

HOSPICE SURVEY STATISTICS  
October - December 2015

	<b>Department of Health Services, State of Wisconsin</b>	
<b>Federal Tag Cited</b>	<b>Regulation Language</b>	<b>Number of Cites</b>
418.54 Initial & Comprehensive Assessment (condition)	Condition of Participation	2
418.56 IDG, Care Planning & Coordination of Services (condition)	Condition of Participation	2
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.	2
418.112(b) Professional Management	The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §418.100 and §418.108.	2
418.52 Patients' Rights (condition)	Condition of Participation	1
418.52(c)(7) Rights of the Patient	[The patient has a right to the following:] (7) Receive information about the services covered under the hospice benefit;	1
418.52(c)(8) Rights of the Patient	[The patient has a right to the following:] (8) Receive information about the scope of services that the hospice will provide and specific limitations on those services.	1
418.54(c) Content of Comprehensive Assessment	The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.	1
418.54(c)(2) Content of the Comprehensive Assessment	[The comprehensive assessment must take into consideration the following factors:] (2) Complications and risk factors that affect care planning.	1
418.54(c)(7) Content of the 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.	1

**HOSPICE SURVEY STATISTICS**  
**October - December 2015**

	<p align="center"><b>Department of Health Services, State of Wisconsin</b></p>	
Federal Tag Cited	Regulation Language	Number of Cites
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.	1
418.56 IDG, Care Planning & Coordination of Services	The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.	1
418.56(c) Content of Plan of Care	The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:	1
418.56(c)(2) 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:] (2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.	1
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.	1
418.56(d) Review of the Plan of Care (frequency)	The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.	1
418.56(d) Review of the Plan of Care (content)	A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.	1
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.	1

**HOSPICE SURVEY STATISTICS**  
**October - December 2015**

	<p align="center"><b>Department of Health Services, State of Wisconsin</b></p>	
<p align="center"><b>Federal Tag Cited</b></p>	<p align="center"><b>Regulation Language</b></p>	<p align="center"><b>Number of Cites</b></p>
<p>418.54(e)(2) Patient Outcome Measures</p>	<p>[The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (2) Ensure that the care and services are provided in accordance with the plan of care.</p>	<p align="center">1</p>
<p>418.58 Quality Assessment &amp; Performance (Condition)</p>	<p>Condition of Participation</p>	<p align="center">1</p>
<p>418.58 Quality Assessment &amp; Performance (content)</p>	<p>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 align="center">1</p>
<p>418.58(b)(3) Program Data (frequency)</p>	<p>(3) The frequency and detail of the data collection must be approved by the hospice's governing body.</p>	<p align="center">1</p>
<p>418.58(e)(1) Executive Responsibilities</p>	<p>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 align="center">1</p>
<p>418.58(e)(2) Executive Responsibilities</p>	<p>[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 align="center">1</p>
<p>418.72 Physical Therapy, Occupational Therapy and Speech Pathology (condition)</p>	<p>Condition of Participation</p>	<p align="center">1</p>
<p>418.72 Physical Therapy, Occupational Therapy and Speech Pathology (standards)</p>	<p>Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.</p>	<p align="center">1</p>
<p>418.100 Organizational Environment (condition)</p>	<p>Condition of Participation</p>	<p align="center">1</p>

**HOSPICE SURVEY STATISTICS**  
**October - December 2015**

	<b>Department of Health Services, State of Wisconsin</b>	
Federal Tag Cited	Regulation Language	Number of Cites
418.100(b) Governing Body and Administrator	A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.	1
418.100(c)(1) Services	(1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice: (i) Nursing services. (ii) Medical social services. (iii) Physician services. (iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling. (v) Hospice aide, volunteer, and homemaker services. (vi) Physical therapy, occupational therapy, and speech-language pathology services. (vii) Short-term inpatient care. (viii) Medical supplies (including drugs and biologicals) and medical appliances.	1
418.100(e) Professional Management Responsibilities	A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care. Arranged services must be supported by written agreements that require that all services be-- (1) Authorized by the hospice; (2) Furnished in a safe and effective manner by qualified personnel; and (3) Delivered in accordance with the patient's plan of care.	1
418.102 Medical Director (condition)	Condition of Participation	1
418.102(d) Medical Director Responsibility	The medical director or physician designee has responsibility for the medical component of the hospice's patient care program.	1
418.104(c) Protection of Information	The medical director or physician designee has responsibility for the medical component of the hospice's patient care program.	1
418.104(f) Retrieval of Clinical Records	The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority.	1
418.112 Residents of SNF/NF OR ICF/MR (condition)	Condition of Participation	1
418.112(d) Hospice Plan of Care	In accordance with §418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care.	1
418.112(e)(3) Coordination of Services	The hospice must:] (3) Provide the SNF/NF or ICF/MR with the following information: (i) The most recent hospice plan of care specific to each patient; (ii) Hospice election form and any advance directives specific to each patient; (iii) Physician certification and recertification of the terminal illness specific to each patient; (iv) Names and contact information for hospice personnel involved in hospice care of each patient; (v) Instructions on how to access the hospice's 24-hour on-call system; (vi) Hospice medication information specific to each patient; and (vii) Hospice physician and attending physician (if any) orders specific to each patient.	1
<b>Total Federal Tags</b>	<b>41</b>	

