



CMS FY 2011 Top Ten Hospice Survey Deficiencies Compliance Recommendations

Introduction

The Centers for Medicare and Medicaid Services (CMS) identifies the top ten most frequent survey deficiencies cited during Medicare hospice recertification surveys annually. This compliance tip sheet will:

- ✓ List the survey deficiency by Medicare hospice Condition of Participation* and by Hospice Program Interpretive Guidance** L-Tag for federal Fiscal Year 2011
 - ✓ Provide an example of the deficiency based on actual CMS survey deficiency data.
 - ✓ Provide suggestions from a clinical, documentation, and administrative perspective for compliance.
 - ✓ List the standard and practice example from the NHPCO [Standards of Practice for Hospice Programs \(2010\)](#) related to the cited deficiency.
- ★ NHPCO developed a Top Ten CMS Hospice Survey Deficiency Comparison chart for 2009 – 2011. Providers can access this resources at in the NHPCO Regulatory & Compliance Center at Tools for Care and Compliance.

CMS Survey & Certification (S&C) Update

CMS issued guidance to state directors via S&C:12-12 letter on December 9, 2011 that discusses survey activities in 2012 related to the S&C budget. CMS will expand the tier III maximum time interval between surveys of any one Hospice facility to once every 7 years from once every 6.5 years. Since the implementation of the 2008 hospice Conditions of Participation, CMS estimates that the time for a surveyor to complete a survey increased by 54%. (From 45.5 hrs/survey to 95.9 hrs per survey) CMS will retain a high (tier II) priority the survey of a 5% sample of the lowest-performing providers. CMS will continue to examine additional methods to target survey attention to those providers where the risk of non-compliance with CMS quality of care requirements is greatest.

CMS Top Ten Hospice Survey Deficiencies

The top ten hospice survey deficiencies listed **in order of the most frequently cited** are:

1. Medicare hospice CoP: §418.56(b) Standard: 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.

Interpretive Guidelines L-Tag: L543

Examples of Deficiency:	NHPCO Standard: Patient and Family-Centered Care (PFC)
1) Agency failed to follow the POC relative to hospice aides, skilled nursing visits and bereavement services (i.e.: visit frequencies not followed per plan of care) ; 2) No written plan of care developed three weeks into new benefit period even though IDG staff was visiting patient 3) No plan of care developed	<p>PFC 4 - A written plan of care is developed for each patient, family and caregiver prior to providing care and services.</p> <p>PFC 4 Practice example - The plan of care includes the patient’s and family’s problems, issues, opportunities, related interventions and desired outcomes, and the scope and frequency of services to be provided.</p>

Suggestions for Compliance:

Clinical compliance:	Documentation compliance:	Administrative compliance:
<ul style="list-style-type: none"> • Ensure that all members of the interdisciplinary group (IDG) have access to the patient’s current plan of care and that it is updated • Complete a review of the plan of care during the IDG meeting and change the plan of care visit frequency, interventions, etc...per the updates to the comprehensive assessment. • Ensure that the IDG visits patient/family per the frequency established on the plan of care. 	<ul style="list-style-type: none"> • Ensure that the IDG documents why the visit frequency on the patient’s plan of care was not followed or to support the need for a change in frequency or extra visits. • The IDG may change the visit frequency or exceed the number of visits in the range to address patient/ family’s needs. <ul style="list-style-type: none"> ○ Ensure that there is documentation why the visit frequency was adjusted and that the entire IDG was informed about adjustment ○ Document all care plan updates! Voicemails to IDG members of plan of care changes are usually not recorded in the clinical record. 	<ul style="list-style-type: none"> • Audit clinical records for documentation of all care plan updates! Voicemails to IDG members of plan of care changes are usually not recorded in the clinical record. <ul style="list-style-type: none"> ○ Does the staff visit frequency made match the visit frequency on the plan of care? • Ensure that documentation supports that care was delivered according to the plan of care

2. Medicare hospice CoP: 418.76(h) Standard: Supervision of hospice aides.

(1) 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.

