.					
	•	of care identifies					
		0 Respiratory" as a					
	•	ddressed. The plan					
	failed to be indiv						
	_	specific concerns					
	associated with	the identified					
	respiratory prob	lem.					
	•	of care identifies "Care					
		etic Management" as a					
	problem to be a	ddressed. The plan					
	failed to be indiv						
	distinguish the s	specific concerns					
	associated with	the identified diabetic					
	management pi	roblem.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED
		000000			06/23/2016
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
STONE \	/ALLEY HOPSICE			fain St.	
I				ere, US 77000	
(X4) ID		TATEMENT OF DEFICIENCIES CV MUST BE BRECEDED BY ELL I	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.
PREFIX TAG	C. The plan Plan H320 Alter problem to be at failed to be individual distinguish the stassociated with mental status problem to be at care failed to be distinguish the stassociated with safety problem. 2. Clinical recomplan of care estassociated with safety problem. 2. Clinical recomplan of care estassociated with safety problem to be at failed to be individual distinguish the stassociated with medication man	specific concerns the identified altered roblem. of care identifies "Care ility-Safety" as a ddressed. The plan of e individualized and specific concerns the identified mobility- and number 2 included a ablished by the IDG on an identifies "Care Plan on Management" as a ddressed. The plan yidualized and specific concerns	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION DATE
	H16 Pain as a p				
	individualized ar	nd distinguish the			
	•	ns associated with the			
	identified pain p	roblem.			
	•	identifies "Care Plan scular" as a problem to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVI COMPLETED	EY	
AND PLAN	OF CORRECTION	000000	B. WING	00	06/23/2016	
		000000	CTDE	ET ADDRESS, CITY, STATE, ZIP CODE	00/20/2010	,
NAME OF P	ROVIDER OR SUPPLIER	L .		Main St.		
STONE \	/ALLEY HOPSICE			where, US 77000		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	MPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	bereier)	1	DATE
		plan failed to be				
	individualized and distinguish the specific concerns associated with the identified cardiovascular problem.					
	C. The plan H190 Respirato be addressed. I individualized at specific concerr the identified results and the identified results and the identified results and the identified skin-was a specific concerr identified skin-was a concerr identified skin-was a concerr identified community of the identified community and the identified commu	identifies "Care Plan ry" as a problem to The plan failed to be a sassociated with spiratory problem. identifies "Care Plan and" as a problem to The plan failed to be and distinguish the as associated with the plan failed to be and distinguish the as associated with the pound problem. identifies "Care Plan cation" as a problem as a problem to The plan failed to be and distinguish the associated with the plan failed to be and distinguish the associated with the aunication problem. In the plan failed to be a plan failed to be				
		nd distinguish the				
	•	ns associated with the				
		ation management				
	problem.					

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	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000000	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE COMPL 06/23	ETED
	ROVIDER OR SUPPLIER		1234 N	ADDRESS, CITY, STATE, ZIP CODE Main St. nere, US 77000		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	H16 Pain as a paddressed. The individualized ar specific concernidentified pain p B. The plan Plan H190 Respondem to be a failed to be individualized with respiratory probect. The plan Plan H240 Naus to be addressed be individualized the specific concernidentified agitation. The plan H310 Agitation to be addressed individualized ar specific concernidentified agitation.	plan failed to be and distinguish the as associated with the roblem. identifies "Care biratory" as a ddressed. The plan vidualized and specific concerns the identified				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 000000		(X2) MULTIPL A. BUILDING B. WING		ISTRUCTION 00	(X3) DATE (COMPLI 06/23 /	ETED	
		000000		ET AL	DDRESS, CITY, STATE, ZIP CODE	00/23/	2010
NAME OF P	ROVIDER OR SUPPLIER				in St.		
