

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/09/2012
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NAME OF PROVIDER OR SUPPLIER VITAS HEALTHCARE CORPORATION MIDWEST	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY SUITE 118 MERRILLVILLE, IN 46410
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S0000	<p>This visit was for an initial hospice state licensure survey.</p> <p>Survey date: 3/5/12 - 3/8/12</p> <p>Facility #: 012759</p> <p>Medicaid vendor #: N/A</p> <p>Surveyor: Ingrid Miller, PHNS, RN Tonya Tucker, PHNS, RN Janet Brandt, PHNS, RN</p> <p>Skilled Unduplicated Census: 10</p>	S0000	<p>This Plan of Correction, prepared by Vitas Healthcare Corporation Midwest, Northwest Indiana, (Program) describes the actions taken to correct asserted deficiencies found during a survey that concluded on March 9, 2012. This Plan of Correction includes the title of the person responsible for the corrective action and a description of the monitoring/compliance process that will be implemented.</p> <p>Given these actions, Program believes that it is in compliance with all requirements of the Medicare Hospice Benefit Conditions of Participation.</p>	

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.

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	Quality Review: Joyce Elder, MSN, BSN, RN March 19, 2012			

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S0533	<p>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 of the patient requires, but no less frequently than every 15 days.</p> <p>Based on interview, observation, and review of policy and clinical records, the hospice failed to ensure the comprehensive assessment included information on the patient's progress toward desired outcomes as well as a reassessment of the patient's response to care for 1 of 11 clinical records (patient #2) reviewed of patients that received services greater than 15 days.</p> <p>Findings:</p> <p>1. Clinical record #2, start of care 1/22/12, evidenced the patient was receiving Roxanol for pain since 3/4/12 and had issues with eye swelling and matting of eyes. These concerns were identified in the comprehensive assessments dated 2/16/12 and 2/21/12.</p>	S0533	<p>S 533 Update of Comprehensive Assessment Program has reviewed its process for</p> <ul style="list-style-type: none"> - Documenting the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care including an assessment update at least every 15 days. - Completion of a plan of care which specifies the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions. - Facilitating exchange of information among facility staff - Designation of RN to provide coordination of care <p>Corrective Action for patients</p>	04/06/2012

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	<p>However, these concerns were not updated into the latest plan of care as evidenced by the following:</p> <p>A. The hospice document titled "Nursing-Initial/Updated Comprehensive Assessment" and dated 2/16/12 stated, "Patient's R [right] eye had some scant drainage noted. FS [facility] nurse made aware. Will alert RN [Registered Nurse] if continues or worsens. RN to assess further at next visit to determine if intervention is required." This document was signed by Employee A, Registered Nurse.</p> <p>B. The hospice document titled "Nursing - Initial / Updated Comprehensive Assessment" dated 2/21/12 failed to evidence an assessment of patient's right eye. This document was signed by Employee A.</p> <p>C. The hospice document titled "Plan of Care Review" dated 2/22/12 and signed by Employee A documented no assessment of patient's eyes. This document states, "Signature of team member authenticates participation of IDG [interdisciplinary group] in review and revision of this plan of care."</p> <p>D. The skilled nursing facility document titled "SEBOS NURSING</p>		<p>identified by this survey: Patient #2 chart updated with documentation to support the eye assessment and use of Roxanol in the notes on the POC as applicable and on the POC Review form.</p> <p>Corrective action for other patients identified with the potential to be affected by the same deficient practice: Program has completed a 100% review of active patient files to ensure documentation of the assessment of the patient's progress toward outcomes, a reassessment of the patient response to care, a POC reflective of assessed findings and an updated comprehensive assessment including an accurate POC Review form</p> <p>Immediate measures/changes put in place to ensure deficient practice does not recur: Program has completed a review of their process to document assessed findings on the POC as well as on the updated comprehensive assessment POC Review. The focus of the review included documentation of: ·Assessed findings on the initial and updated comprehensive assessment ·Outcomes, goals and interventions on the POC as identified on the initial and updated comprehensive assessments</p>				

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	<p>AND REHABILITATION CENTER Resident Progress Notes: [patient #2]" stated, "3/5/12 6:01 AM Upon CNA getting resident up this morning she reported reddish / purple discoloration to resident's left eye with slight swelling. Discoloration measures 1.5 cm [centimeter] X [by] 1 cm in size. Scratch observed under left eye, measuring 1 cm X 1 cm in size, no bleeding or drainage observed. sclera appears slightly pink, no drainage is coming from eye. Appears resident may be rubbing his eye from possible irritation. CNA stated, 'his eye wasn't like that yesterday.' Resident states, 'I don't know how that got there', resident is confused per usual. No signs / symptoms of pain or discomfort, no facial grimaces observed. Notified family (cousin) emergency contact that's listed. Texted MD [medical doctor] per MD request, MD texted back new orders received to monitor eye for increase in bruising or swelling. Safety maintained will continue to monitor." This was signed by a Licensed Practical Nurse [LPN] at the skilled nursing facility [SNF].</p> <p>E. On 3/6/12 at 9 AM, Employee H, Home Health Aide, gave a shower to patient #2 at the SNF. A certified nursing assistant assisted with the transfer of the patient due to the patient's difficulty</p>		<ul style="list-style-type: none"> ·Patient's progress toward desired outcomes on the initial and updated comprehensive assessments /POC Review forms ·The patient's response to care on the initial and updated comprehensive assessments /POC Review forms ·Coordination of assessed findings and care with facility staff ·Role of designated RN to coordinate care <p>Additionally program managers are completing joint visits with the patient care staff to reinforce documentation training.</p> <p>Title of Person(s) responsible for Corrective Action: Patient Care Administrator</p> <p>Monitoring/Compliance Process: During the 3 month period following the survey, Program will review the charts of active patients according to the VITAS Standard Program Required Reviews using Comprehensive Assessment and Plan of Care Core Review to ensure documentation of assessed findings on the POC, response to care, progress towards outcomes and coordination with LTC facility. The number of reviews conducted after the initial 3 month period will be based on the initial auditing results.</p>				

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	<p>in mobility and continued to assist during the course of the entire shower. Employee H indicated the patient has had matting of both eyes for an extended period of time and frequently scratches and rub both eyes. Employee H removed matting from both eyes as eyes were washed.</p> <p>F. The skilled nursing facility document titled "Resident Progress Notes" with a run date of 3/7/12 and signed by a facility LPN stated, "3/4/2012 12:23 PM Alert but noted to be confused occasionally at 11:40 am patient noted to be increasingly in pain by facial grimacing through denied pain earlier but later confirmed to be in pain to 'general' body. Medicated with, prescribed via hospice via morphine sulfate. Patient more relaxed in activity with other patients with eyes closed and no grimacing noted. Would continue to monitor as required."</p> <p>G. The SNF document titled "Sebos Nursing and Rehabilitation Center PRN Medication notes -- [Patient #2]" stated, "3/4/12 11:40 AM Morphine 0.25 ml [milliliter] sl [sublingual] reason: facial grimacing/pain, initial F [LPN employed by the SNF] result: relief at 12 PM noted by LPN of SNF" and "3/6/12 8 AM Morphine .25 ml sl for facial</p>						