Interpretive Guidelines L-Tag: L629

Examples of Deficiency:	NHPCO Standard: Workforce Excellence (WE)
<p>1) Intervals of 17 days, 18 days and 20 days were noted between supervision documentation; 2) Hospice aide supervision performed by licensed practical nurse versus registered nurse</p>	<p>WE 20.2 - The hospice nurse visits the home at least 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 unless required by state law.</p> <p>WE 20 Practice Examples - The nursing visit note form includes a checklist to document an evaluation of the hospice aide’s services during each nursing visit.</p> <p>✓ The nurse investigates and addresses the stated concerns when the patient or family expresses dissatisfaction with hospice aide’s services.</p>

Suggestions for Compliance:

Clinical compliance:	Documentation compliance:	Administrative compliance:
<ul style="list-style-type: none"> • If the RN makes a supervisory visit on a Tuesday, the next supervisory visit is due by the Tuesday which occurs 14 days later. • In addition to ensuring that hospice aides furnish the care identified in the plan of care, In addition to ensuring that hospice aides furnish the care identified in the plan of care, RN supervisors must assess the adequacy of the aide services in relationship to the needs of the patient and family. 	<ul style="list-style-type: none"> • That RN supervision of hospice aide activity occurs per state hospice regulations. Some states require that the aide be present during supervision. • Provide a space on the Nursing Assessment to verify that the patient and family were consulted regarding their satisfaction with the patient care. Visual inspections and onsite observations should be placed on the nursing assessment on a weekly basis. • Consider documenting supervision of the hospice aide at every visit to ensure timely compliance. 	<ul style="list-style-type: none"> • Initiate a central tracking process for due dates of hospice aide supervision • Review records of patients receiving hospice aide services; verify that aide supervision is occurring no less frequently than every 14 days. NOTE: Supervision must be consistent with federal or state regulations - whichever is more stringent. • Both the hospice aide and the supervising RN should track aide supervision visits. <p>★ Additional guidance available in the Medicare Hospice Interpretive Guidelines</p>

3. Medicare hospice CoP: §418.56(c) Standard: Content of the 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.

Interpretive Guidelines L-Tag: L545

Examples of Deficiency:	NHPCO Standard: Patient and Family-Centered Care (PFC)
<p>1) The hospice failed to develop an individualized, written, plan of care for each patient that included all services necessary for the management of the terminal illness and related conditions; 2) Patient scenario - oxygen use identified as a goal on initial visit, but oxygen therapy was not implemented until 2 months after the initial assessment. Facilitation to have oxygen removed from home per patient’s request was coordinated by spiritual counselor without notification/ coordination with RN/ physician.</p>	<p>PFC 4 - A written plan of care is developed for each patient, family and caregiver prior to providing care and services.</p> <p>PFC 4 Practice Examples</p> <ul style="list-style-type: none"> ✓ The plan of care includes the patient’s and family’s problems, issues, opportunities, related interventions and desired outcomes, and the scope and frequency of services to be provided. ✓ Assessment activities performed by the interdisciplinary team members are included in the plan of care and direct the determination of problems, opportunities, interventions and desired outcomes.

Suggestions for Compliance:

Clinical compliance:	Documentation compliance:	Administrative compliance:
<ul style="list-style-type: none"> • Ensure that all problems identified during assessment are included on the patient’s plan of care and that they are updated during each visit and minimally every 15 days in the update to the comprehensive assessment. • Be consistent in assessment, provision of care, and follow-up. <ul style="list-style-type: none"> ○ I.e.: If a skin assessment was completed at admission and a problem was identified, then there should be follow up skin assessment. 	<ul style="list-style-type: none"> • Ensure consistency of information and coordination of care documentation in the clinical record. <ul style="list-style-type: none"> ○ Review previous visit notes when composing current visit note to ensure that there is documentation addressing previously identified problems. ○ Determine whether documented problems are ongoing, resolved, etc... • Updates to comprehensive assessments should be reflected in care plans; avoid repetitive use of standard phrases or comments. 	<ul style="list-style-type: none"> • Determine through interview/observation and record review whether the plan of care identifies all of the services needed to address problems identified in the initial, comprehensive and updated assessments • Validate if there is evidence of patients receiving the medication/treatments ordered • Validate that the plan of care integrates changes based on assessment findings. • Go on home visit with IDG members and validate care against the plan of care and visit notes. ★ Additional guidance available in the Medicare Hospice Interpretive Guidelines