STONE	VALLEY HOPSICE				re, US 77000		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	Medication Man problem to be a failed to be individualized and specific concernidentified pain polymer identified skin-work. The plan H200 Skin-Wou be addressed. The individualized and specific concernidentified pain polymer identified skin-work. The plan H200 Skin-work C. The plan Plan H220 Nutrito be addressed be individualized the specific conwith the identified problem. D. The plan Plan H240 Naus to be addressed be individualized the specific concernidentified skin-work.	ddressed. The plan vidualized and specific concerns the identified ragement problem. identifies "Care Plan problem to be plan failed to be and distinguish the as associated with the roblem. identifies "Care Plan and" as a problem to The plan failed to be and distinguish the as associated with the round problem. identifies "Care Plan and" as a problem to The plan failed to be and distinguish the as associated with the round problem. identifies "Care ition" as a problem d. The plan failed to d and distinguish cerns associated	TAG				DATE

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000000	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/23/2016
	ROVIDER OR SUPPLIER		1234 M	ADDRESS, CITY, STATE, ZIP CODE Main St. ere, US 77000	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Plan H280 Urina be addressed. To individualized an specific concerns the identified uring a specific concerns identified neurol specific concerns identified pain public addressed. To individualized an specific concerns identified pain public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with cardiovascular public neurol problem to be a failed to be individually associated with the failed neurol problem to be a failed to be individually associated with the failed neurol problem to be a failed neurol problem to be a failed neurol problem to be	identifies "Care Plan cal" as a problem to The plan failed to be and distinguish the as associated with the logical problem. In distinguish the as associated with the logical problem. In distinguish the IDG on an of care identified Pain" as a problem to The plan failed to be and distinguish the las associated with the roblem. In of care identified "Care liovascular" as a logical problem. In of care identified "Care liovascular" as a logical problem. In of care identified "Care liovascular" as a logical problem. In of care identified "Care liovascular" as a logical problem. In of care identified "Care liovascular" as a logical problem. In of care identified "Care liovascular" as a logical problem. In of care identified "Care liovascular" as a logical problem. In of care identified "Care liovascular" as a logical problem. In of care identified "Care liovascular" as a logical problem. In of care identified "Care liovascular" as a logical problem.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		000000	B. WING		06/23/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
			1234 N	lain St.	
STONE VALLEY HOPSICE			Anywh	ere, US 77000	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	individualized ar	nd distinguish the			
	specific concerns associated with the				
	identified skin-wound problem.				
	C. The plan identified "Care				
		tion" as a problem			
		I. The plan failed to			
		d and distinguish			
	·	cerns associated			
	with the identifie	d nutrition problem.			
	D. The plan identified "Care Plan				
	•	Anxiety" as a problem			
	•	I. The plan failed to be			
		nd distinguish the			
		is associated with the			
	•	on/anxiety problem.			
	·	,			
	E. The plan	identified "Care Plan			
	H320 Altered M	ental Status" as a			
	•	ddressed. The plan			
	failed to be indiv	vidualized and			
	distinguish the s	specific concerns			
	associated with	the identified altered			
	mental status p	roblem.			
	6 Clinical recor	d number 6 included a			
		ablished by the IDG on			
	•	n identified "Care Plan			
	•				
		n Management" as a			
	•	ddressed. The plan of individualized and			
	•	specific concerns			
	associated with				
	medication man	agement problem.			
			1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 000000	A. BUILDING B. WING	00	COMPLETED 06/23/2016
		00000		ADDRESS, CITY, STATE, ZIP CODE	00/20/2010
NAME OF P	ROVIDER OR SUPPLIER		1234 M		
STONE \	/ALLEY HOPSICE			ere, US 77000	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG			TAG	,	DATE
	•	identified "Care Plan			
	_	cal" as a problem to			
		The plan failed to be nd distinguish the			
		ns associated with the			
	identified neurol				
	•	of care identified "Care			
		ed Mental Status" as a			
	•	ddressed. The plan			
	failed to be individualized and distinguish the specific concerns				
	_	the identified altered			
	mental status pi				
	montai status pi	iobiciii.			