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	<p>grimacing/pain by LPN of the SNF with relief noted at 8:40 AM."</p> <p>H. At a home visit observation on 3/6/12 at 8:55 AM, a LPN at SNF indicated patient #2 had a dose of Roxanol per facility order less than an hour prior to this visit. This facility nurse reported patient #2 had facial grimacing indicating nonverbal response to pain prior to receiving pain medication.</p> <p>I. On 3/7/12 at 10 AM, the IDG discussed the needs of Patient #2. Employee A and Employee H were present at this meeting. No discussion of the patient's eye concerns or recent addition of Roxanol occurred with the IDG and Employees A and H.</p> <p>J. The hospice document titled "Plan of Care Review" dated 3-7-12 and signed by Employee A documented no assessment of patient's eyes. This document states, "Signature of team member authenticates participation of IDG in review and revision of this plan of care".</p> <p>2. On 3/8/12 at 3 PM, Employee N, the patient care coordinator, and employee O, the corporate nurse, indicated these concerns noted in the comprehensive assessment were not updated on the plan of care.</p>			

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	<p>3. The hospice policy titled "Plan of Care Review" and dated 8-12-10 stated, "What: Review of the plan of care [poc] for the prior 2 weeks (or less) and the plan for the next 2 weeks. Includes information from the patient's Updated Comprehensive Assessment and the patient's progress toward outcomes specified in the POC."</p> <p>4. The hospice policy titled "Vitas Innovative Hospice Care ... Vitas Standard" and dated 5/10/10 stated, "General Instructions: Review each assessment category for which there are open care plans (POC review form) ... consider all assessment findings from the updated comprehensive assessment including physical findings, emotional response to symptoms, response to care, patient level of concern, and amount of assistance needed ... Using the scale below, the team should come to a consensus regarding the level of impairment for each assessment category for which there is an open care plan."</p> <p>5. The hospice policy titled "Interdisciplinary Team Policies Assessment" with a policy number 5:16, original date 10/1/93 and revision date 12/2/08, stated, "Comprehensive Assessment: to identify the physical, psychosocial, emotional and spiritual care</p>						

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	<p>needs related to the terminal illness that will be addressed in order to promote the hospice patients well being, comfort and dignity throughout the dying process.</p> <p>Updated comprehensive assessment: to identify changes that have taken place since the initial assessment and includes information on the patients progress toward desired outcomes, as well as a reassessment of the patients response to care ... all significant findings identified during assessments and updated assessments will be documented in the patient's records."</p> <p>6. The hospice policy titled "Interdisciplinary Team Policies Care Planning" policy 5:17 with a date of 10/1/03 and revision date of 6/23/09 stated, "Content of the Plan of Care ... Measurable outcomes anticipated and coordinating the plan of care."</p>			

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S0538	<p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.</p> <p>Based on home visit observation, clinical record review, policy review, and interview, the hospice failed to ensure a plan of care was developed based on the patient / family needs identified for 1 of 11 records (Record #2) reviewed with the potential to affect all the facility's patients.</p> <p>Findings</p> <p>1. Clinical record #2, start of care 1/22/12, evidenced the patient was receiving Roxanol for pain since 3/4/12 and had issues with eye swelling and matting of eyes. These concerns were identified in the comprehensive assessments dated 2/16/12 and 2/21/12. However, these concerns were not updated into the latest plan of care as evidenced by the following:</p> <p>A. The hospice document titled "Nursing-Initial/Updated Comprehensive Assessment" and dated 2/16/12 stated,</p>	S0538	<p>S 538 IDG, Care Planning, Coordination of Services See 533</p> <p>Corrective Action for patients identified by this survey: See 533</p> <p>Corrective action for other patients identified with the potential to be affected by the same deficient practice: See 533</p> <p>Immediate measures/changes put in place to ensure deficient practice does not recur: See 533</p> <p>Title of Person(s) responsible for Corrective Action: Patient Care Administrator</p> <p>Monitoring/Compliance Process: See 533</p>	04/06/2012			

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	<p>"Patient's R [right] eye had some scant drainage noted. FS [facility] nurse made aware. Will alert RN [Registered Nurse] if continues or worsens. RN to assess further at next visit to determine if intervention is required." This document was signed by Employee A, Registered Nurse.</p> <p>B. The hospice document titled "Nursing - Initial / Updated Comprehensive Assessment" dated 2/21/12 failed to evidence an assessment of patient's right eye. This document was signed by Employee A.</p> <p>C. The hospice document titled "Plan of Care Review" dated 2/22/12 and signed by Employee A documented no assessment of patient's eyes. This document states, "Signature of team member authenticates participation of IDG [interdisciplinary group] in review and revision of this plan of care."</p> <p>D. The skilled nursing facility document titled "SEBOS NURSING AND REHABILITATION CENTER Resident Progress Notes: [patient #2]" stated, "3/5/12 6:01 AM Upon CNA getting resident up this morning she reported reddish / purple discoloration to resident's left eye with slight swelling. Discoloration measures 1.5 cm</p>			

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	<p>[centimeter] X [by] 1 cm in size. Scratch observed under left eye, measuring 1 cm X 1 cm in size, no bleeding or drainage observed. sclera appears slightly pink, no drainage is coming from eye. Appears resident may be rubbing his eye from possible irritation. CNA stated, 'his eye wasn't like that yesterday.' Resident states, 'I don't know how that got there', resident is confused per usual. No signs / symptoms of pain or discomfort, no facial grimaces observed. Notified family (cousin) emergency contact that's listed. Texted MD [medical doctor] per MD request, MD texted back new orders received to monitor eye for increase in bruising or swelling. Safety maintained will continue to monitor." This was signed by a Licensed Practical Nurse [LPN] at the skilled nursing facility [SNF].</p> <p>E. On 3/6/12 at 9 AM, Employee H, Home Health Aide, gave a shower to patient #2 at the SNF. A certified nursing assistant assisted with the transfer of the patient due to the patient's difficulty in mobility and continued to assist during the course of the entire shower. Employee H indicated the patient has had matting of both eyes for an extended period of time and frequently scratches and rub both eyes. Employee H removed matting from both eyes as eyes were</p>						

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	<p>washed.</p> <p>F. The skilled nursing facility document titled "Resident Progress Notes" with a run date of 3/7/12 and signed by a facility LPN stated, "3/4/2012 12:23 PM Alert but noted to be confused occasionally at 11:40 am patient noted to be increasingly in pain by facial grimacing through denied pain earlier but later confirmed to be in pain to 'general' body. Medicated with, prescribed via hospice via morphine sulfate. Patient more relaxed in activity with other patients with eyes closed and no grimacing noted. Would continue to monitor as required."</p> <p>G. The SNF document titled "Sebos Nursing and Rehabilitation Center PRN Medication notes -- [Patient #2]" stated, "3/4/12 11:40 AM Morphine 0.25 ml [milliliter] sl [sublingual] reason: facial grimacing/pain, initial F [LPN employed by the SNF] result: relief at 12 PM noted by LPN of SNF" and "3/6/12 8 AM Morphine .25 ml sl for facial grimacing/pain by LPN of the SNF with relief noted at 8:40 AM."</p> <p>H. At a home visit observation on 3/6/12 at 8:55 AM, a LPN at SNF indicated patient #2 had a dose of Roxanol per facility order less than an</p>			

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	<p>hour prior to this visit. This facility nurse reported patient #2 had facial grimacing indicating nonverbal response to pain prior to receiving pain medication.</p> <p>I. On 3/7/12 at 10 AM, the IDG discussed the needs of Patient #2. Employee A and Employee H were present at this meeting. No discussion of the patient's eye concerns or recent addition of Roxanol occurred with the IDG and Employees A and H.</p> <p>J. The hospice document titled "Plan of Care Review" dated 3-7-12 and signed by Employee A documented no assessment of patient's eyes. This document states, "Signature of team member authenticates participation of IDG in review and revision of this plan of care".</p> <p>2. On 3/8/12 at 3 PM, Employee N, the patient care coordinator, and employee O, the corporate nurse, indicated these concerns noted in the comprehensive assessment were not updated on the plan of care.</p> <p>3. The hospice policy titled "Plan of Care Review" and dated 8-12-10 stated, "What: Review of the plan of care [poc] for the prior 2 weeks (or less) and the plan for the next 2 weeks. Includes information from the patient's Updated Comprehensive</p>						