4. Medicare hospice CoP: 418.54(c)(6) – Drug profile.

A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:

- (i) Effectiveness of drug therapy
- (ii) Drug side effects
- (iii) Actual or potential drug interactions
- (iv) Duplicate drug therapy
- (v) Drug therapy currently associated with laboratory monitoring.

Interpretive Guidelines L-Tag: L530

Examples of Deficiency:	Standard: Clinical Excellence and Safety (CES) 4.2
<p>1) The hospice failed to ensure a review of medications on the initial comprehensive assessment;</p> <p>2) Morphine allergy noted on same physician's order sheet that had a morphine order; 3) A patient mentioned a back rash with itching. The RN recommended Benadryl and cortisone lotion yet as of 11 days later (during the survey) no mention on the drug profile.</p>	<p>CES 4 - A patient-specific medication profile is maintained and periodically reviewed to monitor for medication effectiveness, actual or potential medication-related effects and untoward interactions.</p> <p>CES 4 Practice Examples</p> <ul style="list-style-type: none"> ✓ The pharmacist provides consultation regarding complex medication regimens and educational opportunities and updates for the hospice team members. ✓ The hospice nurse reviews all written medication information with the family and/or caregivers.

Suggestions for Compliance:

Clinical compliance:	Documentation compliance:	Administrative compliance:
<ul style="list-style-type: none"> • Review of drug profiles by an individual with education and training in drug management • Ensure nurse continuously updates the medication profile and provides a copy to the patient/ family • Ensure consistent assessment of medication at every patient visit 	<ul style="list-style-type: none"> • Require documentation of a drug review and reconciliation of all medications in the home at each clinical visit. • Ensure documentation of a drug review and reconciliation of all medications in the home at each clinical visit and profile is up to date. • Implement provisions for documenting and updating the patient's drug profile in the comprehensive assessment tool • Make sure that there is a documented review of drug profiles by an individual with education and training in drug management. 	<ul style="list-style-type: none"> • Ensure organization policies and procedures and assessment forms include all of the components required in the Medicare hospice CoPs at 418.54(c)(6). • Provide updated staff training on completing drug profiles . • Ensure that an updated drug profile is part of the update to the plan of care. • Conduct an audit of medical records to make certain that each patient's comprehensive assessment includes an accurate drug profile. ★ Additional guidance available in the Medicare Hospice Interpretive Guidelines

5. Medicare hospice CoP: 418.56(e)(2) Standard: Coordination of Services.

Ensure that the care and services are provided in accordance with the plan of care.

Interpretive Guidelines L-Tag: L555

Examples of Deficiency	NHPCO Standard: Care Planning (PFC)
<p>A patient residing in an ALF did not receive 2 medications in accordance with the plan of care. The patient was on automatic drug refills with the pharmacy but because there were temporary changes to the dosages the auto refills were placed on hold. The patient went without these meds for approximately one month.</p>	<p>PFC 7 - The interdisciplinary team members implement the interventions identified in the plan of care.</p> <p>PFC 7 Practice Example:</p> <ul style="list-style-type: none"> • The clinical record contains documentation that the frequency of visits performed by the interdisciplinary team members is in accordance with the visit frequency stated in the plan of care. • The interventions related to the specific problems, issues and opportunities are documented on each care provider’s visit note. • During meetings, team members discuss the appropriate interventions and plan for the patient’s care accordingly.