	•	of care identified "Care			
	Plan H330 Mobi				
	•	ddressed. The plan of			
		e individualized and			
	_	specific concerns the identified mobility-			
	safety problem.	the identified mobility-			
	Salety problem.				
		d number 7 included a			
		ablished by the IDG on			
	•	an identified "Care Plan			
		n Management" as a ddressed. The plan of			
	•	e individualized and			
		specific concerns			
	associated with	•			
		agement problem.			
	•	of care identified			
		Pain" as a problem to			
	be				
			•	•	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED
		000000			06/23/2016
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
STONE !	/ALLEY HOPSICE			Main St.	
				nere, US 77000	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	COMPLETION DATE
TAG		,	IAG	,	DATE
		plan failed to be			
	individualized and distinguish the				
	•	is associated with the			
	identified pain p	roblem.			
	D Thom	lan identified "Care			
	•	lan identified "Care tion" as a problem			
		l. The plan failed to			
		d and distinguish			
		cerns associated			
	with the identified nutrition problem.				
	C. The plan	identified "Care			
	Plan H250 Bow	el" as a problem to			
	be addressed. T	he plan failed to be			
	individualized ar	nd distinguish the			
	specific concern	s associated with			
	the identified bo	wel problem.			
		identified "Care Plan			
	-	Anxiety" as a problem			
		I. The plan failed to be			
		nd distinguish the			
	•	s associated with the			
	identilled agitation	on/anxiety problem.			
	E. The plan	of care identified "Care			
	Plan H330 Mobi				
		ddressed. The plan of			
	•	individualized and			
		specific concerns			
	-	the identified mobility-			
	safety problem.	,			
	, ,				
	F. The plan	of care identified "Care			
			1		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000000	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/23/2016
		000000			00/23/2010
NAME OF F	PROVIDER OR SUPPLIER		1234 M	ADDRESS, CITY, STATE, ZIP CODE	
STONE	VALLEY HOPSICE			ere, US 77000	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	Fie, 03 11000	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	care failed to be distinguish the sassociated with problem. 8. Clinical recomplan of care estables. The plan "Care Plan H120 Management" and addressed. The be individualized specific concern	ddressed. The plan of individualized and pecific concerns the identified sleep d number 8 included a ablished by the IDG on of care identified			
	"Care Plan H16 be addressed. T individualized ar specific concern identified pain pr B. The plan of Plan H200 Skinto be addressed individualized ar concerns associ skin-wound prob C. The pla Plan H220 Nutrit to be addressed	of care identified "Care Wound" as a problem . The plan failed to be nd distinguish specific ated with the identified			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		000000	B. WING		06/23/2016
	ROVIDER OR SUPPLIER		1234 M	ADDRESS, CITY, STATE, ZIP CODE lain St. ere, US 77000	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	identified nutrition	·			
	Plan H240 Naus to be addressed be individualized the specific cond	an identified "Care sea" as a problem I. The plan failed to I and distinguish cerns associated d nausea problem.			
	H310 Agitation/A to be addressed individualized ar specific concern	dentified "Care Plan Anxiety" as a problem I. The plan failed to be nd distinguish the is associated with the on/anxiety problem.			
	Plan H330 Mobi problem to be a care failed to be distinguish the s	of care identified "Care lity-Safety" as a ddressed. The plan of individualized and specific concerns the identified mobility-			
	plan of care esta 10-23-15. The p "Care Plan H120 Management" a addressed. The be individualized specific concern	d number 9 included a ablished by the IDG on lan of care identified D Medication s a problem to be plan of care failed to d and distinguish the s associated with the ation management			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

For Training Purposes Only

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
		000000	B. WING			06/23/	2016
NAME OF B	DOLUDED OD GUDDU IED		ST	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		12	234 Ma	ain St.		
