1. PATIENT & ADMISSION OVERVIEW

Patient Name:

Medical Record #:

Date of Birth:

Admission / Start of Care Date: 10/28/2025

Benefit Period: Initial

Primary Hospice Diagnosis (ICD-10): I25.10 – Atherosclerotic heart disease of native coronary artery without angina pectoris

Related / Secondary Conditions: Congestive heart failure, dyspnea, fatigue, debility, weakness

Level of Care: Routine Home Care

Residence / Site of Care: Facility

Payor Source: Medicare Part A

Attending Physician: Diego F. Restrepo, MD

Code Status: INCONSISTENT (see Section 6)

Detailed Findings:

The face sheet, treatment orders, and admission documentation consistently identify the patient's demographics, diagnosis, SOC date, and level of care. However, the record contains early and persistent internal inconsistencies related to code status and attending physician designation, which impact downstream compliance across assessment, IDG, and plan of care documentation.

Compliance Status: PARTIALLY COMPLIANT

CMS: 42 CFR §418.24(c); §418.54

HHSC: 26 TAC §558.213; §558.297

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2. HOPE / COMPREHENSIVE ASSESSMENT

Compliance Status: NON-COMPLIANT

Detailed Findings (verbatim):

The HOPE/comprehensive assessment documents:

- “DNR status: No”
- Mild pain and dyspnea with activity

However, physician treatment orders state:

- “Patient is an OOH-DNR.”

Deficiency:

The hospice failed to ensure internal consistency between the HOPE assessment and active physician orders regarding code status. This discrepancy directly affects emergency response planning, patient rights, and care delivery and represents a frequently cited HHSC deficiency.

Additionally, the HOPE does not clearly reconcile symptom findings with subsequent nursing documentation, limiting its effectiveness in establishing a baseline for decline trending.

CMS Tags: G0700, G0703

HHSC: §558.297; §558.213

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3. DISCHARGE PLANNING

Compliance Status: NON-COMPLIANT

Detailed Findings:

No documentation was identified addressing discharge planning, potential live discharge risk, transfer criteria, or contingency planning. IDG documentation repeatedly states “continue plan of care” without addressing discharge considerations, despite regulatory expectations for proactive discharge planning throughout the hospice episode.

CMS: 42 CFR §418.56

HHSC: §558.281

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4. ELECTION, CONSENTS & NON-COVERED ITEMS

Compliance Status: NON-COMPLIANT

Detailed Findings:

Executed hospice election statement, patient rights acknowledgment, and consent documentation were not readily retrievable in the reviewed record. Surveyors expect these documents to be immediately producible upon request. Absence or poor retrievability constitutes a documentation deficiency regardless of whether care was delivered.

CMS Tags: G0210, G0216

HHSC: §558.271; §558.213

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5. ATTENDING PHYSICIAN

Compliance Status: PARTIALLY COMPLIANT

Detailed Findings:

IDG documentation lists the hospice physician as the attending physician. However, the record does not clearly demonstrate patient or representative choice of attending physician, as required to be documented in the election statement. This creates survey vulnerability if the hospice physician is functioning as attending without documented patient designation.

CMS: 42 CFR §418.52(b)

HHSC: §558.259

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6. ADVANCE DIRECTIVES / TEXAS OOH-DNR

Compliance Status: NON-COMPLIANT

Detailed Findings (verbatim):

- HOPE: “DNR status: No”
- Physician orders: “Patient is an OOH-DNR”

A completed Texas Out-of-Hospital DNR form with required signatures was not present. The hospice failed to reconcile contradictory documentation or ensure legally valid advance directive documentation.

Survey Impact:

This represents a high-risk HHSC deficiency related to patient rights and emergency care.

CMS Tag: G0350

HHSC: §558.295; §558.213

Texas Health & Safety Code: Chapter 166

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7. HISTORY & PHYSICAL / TERMINAL DIAGNOSIS

Compliance Status: PARTIALLY COMPLIANT

Detailed Findings:

Physician narrative supports terminal cardiac disease and functional decline. However, documentation lacks consistent detail regarding disease progression, response to optimal medical management, and symptom burden at rest, which are critical to fully support terminal prognosis under the cardiac LCD.

CMS: 42 CFR §418.22(b)

HHSC: §558.233

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8. LCD COMPLETION

Compliance Status: PARTIALLY COMPLIANT

Detailed Findings:

While cardiac disease is identified, the record does not consistently document NYHA Class IV symptoms, poor response to optimal medical management, or symptoms at rest across disciplines. LCD elements are referenced but not reinforced throughout the record.

CMS: 42 CFR §418.22(b)

HHSC: §558.233

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9. MEDICATION MANAGEMENT

Compliance Status: PARTIALLY COMPLIANT

Detailed Findings:

Comfort medications are ordered; however, nursing documentation does not consistently demonstrate ongoing evaluation of medication effectiveness, adverse effects, or symptom response. Medication reconciliation with HOPE findings is inconsistent.