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	<p>Assessment and the patient's progress toward outcomes specified in the POC."</p> <p>4. The hospice policy titled "Vitas Innovative Hospice Care ... Vitas Standard" and dated 5/10/10 stated, "General Instructions: Review each assessment category for which there are open care plans (POC review form) ... consider all assessment findings from the updated comprehensive assessment including physical findings, emotional response to symptoms, response to care, patient level of concern, and amount of assistance needed ... Using the scale below, the team should come to a consensus regarding the level of impairment for each assessment category for which there is an open care plan."</p> <p>5. The hospice policy titled "Interdisciplinary Team Policies Assessment" with a policy number 5:16, original date 10/1/93 and revision date 12/2/08, stated, "Comprehensive Assessment: to identify the physical, psychosocial, emotional and spiritual care needs related to the terminal illness that will be addressed in order to promote the hospice patients well being, comfort and dignity throughout the dying process. Updated comprehensive assessment: to identify changes that have taken place since the initial assessment and includes</p>						

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	<p>information on the patients progress toward desired outcomes, as well as a reassessment of the patients response to care ... all significant findings identified during assessments and updated assessments will be documented in the patient's records."</p> <p>6. The hospice policy titled "Interdisciplinary Team Policies Care Planning" policy 5:17 with a date of 10/1/03 and revision date of 6/23/09 stated, "Content of the Plan of Care ... Measurable outcomes anticipated and coordinating the plan of care."</p>						

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S0540	<p>418.56(a)(1) APPROACH TO SERVICE DELIVERY The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care.</p> <p>Based on home visit observation, clinical record review, policy review, and interview, the hospice failed to ensure the registered nurse and a member of the interdisciplinary group provided coordination of care for 1 of 2 patients (patient #2) observed in a skilled nursing facility with the potential to affect all the facility's patients who reside in a skilled nursing facility.</p> <p>Findings</p> <p>1. Clinical record #2, start of care 1/22/12, evidenced the patient was receiving Roxanol for pain since 3/4/12 and had issues with eye swelling and matting of eyes. These concerns were identified in the comprehensive assessments dated 2/16/12 and 2/21/12. However, these concerns were not updated into the latest plan of care as evidenced by the following:</p> <p>A. The hospice document titled</p>	S0540	<p>S 540 Approach to Service Delivery See 533</p> <p>Corrective Action for patients identified by this survey: See 533</p> <p>Corrective action for other patients identified with the potential to be affected by the same deficient practice: See 533</p> <p>Immediate measures/changes put in place to ensure deficient practice does not recur: See 533</p> <p>Title of Person(s) responsible for Corrective Action: Patient Care Administrator</p> <p>Monitoring/Compliance Process: See 533</p>	04/06/2012			

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	<p>"Nursing-Initial/Updated Comprehensive Assessment" and dated 2/16/12 stated, "Patient's R [right] eye had some scant drainage noted. FS [facility] nurse made aware. Will alert RN [Registered Nurse] if continues or worsens. RN to assess further at next visit to determine if intervention is required." This document was signed by Employee A, Registered Nurse.</p> <p>B. The hospice document titled "Nursing - Initial / Updated Comprehensive Assessment" dated 2/21/12 failed to evidence an assessment of patient's right eye. This document was signed by Employee A.</p> <p>C. The hospice document titled "Plan of Care Review" dated 2/22/12 and signed by Employee A documented no assessment of patient's eyes. This document states, "Signature of team member authenticates participation of IDG [interdisciplinary group] in review and revision of this plan of care."</p> <p>D. The skilled nursing facility document titled "SEBOS NURSING AND REHABILITATION CENTER Resident Progress Notes: [patient #2]" stated, "3/5/12 6:01 AM Upon CNA getting resident up this morning she reported reddish / purple discoloration to</p>						

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	<p>resident's left eye with slight swelling. Discoloration measures 1.5 cm [centimeter] X [by] 1 cm in size. Scratch observed under left eye, measuring 1 cm X 1 cm in size, no bleeding or drainage observed. sclera appears slightly pink, no drainage is coming from eye. Appears resident may be rubbing his eye from possible irritation. CNA stated, 'his eye wasn't like that yesterday.' Resident states, 'I don't know how that got there', resident is confused per usual. No signs / symptoms of pain or discomfort, no facial grimaces observed. Notified family (cousin) emergency contact that's listed. Texted MD [medical doctor] per MD request, MD texted back new orders received to monitor eye for increase in bruising or swelling. Safety maintained will continue to monitor." This was signed by a Licensed Practical Nurse [LPN] at the skilled nursing facility [SNF].</p> <p>E. On 3/6/12 at 9 AM, Employee H, Home Health Aide, gave a shower to patient #2 at the SNF. A certified nursing assistant assisted with the transfer of the patient due to the patient's difficulty in mobility and continued to assist during the course of the entire shower. Employee H indicated the patient has had matting of both eyes for an extended period of time and frequently scratches</p>			

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	<p>and rub both eyes. Employee H removed matting from both eyes as eyes were washed.</p> <p>F. The skilled nursing facility document titled "Resident Progress Notes" with a run date of 3/7/12 and signed by a facility LPN stated, "3/4/2012 12:23 PM Alert but noted to be confused occasionally at 11:40 am patient noted to be increasingly in pain by facial grimacing through denied pain earlier but later confirmed to be in pain to 'general' body. Medicated with, prescribed via hospice via morphine sulfate. Patient more relaxed in activity with other patients with eyes closed and no grimacing noted. Would continue to monitor as required."</p> <p>G. The SNF document titled "Sebos Nursing and Rehabilitation Center PRN Medication notes -- [Patient #2]" stated, "3/4/12 11:40 AM Morphine 0.25 ml [milliliter] sl [sublingual] reason: facial grimacing/pain, initial F [LPN employed by the SNF] result: relief at 12 PM noted by LPN of SNF" and "3/6/12 8 AM Morphine .25 ml sl for facial grimacing/pain by LPN of the SNF with relief noted at 8:40 AM."</p> <p>H. At a home visit observation on 3/6/12 at 8:55 AM, a LPN at SNF</p>						

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	<p>indicated patient #2 had a dose of Roxanol per facility order less than an hour prior to this visit. This facility nurse reported patient #2 had facial grimacing indicating nonverbal response to pain prior to receiving pain medication.</p> <p>I. On 3/7/12 at 10 AM, the IDG discussed the needs of Patient #2. Employee A and Employee H were present at this meeting. No discussion of the patient's eye concerns or recent addition of Roxanol occurred with the IDG and Employees A and H.</p> <p>J. The hospice document titled "Plan of Care Review" dated 3-7-12 and signed by Employee A documented no assessment of patient's eyes. This document states, "Signature of team member authenticates participation of IDG in review and revision of this plan of care".</p> <p>2. On 3/8/12 at 3 PM, Employee N, the patient care coordinator, and employee O, the corporate nurse, indicated these concerns noted in the comprehensive assessment were not updated on the plan of care.</p> <p>3. The hospice policy titled "Plan of Care Review" and dated 8-12-10 stated, "What: Review of the plan of care [poc] for the prior 2 weeks (or less) and the plan for the</p>						

