STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	633009	A. BUILDING ______ B. WING ______	**5/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Hospice, LLC	**24333 Orchard Lake Rd, Suite H** **Farmington Hills, MI 48336**

(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
L0000	INITIAL COMMENTS A Medicare complaint investigation was conducted by the Michigan Department of Licensing and Regulatory Affairs (MDLARA) on 5/31/23 at: Evergreen Hospice 24333 Orchard Lake Rd. suite 8 Farmington Hills, MI 48336 The agency's new address is reflected on their submitted 855A. The agency has no other locations. Clinical records reviewed for this survey: 5 records including the subject of the complaint. The Agency was out of compliance at the standard level for the conditions of participation at 45 CFR §418, Hospices.	L0000		
L0543	PLAN OF CARE CFR(s): 418.56(b) 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	L0543		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
	633009	A. BUILDING ______ B. WING ______	5/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Hospice, LLC	**24333 Orchard Lake Rd, Suite H Farmington Hills, MI 48336**

(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
	patient's needs if any of them so desire. This STANDARD is NOT MET as evidenced by: Based on interview and record review, the agency failed to ensure that an individualized written plan of care established by the hospice interdisciplinary group was followed for services provided to 1 (MR# 3) of 5 records reviewed, resulting in the potential for unmet care needs for all patients receiving care from this agency. Findings include: MR #3: This 83-year-old patient was admitted to Hospice on 9/27/22 with the terminal diagnosis of secondary malignant neoplasm of the liver and intrahepatic bile duct. During record review on 5/31/23, the plan of care dated 9/27/22 ordered hospice aide services 2 times per week. It was noted that the first hospice aide visit was on 10/26/22. There was no documentation regarding the reason for a delayed initiation of service. Upon further review of the record, the documentation of the interdisciplinary group meeting during held on 10/3/22 did not show any evidence of an order to change the frequency or delay the start of care. The administrative assistant (Staff-B) was queried regarding the reason for delay of care during an interview on 5/31/23 at 3:00 p.m. She reported that maybe the patient had refused to start care on time, but was unable to provide any evidence of this documented in the chart. Findings were further reviewed with and acknowledged by the Administrator during an interview on 5/31/23 at 4:00 p.m.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	633009	A. BUILDING ____ B. WING ____	5/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Hospice, LLC	24333 Orchard Lake Rd, Suite H Farmington Hills, MI 48336

(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
L0552	REVIEW OF THE PLAN OF CARE CFR(s): 418.56(d) 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. This STANDARD is NOT MET as evidenced by: Based on interview and record review, the agency failed to ensure the plan of care was reviewed, revised and documented by the interdisciplinary group at least every 15 days in 2 (MR #3, 4) of 5 records reviewed, resulting in the potential for unmet care needs for all patients receiving care from this agency. Findings include: MR #4: This patient was admitted to Hospice on 10/14/22 with the terminal diagnosis of dementia. During record review on 5/31/23, it was determined that interdisciplinary group (IDG) meetings were held on 10/3/22, 11/14/22 and 11/28/22. There were 5 missing IDG meetings. The requirement for an IDG meeting at least every 15 days was not met. The administrative assistant (Staff-C) was interviewed on 5/31/23 at 4:05 p.m. regarding the missing meeting notes. Staff-C was able to provide a binder of sign in sheets for IDG meetings, but there was no evidence of any documentation of what was discussed. Findings were reviewed with and	L0552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	633009	A. BUILDING ______ B. WING ______	5/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Hospice, LLC	**24333 Orchard Lake Rd, Suite H Farmington Hills, MI 48336**

(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
	acknowledged by the administrator on 5/31/23 at 4:15 p.m. MR #3: This 83-year-old patient was admitted to Hospice on 9/27/22 with the terminal diagnosis of secondary malignant neoplasm of the liver and intrahepatic bile duct. During record review on 5/31/23, it was determined that an interdisciplinary group (IDG) meeting was held on 10/3/22 and not again until 11/18/22. There should have been 3 other IDG meetings held during this time period to discuss and update the patient's plan of care. The administrative assistant (Staff-B) was interviewed on 5/31/23 at 3:00 p.m. regarding the missing meeting notes. Staff-B was able to provide a binder of sign in sheets for IDG meetings during this time, but there was no documentation of what was discussed at these meetings. Findings were reviewed with and acknowledged by the Administrator during an interview on 5/31/23 at 4:00 p.m.			