Suggestions for Compliance:

Clinical compliance:	Documentation compliance:	Administrative compliance:
<ul style="list-style-type: none"> • Ensure that all members of the interdisciplinary group (IDG) have access to the patient’s current plan of care and that it is updated • Complete a review of the plan of care during the IDG meeting and change the plan of care visit frequency, interventions, etc...per the updates to the comprehensive assessment. • Ensure that the IDG visits patient/family per the frequency established on the plan of care. 	<ul style="list-style-type: none"> • Ensure that the IDG documents why the visit frequency on the patient’s plan of care was not followed or to support the need for a change in frequency or extra visits. • The IDG may change the visit frequency or exceed the number of visits in the range to address patient/ family’s needs. • Ensure that there is documentation why the visit frequency was adjusted and that the entire IDG was informed about adjustment • Document all care plan updates! Voicemails to IDG members of plan of care changes are usually not recorded in the clinical record. 	<ul style="list-style-type: none"> • Audit for accuracy and consistency: <ul style="list-style-type: none"> ○ Does the staff visit frequency made match the visit frequency on the plan of care?

6. Medicare hospice CoP: 418.64(b) Standard: Nursing Services.

The hospice must provide nursing care and services by or under the supervision of an RN. Nursing services must ensure the nursing needs of the pt are met as identified in the patient’s initial assessment, comprehensive assessment, and updated assessments.

Interpretive Guidelines L-Tag: L591

Examples of Deficiency	NHPCO Standard: Workforce Excellence - Interdisciplinary Team : Nursing
<p>1) No documented measurements of wounds; 2) A hospice aide was changing the dressings to a patient’s neck and around the feeding tube on a regular basis. The RN was aware of this practice although the RN never instructed her to do this. These dressing changes were outside the scope of the hospice aides practice. There was also no evidence in the clinical record that the RN provided any wound care or assessment; 3) LPN’s noted performing care outside their scope of practice.</p>	<p>WE 14 - Hospice nursing services are based on initial and ongoing assessments of the patient’s needs by a registered nurse and are provided in accordance with the interdisciplinary team’s plan of care. Services include:</p> <ul style="list-style-type: none"> • Completion of the initial and comprehensive assessment of patient/ family needs; • Coordination of the patient’s plan of care; • Provision of dietary counseling; • Medication profile review and update; and • Supervision of Hospice Aides. <p>WE 14 Practice Example:</p> <ul style="list-style-type: none"> • A complete physical assessment is performed and documented for each patient upon admission. • Each nursing visit includes a reassessment of the patient’s physical status.

Suggestions for Compliance:

Clinical compliance:	Documentation compliance:	Administrative compliance:
<ul style="list-style-type: none"> • Ensure that all nursing staff is functioning within the parameters of the state nurse practice act. • Ensure that supervision of licensed practical/vocational nurse is performed by registered nurse (RN) per the state nurse practice act guidelines or your policy to make sure staff is not functioning outside of their scope of practice. • Make certain that RN’s consistently assess the patient on every visit as address all previous and new problems. 	<ul style="list-style-type: none"> • All assessment outcomes are documented on the nursing note at every visit. • RN consistently documents supervision of licensed practical/vocational nurses and hospice aides per regulatory standards and or state practice act. • RN documents staff education of any delegated clinical care within that’s staffs’ scope of practice. 	<ul style="list-style-type: none"> • Audit clinical records for accuracy and consistency of nursing service provision, supervision, and education of staff members under the RN’s supervision. • Educate staff members regarding comprehensive assessment components and supervision requirements/policy.

7. Medicare hospice CoP: §418.56(d) Standard: Review of the plan of care.

The hospice IDG 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.