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	<p>next 2 weeks. Includes information from the patient's Updated Comprehensive Assessment and the patient's progress toward outcomes specified in the POC."</p> <p>4. The hospice policy titled "Vitas Innovative Hospice Care ... Vitas Standard" and dated 5/10/10 stated, "General Instructions: Review each assessment category for which there are open care plans (POC review form) ... consider all assessment findings from the updated comprehensive assessment including physical findings, emotional response to symptoms, response to care, patient level of concern, and amount of assistance needed ... Using the scale below, the team should come to a consensus regarding the level of impairment for each assessment category for which there is an open care plan."</p> <p>5. The hospice policy titled "Interdisciplinary Team Policies Assessment" with a policy number 5:16, original date 10/1/93 and revision date 12/2/08, stated, "Comprehensive Assessment: to identify the physical, psychosocial, emotional and spiritual care needs related to the terminal illness that will be addressed in order to promote the hospice patients well being, comfort and dignity throughout the dying process. Updated comprehensive assessment: to</p>						

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	<p>identify changes that have taken place since the initial assessment and includes information on the patients progress toward desired outcomes, as well as a reassessment of the patients response to care ... all significant findings identified during assessments and updated assessments will be documented in the patient's records."</p>			

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S0543	<p>418.56(b) 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.</p>	S0543	<p>S 543 Plan of Care See 533</p> <p>Corrective Action for patients identified by this survey: Patient #3, #7 and #8 files contain a written POC reflecting patient and family specific measurable outcomes and coordination of care with LTC as applicable.</p> <p>Corrective action for other patients identified with the potential to be affected by the same deficient practice: See 533</p> <p>Immediate measures/changes put in place to ensure deficient practice does not recur: See 533</p> <p>Title of Person(s) responsible for Corrective Action: Patient Care Administrator</p> <p>Monitoring/Compliance Process: .See 533</p>	04/06/2012			

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	<p>Based on medical record review, interdisciplinary group meeting observation, and policy review, the hospice failed to have a written plan of care that reflected patient and family specific measurable outcomes from implementation and coordinating the plan of care for 3 of 11 records reviewed (#3, #7, #8) with the potential to affect all the facility's patients.</p> <p>Findings include:</p> <p>1. Medical record #3 with a start of care 10-20-11 and a diagnosis of "End Stage Dementia evidenced an "Updated Comprehensive Assessment" dated 2-14-12 completed by the registered nurse. The assessment evidenced under "Integumentary," "No skin breakdown but skin very dry. Crusty area noted behind right ear." The clinical record failed to evidence a written POC (Plan of Care) in consultation with the IDT (Interdisciplinary Team) that addressed the patient's crusty ear.</p> <p>A. "Plan of Care review" dated 2-29-12 evidenced under "integumentary" a note that stated, "Bruise noted to top of left foot. No skin breakdown noted or reported."</p> <p>B. A POC titled "Otitis / ear pain"</p>			
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	<p>dated 1-18-12 evidenced a physician order for "Levaquin-oral, 1 tab x 5 days." The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and outcomes for the Otitis.</p> <p>C. Review of the "Infection Control Surveillance Form" dated 1-26-12 by the registers nurse identified under "Location of Infection" that a respiratory and Ear / Nose / Throat infection. The clinical record failed to evidence a written POC in consultation with the IDT that addressed the respiratory or ear infection.</p> <p>D. Review of the "Infection Control Surveillance Form" dated 11-21-11 evidenced a respiratory infection identified 11-20-11. The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and outcomes for the infections identified.</p> <p>E. The "Appropriateness Evaluation" completed for patient #3 on 10-20-11 by the registered nurse and patient / POA (power of attorney) states, under "Self Determination / Other documented specifications" (as identified by the patient/POA), "No antibiotics, No dialysis, no blood products, no surgery, no invasive diagnostics, no mechanical</p>						

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	<p>respiration."</p> <p>F. The clinical record failed to evidence a written POC in consultation with the IDT that addressed weight loss identified by the registered nurse on the "Updated Comprehensive Assessment" completed 1-13-12. Under "Gastrointestinal" the nurse documented, "Patient slowly losing weight despite eating 100% of all meals" (per facility staff report).</p> <p>G. The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and specific outcomes for the Dysphasia POC dated 1-23-12. There is a physician order for "Thickened liquids with pureed diet." The "Outcome" stated, "Maximize symptom management." The "Intervention" was to "Assess and monitor symptoms at each visit-Swallowing", without identifying what the symptoms to be monitored were,</p> <p>2. Clinical record #7 evidenced a start of care date of 12-09-11 with a diagnosis of "End Stage Dementia." The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and specific outcomes for a urinary tract infection identified 1-5-12 per the "Infection</p>			

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	<p>Control Surveillance Form" dated 1-16-12.</p> <p>The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and specific outcomes for "greenish drainage from eyes, Left greater than right crustiness in a.m." documented on the 2-20-12 "Updated Comprehensive Assessment" completed by the registered nurse. "The Plan of Care Review" was dated 2-22-12.</p> <p>3. Clinical record #8 failed to evidence a written POC in consultation with the IDT that addressed specific interventions and outcomes related to the patient's right heel ulcer.</p> <p>Documentation of the right heel ulcer was evidenced per "Wound Information/Progress Report[s]" dated 1-6-12, 1-17-12, 1-20-12, 1-27-12, 2-3-12, 2-7-12, 2-14-12, and 2-21-12.</p> <p>The "Nursing Initial / Updated Comprehensive Assessment" document dated 1-6-12, under "Integumentary", states, "Right heel pressure ulcer was debrided yesterday by facility staff. No new skin breakdown noted or reported."</p> <p>A. A document titled "Interdisciplinary Plan of Care Revision / Physician Orders" dated 10-12-11 stated,</p>						

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	<p>"Granulex and dry dressing to right heel ulcer, change daily." The documents failed to evidence "Interventions", "Outcome", or "Discipline", or "Discontinuation or Change Date".</p> <p>No further documentation related to this POC/Physician order was available per employee O per interview on 3/7/12 at 4:00 PM. Employee O stated, "There were measurements done weekly, I believe the care is being done, but maybe not always documented."</p> <p>B. The failed to evidence a written POC in consultation with the IDT that addressed "Outcomes" or "Interventions" related to the "head wound" documented on the "Interdisciplinary Plan of Care Revision/Physician Orders" document dated 1-2-11 with onset date documented 12-21-11 and physician signature dated 1-14-12.</p> <p>4. On 3/7/12 at 4:00 PM, employee O indicated the registered nurse nurse measures wounds weekly and documents on the "Wound Information/Progress Report" document. Any changes to treatment or care are per "Physician Orders/Plan of Care" documents and are reviewed (as documented on the "Plan of Care Review" document.) Employee O indicated the registered nurse reviews</p>						

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	<p>pertinent data related to wounds with IDT at the IDT meetings and the medication review may include the treatments the patient is receiving so the treatments may be reviewed as part of that process.</p> <p>There is to be a Plan of Care for any issues identified in the "Initial / Updated Comprehensive Assessment" note completed by each discipline making visits to the patient. Issues that generate a plan of care are to be reviewed at the interdisciplinary team meeting. The interdisciplinary team reviews each patient every two weeks. The interdisciplinary team reviews the prior two weeks of care and plans and determines any changes in treatment that need to be made at each IDT meeting. The Initial POC (Plan of Care) review is completed at the first team meeting after admission and then at least every 14-15 days for every patient. The initial comprehensive assessment, the medication profile/record and the initial physician orders may be part of the terminal plan of care along with the updated plans of care / physician orders.</p> <p>5. The policy 8.12.10 "Plan of Care Review" states, "The POC (Plan of Care) Review is a review of the plan of care for the prior 2 weeks (or less) and the plan for the next 2 weeks. Includes information</p>				

