Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

November 18, 2014

Ronald Cioffi, Administrator
Southwestern Vt Hospice Network
7 Albert Cree Drive
Rutland, VT 05702-0787

Dear Mr. Cioffi,

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 22, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471507	A. BUILDING _____ B. WING _____	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VT HOSPICE NETWORK	7 ALBERT CREE DRIVE RUTLAND, VT 05702

(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
L 000	INITIAL COMMENTS An unannounced onsite Hospice Survey was conducted on 10/20/14 - 10/22/14 by the Division of Licensing and Protection. The following are Hospice regulatory findings.	L 000		
L 543	418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. This STANDARD is not met as evidenced by: Based on record review and interview the Hospice failed to provide services according to the plan of care for 1 of 13 a patients in the sample (Patient #8). Findings include: 1. Per review on 10/21/14 of the clinical record for Patient #8, the plan of care/ Physician order (485 dated 04/08 -07/06/14) notes that the narcotic count was to be done weekly. Per review of the nursing notes from April 28th until June 23.2014 the narcotics counts were not done as care planned/ordered. No counts were done on May 5, 19, 27 June 3, 8, or 9th. Additionally, the nursing note of June 23rd states "all controlled drugs were flushed down the toilet-med count complete" . Per review of the Agency's Policy and Procedure, staff are to dispose of medications either in kitty litter, coffee grounds or a 'safe green' material. Per interview on 10/22/14 at 2:14 PM the Clinical	L 543	See attached Plan of Corrections	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ronald J. Cuker — TITLE: CEO — (X6) DATE: 11/7/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471507	A. BUILDING _____ B. WING _____	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VT HOSPICE NETWORK	7 ALBERT CREE DRIVE RUTLAND, VT 05702

(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
L 543	Continued From page 1 Manager confirmed the nurse did not do weekly narcotic counts on the above dates and staff did not dispose of medications according to Policy and procedures.	L 543		
L 557	418.56(e)(4) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement. This STANDARD is not met as evidenced by: Based on interview and record review, the Hospice agency failed to provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings for 1 of 13 patients in the sample. (Patient #1) Findings include: 1. Per review of the medical record of Patient # 1 on 10/20/2014 at 11:30 am, the Hospice failed to provide documentation to indicate why the start of care was delayed for Patient # 1. The referral was made on 11/20/2013 and the admission did not occur until 11/24/2013. There are no notes or sharing of information to indicate that the staff made attempts to begin care earlier than 11/24/2013 or that the client delayed the start of care. This is confirmed by staff during interview on 11/22/2014 at 3:30 PM.	L 557	See attached Plan of Corrections	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471507	A. BUILDING _____ B. WING _____	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VT HOSPICE NETWORK	7 ALBERT CREE DRIVE RUTLAND, VT 05702

(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
L 557	Continued From page 2 Per review of the medical record of Patient # 1 on 10/20/2014 at 11:30 am, the Hospice failed to follow through on orders for LNA services. LNA orders, dated 04/01/2014 for Patient # 1, are for 5 times per week 1, 7 times per week 1. LNA services were not provided during this period of time and there is no indication to alert other team members as to why this happened. This is confirmed by staff during interview on 11/22/2014 at 3:30 PM	L 557		
L 620	418.76(d) IN-SERVICE TRAINING A hospice aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient. This STANDARD is not met as evidenced by: Based on interview and record review the Hospice agency failed to assure all aides received at least 12 hours of in-service training during each 12-month period for 4 of 6 aides. Findings include: 1. Review on 10/22/14 of the in-service training records for the evidence of 12 hours of in-service for Licensed Nursing Assistant (LNA)/Personal Care Attendant (PCA) revealed: LNA #1 completed only 1.30 hours; LNA #2 completed only 3.5 hours; LNA #3 completed only 5.30; and LNA #4 completed only 5.30 hours. This was confirmed on the afternoon of 10/22/14 by the Human Resources Director.	L 620	See attached Plan of Corrections	
L 622	418.76(d)(2) IN-SERVICE TRAINING (2) The hospice must maintain documentation that demonstrates the requirements of this standard are met.	L 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471507	A. BUILDING _____ B. WING _____	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VT HOSPICE NETWORK	7 ALBERT CREE DRIVE RUTLAND, VT 05702

