STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	X3) DATE SURVEY COMPLETED
	151564	A. BUILDING 00	10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRY COUNTY MEMORIAL HOSPITAL HOSPICE	1007 N 16TH ST NEW CASTLE, IN 47362

(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	This was a Federal Hospice Recertification and State Hospice Relicensure and complaint survey. Survey Dates: September 29, 2015 to October 1, 2015 Facility Number: 010143 Medicaid Number: 200148070B Clinical Records Reviewed: 11 Home Visits: 3 Census: 11	L 0000		
L 0533 Bldg. 00	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			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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NAME OF PROVIDER OR SUPPLIER HENRY COUNTY MEMORIAL HOSPITAL HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 N 16TH ST NEW CASTLE, IN 47362	

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	of the patient requires, but no less frequently than every 15 days. Based on observation, record review and interview, the agency failed to ensure that the Interdisciplinary Group, (in collaboration with the individual's attending physician, if any), updated the comprehensive assessment at least every 15 days for 4 of 11 records reviewed. (#1 - 3, and 10) Findings include: 1. Clinical record #1, Election date of 03/20/15. The patient's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and recurrent history of pneumonia. a. On 09/30/15 at 9:10 AM, Employee D was observed measuring the patient's left arm circumference. Employee D stated the arm was measured for weight loss and the skilled nursing facility weighs the patient monthly. b. Review of the IDG plan of care update dated 09/17/15, failed to include nutritional assessment, arm circumference measurements, and the skilled nursing facility weighing the patient monthly. 2. Clinical record #2, Election date of	L 0533	Department Director will be responsible for the following: EMR report will be run prior to each IDG with changes in the last two weeks highlighted to assist clinician in determining accuracy of IDG notes. Staff educated of expectation of using report to ensure accuracy of notes 10/20/2015 Staff education to include survey findings, expectations and reeducation of Comprehensive Assessment Policy, Plan of Care Policy and Medication Review Policy 10/20/2015 IDG note audits will occur following each IDG to ensure all changes since last IDG and follow up on actions are documented as needed as per policy “on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care”- Clinical coordinator will be responsible for audit and follow up.	10/20/2015

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	04/08/15. The patient's diagnoses included, but were not limited to, cerebral vascular accident (stroke) and diabetes mellitus. a. On 09/30/15 at 10:40 AM, the patient's record was reviewed at the skilled nursing facility. The skilled nursing facility medication orders indicated the patient was taking Seroquel 50 milligrams by mouth in the morning and 75 milligrams by mouth at bedtime. b. Review of the IDG updated plan of care dated 09/17/15, under the Agitation / Anxiety section, it was indicated on 09/09/15, Seroquel 50 milligrams was to be taken in the morning and 75 milligrams was to be taken at bedtime. The IDG conclusion section indicated, "Medication Changes since last IDG: None." c. During this time, Employee F, Hospice Clinical Director, stated that the computer would not allow the medication to split the 50 milligram dose and that it would have to be put in as a separate order. d. The plan of care failed to evidence the medication profile was updated to reflect the correct dose of Seroquel and correct time for dosage to be taken.			

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	3. Clinical record #3, Election date of 02/10/15. The patient's diagnoses included, but were not limited to, cerebral atherosclerosis and adult failure to thrive a. On 09/30/15 at 1:30 PM, Employee C was observed measuring the patient's left arm circumference and obtaining a pulse oximetry. During the home visit, Employee C and the patient's adult child was discussing the patient's foley catheter and irrigation. The adult child also stated that the patient had a poor appetite and eats less than two meals per day. Observation of the patient's living area, the patient was observed to have a bedside table and wheelchair in the home. b. Review of the IDG plan of care update dated 09/17/15, included orders for pulse oximetry to be taken as needed. The plan of care failed to include parameters for pulse oximetry to be taken, nutritional assessment, arm circumference measurements, bedside table, wheelchair, and foley catheter irrigation flushes. 4. Clinical record #10, Election date of 08/20/15. The patient's diagnosis included, but was not limited to, lung cancer.			