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	<p>from the patient's Updated Comprehensive Assessment and the patient's progress toward outcomes specified in the POC."</p> <p>6. The hospice policy titled "Interdisciplinary Team Policies Care Planning, Policy Number: 5:17 1 of 4" with an origination date of 10/01/1993 and last revised date of 06/23/09 stated, "Objective(s) ... The initial plan of care begins at the time of admission based on the first part of the comprehensive assessment, is updated based on completion of the comprehensive assessment and is continually updated while the patient remains while the patient remains on hospice based on continuing updates to the comprehensive assessment ... Procedure(s), Approach to service delivery ... the primary registered nurse provides coordination of care, to ensure continuous assessment of each patient's and family's needs and implementation of interdisciplinary plan of care."</p>			

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S0545	<p>418.56(c) CONTENT OF 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, including the following:</p> <p>Based on home visit observation, record review, policy review, and interview, the hospice failed to ensure each patient had an individualized plan of care based on the problems identified in the initial, comprehensive, and updated comprehensive assessments for 5 of 11 patients (#2, 3, 6, 7 and 8) with the potential to affect all the patients of the hospice.</p> <p>Findings</p> <p>1. Clinical record #2, start of care 1/22/12, evidenced the patient was receiving Roxanol for pain since 3/4/12 and had issues with eye swelling and matting of eyes. These concerns were identified in the comprehensive assessments dated 2/16/12 and 2/21/12. However, these concerns were not updated into the latest plan of care as evidenced by the following:</p>	S0545	<p>S 545 Content of POC See 533</p> <p>Corrective Action for patients identified by this survey: Patient #2, #3, #6, #7 and #8 files contain a current POC based on problems identified in the updated comprehensive assessment</p> <p>Corrective action for other patients identified with the potential to be affected by the same deficient practice: See 533</p> <p>Immediate measures/changes put in place to ensure deficient practice does not recur: See 533</p> <p>Title of Person(s) responsible for Corrective Action: Patient Care Administrator</p> <p>Monitoring/Compliance Process: See 533</p>	04/06/2012			

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	<p>A. The hospice document titled "Nursing-Initial/Updated Comprehensive Assessment" and dated 2/16/12 stated, "Patient's R [right] eye had some scant drainage noted. FS [facility] nurse made aware. Will alert RN [Registered Nurse] if continues or worsens. RN to assess further at next visit to determine if intervention is required." This document was signed by Employee A, Registered Nurse.</p> <p>B. The hospice document titled "Nursing - Initial / Updated Comprehensive Assessment" dated 2/21/12 failed to evidence an assessment of patient's right eye. This document was signed by Employee A.</p> <p>C. The hospice document titled "Plan of Care Review" dated 2/22/12 and signed by Employee A documented no assessment of patient's eyes. This document states, "Signature of team member authenticates participation of IDG [interdisciplinary group] in review and revision of this plan of care."</p> <p>D. The skilled nursing facility document titled "SEBOS NURSING AND REHABILITATION CENTER Resident Progress Notes: [patient #2]" stated, "3/5/12 6:01 AM Upon CNA</p>			

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	<p>getting resident up this morning she reported reddish / purple discoloration to resident's left eye with slight swelling. Discoloration measures 1.5 cm [centimeter] X [by] 1 cm in size. Scratch observed under left eye, measuring 1 cm X 1 cm in size, no bleeding or drainage observed. sclera appears slightly pink, no drainage is coming from eye. Appears resident may be rubbing his eye from possible irritation. CNA stated, 'his eye wasn't like that yesterday.' Resident states, 'I don't know how that got there', resident is confused per usual. No signs / symptoms of pain or discomfort, no facial grimaces observed. Notified family (cousin) emergency contact that's listed. Texted MD [medical doctor] per MD request, MD texted back new orders received to monitor eye for increase in bruising or swelling. Safety maintained will continue to monitor." This was signed by a Licensed Practical Nurse [LPN] at the skilled nursing facility [SNF].</p> <p>E. On 3/6/12 at 9 AM, Employee H, Home Health Aide, gave a shower to patient #2 at the SNF. A certified nursing assistant assisted with the transfer of the patient due to the patient's difficulty in mobility and continued to assist during the course of the entire shower. Employee H indicated the patient has had</p>			
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	<p>matting of both eyes for an extended period of time and frequently scratches and rub both eyes. Employee H removed matting from both eyes as eyes were washed.</p> <p>F. The skilled nursing facility document titled "Resident Progress Notes" with a run date of 3/7/12 and signed by a facility LPN stated, "3/4/2012 12:23 PM Alert but noted to be confused occasionally at 11:40 am patient noted to be increasingly in pain by facial grimacing through denied pain earlier but later confirmed to be in pain to 'general' body. Medicated with, prescribed via hospice via morphine sulfate. Patient more relaxed in activity with other patients with eyes closed and no grimacing noted. Would continue to monitor as required."</p> <p>G. The SNF document titled "Sebos Nursing and Rehabilitation Center PRN Medication notes -- [Patient #2]" stated, "3/4/12 11:40 AM Morphine 0.25 ml [milliliter] sl [sublingual] reason: facial grimacing/pain, initial F [LPN employed by the SNF] result: relief at 12 PM noted by LPN of SNF" and "3/6/12 8 AM Morphine .25 ml sl for facial grimacing/pain by LPN of the SNF with relief noted at 8:40 AM."</p>						

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	<p>H. At a home visit observation on 3/6/12 at 8:55 AM, a LPN at SNF indicated patient #2 had a dose of Roxanol per facility order less than an hour prior to this visit. This facility nurse reported patient #2 had facial grimacing indicating nonverbal response to pain prior to receiving pain medication.</p> <p>I. On 3/7/12 at 10 AM, the IDG discussed the needs of Patient #2. Employee A and Employee H were present at this meeting. No discussion of the patient's eye concerns or recent addition of Roxanol occurred with the IDG and Employees A and H.</p> <p>J. The hospice document titled "Plan of Care Review" dated 3-7-12 and signed by Employee A documented no assessment of patient's eyes. This document states, "Signature of team member authenticates participation of IDG in review and revision of this plan of care."</p> <p>2. Clinical record #6, SOC 2/10/12, evidenced an active medication profile report with Sulfamethoxazole / Trimethoprim oral tablet 800-160 mg, take 1 tablet via peg tube twice a day for 5 days for urinary tract infection. This medication and infection were not on the plan of care. The clinical document titled "Hospice Pharmacia Active Medication</p>						

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	<p>Profile Report with a print date of 3/7/12 stated, "Urinary Tract Infections: Sulfamethoxazole / Trimethoprim oral tablet 800 -160 mg [milligrams] take one tablet via peg tube twice a day for 5 days for urinary tract infection. Start date 2/14/12. Stop date 2/14/12. Related."</p> <p>3. Policies</p> <p>A. The hospice policy titled "Vitas Innovative Hospice Care ... Vitas Standard" and dated 5/10/10 stated, "General Instructions: Review each assessment category for which there are open care plans (POC review form) ... consider all assessment findings from the updated comprehensive assessment including physical findings, emotional response to symptoms, response to care, patient level of concern, and amount of assistance needed ... Using the scale below, the team should come to a consensus regarding the level of impairment for each assessment category for which there is an open care plan."</p> <p>B. The hospice policy titled "Interdisciplinary Team Policies Assessment" with a policy number 5:16, original date 10/1/93 and revision date 12/2/08, stated, "Comprehensive Assessment: to identify the physical, psychosocial, emotional and spiritual care</p>						