CMS Tag: G0410

HHSC: §558.305; §558.213

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10. DISCIPLINE-SPECIFIC – NURSING

Compliance Status: PARTIALLY COMPLIANT

Detailed Findings:

Nursing notes contain repetitive language such as “no acute distress” without clearly trending symptom progression, functional decline, or response to interventions. Documentation does not consistently demonstrate skilled assessment reflective of terminal decline.

CMS: 42 CFR §418.54(c)

HHSC: §558.301; §558.213

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11. DISCIPLINE-SPECIFIC – SOCIAL WORK (MSW)

Compliance Status: NON-COMPLIANT

Detailed Findings:

No standalone psychosocial assessment completed within 5 calendar days of SOC was identified. Although MSW is listed on the IDG, the absence of timely assessment constitutes a direct regulatory violation.

CMS Tag: G0205

HHSC: §558.301(c)

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12. DISCIPLINE-SPECIFIC – CHAPLAIN / SPIRITUAL CARE

Compliance Status: PARTIALLY COMPLIANT

Detailed Findings:

Documentation indicates inability to complete visits due to facility restrictions; however, the record does not clearly demonstrate timely spiritual assessment or documented refusal within required timeframes, nor how spiritual needs are otherwise addressed.

CMS: 42 CFR §418.54(c)(5)

HHSC: §558.301

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13. DISCIPLINE-SPECIFIC – HOSPICE AIDE / HOMEMAKER

Compliance Status: NON-COMPLIANT

Detailed Findings:

Aide services are referenced; however, no physician order authorizing homemaker services was identified. Provision or planning of services without corresponding orders constitutes a compliance deficiency.

CMS Tag: G0630

HHSC: §558.307

14. INTERDISCIPLINARY GROUP (IDG)

Compliance Status: NON-COMPLIANT

Expanded Detailed Findings (HHSC/CMS Survey Style):

The hospice failed to demonstrate effective interdisciplinary group (IDG) oversight as required by CMS and HHSC regulations. IDG documentation lacks evidence of active clinical decision-making, eligibility review, and coordinated care planning.

1. Lack of Substantive Interdisciplinary Review
    - IDG documentation repeatedly contains the statement:
        - “Continue plan of care”
    - There is no accompanying narrative explaining:
        - Changes in patient condition
        - Symptom progression or stabilization
        - Evaluation of goals and interventions
        - Rationale for continuation or modification of services
2. CMS and HHSC require IDG documentation to reflect analysis and clinical judgment, not conclusory or boilerplate statements.
3. Failure to Address Identified High-Risk Issues
    - IDG notes do not address or reconcile:
        - Contradictory code status documentation (HOPE vs physician orders)
        - Missing MSW initial assessment
        - Homemaker/aide order deficiencies
        - Ongoing hospice eligibility and LCD support
4. The absence of documented IDG discussion regarding these deficiencies demonstrates a failure of the interdisciplinary team to identify and mitigate compliance and patient

safety risks.

5. Eligibility & Prognosis Not Reassessed
    - IDG documentation does not include explicit reassessment of terminal prognosis or continued hospice eligibility.
    - There is no documented discussion of trajectory of decline, response to interventions, or anticipated course of illness.
6. Surveyors expect IDG documentation to clearly demonstrate that continued hospice services remain appropriate and justified.

Survey Impact:

HHSC surveyors may determine that the hospice failed to ensure ongoing interdisciplinary evaluation and coordination of care, which can result in a Condition-level deficiency under IDG requirements.

CMS Regulation: 42 CFR §418.56(c); §418.64

HHSC Tags: 26 TAC §558.283(b), §558.283(c)

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15. PLAN OF CARE (POC)

Compliance Status: NON-COMPLIANT

Expanded Detailed Findings (HHSC/CMS Survey Style):

The plan of care (POC) does not meet regulatory requirements for an individualized, interdisciplinary, and outcome-driven plan reflective of the patient's current condition and documented risks.

1. Lack of Measurable, Patient-Specific Goals
    - The POC primarily lists generalized problems (e.g., dyspnea, pain, weakness) without:

        - Measurable goals
        - Timeframes for reassessment
        - Criteria for goal achievement or decline

2. Goals are task-oriented rather than outcome-oriented, which does not meet CMS expectations for individualized care planning.

3. Incomplete Interdisciplinary Representation
    - The POC does not clearly document:
        - Psychosocial goals and interventions from MSW
        - Spiritual goals or documented refusal from chaplain
        - Clear integration of aide/homemaker services into the overall care strategy

4. Absence of discipline-specific problems, goals, and interventions indicates that the POC is not truly interdisciplinary.

5. Failure to Reflect Identified Risks and Deficiencies
    - The POC does not address:
        - Conflicting advance directive/code status documentation
        - Identified documentation integrity issues
        - Need for caregiver education regarding disease progression and end-of-life expectations

6. CMS and HHSC require that the POC be updated to reflect identified problems and risks, including compliance-related issues that impact patient care.

7. Lack of Evidence of IDG-Driven Updates
    - There is no clear documentation that the POC has been reviewed and revised by the IDG in response to:
        - Changes in condition

    - Assessment findings
    - Missing or delayed discipline involvement
8. This demonstrates a disconnect between IDG review and active plan-of-care management.