STONE	VALLEY HOPSICE		Ar	nywhe	ere, US 77000		
(X4) ID		TATEMENT OF DEFICIENCIES	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1 A	U	DEFICIENCY)		DATE
	A. The plan	of care identified					
	"Care Plan H16	Pain" as a problem to					
	be addressed. 1	Γhe plan failed to be					
		nd distinguish the					
		ns associated with the					
	identified pain p						
	-	of care identified "Care					
		-Wound" as a problem					
		d. The plan failed to be					
	individualized aı	nd distinguish specific					
	concerns assoc	iated with the identified					
	skin-wound prob	blem.					
	C. The pla	an identified "Core					
	·	an identified "Care					
		ition" as a problem					
		d. The plan failed to					
		d and distinguish					
	•	cerns associated					
	with the identifie	ed nutrition					
	problem.						
	D The nlan	identified "Care					
	·	ary" as a problem to					
		The plan failed to be					
		-					
		nd distinguish the					
	-	ns associated with					
	the identified uri	пату рговіент.					
	E. The plan	identified "Care Plan					
	•	Anxiety" as a problem					
	_	d. The plan failed to be					
		nd distinguish the					
		ns associated with the					
	•	on/anxiety problem.					
	identilied agitati	on, anxiety problem.					

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	PROVIDER OR SUPPLIER VALLEY HOPSICE	1234 M	ADDRESS, CITY, STATE, ZIP CODE Main St. ere, US 77000	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE COMPLETION
	10. Clinical record number 10 included a plan of care established by the IDG on 1-29-16. The plan of care identified "Care Plan H120 Medication Management" as a problem to be addressed. The plan of care failed to be individualized and distinguish the specific concerns associated with the identified medication management problem. A. The plan of care identified "Care Plan H16 Pain" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified pain problem. B. The plan identified "Care Plan H220 Nutrition" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified nutrition problem. C. The plan identified "Care Plan H250 Bowel" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified "Care Plan H250 Bowel" as a problem to be addressed. The plan failed to be individualized and distinguish the specific concerns associated with the identified bowel problem.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPL	ETED
		000000	B. WI	NG		06/23/	/2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R.		1234 M			
STONE	VALLEY HOPSICE			_	ere, US 77000		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PROVIDERS PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROFI DEFICIENCY)		(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			IL	DATE	
	D. The plan H300 Neurologic be addressed. To individualized and specific concernidentified neurological E. The plan H330 Mobility of the plan H330 Mobility of the plan H330 Mobility of the second problem to be a care failed to be distinguish the second associated with safety problem. 11. Clinical reconstruction of the IDG on 3-11 identified "Care Medication Man problem to be a care failed to be distinguish the second associated with medication man. A. The plan "Care Plan H16 be addressed. To individualized and specific concernidentified pain position." B. The plan H16 be The plan H16 plan Plan H16 plan Plan Plan Plan Plan Plan Plan Plan P	identified "Care Plan cal" as a problem to The plan failed to be a sassociated with the logical problem. of care identified "Care ility-Safety" as a ddressed. The plan of a individualized and specific concerns the identified mobility- ord number 11 of care established by 1-16. The plan of care Plan H120 agement" as a ddressed. The plan of a individualized and specific concerns the identified hagement problem. of care identified and specific concerns the identified agement problem. of care identified hagement problem to The plan failed to be and distinguish the as associated with the					
	problem						

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	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000000	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/23/2016
	ROVIDER OR SUPPLIER		1234 N	ADDRESS, CITY, STATE, ZIP CODE lain St. ere, US 77000	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	individualized an specific concern	d. The plan failed to be nd distinguish the ns associated with the vascular problem.			
	H200 Skin-Wou be addressed. I individualized an	identified "Care Plan nd" as a problem to The plan failed to be nd distinguish the ns associated with the yound problem.			