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	<p>needs related to the terminal illness that will be addressed in order to promote the hospice patients well being, comfort and dignity throughout the dying process. Updated comprehensive assessment: to identify changes that have taken place since the initial assessment and includes information on the patients progress toward desired outcomes, as well as a reassessment of the patients response to care ... all significant findings identified during assessments and updated assessments will be documented in the patient's records."</p> <p>C. The hospice policy titled "Interdisciplinary Team Policies Care Planning" policy 5:17 with a date of 10/1/03 and revision date of 6/23/09 stated, "Content of the Plan of Care ... Measurable outcomes anticipated and coordinating the plan of care."</p> <p>4. Medical record #3 with a start of care 10-20-11 and a diagnosis of "End Stage Dementia evidenced an "Updated Comprehensive Assessment" dated 2-14-12 completed by the registered nurse. The assessment evidenced under "Integumentary," "No skin breakdown but skin very dry. Crusty area noted behind right ear." The clinical record failed to evidence a written POC (Plan of</p>						

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	<p>Care) in consultation with the IDT (Interdisciplinary Team) that addressed the patient's crusty ear.</p> <p>A. "Plan of Care review" dated 2-29-12 evidenced under "integumentary" a note that stated, "Bruise noted to top of left foot. No skin breakdown noted or reported."</p> <p>B. A POC titled "Otitis / ear pain" dated 1-18-12 evidenced a physician order for "Levaquin-oral, 1 tab x 5 days." The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and outcomes for the Otitis.</p> <p>C. Review of the "Infection Control Surveillance Form" dated 1-26-12 by the registers nurse identified under "Location of Infection" that a respiratory and Ear / Nose / Throat infection. The clinical record failed to evidence a written POC in consultation with the IDT that addressed the respiratory or ear infection.</p> <p>D. Review of the "Infection Control Surveillance Form" dated 11-21-11 evidenced a respiratory infection identified 11-20-11. The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and outcomes for</p>						

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	<p>the infections identified.</p> <p>E. The "Appropriateness Evaluation" completed for patient #3 on 10-20-11 by the registered nurse and patient / POA (power of attorney) states, under "Self Determination / Other documented specifications" (as identified by the patient/POA), "No antibiotics, No dialysis, no blood products, no surgery, no invasive diagnostics, no mechanical respiration."</p> <p>F. The clinical record failed to evidence a written POC in consultation with the IDT that addressed weight loss identified by the registered nurse on the "Updated Comprehensive Assessment" completed 1-13-12. Under "Gastrointestinal" the nurse documented, "Patient slowly losing weight despite eating 100% of all meals" (per facility staff report).</p> <p>G. The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and specific outcomes for the Dysphasia POC dated 1-23-12. There is a physician order for "Thickened liquids with pureed diet." The "Outcome" stated, "Maximize symptom management." The "Intervention" was to "Assess and monitor symptoms at each</p>						

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	<p>visit-Swallowing", without identifying what the symptoms to be monitored were,</p> <p>5. Clinical record #7 evidenced a start of care date of 12-09-11 with a diagnosis of "End Stage Dementia." The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and specific outcomes for a urinary tract infection identified 1-5-12 per the "Infection Control Surveillance Form" dated 1-16-12.</p> <p>The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and specific outcomes for "greenish drainage from eyes, Left greater than right crustiness in a.m." documented on the 2-20-12 "Updated Comprehensive Assessment" completed by the registered nurse. "The Plan of Care Review" was dated 2-22-12.</p> <p>6. Clinical record #8 failed to evidence a written POC in consultation with the IDT that addressed specific interventions and outcomes related to the patient's right heel ulcer.</p> <p>Documentation of the right heel ulcer was evidenced per "Wound Information/Progress Report[s]" dated 1-6-12, 1-17-12, 1-20-12, 1-27-12,</p>			

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	<p>2-3-12, 2-7-12, 2-14-12, and 2-21-12. The "Nursing Initial / Updated Comprehensive Assessment" document dated 1-6-12, under "Integumentary", states, "Right heel pressure ulcer was debrided yesterday by facility staff. No new skin breakdown noted or reported."</p> <p>A. A document titled "Interdisciplinary Plan of Care Revision / Physician Orders" dated 10-12-11 stated, "Granulex and dry dressing to right heel ulcer, change daily." The documents failed to evidence "Interventions", "Outcome", or "Discipline", or "Discontinuation or Change Date".</p> <p>No further documentation related to this POC/Physician order was available per employee O per interview on 3/7/12 at 4:00 PM. Employee O stated, "There were measurements done weekly, I believe the care is being done, but maybe not always documented."</p> <p>B. The failed to evidence a written POC in consultation with the IDT that addressed "Outcomes" or "Interventions" related to the "head wound" documented on the "Interdisciplinary Plan of Care Revision/Physician Orders" document dated 1-2-11 with onset date documented 12-21-11 and physician signature dated 1-14-12.</p>						

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	<p>7. On 3/7/12 at 4:00 PM, employee O indicated the registered nurse nurse measures wounds weekly and documents on the "Wound Information/Progress Report" document. Any changes to treatment or care are per "Physician Orders/Plan of Care" documents and are reviewed (as documented on the "Plan of Care Review" document.) Employee O indicated the registered nurse reviews pertinent data related to wounds with IDT at the IDT meetings and the medication review may include the treatments the patient is receiving so the treatments may be reviewed as part of that process.</p> <p>There is to be a Plan of Care for any issues identified in the "Initial / Updated Comprehensive Assessment" note completed by each discipline making visits to the patient. Issues that generate a plan of care are to be reviewed at the interdisciplinary team meeting. The interdisciplinary team reviews each patient every two weeks. The interdisciplinary team reviews the prior two weeks of care and plans and determines any changes in treatment that need to be made at each IDT meeting. The Initial POC (Plan of Care) review is completed at the first team meeting after admission and then at least every 14-15 days for every patient. The initial</p>						

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	<p>comprehensive assessment, the medication profile/record and the initial physician orders may be part of the terminal plan of care along with the updated plans of care / physician orders.</p> <p>8. The policy 8.12.10 "Plan of Care Review" states, "The POC (Plan of Care) Review is a review of the plan of care for the prior 2 weeks (or less) and the plan for the next 2 weeks. Includes information from the patient's Updated Comprehensive Assessment and the patient's progress toward outcomes specified in the POC."</p>			

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S0548	<p>418.56(c)(3) 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:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.</p> <p>Based on home visit observation, record review, policy review, and interview, the hospice failed to ensure each patient had measurable outcomes anticipated from implementing and coordinating care for 5 of 11 patients (#2, 3, 6, 7 and 8) with the potential to affect all the patients of the hospice.</p> <p>Findings</p> <p>1. Clinical record #2, start of care 1/22/12, evidenced the patient was receiving Roxanol for pain since 3/4/12 and had issues with eye swelling and matting of eyes. These concerns were identified in the comprehensive assessments dated 2/16/12 and 2/21/12. However, these concerns were not updated into the latest plan of care as evidenced by the following:</p> <p>A. The hospice document titled "Nursing-Initial/Updated Comprehensive Assessment" and dated 2/16/12 stated,</p>	S0548	<p>S 548 Content of Plan of Care See 533</p> <p>Corrective Action for patients identified by this survey: Patient #2, #3, #6, #7 and #8 files contain a current POC with measurable outcomes based on problems identified in the updated comprehensive assessment</p> <p>Corrective action for other patients identified with the potential to be affected by the same deficient practice: See 533</p> <p>Immediate measures/changes put in place to ensure deficient practice does not recur: See 533</p> <p>Title of Person(s) responsible for Corrective Action: Patient Care Administrator</p> <p>Monitoring/Compliance Process: See 533</p>	04/06/2012			