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	Review of the updated plan of care dated 09/17/15, included orders for pulse oximetry to be obtained as needed and oxygen to be administered as needed. The plan of care failed to include parameters for pulse oximetry to be obtained. 5. An interview with the Family Director, on 10/01/15 at 11:15 AM, stated she felt the arm circumference was part of the assessment and the Medical Director required that all patients have his / her arm circumference measured to monitor weight loss at each nursing visit. The Director of Nursing stated the arm circumference measurement was not included in the nursing assessment policy. 6. Employee F was interviewed on 10/01/15 at 11:45 AM. Employee F stated that the plan of care should include parameters for pulse oximetry. 7. A policy titled Update of the Comprehensive Assessment dated 10/17/14, indicated "The update of the comprehensive assessment is accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and considers changes that have			

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	taken place since the initial assessment. It includes information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care .... " 8. A policy titled Plan of Care dated 10/17/14, indicated " ... 3. The plan of care must include all services necessary for the palliation and management of there terminal illness and related conditions ... drugs and treatment necessary to meet the needs of the patient, medical supplies and appliances necessary to meet the needs of the patient ... 4. The hospice interdisciplinary group (in collaboration with he individual's attending physician, if any) must review, revise, and document the individualized plan as frequently as the patient's condition requires .... " 9. A policy titled Medication Review dated 09/16/15, indicated " ... The RN will review all medications on the list during the initial assessment, when updating the comprehensive assessment and as needed as new medications are added or changed .... "			
L 0537 Bldg. 00	418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES The hospice must designate an interdisciplinary group or groups as specified			

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	in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.			
	Based on record review and interview, the agency failed to ensure that the Interdisciplinary Group, (in collaboration with the individual's attending physician, if any), included parameters for pulse oximetry and clarified oxygen administration upon admission for 1 of 11 records reviewed. (#7) Findings include: 1. Clinical record #7, Election date of 09/16/15, with an established plan of care with orders for pulse oximetry to be obtained as needed and oxygen to be administered as needed. The medication profile indicated the patient was to receive oxygen continuously. The patient's diagnoses included, but were not limited to heart disease and chronic obstructive pulmonary disease. Review of the plan of care dated 09/17/15, failed to include parameters for pulse oximetry to be taken and failed to clarify if the oxygen was to be administered continuously or as needed. 2. Employee F was interviewed on 10/01/15 at 11:45 AM. Employee F stated that the plan of care should include parameters for pulse oximetry.	L 0537	Department Director is Responsible for the following: Pulse Ox intervention default setting in EMR changed to take out PRN: Order will determine frequency and staff educated to include frequency and indication for any PRN order in intervention modifier. Staff Educated 10/20/2015 Clarification of Oxygen order completed 10/16/2015 Staff educated to document oxygen order on the medication screen as always and the statement in care plan should state, “oxygen to be administered per medication order” to decrease possibility of confusion or error. Staff educated. 10/20/2015 Reeducated staff of Policy Plan of Care 10/20/2015	10/20/2015

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	3. A policy titled Plan of Care dated 10/17/14, indicated " ... 3. The plan of care must include all services necessary for the palliation and management of there terminal illness and related conditions ... drugs and treatment necessary to meet the needs of the patient, medical supplies and appliances necessary to meet the needs of the patient ... 4. The hospice interdisciplinary group (in collaboration with he individual's attending physician, if any) must review, revise, and document the individualized plan as frequently as the patient's condition requires .... "		Chart review will be changed to include Oxygen orders/ Oxygen administration in plan of care and Pulse Ox frequency and indication if needed. This audit will occur to check for compliance. –Clinical Coordinator will be responsible for follow up	
L 0549 Bldg. 00	418.56(c)(4) 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:] (4) Drugs and treatment necessary to meet the needs of the patient. Based on observation, record review and interview, the agency failed to ensure that the Interdisciplinary Group, (in collaboration with the individual's attending physician, if any), included measurement of arm circumference, nutritional assessment, parameters for pulse oximetry, clarified oxygen	L 0549	Department Director is Responsible for the following: Review of Policy: Comprehensive Assessment/Plan of care and Medication review as well as findings of survey and deficits and expectations. Staff Educated 10/20/2015	10/20/2015

