

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  STATE OF THE HEART CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1237 W SR 67 PORTLAND, IN 47371
---	---

(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 0000  Bldg. 00	<p>This was a follow up Federal and State hospice recertification and relicensure survey.</p> <p>Survey dates: June 7 and 8, 2016</p> <p>Facility Number: 003227</p> <p>Medicaid Number: 200418750A</p> <p>Clinical Records Reviewed: 5 Home Visit: 1</p> <p>Census: 26</p>	L 0000		
L 0543  Bldg. 00	<p>418.56(b) PLAN OF CARE</p> <p>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.</p> <p>Based on record review and interview, the skilled nurse failed to ensure wound treatments orders were followed per the plan of care for 1 of 5 records reviewed</p>	L 0543	The deficiency, "All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice	07/15/2016

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:  151580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2016
NAME OF PROVIDER OR SUPPLIER  STATE OF THE HEART CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1237 W SR 67 PORTLAND, IN 47371		
(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	
	<p>for wound care in a sample of 6. (#17)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 17, SOC (start of care) 05/27/16, had a plan of care for the certification period of 05/27/16 to 08/24/16, with orders for wound treatment to the right upper arm. The treatment order indicated to cleanse the area with soap and water, pat dry, apply vaseline gauze followed by gauze pad, secure with ecofix tape, and to change the dressing every 2 to 3 days and (prn) as needed.</p> <p>a. A skilled nursing visit note dated 05/28/16, indicated "This LN [Licensed Nurse] did not have vaseline gauze neither did the patient. This LN cleansed the area. Applied ABT [antibiotic ointment] that patient had in the home and covered with optifoam .... " The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the skilled nursing visit notes dated 05/29/16, 05/30/16, 05/31/16, 06/01/16, 06/04/16, 06/05/16, and 06/06/16, failed to indicate if treatment had been provided to the patient's wound to the right upper arm. The skilled nurses failed to follow the plan of care.</p>		<p>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" will be corrected by ensuring compliance with L543 by the following: 1.The Agency's Wound Care Policy was updated to reflect the following additions: a. Documentation in the EMR by the nurse will describe the appearance of the wound at each dressing change by the RN or designee as stated in the wound care policy. b. Documentation in the EMR by the nurse will reflect the specific treatment of the wound at each dressing change by the RN or designee as stated in the wound care policy. c. The policy will be sent to all nurses. 2. Education will be provided to all nurses concerning the policy updates and proper documentation in the EMR regarding wound assessment will be provided. 3. Education for all nurses will be provided to emphasize following the patient's Plan of Care as written. 4. The QAPI Coordinator will audit active patient charts with a wound(s) for compliance and quality assurance. 5. This standard will be met in full by July 15, 2016.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2016	
NAME OF PROVIDER OR SUPPLIER  STATE OF THE HEART CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1237 W SR 67 PORTLAND, IN 47371			
(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 0591 Bldg. 00	<p>2. The Administrator and Employee HH, Training and Development Coordinator was interviewed on 06/07/16 at 4:30 PM. The Administrator and Employee HH were not able to provide any further information and / or documentation when asked.</p> <p>418.64(b)(1) NURSING SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. Based on record review and interview, the agency failed to ensure skilled nursing visit notes included documentation of wound appearance and wound treatments provided for 2 of 5 records reviewed for wound care in a sample of 6. (# 16 and 17)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 16, SOC (start of care) 04/13/16, had a plan of care for the certification period of 04/13/16 to 07/11/16.</p> <p>a. A physician order dated 05/25/16, indicated to cleanse the right shin skin</p>			L 0591	<p>The deficiency, "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" will be corrected by ensuring compliance with L543 by the following: 1.The Agency's Wound Care Policy was updated to reflect the following additions: a. Documentation in the EMR by the nurse will describe the appearance of the wound at each dressing change by the RN or designee as stated in the wound</p>		07/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2016	
NAME OF PROVIDER OR SUPPLIER  STATE OF THE HEART CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1237 W SR 67 PORTLAND, IN 47371			
(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			
	<p>tear with soap and water, apply non-adherent gauze, cover with coflex two times a week and prn (as needed).</p> <p>b. Review of a skilled nursing visit note dated 05/27/16, provided an observation of the patient's wound but failed to document if the wound treatment had been provided.</p> <p>2. The clinical record for patient number 17, SOC 05/27/16, had a plan of care for the certification period of 05/27/16 to 08/24/16, with orders for wound treatment to the right upper arm. The treatment order indicated to cleanse the area with soap and water, pat dry, apply vaseline gauze followed by gauze pad, secure with ecofix tape, and to change the dressing every 2 to 3 days and prn.</p> <p>a. A skilled nursing visit note dated 06/02/16, indicated the patient had an "abrasion on right forearm, dressing changed today per order." The skilled nurse failed to document the appearance of the wound and failed to document the specific treatment order provided.</p> <p>b. A skilled nursing visit note dated 06/03/16, indicated the patient's right forearm "dressing changed per order." The skilled nurse failed to document the specific treatment order provided.</p>		<p>care policy. b. Documentation in the EMR by the nurse will reflect the specific treatment of the wound at each dressing change by the RN or designee as stated in the wound care policy. c. The policy will be sent to all nurses. 2. Education will be provided to all nurses concerning the policy updates and proper documentation in the EMR regarding wound assessment will be provided. 3. Education for all nurses will be provided to emphasize following the patient's Plan of Care as written. 4. The QAPI Coordinator will audit active patient charts with a wound(s) for compliance and quality assurance. 5. This standard will be met in full by July 15, 2016.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2016
NAME OF PROVIDER OR SUPPLIER  STATE OF THE HEART CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1237 W SR 67 PORTLAND, IN 47371		
(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 9999  Bldg. 00	3. The Administrator and Employee HH, Training and Development Coordinator was interviewed on 06/07/16 at 4:30 PM. The Administrator and Employee HH indicated they thought assessments were only documented with weekly measurements and were not aware of needing to provide documentation of the assessment / appearance of the wound with each nursing visit where treatment was provided.	L 9999	No response necessary	07/15/2016	