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	<p>"Patient's R [right] eye had some scant drainage noted. FS [facility] nurse made aware. Will alert RN [Registered Nurse] if continues or worsens. RN to assess further at next visit to determine if intervention is required." This document was signed by Employee A, Registered Nurse.</p> <p>B. The hospice document titled "Nursing - Initial / Updated Comprehensive Assessment" dated 2/21/12 failed to evidence an assessment of patient's right eye. This document was signed by Employee A.</p> <p>C. The hospice document titled "Plan of Care Review" dated 2/22/12 and signed by Employee A documented no assessment of patient's eyes. This document states, "Signature of team member authenticates participation of IDG [interdisciplinary group] in review and revision of this plan of care."</p> <p>D. The skilled nursing facility document titled "SEBOS NURSING AND REHABILITATION CENTER Resident Progress Notes: [patient #2]" stated, "3/5/12 6:01 AM Upon CNA getting resident up this morning she reported reddish / purple discoloration to resident's left eye with slight swelling. Discoloration measures 1.5 cm</p>						

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	<p>[centimeter] X [by] 1 cm in size. Scratch observed under left eye, measuring 1 cm X 1 cm in size, no bleeding or drainage observed. sclera appears slightly pink, no drainage is coming from eye. Appears resident may be rubbing his eye from possible irritation. CNA stated, 'his eye wasn't like that yesterday.' Resident states, 'I don't know how that got there', resident is confused per usual. No signs / symptoms of pain or discomfort, no facial grimaces observed. Notified family (cousin) emergency contact that's listed. Texted MD [medical doctor] per MD request, MD texted back new orders received to monitor eye for increase in bruising or swelling. Safety maintained will continue to monitor." This was signed by a Licensed Practical Nurse [LPN] at the skilled nursing facility [SNF].</p> <p>E. On 3/6/12 at 9 AM, Employee H, Home Health Aide, gave a shower to patient #2 at the SNF. A certified nursing assistant assisted with the transfer of the patient due to the patient's difficulty in mobility and continued to assist during the course of the entire shower. Employee H indicated the patient has had matting of both eyes for an extended period of time and frequently scratches and rub both eyes. Employee H removed matting from both eyes as eyes were</p>						

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	<p>washed.</p> <p>F. The skilled nursing facility document titled "Resident Progress Notes" with a run date of 3/7/12 and signed by a facility LPN stated, "3/4/2012 12:23 PM Alert but noted to be confused occasionally at 11:40 am patient noted to be increasingly in pain by facial grimacing through denied pain earlier but later confirmed to be in pain to 'general' body. Medicated with, prescribed via hospice via morphine sulfate. Patient more relaxed in activity with other patients with eyes closed and no grimacing noted. Would continue to monitor as required."</p> <p>G. The SNF document titled "Sebos Nursing and Rehabilitation Center PRN Medication notes -- [Patient #2]" stated, "3/4/12 11:40 AM Morphine 0.25 ml [milliliter] sl [sublingual] reason: facial grimacing/pain, initial F [LPN employed by the SNF] result: relief at 12 PM noted by LPN of SNF" and "3/6/12 8 AM Morphine .25 ml sl for facial grimacing/pain by LPN of the SNF with relief noted at 8:40 AM."</p> <p>H. At a home visit observation on 3/6/12 at 8:55 AM, a LPN at SNF indicated patient #2 had a dose of Roxanol per facility order less than an</p>						

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	<p>hour prior to this visit. This facility nurse reported patient #2 had facial grimacing indicating nonverbal response to pain prior to receiving pain medication.</p> <p>I. On 3/7/12 at 10 AM, the IDG discussed the needs of Patient #2. Employee A and Employee H were present at this meeting. No discussion of the patient's eye concerns or recent addition of Roxanol occurred with the IDG and Employees A and H.</p> <p>J. The hospice document titled "Plan of Care Review" dated 3-7-12 and signed by Employee A documented no assessment of patient's eyes. This document states, "Signature of team member authenticates participation of IDG in review and revision of this plan of care."</p> <p>K. On 3/8/12 at 3 PM, Employee N, the patient care coordinator, and employee O, the corporate nurse, indicated no measurable outcomes were anticipated with the concern with the eyes and the pain control.</p> <p>2. The hospice policy titled "Interdisciplinary Team Policies Care Planning" policy 5:17 with a date of 10/1/03 and revision date of 6/23/09 stated, "Content of the Plan of Care ... Measurable outcomes anticipated and</p>						

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	<p>coordinating the plan of care ... Review of the plan of care the hospice interdisciplinary group (in collaboration with the individual's attending physician) if any shall review, revise and document the individualized plan as frequently as the patient's condition requires, but no less than 15 calendar days ... coordination of agency services with all other facilities or agencies actively involved in patient's care."</p> <p>3. Medical record #3 with a start of care 10-20-11 and a diagnosis of "End Stage Dementia evidenced an "Updated Comprehensive Assessment" dated 2-14-12 completed by the registered nurse. The assessment evidenced under "Integumentary," "No skin breakdown but skin very dry. Crusty area noted behind right ear." The clinical record failed to evidence a written POC (Plan of Care) in consultation with the IDT (Interdisciplinary Team) that addressed the patient's crusty ear.</p> <p>A. "Plan of Care review" dated 2-29-12 evidenced under "integumentary" a note that stated, "Bruise noted to top of left foot. No skin breakdown noted or reported."</p> <p>B. A POC titled "Otitis / ear pain"</p>						

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	<p>dated 1-18-12 evidenced a physician order for "Levaquin-oral, 1 tab x 5 days." The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and outcomes for the Otitis.</p> <p>C. Review of the "Infection Control Surveillance Form" dated 1-26-12 by the registers nurse identified under "Location of Infection" that a respiratory and Ear / Nose / Throat infection. The clinical record failed to evidence a written POC in consultation with the IDT that addressed the respiratory or ear infection.</p> <p>D. Review of the "Infection Control Surveillance Form" dated 11-21-11 evidenced a respiratory infection identified 11-20-11. The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and outcomes for the infections identified.</p> <p>E. The "Appropriateness Evaluation" completed for patient #3 on 10-20-11 by the registered nurse and patient / POA (power of attorney) states, under "Self Determination / Other documented specifications" (as identified by the patient/POA), "No antibiotics, No dialysis, no blood products, no surgery, no invasive diagnostics, no mechanical</p>						

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	<p>respiration."</p> <p>F. The clinical record failed to evidence a written POC in consultation with the IDT that addressed weight loss identified by the registered nurse on the "Updated Comprehensive Assessment" completed 1-13-12. Under "Gastrointestinal" the nurse documented, "Patient slowly losing weight despite eating 100% of all meals" (per facility staff report).</p> <p>G. The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and specific outcomes for the Dysphasia POC dated 1-23-12. There is a physician order for "Thickened liquids with pureed diet." The "Outcome" stated, "Maximize symptom management." The "Intervention" was to "Assess and monitor symptoms at each visit-Swallowing", without identifying what the symptoms to be monitored were,</p> <p>4. Clinical record #7 evidenced a start of care date of 12-09-11 with a diagnosis of "End Stage Dementia." The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and specific outcomes for a urinary tract infection identified 1-5-12 per the "Infection</p>						