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	administration upon admission, antipsychotic medication was updated on the medication profile for 5 of 11 records reviewed. (#1, 2, 3, 7, and 10) Findings include: 1. Clinical record #1, Election date of 03/20/15. The patient's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and recurrent history of pneumonia. a. On 09/30/15 at 9:10 AM, Employee D was observed measuring the patient's left arm circumference. Employee D stated the arm was measured for weight loss and the skilled nursing facility weighs the patient monthly. b. Review of the IDG plan of care update dated 09/17/15, failed to include nutritional assessment, arm circumference measurements, and the skilled nursing facility weighing the patient monthly. 2. Clinical record #2, Election date of 04/08/15. The patient's diagnoses included, but were not limited to, cerebral vascular accident (stroke) and diabetes mellitus. a. On 09/30/15 at 10:40 AM, the		Staff included these assessments to determine need of Nutritional intervention and determine baseline as directed by Medical Director. Change made to EMR to include Problem: Risk for imbalanced nutrition Goals: Determine nutritional baseline Intervention: obtain weight and arm circumference All areas will have modifier to add specific frequency and parameters, indications if needed as well as individualized patient information. Staff educated of changes made to the care plan and instructed on expectations 10/20/2015 EMR report will be run prior to each IDG with changes in the last two weeks highlighted to assist clinician in determining accuracy of IDG notes. Staff educated of expectation of using report to ensure accuracy of notes 10/20/2015	

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	patient's record was reviewed at the skilled nursing facility. The skilled nursing facility medication orders indicated the patient was taking Seroquel 50 milligrams by mouth in the morning and 75 milligrams by mouth at bedtime. b. Review of the IDG updated plan of care dated 09/17/15, under the Agitation / Anxiety section, it was indicated on 09/09/15, Seroquel 50 milligrams was to be taken in the morning and 75 milligrams was to be taken at bedtime. The IDG conclusion section indicated, "Medication Changes since last IDG: None." c. During this time, Employee F, Hospice Clinical Director, stated that the computer would not allow the medication to split the 50 milligram dose and that it would have to be put in as a separate order. d. The plan of care failed to evidence the medication profile was updated to reflect the correct dose of Seroquel and correct time for dosage to be taken. 3. Clinical record #3, Election date of 02/10/15. The patient's diagnoses included, but were not limited to, cerebral atherosclerosis and adult failure to thrive		IDG note review will occur following each IDG to ensure all changes since last IDG and follow up on actions are documented as needed as per policy “on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care”- Clinical Coordinator will be responsible for review and follow up	

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	a. On 09/30/15 at 1:30 PM, Employee C was observed measuring the patient's left arm circumference and obtaining a pulse oximetry. During the home visit, Employee C and the patient's adult child was discussing the patient's foley catheter and irrigation. The adult child also stated that the patient had a poor appetite and eats less than two meals per day. Observation of the patient's living area, the patient was observed to have a bedside table and wheelchair in the home. b. Review of the IDG plan of care update dated 09/17/15, included orders for pulse oximetry to be taken as needed. The plan of care failed to include parameters for pulse oximetry to be taken, nutritional assessment, arm circumference measurements, bedside table, wheelchair, and foley catheter irrigation flushes. 4. Clinical record #7, Election date of 09/16/15. The patient's diagnoses included, but were not limited to, heart disease and chronic obstructive pulmonary disease. Review of the initial plan of care dated 09/17/15, included orders for pulse oximetry to be obtained as needed and oxygen to be administered as needed.			