(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 SHDULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 622	Continued From page 3 This STANDARD is not met as evidenced by: Based on interview and record review, the Hospice agency failed to assure documentation was maintained to demonstrate training requirements were provided and documented. Findings include: 1. Per record review on 10/22/14, there was a lack of evidence to demonstrate what required training's had been provided to LNA staff, the content of the training, the amount of time designated for each topic and the assurance all staff had attended when applicable. This was confirmed on the afternoon of 10/22/14 by the Human Resources Director.	L 622		
L 629	418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES (I) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit. This STANDARD is not met as evidenced by: Based on record review and interview the registered nurse failed to make an on-site visit to the patient's home: No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide for 2 of 5 applicable patients (Patients #2 & #5) Findings include: 1. Per review on 10/21/14, Patient #2 had	L 629	See attached Plan of Corrections	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471507	A. BUILDING _____ B. WING _____	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VT HOSPICE NETWORK	7 ALBERT CREE DRIVE RUTLAND, VT 05702

(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
L 629	Continued From page 4 received LNA services from 04/29/14 - 06/03/14. Per review of the nursing notes and supervisory notes during this time period, the nurse made a supervisory visit on 05/01/14 and approximately one month later on 06/03/14. Per interview on 10/21/14 at 2:44 PM the Clinical Manager confirmed the nurse failed to document that an on-site 2 week supervisory visit was made in the patient's home. 2. Per review on 10/22/14, Patient #5 was assigned LNA services to assist with personal care and activities of daily living. After a brief hospitalization, Patient #5 was transferred on 9/24/14 to a long term care (LTC) facility due to the patient's wife's inability to continue to provide care within their home. Hospice services were continued at the LTC facility for Patient #5 which included both nursing and LNA visits. From 9/26/14 through 10/21/14 there was no evidence in Patient #5's record of the registered nurse conducting LNA supervisory visits. The omissions were confirmed by the Hospice Clinical Manager at 3:25 PM on 10/22/14.	L 629		
L 632	418.76(h)(2) SUPERVISION OF HOSPICE AIDES (2) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care. This STANDARD is not met as evidenced by: A registered nurse failed to make annual on-site visits to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care. Findings include:	L 632	See attached Plan of Corrections	

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471507	A. BUILDING _____ B. WING _____	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VT HOSPICE NETWORK	7 ALBERT CREE DRIVE RUTLAND, VT 05702

(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
L 632	Continued From page 5 Per interview on 10/22/14 at 4:10 PM the Clinical Manger stated that "we are suppose to do annual on sites but the staff person who does the scheduling is not available this week, I don't know where that information is kept". The Clinical Manager was unable to state nor show evidence via documentation that on-site supervisory visits in the patient's home were done annually . The Clinical Manger, at that time, confirmed the Hospice agency was unable to show evidence how Hospice assures that all aides are supervised on-site annually.	L 632		
L 638	418.76(k)(1) HOMEMAKER SUPERVISION AND DUTIES (1) Homemaker services must be coordinated and supervised by a member of the interdisciplinary group. This STANDARD is not met as evidenced by: Based on interview and record review there is no evidence of supervision of the Homemakers services for 1 of 5 applicable patients in the sample. (Patients #5,) Findings include: 1. Per record review, Patient #5 was admitted to Hospice on 8/10/14. At age 90 and significantly debilitated due to cardiovascular disease with congested heart failure, Patient #5 was dependent on his elderly wife for multiple needs. A homemaker was assigned to assist with housekeeping chores relieving Patient #5's wife of some of the daily responsibilities she had attempted to maintain. There was no evidence of supervision of the homemaker staff providing services for Patient #5.	L 638	See attached Plan of Corrections	
L 679	418.104(b) AUTHENTICATION	L 679	See attached Plan of Corrections	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471507	A. BUILDING _____ B. WING _____	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VT HOSPICE NETWORK	7 ALBERT CREE DRIVE RUTLAND, VT 05702

(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
L 679	Continued From page 6 All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice. This STANDARD is not met as evidenced by: The Hospice failed to have dated and authenticated LNA/Homemaker care plans, according to currently accepted standards of practice for 5 of 9 applicable patients. (Patients #2, #5, #6, #7 and #9) This has the potential to affect all patients. Findings include: Based on record review for Patients #2, #5, #6, #7 and #9, who had or are receiving LNA and/or Homemaker (HM) services, the care plans in the electronic chart did not identify the author of the LNA/HM care plans nor were those care plans dated. Per interview on 10/22/14 at 4:10 PM the Clinical Manager stated " we can assume the nurse initiated the LNA/HM care plan but [the operating system] does not have a way to sign or date the care plan. The nurse surveyor asked for a printed hard copy to verify if a signature, date or another method to identify the author could be noted. No information was found on the hard copies nor were there notations elsewhere in patient charts of who composed the care plans and when. The Clinical Manger at that time confirmed the LNA/HM care plans did not identify the author or the date.	L 679		
L 682	418.104(e)(1) DISCHARGE OR TRANSFER OF CARE (1) If the care of a patient is transferred to another Medicare/Medicaid-certified facility, the hospice	L 682	See attached Plan of Corrections	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471507	A. BUILDING _____ B. WING _____	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VT HOSPICE NETWORK	7 ALBERT CREE DRIVE RUTLAND, VT 05702