**HOSPICE SURVEY STATISTICS**  
**October - December 2015**

	<p align="center"><b>Department of Health Services, State of Wisconsin</b></p>	
<p><b>State Tags Cited</b></p>	<p><b>Code Language</b></p>	<p><b>Number of Cites</b></p>
<p>131.21(1) Plan of Care</p>	<p>GENERAL REQUIREMENTS. A written plan of care shall be established and maintained for each patient admitted to the hospice program and the patient's family. The hospice plan of care is a document that describes both the palliative and supportive care to be provided by the hospice to the patient and the patient's family, as well as the manner by which the hospice will provide that care. The care provided to the patient and the patient's family shall be in accordance with the plan of care.</p>	<p align="center">2</p>
<p>131.21(3)(b) Plan of Care</p>	<p>PLAN OF CARE. Content of the plan of care. The hospice shall develop an individualized written plan of care for each patient. The plan of care shall reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care shall include all services necessary for the palliation and management of the terminal illness and related conditions.</p>	<p align="center">2</p>
<p>131.17(4)(b)1 Admission</p>	<p>PATIENT ACKNOWLEDGEMENT AND HOSPICE ACCEPTANCE. The person seeking admission to the hospice shall be recognized as being admitted after completion of a service agreement in which the person or the person's representative, if any, acknowledges, in writing, that he or she has been informed about admission policies and services.</p>	<p align="center">1</p>
<p>131.19(2)(L) Patient Rights</p>	<p>RIGHTS OF PATIENTS. In addition to rights to the information under sub. (1), each patient shall have the following right: To be informed prior to admission of the types of services available from the hospice, including contracted services and specialized services for unique patient groups such as children.</p>	<p align="center">1</p>
<p>131.20(3) Assessment</p>	<p>CONTENT OF THE COMPREHENSIVE ASSESSMENT. The comprehensive assessment shall identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that shall be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.</p>	<p align="center">1</p>
<p>131.20(3)(b) Assessment</p>	<p>CONTENT OF THE COMPREHENSIVE ASSESSMENT. The comprehensive assessment shall identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that shall be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment shall take into consideration the following factor: Complications and risk factors that affect care planning.</p>	<p align="center">1</p>
<p>131.20(3)(g) Assessment</p>	<p>CONTENT OF THE COMPREHENSIVE ASSESSMENT. The comprehensive assessment shall identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that shall be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment shall take into consideration the following factor: 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 shall be incorporated into the plan of care and considered in the bereavement plan of care.</p>	<p align="center">1</p>

**HOSPICE SURVEY STATISTICS**  
**October - December 2015**

	<p align="center"><b>Department of Health Services, State of Wisconsin</b></p>	
<p><b>State Tags Cited</b></p>	<p><b>Code Language</b></p>	<p><b>Number of Cites</b></p>
<p>131.20(4) Assessment</p>	<p>UPDATE OF THE COMPREHENSIVE ASSESSMENT. The update of the comprehensive assessment shall be accomplished by the hospice interdisciplinary group in collaboration with the individual's attending physician, if any, and shall consider changes that have taken place since the initial assessment. The comprehensive assessment shall 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 shall be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. The hospice interdisciplinary group shall primarily meet in person to conduct the update of the comprehensive assessment.</p>	<p align="center">1</p>
<p>131.21(2)(c) Plan of care</p>	<p>INITIAL PLAN OF CARE. The initial plan of care shall be developed jointly by the employee who performed the initial assessment and at least one other member of the core team.</p>	<p align="center">1</p>
<p>131.21(3)(b)2 Plan of Care</p>	<p>PLAN OF CARE. Content of the plan of care. The hospice shall develop an individualized written plan of care for each patient. The plan of care shall reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care shall include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.</p>	<p align="center">1</p>
<p>131.21(3)(b)3 Plan of Care</p>	<p>PLAN OF CARE. Content of the plan of care. The hospice shall develop an individualized written plan of care for each patient. The plan of care shall reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care shall include 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.</p>	<p align="center">1</p>
<p>131.21(3)(c) Plan of care</p>	<p>PLAN OF CARE. Review of the plan of care. The hospice interdisciplinary group in collaboration with the individual's attending physician, if any, shall review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care shall include information from the patient's updated comprehensive assessment and shall note the patient's progress toward outcomes and goals specified in the plan of care. The hospice interdisciplinary group shall primarily meet in person to review and revise the individualized plan of care.</p>	<p align="center">1</p>
<p>131.21(3)(d) Plan of care</p>	<p>PLAN OF CARE. Bereavement plan of care. The hospice core team shall review and update the bereavement plan of care.</p>	<p align="center">1</p>
<p>131.22(1)(b) Quality assessment &amp; performance improvement</p>	<p>PROGRAM STANDARDS. The hospice's governing body shall 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.</p>	<p align="center">1</p>
<p>131.22(3)(c) Quality assessment &amp; performance improvement</p>	<p>PROGRAM DATA. The frequency and detail of the data collection shall be approved by the hospice's governing body.</p>	<p align="center">1</p>
<p>131.22(6)(a) Quality assessment &amp; performance improvement</p>	<p>EXECUTIVE RESPONSIBILITIES. The hospice's governing body is responsible for ensuring the following: That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.</p>	<p align="center">1</p>