Interpretive Guidelines L-Tag: L552

Examples of Deficiency	NHPCO Standard: Patient and Family-Centered Care (PFC)
<ul style="list-style-type: none"> Clinical records evidenced plans of care that were reviewed on a monthly basis even though there was a policy in place for an every 14 day review. The length of time between plan of care reviews ranged from 19 to 33 days. The agency policy was for every 2 weeks. 	<ul style="list-style-type: none"> (PFC) 6.1 - The plan of care is reviewed by the interdisciplinary team no less than every 15 calendar days and documented on the patient’s clinical record. (PFC) 6.2 - The interdisciplinary team revises the plan of care as often as needed to reflect changes in the patient’s and family’s status and needs. <p>PFC 6 Practice Examples:</p> <ul style="list-style-type: none"> The plan of care is updated whenever there is a change in the patient’s and family’s condition that alters their status or needs (e.g., inpatient placement, new onset or increased severity of symptoms, caregiving crisis, inadequate financial resources, etc.). Documentation supports collaboration by team members as the plan of care is revised in response to the patient and family’s reassessment. The patient, family and caregiver plan of care is reviewed regularly during the interdisciplinary team meeting.

Suggestions for Compliance:

Clinical compliance:	Documentation compliance:	Administrative compliance:
<ul style="list-style-type: none"> Ensure that the IDG is communicating and collaborating continuously regarding the patient’s care both internally and externally. Include communication/ collaboration with the attending physician, community resources, and the communication with patient, caregiver and family. Ensure that the patient, caregiver/ family are included in the process to update the plan of care. 	<ul style="list-style-type: none"> Document the review of the plan of care as the patient’s status requires or minimally every 15 calendar days. Changes in the patient’s condition which require an update to the plan of care are documented at the time of the change. Documentation that members of the IDG were informed regarding updates to the plan of care should be documented in the clinical record. 	<ul style="list-style-type: none"> Audit clinical records to assess consistency with updates to POC every 15 days minimally. Assess for documentation of collaboration between attending physician and IDG staff. Assess for evidence of internal and external communication documentation outside of the IDG meeting.

8. Medicare hospice CoP: §418.64(d) – Standard: Counseling services- Bereavement counseling

(1) - Bereavement counseling. The hospice must:

- (i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling
- (ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care
- (iii) Ensure that bereavement services reflect the needs of the bereaved.
- (iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery.

Interpretive Guidelines L-Tag: L596

Examples of Deficiency	NHPCO Standard: Patient and Family-Centered Care (PFC)
<ul style="list-style-type: none"> • The was no documented evidence that families were contacted to offer and/or determine need for Bereavement services following the patient’s death. 	<ul style="list-style-type: none"> • PFC 2 - Care is fully coordinated to assure ongoing continuity for the patient, family and caregiver. • PFC 2 Practice example - Bereavement services are addressed at the time of admission and reinforced ongoing through written materials, direct contact and a plan for bereavement following the patient’s death. • PFC 18 - Hospice patients and all significant family members and caregivers are assessed for grief and bereavement needs. • PFC 18 example - The assessment process is ongoing (<i>i.e., initially upon admission, periodically during the patient’s hospice care and following the patient’s death</i>).

Suggestions for Compliance:

Clinical compliance:	Documentation compliance:	Administrative compliance:
<ul style="list-style-type: none"> • Ensure that an initial bereavement assessment is completed and documented as a component of the comprehensive assessment and that bereavement professional participates in the update to the plan of care process as an IDG member as appropriate. • Make certain that the bereavement professional is alerted immediately when a patient dies. 	<ul style="list-style-type: none"> • Make certain there is documentation in the clinical record of initial bereavement assessment, ongoing assessment and update to plan of care as appropriate. • Make sure bereavement professional follows policy/procedures regarding contact and assessment post patient death and document all contact & assessment outcomes. 	<ul style="list-style-type: none"> • Review patient records for initial bereavement assessment documentation. • Review bereavement records to assess for Initial and ongoing contact after patient death and development of a bereavement care plan for caregiver or family. ★ Additional guidance available in the Medicare Hospice Interpretive Guidelines

9. Medicare hospice CoP: §418.76(c) – Standard: Competency Evaluation.

An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in the regulation at 42CFR418.76(c)(1).