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	Review of the medication profile indicated the patient was to receive oxygen continuously. The plan of care failed to include parameters for pulse oximetry to be obtained and failed to clarify if the oxygen was to be administered continuously or as needed. 5. Clinical record #10, Election date of 08/20/15. The patient's diagnosis included, but was not limited to, lung cancer. Review of the updated plan of care dated 09/17/15, included orders for pulse oximetry to be obtained as needed and oxygen to be administered as needed. The plan of care failed to include parameters for pulse oximetry to be obtained. 6. An interview with the Family Director, on 10/01/15 at 11:15 AM, stated she felt the arm circumference was part of the assessment and the Medical Director required that all patients have his / her arm circumference measured to monitor weight loss at each nursing visit. The Director of Nursing stated the arm circumference measurement was not included in the nursing assessment policy. 7. Employee F was interviewed on			

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	10/01/15 at 11:45 AM. Employee F stated that the plan of care should include parameters for pulse oximetry. 8. A policy titled Update of the Comprehensive Assessment dated 10/17/14, indicated "The update of the comprehensive assessment is accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and considers changes that have taken place since the initial assessment. It includes information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care .... " 9. A policy titled Plan of Care dated 10/17/14, indicated " ... 3. The plan of care must include all services necessary for the palliation and management of there terminal illness and related conditions ... drugs and treatment necessary to meet the needs of the patient, medical supplies and appliances necessary to meet the needs of the patient ... 4. The hospice interdisciplinary group (in collaboration with he individual's attending physician, if any) must review, revise, and document the individualized plan as frequently as the patient's condition requires .... "			

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	10. A policy titled Medication Review dated 09/16/15, indicated " ... The RN will review all medications on the list during the initial assessment, when updating the comprehensive assessment and as needed as new medications are added or changed .... "			
L 0591 Bldg. 00	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 the Registered Nurse met the nursing needs of the patient and family in relation to assessing wounds for 2 of 3 records reviewed for wound care. (#4 and 7) Findings include: 1. Clinical record #4, Election date of 09/17/15, with an established plan of care for skilled nursing one time a week for one week then two times a week for thirteen weeks. a. An initial skilled nursing assessment dated 09/17/15 indicated the patient had a surgical incision to the left	L 0591	Department Director is Responsible for the following: Plan of Care Policy updated to include wound assessment and documentation expectations. Staff educated on changes 10/20/2015 Initial and Comprehensive Assessment Policy Reviewed. Staff educated 10/20/15 Clinical record review will be updated to include wound assessment according to care	10/20/2015

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	hip, a skin tear to the left arm and another skin tear to the right arm. The assessment indicated that all three wounds were not measured. The visit note indicated that the wound dressings were changed per orders and to see the plan of care. The visit note failed to evidence a reason for the inability to measure the wound, failed to evidence if the surgical incision had staples or stitches, and failed to include the specific treatment for wound treatments. b. The skilled nursing visit notes dated 09/22/15 and 09/24/15, failed to evidence that the left arm, right arm, and left hip incision wounds were measured. The visit note indicated that the wound dressings were changed per orders and to see the plan of care. The visit notes failed to evidence a reason for the inability to measure the wound, failed to evidence if the surgical incision had staples or stitches, and failed to include the specific treatment for wound treatments. 2. Clinical record #7, with an established plan of care for skilled nursing two times a week for eight weeks then two times a week for one week. The patient resides in a skilled nursing facility. a. A skilled nursing visit note dated		plan and/or coordination of care/services –Clinical coordinator will be responsible for follow up	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151564	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/01/2015
NAME OF PROVIDER OR SUPPLIER HENRY COUNTY MEMORIAL HOSPITAL HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 N 16TH ST NEW CASTLE, IN 47362	

(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
	07/20/15 indicated the patient had a stage I wound to the left buttock measuring 1 x 1 centimeters. The measurement was provided by the facility. The visit note indicated that the wound dressings were changed per orders and to see the plan of care. The visit note failed to include the specific treatment for the left buttock wound. b. Skilled nursing visit notes dated 07/24/15, indicated the left buttock wound was not assessed due to the patient was already up and dressed. Skilled nursing visit note dated 07/28/15, indicated the left buttock wound was not assessed due to the patient was up in the dining room. On 07/31/15, the skilled nursing visit note indicated the left buttock was not assessed, evaluated, or measured. The clinical record failed to evidence that the left buttock wound had been assessed for three consecutive visits and failed to include documentation of coordination with the facility staff nurse in regards to pressure wound appearance and measurements. 3. The Director was interviewed on 10/01/15 at 11:30 AM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRY COUNTY MEMORIAL HOSPITAL HOSPICE	1007 N 16TH ST NEW CASTLE, IN 47362