(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
L 682	Continued From page 7 must forward, to the receiving facility, a copy of- (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested. This STANDARD is not met as evidenced by: Based on record review and interview the Hospice agency failed to forward, to the receiving facility, a copy of the discharge summary; for one applicable (Patient #6). Findings include: 1. Patient #6 was identified as being discharged from services on 05/23/14. Per the case conference note, states the family called the Hospice to report the patients was being transferred to a Veterans' Hospital, for various reasons. There is no summary found in the patient's record that contained information regarding the patient's treatments, symptoms and pain management or current plan of care. Per interview on 10/22/14 at 4:10 PM the Clinical Manager confirmed that no discharge summary was sent to the facility to which the patient was transferred.	L 682	See attached Plan of Corrections	

Rutland Area Visiting Nurse Association & Hospice

L543 4.1856(b) Plan of Care

Plan of Correction:

A narcotic count sheet with be developed and left in the home for patients who have an MD order to have their narcotics counted. The nurses will be required to document in their clinical notes, that the narcotic count occurred and the outcome of the count. A narcotic sheet will be developed and nursing staff will be educated on the process at our next staff meeting on 11/12/2014. The clinical hospice manager will review at the weekly IDT meetings, individuals who have an n MD order for routine counts. The clinical hospice manager will review the clinical notes of nurses to assure appropriate documentation of the narcotic count. We will review the Tracking and Disposing of Controlled Drugs in the Patients home with the Nursing Staff during the 11/12/14 meeting. The Clinical manager will review nursing notes to ensure that appropriate disposal of medication has been documented. The Policy on Disposal has been attached to this plan of correction. The Policy is to perform a narcotic count every two weeks unless otherwise ordered.

L543 POC accepted 11/14/14 SEmmons RN/PMC

L557 418.56 Coordination of Services

Plan of Correction:

On receipt of referral the patient and family will be contacted within 24hr to set up an admission. If the patient or family chooses to defer the admission outside of the facility policy of admission within 24-48hr of referrals, then it will be documented by the Director of Hospice/Hospice manager/Hospice RN within the clinical note. The MD and the Hospice team will also be notified of the patient/family preference of admission date. All staff will be re-educated on the admission policy on 11/12/2014 during the staff meeting. A new policy will be written to this effect and charged with the staff at the meeting.

Medical records were reviewed and showed that patient #1 has cancelled on April 1 & 2 and had LNA'S services on the 3rd and 4th of April. A note in the EMR from the Scheduler indicated that the patient wanted to cancel some dates of Service. I have attached the supportive documents that I have referenced. Every two weeks during IDT meeting, a review of LNA Services will be discussed and verified during the meeting. The Hospice Clinical Manger will bring any scheduling discrepancy to the Scheduling manager. A staff in-service on this practice will occur on 11/12/2014.

L557 POC accepted 11/14/14 SEmmons RN/PMC

L620 & L622 418.76 In Service Training

Plan of Correction:

The Director of Hospice will review/develop the following policy as necessary by December 1, 2014, training and education of hospice aide. The CFC manager will provide education to all PCA/LNA on the

policy. We will provide copies of educational handout, meeting minutes, sign in sheets, staff not in attendance will be given written information. The HR department will provide quarterly progress report to the CFC manager outline the status of the PCA/ LNA education hours on a quarterly basis.

L620 + L622 POC accepted 11/14/14 SemmonsRN/FMC

L629 418.76 Supervision of Hospice Aides

L638 418.76 Homemaker Supervision and Duties

Plan of Correction:

Hospice Clinical Manager will review patient records every 10 days to verify if a supervisory visit was performed and documented. The hospice manger will notify the nurse if a visit or documentation has not occurred. An in-service was held on 11/5/14 to re-educate the staff on supervisory visits requirements. The registered nurse will make an on-site visit within the first 14 days of Admission to Hospice Services. The Clinical manger will review the visit during the IDT meeting on the patient receiving Hospice Aid Services. Staff will be educated on this new process and be able to review the new policy at the 11/12/14 staff meeting.

L629 + L638 POC accepted 11/14/14 SemmonsRN/FMC

L679 418.10 Authentication

Plan of Correction:

The Nurse who generates the LNA/Homemaker care plan will print them out, sign, date and place in the patient chart. The Hospice manger will review the charts on a monthly basis to ensure that the LNA/Homemaker care plans are in the chart, signed and dated. The staff will be in services on 11/12/14 on this process.