Survey Impact:

HHSC surveyors may cite the hospice for failure to maintain a current, individualized, interdisciplinary plan of care, increasing risk for condition-level findings related to care coordination and oversight.

CMS Regulation: 42 CFR §418.56(d); §418.56(a)

HHSC Tags: 26 TAC §558.281(a), §558.281(b)

16. BEREAVEMENT & VOLUNTEER SERVICES

Compliance Status: PARTIALLY COMPLIANT

Detailed Findings:

Bereavement services are listed; however, documentation does not clearly demonstrate volunteer services were offered or declined, nor how bereavement follow-up will be provided consistent with assessed risk.

CMS: 42 CFR §418.64

HHSC: §558.323; §558.331

17. DOCUMENTATION INTEGRITY

Compliance Status: NON-COMPLIANT

Expanded Detailed Findings (HHSC/CMS Survey Style):

The medical record demonstrates systemic documentation integrity failures that compromise reliability, continuity of care, and survey defensibility. The following issues were identified:

1. Contradictory Code Status Documentation
    - The HOPE/comprehensive assessment documents “DNR status: No.”
    - Physician treatment orders state “Patient is an OOH-DNR.”
    - No executed Texas Out-of-Hospital DNR form with required signatures was located.
2. This represents a direct internal contradiction within the clinical record regarding life-sustaining treatment preferences. HHSC surveyors routinely cite this type of discrepancy as failure to maintain an accurate and complete medical record and failure to ensure patient rights regarding advance directives.
3. Repetitive and Templated Language
    - Nursing and IDG documentation repeatedly uses non-individualized phrases such as:
        - “No acute distress noted”
        - “Continue plan of care”
    - These statements are documented despite evidence elsewhere in the record of dyspnea, functional decline, and high symptom burden.
4. Use of repetitive, non-patient-specific language without reconciliation of clinical changes suggests copy-forward documentation, which undermines the credibility of the record and obscures the patient’s true condition.
5. Missing or Unverifiable Required Documentation
    - Required psychosocial documentation (MSW initial assessment within 5 days of SOC) is not present.
    - Election/consent documentation is not readily retrievable.
    - Homemaker/aide services are referenced without corresponding physician orders.
6. The absence of these required elements constitutes a failure to maintain a complete and survey-ready record.

Survey Impact:

HHSC and CMS surveyors may determine that the hospice cannot demonstrate that care was planned, delivered, and evaluated based on an accurate medical record, increasing risk for condition-level findings.

CMS Regulation: 42 CFR §418.24(c)

HHSC Tags: 26 TAC §558.213(a)(1), §558.213(a)(2)

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18. TRAJECTORY OF DECLINE & ELIGIBILITY

Compliance Status: PARTIALLY COMPLIANT

Expanded Detailed Findings (HHSC/CMS Survey Style):

The record contains indicators suggestive of terminal decline, but the hospice failed to consistently trend, update, and reconcile decline over time, resulting in survey vulnerability related to ongoing eligibility support.

1. Initial Eligibility Indicators Present
    - Diagnosis of advanced cardiac disease.
    - Documentation of dyspnea, fatigue, weakness, and functional dependence.
    - PPS and functional impairment are referenced in admission documentation.
2. These elements support hospice eligibility at admission.
3. Failure to Trend Decline Over Time
    - Subsequent nursing and IDG documentation does not clearly demonstrate:
        - Worsening dyspnea (e.g., symptoms at rest vs. exertion)
        - Increasing functional dependence
        - Escalation of symptom management needs

        - Decline in oral intake or weight

    - Later notes document stable or minimal symptoms without explaining whether this reflects true stabilization versus effective palliation.

4. CMS and HHSC expect hospice records to show a clear, ongoing trajectory of decline, not merely static or repetitive documentation.

5. LCD Support Not Reinforced Across Disciplines

    - Cardiac LCD elements (e.g., NYHA Class IV, poor response to optimal medical management) are not consistently reinforced in nursing, IDG, and POC documentation.

    - IDG notes do not explicitly address continued eligibility or reassess prognosis.

6. This creates risk that the hospice cannot demonstrate continued eligibility if reviewed beyond the initial certification period or during an ADR.

Survey Impact:

While eligibility may be defensible at admission, failure to document progressive decline and interdisciplinary reassessment places the hospice at risk for denial or citation for insufficient eligibility support.

CMS Regulation: 42 CFR §418.22(b)

HHSC Tags: 26 TAC §558.233(b), §558.233(c)

19. DEFICIENCY SUMMARY & SURVEY RISK

Primary Deficiencies:

- Contradictory and incomplete advance directive documentation
- Missing MSW 5-day assessment
- Inadequate IDG oversight
- Non-individualized POC

- Missing homemaker order
- Poor documentation integrity

Survey Risk Level: HIGH

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20. OVERALL COMPLIANCE DETERMINATION

Overall Status: NON-COMPLIANT

HHSC Surveyor Summary:

The hospice failed to maintain a complete, consistent, and interdisciplinary medical record and failed to ensure compliance with advance directive, psychosocial, IDG, and plan-of-care requirements, placing the agency at high risk for HHSC enforcement action.