	H220 Nutrition" addressed. The individualized ar	identified "Care Plan as a problem to be plan failed to be nd distinguish the as associated with atrition problem.			
	provide any add and/or informati	strator was unable to litional documentation on when asked on 6-22- and 6-23-16 at 3:15 PM.			
	Care, HC.31" st Agencies provid patient and their	n individualized plan of by the IDG in th the attending v, and, when			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 000000		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 23/2016			
		ROVIDER OR SUPPLIER		1234 M	address, city, state, zip c lain St. ere, US 77000	ODE		
PRI	i) ID EFIX AG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
		Regarding care with plan of care	provided in accordance e:					
		plan of care estainterdisciplinary The plan identification in the plan identification in the per week for 9 wevidenced only visits had been 29-16 (week 2). A. The reconsures visit note evidenced the scollected a urine urinalysis. The revidence an order the urine specing. B. The reconsure a skin tear on the arm. The reconsure order for the dreed. Clinical reconsum initial compression initial compression initial compression in the physician orders services were noted.	group (IDG) on 5-20-16. ied home health aide be provided 3 times weeks. The record 2 home health aide provided the week of 5- ind included a skilled dated 6-7-16 that killed nurse (SN) had be specimen for a record failed to ler for the collection of inen for a urinalysis. Ind included a SN visit included a SN visit included a SN visit included a dressing change to ine patient's left upper included to evidence an					
					1			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMP	LETED
		000000	B. WING		06/23	3/2016
			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	t .	1234	Main St.		
STONE	VALLEY HOPSICE		Anyw	here, US 77000		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	care was not es	stablished by the IDG				
		e record evidenced				
	additional SN vi	sits had been provided				
	on 4-28-16, 4-2	9-16, 5-2-16, and 5-4-				
	16.					
	Δ The reco	rd evidenced the				
		ounselor (SCC) had				
		ssessment on 5-25-16.				
	-	uded a SCC visit note				
		The record failed to				
		an of care, established				
	-	i-6-16, had been				
	_	ide the SCC services.				
	updated to inclu	ide the SCC services.				
	B. The plan	of care, established by				
	the IDG on 5-6-	16, evidenced home				
	health aide serv	rices were to be				
	provided 2 time	s per week for the first				
	week and 3 time	es per week for the next				
	11 weeks.	·				
	4 \ Th = ==	and scidenced only 4				
	·	cord evidenced only 1				
		le visit had been				
	completed the f	irst week.				
	2.) The re	cord evidenced only 2				
	home health aid	le visits per week had				
	been provided f	rom 5-9-16 to 6-16-16.				
	3 Clinical recor	d number 3 evidenced				
	the RN on 3-7-1	ehensive assessment by				
		nitial physician orders				
	•	e and services were not				
		ttending physician (also				
	the hospice					

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CENTERS FOR MEDICARE & MEDICAID SERVICES

For Training Purposes Only

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		000000	B. WING		06/23/2016	
			STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t.	1234 M			
STONE VALLEY HOPSICE		Anywhe	ere, US 77000			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	medical directo	or) until 3-11-16 and				
	the plan of care	e was not established				
	by the IDG until	3-11-16.				
	4 00 1					
		d number 4 included a				
		iewed by the IDG on 6-				
		, "Initiate care of				
		eter change every				
		ord failed to evidence				
		d been changed the				
	week of 6-12-16	5.				
	5 Clinical recor	d number 5 evidenced				
		een provided 3 times				
		eeks of 5-22-16, 5-29-				
	· ·	6. The record failed to				
		an of care had been				
		ide the SN visits 3				
	times per week.					
	times per week.					
	A. "Physicia	n Orders/Plan of				
	Care from 05-17	7-16 to 07-15-16"				
	states "SN 05-1	7-16 2 x week x 1				
	week."					
	D 45100	ndate to the plan of				
		pdate to the plan of				
		-16 states, "SN 05-15-				
	16 1 x week x 1	week.				