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	<p>Control Surveillance Form" dated 1-16-12.</p> <p>The clinical record failed to evidence a written POC in consultation with the IDT that addressed specific interventions and specific outcomes for "greenish drainage from eyes, Left greater than right crustiness in a.m." documented on the 2-20-12 "Updated Comprehensive Assessment" completed by the registered nurse. "The Plan of Care Review" was dated 2-22-12.</p> <p>5. Clinical record #8 failed to evidence a written POC in consultation with the IDT that addressed specific interventions and outcomes related to the patient's right heel ulcer. Documentation of the right heel ulcer was evidenced per "Wound Information/Progress Report[s]" dated 1-6-12, 1-17-12, 1-20-12, 1-27-12, 2-3-12, 2-7-12, 2-14-12, and 2-21-12. The "Nursing Initial / Updated Comprehensive Assessment" document dated 1-6-12, under "Integumentary", states, "Right heel pressure ulcer was debrided yesterday by facility staff. No new skin breakdown noted or reported."</p> <p>A. A document titled "Interdisciplinary Plan of Care Revision / Physician Orders" dated 10-12-11 stated,</p>						

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	<p>"Granulex and dry dressing to right heel ulcer, change daily." The documents failed to evidence "Interventions", "Outcome", or "Discipline", or "Discontinuation or Change Date".</p> <p>No further documentation related to this POC/Physician order was available per employee O per interview on 3/7/12 at 4:00 PM. Employee O stated, "There were measurements done weekly, I believe the care is being done, but maybe not always documented."</p> <p>B. The failed to evidence a written POC in consultation with the IDT that addressed "Outcomes" or "Interventions" related to the "head wound" documented on the "Interdisciplinary Plan of Care Revision/Physician Orders" document dated 1-2-11 with onset date documented 12-21-11 and physician signature dated 1-14-12.</p> <p>6. On 3/7/12 at 4:00 PM, employee O indicated the registered nurse nurse measures wounds weekly and documents on the "Wound Information/Progress Report" document. Any changes to treatment or care are per "Physician Orders/Plan of Care" documents and are reviewed (as documented on the "Plan of Care Review" document.) Employee O indicated the registered nurse reviews</p>						

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	<p>pertinent data related to wounds with IDT at the IDT meetings and the medication review may include the treatments the patient is receiving so the treatments may be reviewed as part of that process.</p> <p>There is to be a Plan of Care for any issues identified in the "Initial / Updated Comprehensive Assessment" note completed by each discipline making visits to the patient. Issues that generate a plan of care are to be reviewed at the interdisciplinary team meeting. The interdisciplinary team reviews each patient every two weeks. The interdisciplinary team reviews the prior two weeks of care and plans and determines any changes in treatment that need to be made at each IDT meeting. The Initial POC (Plan of Care) review is completed at the first team meeting after admission and then at least every 14-15 days for every patient. The initial comprehensive assessment, the medication profile/record and the initial physician orders may be part of the terminal plan of care along with the updated plans of care / physician orders.</p> <p>7. The policy 8.12.10 "Plan of Care Review" states, "The POC (Plan of Care) Review is a review of the plan of care for the prior 2 weeks (or less) and the plan for the next 2 weeks. Includes information</p>				

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	from the patient's Updated Comprehensive Assessment and the patient's progress toward outcomes specified in the POC."			

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S0578	<p>418.60 INFECTION CONTROL The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.</p> <p>Based on record review, interview, infection control log review, and policy review, the hospice failed to ensure the infection control program monitored 1 of 11 patient record reviewed (Clinical record 6).</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Clinical record #6, start of care (SOC) 2/10/12, evidenced an active medication profile report with Sulfamethoxazole / Trimethoprim oral tablet 800-160 mg, take 1 tablet via peg tube twice a day for 5 days for urinary tract infection. The infection control log failed to evidence the infection. 2. On 3/7/12 at 3:05 PM, Employee N, the patient care coordinator, indicated the infection control log failed to monitor patient #6's documented urinary tract infection. 3. The hospice policy titled "Interdisciplinary Team Policies Infection 	S0578	<p>S 578 Infection Control Program has reviewed its infection control program including monitoring through infection control surveillance forms</p> <p>Corrective Action for patients identified by this survey: UTI for patient #6 is logged on the infection control surveillance form.</p> <p>Corrective action for other patients identified with the potential to be affected by the same deficient practice: All active patients with infections have been logged on the infection control surveillance form per the VITAS process</p> <p>Immediate measures/changes put in place to ensure deficient practice does not recur: Program has revised its process for collecting information on infections to prevent an incomplete infection control tracking. Since the infection control surveillance form is updated during the course of the infection, the team will keep the form</p>	04/06/2012

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	Control, Policy Number: 5:37" date originated 10/01/1993 date of last revision: 07/24/2006 stated, "4. When a patient has an identified (by culture or prescription or antibiotics) infection, an infection control surveillance form will be completed by the nurse or team manager."		<p>Program has trained their management staff to collect infection control information identified on the infection control surveillance form during their weekly IDG meetings. Program will now store the forms in an office location to be reviewed and updated during weekly IDG meetings to ensure management has access to reports in the process of completion.</p> <p>Title of Person(s) responsible for Corrective Action: Patient Care Administrator</p> <p>Monitoring/Compliance Process: During the 3 month period following the survey, Program will monitor completion of review Infection Control Surveillance for during regular management meetings. The number of reviews conducted after the initial 3 month period will be based on the initial auditing results.</p>				

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S0579	<p>418.60(a) PREVENTION The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.</p> <p>Based on home visit observation, interview, and policy review, the hospice failed to ensure 1 of 1 registered nurse (#B) followed the hospice policy with gloving while performing a sterile procedure for 1 of 1 patients (patient #4) observed receiving a sterile procedure during an observed home visit.</p> <p>Findings</p> <p>1. On 3/6/12 at 10:30 AM, Employee B, Registered Nurse, was observed performing a sterile procedure on patient #4. As Employee B donned the sterile right glove, the glove tore at the junction of the hand and wrist. Employee B continued with the sterile procedure without donning a new sterile glove.</p> <p>2. On 3/8/12 at 2:50 PM, Employee N, Patient Care Coordinator, indicated the sterile glove should have been changed after it tore.</p> <p>3. The hospice policy titled "VITAS Infection Control Manual, Revised July, 2006" stated, "Gloves ... Replace if they</p>	S0579	<p>S 579 Prevention Program has reviewed its infection control process including Standards of practice to prevent the transmission of infections and communicable diseases and use of standard precautions</p> <p>Corrective Action for patients identified by this survey: Employee #B was coached regarding sterile glove process immediately and employee has resigned.</p> <p>Immediate measures/changes put in place to ensure deficient practice does not recur: Program has reviewed infection control processes with team nurses on 3/14/12. The review included application of sterile gloves.</p> <p>In addition to the review, program managers are reinforcing and monitoring infection control practices at the bedside during joint visits with patient care staff.</p> <p>Title of Person(s) responsible for Corrective Action: Patient Care Administrator</p> <p>Monitoring/Compliance</p>	04/06/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/09/2012
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	are torn, punctured or when their ability to function as a barrier is compromised."		Process: During the 3 month period following the survey, Program will complete visit observation according to the VITAS Standard Program Required Reviews using Visit Observation Core Review to ensure infection control practices are followed. The number of visits conducted after the initial 3 month period will be based on the initial auditing results.		