Interpretive Guidelines L-Tag: L615

Examples of Deficiency	NHPCO Standard: Workforce Excellence (WE)
<ul style="list-style-type: none"> A review of hospice aides' personnel files showed that the hospice failed to ensure the competency of the aides was evaluated. The hospices policy was to review the skills of the aides 90 days after hire. 100% of files reviewed had no evidence of a skills check at the 90 days per agency policy. There was no evidence of a skills checklist at the time of hire, either in practice or in policy. 	<p>WE 1.7 - The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.</p> <p>WE 3 - The hospice maintains a consistent, nondiscriminatory process for recruiting and selecting staff with optimal qualifications which includes competence and license validation, a personal interview, criminal background checks and other checks as required by law and regulation.</p> <p>WE 3 Practice example - The hospice maintains a consistent process for recruiting and selecting staff with optimal qualifications that includes competency validation and interviews with managers and others.</p>

Suggestions for Compliance:

Clinical compliance:	Documentation compliance:	Administrative compliance:
<ul style="list-style-type: none"> Designated nursing staff must assess hospice aide competency prior to assignment of patients. 	<ul style="list-style-type: none"> Human resources must assure documentation of aide qualifications including competency validation. Designated nursing staff must document hospice aide competency assessment prior to assignment of patients. 	<ul style="list-style-type: none"> Audit personnel files to ensure hospice aide competency evidence at hire and competency validation by a registered nurse prior to assignment of patients. ★ Additional guidance available in the Medicare Hospice Interpretive Guidelines

10. Medicare hospice CoP: §418.54(b) – Standard: Timeframe for completion of the comprehensive assessment.

Timeframe for the completion of the comprehensive assessment. The IDG, in consultation with the attending MD (if any) must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care.

Interpretive Guidelines L-Tag: L523

Examples of Deficiency	NHPCO Standard: Clinical Excellence and Safety (CES)
<ul style="list-style-type: none"> Clinical record review revealed admission of patient on 3/22/11. RN visited the home on 3/22/11 for admission assessment visit. Although admission note was electronically signed on 3/22/11, the assessment data was not entered in the electronic record until 3/30/11. There was no evidence of a psychosocial assessment. 	<p>CES 1.2 - The interdisciplinary group, in consultation with the individual's attending physician, completes the comprehensive assessment within five calendar days of the effective date of the Notice of election.</p> <p>CES 1 Practice Examples:</p> <ul style="list-style-type: none"> ✓ The hospice includes assessment of common co-morbid conditions as part of the initial nursing assessment. ✓ There is an interdisciplinary assessment tool.

Suggestions for Compliance:

Clinical compliance:	Documentation compliance:	Administrative compliance:
<ul style="list-style-type: none"> Ensure that IDG staff understand: The process for completion of the comprehensive assessment That the timeframe for the completion of the comprehensive assessment by the IDG is 5 calendar days from the effective date of the notice of hospice election The process to address urgent needs of the patient/ family The process for assessment if a member of the IDG is refused 	<ul style="list-style-type: none"> The comprehensive assessment process should be documented in the clinical record within 5 calendar days of the effective date of the notice of hospice election If the comprehensive assessment is in parts (i.e.: multiple forms), develop a tracking mechanism to ensure completion/ documentation within the specified timeframe Comprehensive assessment must be readily identifiable in the clinical record 	<ul style="list-style-type: none"> Conduct a monthly review of clinical records to ensure that the comprehensive assessment is completed within 5 days after the effective date of the notice of election. Review records for patients admitted in the last 7-14 days; start with the initial nursing assessment and care plan (or similar documents as defined by organization policies and procedures). Does every record look the same? (Example: nursing visits occur during the first week, but there is no contact by the social worker or spiritual counselor.) Establish clinical oversight to track compliance during patient care delivery. ★ Additional guidance available in the Medicare Hospice Interpretive Guidelines

Works Cited

42 CFR Part 418, Medicare and Medicaid Programs: Hospice Conditions of Participation; Final Rule, Centers for Medicare and Medicaid Services, June 5, 2008. <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-part418.pdf>

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http://cms.gov/manuals/Downloads/som107ap_m_hospice.pdf

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http://iweb.nhpco.org/iweb/Purchase/ProductDetail.aspx?Product_code=711077