**HOSPICE SURVEY STATISTICS**  
**October - December 2015**

	<p align="center"><b>Department of Health Services, State of Wisconsin</b></p>	
<p><b>State Tags Cited</b></p>	<p><b>Code Language</b></p>	<p><b>Number of Cites</b></p>
<p>131.22(6)(a) Quality assessment &amp; performance improvement</p>	<p>EXECUTIVE RESPONSIBILITIES. The hospice's governing body is responsible for ensuring the following: 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 align="center">1</p>
<p>131.26(1)(a) Non-core services</p>	<p>GENERAL REQUIREMENTS. A hospice is responsible for providing care and services to a patient and, as necessary, the patient's family, based on the plan of care developed by the core team. Volunteers shall participate in the delivery of program services. The hospice may provide other services as follows: Therapy services. Therapy services are provided in accordance with the plan of care for the patient and by individuals who meet qualification requirements for therapy service delivery such as evidence of current licensure or registration and academic training. Therapy services shall consist of all of the following:</p>	<p align="center">1</p>
<p>131.28(1) Governing body</p>	<p>Each hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring the overall conduct and operation of the program, including the quality of the care and services.</p>	<p align="center">1</p>
<p>131.30(1) Professional Management Responsibility</p>	<p>RESPONSIBILITY. The hospice is responsible for providing services to the patient or family, or both, based on assessed need and as established by the plan of care.</p>	<p align="center">1</p>
<p>131.30(2)(a) Professional management responsibility</p>	<p>CONTRACT SERVICES. The hospice may contract with other providers for the provision of services to a patient or the patient's family, or both, in which case the hospice shall retain responsibility for the quality, availability, safety, effectiveness, documentation and overall coordination of the care provided to the patient or the patient's family, or both, as directed by the hospice plan of care. The hospice shall: Ensure that there is continuity of care for the patient or the patient's family, or both, in the relevant care setting.</p>	<p align="center">1</p>
<p>131.32(2)(a) Medical Director</p>	<p>The medical director shall do all of the following: Direct the medical components of the program.</p>	<p align="center">1</p>
<p>131.33(2) Clinical record</p>	<p>DOCUMENTATION AND ACCESSIBILITY. The clinical record shall be completely accurate and up-to-date, readily accessible to all individuals providing services to the patient or the patient's family, or both, and shall be systematically organized to facilitate prompt retrieval of information.</p>	<p align="center">1</p>
<p>133.33(4)(d) clinical record</p>	<p>AUTHENTICATION. Protection of information. Written record policies shall ensure that all record information is safeguarded against loss, destruction and unauthorized usage.</p>	<p align="center">1</p>
<p><b>Total State</b></p>		<p align="center"><b>26</b></p>
<p><b>Total Tags Cited:</b></p>		<p align="center"><b>67</b></p>

HOSPICE SURVEY STATISTICS  
 October - December 2015

	Department of Health Services, State of Wisconsin	
<b>Surveys Completed:</b>		<b>4</b>
<b>State Licensing</b>		<b>0</b>
<b>Recertification</b>		<b>1</b>
<b>Initials</b>		<b>0</b>
<b>Complaints</b>		<b>0</b>
<b>Other</b>		<b>0</b>
<b>Revisits</b>		<b>3</b>
<b>Total Complaints Received:</b>		<b>2</b>
<b>Complaints Assigned for Investigation:</b>		<b>2</b>
<b>Complaint Subject Areas:</b>	Nursing Services (2)	