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	4. A policy titled Registered Nurse Initial and Comprehensive Assessment of the Patient dated 08/17/15, indicated " ... The initial assessment will be conducted to gather the critical information necessary to treat the patient / family's immediate needs and is necessary to gather the essential information needed to begin to formulate the plan of care and services .... "			
L 0778 Bldg. 00	418.112(e)(1)(i) COORDINATION OF SERVICES [The designated interdisciplinary group member is responsible for:] (i) Providing overall coordination of the hospice care of the SNF/NF or ICF/MR resident with SNF/NF or ICF/MR representatives; Based on observation, record review, and interview, the agency failed to ensure the Registered Nurse provided overall coordination of the hospice care for 2 of patient's who reside in a skilled nursing facility. (#2 and 7) 1. Clinical record #2, Election date of 04/08/15, with an established plan of care with orders for a hospital bed, bedside table, and air mattress. The patient resides in a skilled nursing facility. a. On 09/30/15 at 10:15 AM, the patient was observed to be lying on a regular mattress in a regular bed provided	L 0778	Department Director is Responsible for the following: Clinical record review will be updated to include wound assessment according to care plan and/or coordination of care/services –Clinical coordinator will be responsible for follow up. Staff educated 10/20/2015 Plan of Care Policy updated to include wound assessment and documentation expectations.	10/20/2015

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	by the skilled nursing facility. b. During the observation, Employee F, the Clinical Coordinator, and Employee B, home health aide, verified that the patient was lying on a regular mattress and bed provided by the facility. c. On 10/01/15 at 11:55 AM, Employee D stated the patient had the hospital bed and air mattress at home and was sent with the patient when transferred to the skilled nursing facility. Employee D stated that the patient had changed rooms at the facility and she did notice if the bed and mattress transferred with the patient. 2. Clinical record #7, with an established plan of care for skilled nursing two times a week for eight weeks then two times a week for one week. The patient resides in a skilled nursing facility. a. A skilled nursing visit note dated 07/20/15 indicated the patient had a stage I wound to the left buttock measuring 1 x 1 centimeters. The measurement was provided by the facility. The visit note indicated that the wound dressings were changed per orders and to see the plan of care. The visit note failed to include the specific treatment for the left buttock wound.		Staff educated on changes 10/20/2015 Initial and Comprehensive Assessment Policy Reviewed. Staff educated10/21/15	

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	b. Skilled nursing visit notes dated 07/24/15, indicated the left buttock wound was not assessed due to the patient was already up and dressed. Skilled nursing visit note dated 07/28/15, indicated the left buttock wound was not assessed due to the patient was up in the dining room. On 07/31/15, the skilled nursing visit note indicated the left buttock was not assessed, evaluated, or measured. The clinical record failed to evidence that the left buttock wound had been assessed for three consecutive visits and failed to include documentation of coordination with the facility staff nurse in regards to pressure wound appearance and measurements. 3. Employee F, Hospice Clinical Coordinator was interviewed on 10/01/15 at 1:30 PM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.			
L 0782 Bldg. 00	418.112(f) ORIENTATION AND TRAINING OF STAFF Hospice staff must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses			

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	to death, patient rights, appropriate forms, and record keeping requirements. Based on record review and interview, the agency failed to ensure to meet record keeping requirements when providing inservices to skilled nursing facilities. Findings include: 1. During the entrance conference on 09/29/15 at 12:00 PM, the Director was instructed to provide all 7 facility orientation training information and logs. 2. On 09/29/15 at 4:45 PM, the agency was instructed again to provide all 7 facility orientation training information and logs. 3. On 09/30/15 at 2:00 PM, the Supporting Director indicated that she had to contact the facilities to obtain record keeping logs and that the agency probably should start keeping record of inservices provided.	L 0782	Department Director is responsible for the following: In-services are provided to Contracted facilities annually. Records of attendance for the in-services have been housed in the respective facilities. Facilities will be contacted to provide hospice a copy of in-service attendance records when Hospice in-service has been completed. A copy of in-service record will be kept in Hospice office with contract. All Facilities will be notified of expectation by 10/23/2015	10/20/2015