L679 POC accepted 11/14/14 SemmonsRN/FMC

L682 418.104 Discharge of Transfer of Care

Plan of Correction:

The policy of the facility is to send out a patient discharge summary to the receiving facility. I have attached a copy of the policy to this plan of correction. There will be an in-service on 11/12/2014 to reeducate the staff on the policy. The Clinical manger will review all the discharges to ensure that a discharge summary is sent to all receiving agencies.

L682 POC accepted 11/14/14 SemmonsRN/FMC

MEDICATION – Tracking and Disposing of Controlled Drugs in the Patient's Home	Policy Number: CES.M45 Page 1 of 2
NHPCO Standard(s): CES 4.4	
Regulatory Citation / Other: 42 CFR 418.96(b); Proposed CoP 418.106(b)	

POLICY STATEMENT:

The hospice and the patient/caregiver share in the responsibility for tracking, collecting and disposing of controlled substances that are maintained in the patient's home.

PROCEDURES:

1. At the time when controlled substances are first ordered, the IDT:
   a. provides a copy of the hospice's written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family;
   b. discusses the hospice's policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; and
   c. documents in the patient's clinical record that the written policies and procedures for managing controlled drugs were provided and discussed.
   d. ensures admission agreement signed by patient includes that patient has received policy.

TRACKING:

1. The RN Case Manager or designee documents on the *Medication Profile* the date, medication name and strength, and administration frequency.
2. Quantity dispensed of all controlled drugs, ordered for and received by the patient, is to be documented in the clinical record.
3. Controlled drugs will be counted by the nurse on the first visit made after the meds are delivered. Documentation in the clinical record will include the date the medications were delivered and the amount of medications present in the home.
4. Every two weeks, or more often if circumstances determine a need, during the visit in the patient's home, the RN conducts a count of the amount or quantity of medication remaining and notes any discrepancies between amount of medication administered to the patient and the amount of medication remaining.
5. The RN identifies and documents any misuse of controlled substances and notifies the patient's attending physician, the pharmacist and the Clinical Director for further intervention.
6. An *Incident Report* is completed for suspected or actual diversion of controlled substances and the interdisciplinary team, in consultation with the Hospice Medical Director, the patient's attending physician and the pharmacist determine the appropriate course of action, including reporting the diversion to appropriate authorities.

DISPOSAL:

1. Controlled drugs no longer needed by the patient are disposed of in compliance with State and Federal regulations and disposal instructions and activities are documented.
2. A hospice nurse, accompanied by a witness, is responsible for disposing of the patient's drugs by using Green Z Method. If Green Z is not available, may use coffee grounds, kitty litter, etc. The RN and witness will sign the attached form validating what meds were disposed.
3. At the time of destruction, the following information is documented in the patient's clinical Record:
   a. name and dose of the medication;
   b. amount or quantity of the medication remaining and destroyed;
   c. date of destruction and signature of the nurse and witness.

4. In the event the patient/caregiver refuses to allow medication to be destroyed, the refusal is documented in the patient's clinical record with the name and strength of the medication and the amount remaining. Included with the documentation is the patient/caregiver's signature attesting to the refusal, and the date the patient's attending physician was notified of the refusal.

5. If medications cannot be destroyed in the home and must be destroyed in the office due to extenuating circumstances such as patient hospitalized or at family request, the Manager/Associate Director must approve first. Medications brought back to RAVNAH will be disposed of using Green Z, documented and witnessed, using the attached form.

TRANSFER OF A HOSPICE PATIENT	Policy Number: CES.T10
NHPCO Standard(s): CES 9; CES 9.1; CES 9.2; CES 9.3; CES 9.4; CES 21.5	
Regulatory Citation / Other: Proposed CoP 418.104(e)	

POLICY STATEMENT: Continuity of care is maintained when a hospice patient is transferred to another treatment setting or provider.

PROCEDURES:

1. 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.

2. A written transfer summary is prepared for the receiving provider that includes, at a minimum:
    a. the reason for the transfer;
    b. a current medication profile;
    c. documentation of the existence of advance directives and DNR status; and
    d. a summary of the patient's current status and the problems, interventions, and goals identified in the patient's plan of care.

3. The patient's attending physician provides orders as appropriate for the transfer to another provider.

4. Members of the interdisciplinary team and the hospice billing department are notified that the patient has transferred to another provider.

5. The RN Case Manager or the Social Worker provides complete documentation of the patient's transfer in the patient's clinical record.