	C. An IDG	update to the plan of				
	care dated 6-3-	-16 states, "SN 05-17-				
	2016 2 x week	x 1 week ended on 05-				
	21-2016."					
		undata ta tha mis:f				
		ipdate to the plan of				
		7-16 states, "SN 05-17-				
		x 1 week ended on 05-				
	21-2016."					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 000000		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPLI 06/23/	ETED	
	ROVIDER OR SUPPLIER		1234 M	ADDRESS, CITY, STATE, ZIP CODE Main St. ere, US 77000		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPI	Ε	(X5) COMPLETION DATE
	IDG updates to dated 5-20-16, 6 that state "Aid 0 12 weeks." The record evisits had been per week the we 29-16 and only week of 6-5-16. 7. Clinical record a hospice aide woon 3-23-16. The evidence an updoor the aide visit 8. Clinical recordinitial comprehed initiated by the 1 start of care date evidenced the inhospice care and signed by the aide service to had been provided. A. The recordinate of the pestablished by the aide services had been provided. B. The recordinate of the pestablished by the aide services had been provided. B. The recordinate of the pestablished by the aide services had been provided.	rd number 7 evidenced risit had been provided e plan of care failed to date to include an order				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 000000	A. BUILDI B. WING	ING	00	COMPLI	
		000000				06/23/	2010
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		'REET A' 2 34 M a	DDRESS, CITY, STATE, ZIP CODE		
STONE \	/ALLEY HOPSICE			-			
1					re, US 77000		
(X4) ID			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
TAG	•				TE	DATE	
PREFIX TAG	9. Clinical recor SN visit note da identified the SN dressing change the bottom of the note states, "Dre described: clear medipore dressi A. The recor plan of care, est 10-23-15, had be an order for a dre foot. B. The adme 6-23-16 at 9:40 include an order change to the lear C. The record Orders/Plan of control of the control of the 120-16, 12-18-16 evidenced hosp to be provided 3 1.) The recorded and 1-3-16.	rd failed to evidence the tablished by the IDG on been updated to include ressing change to left inistrator indicated, on AM, the record did not der for the dressing eft foot. rd included "Physician Care from 10-14-15 to DG updates dated 11-6, and 12-30-16, that sice aide services were 8 times per week.			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000000	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	te survey pleted 23/2016
	PROVIDER OR SUPPLIER		1234 M	ADDRESS, CITY, STATE, ZIP (lain St. ere, US 77000	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		additional documentation on when asked on 6-23-				
	IDG reviews of 26-16 and 3-11- social services were to be prov	ord number 10 included the plan of care dated 2-16 that identified medical (MSS) and SCC services ided 1 time per month for as needed visits each.				
	SCC services h	ailed to evidence any ad been provided from ime of discharge on 3-				
	IDG reviews of 29-16 and 2-12- aide services w times per week aide services ha	ord number 11 included the plan of care dated 1-16 that identified hospice ere to be provided 3. The record evidenced ad been provided only 2 the weeks of 1-31-16, 2-16.				
	of the plan of ca identified hospid been increased The record evid services had be per week the we 2 times per week	ncluded an IDG review are dated 2-26-16 that be aide services had to 5 times per week. The enced hospice aide the provided only 1 time the eek of 2-28-16 and only the erecord evidenced the on 3-22-16.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		000000	B. WING		06/23/2016
			CTDEET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	L	1234 M		
STONE VALLEY HOPSICE					
STONE VALLET HOPSICE		Anywhe	ere, US 77000		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	12 The adminis	strator was unable to			
		litional documentation			
	-	on when asked on 6-22-			
	16 at 2:55 PM a	and 6-23-16 at 3:15 PM.			
	13 The hospics	e's 09/2015 "Plan of			
	•				
		olicy states, "Hospice			
		ivered in accordance to			
	the plan of care	•"			

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