

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151515	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/30/2012
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NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 E COOLSPRING AVE STE 1E MICHIGAN CITY, IN 46360
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L0000	<p>This visit was for a federal hospice recertification and state relicensure survey.</p> <p>Survey date: 3/27/12 - 3/30/12</p> <p>Facility #: 005809</p> <p>Medicaid vendor: 151515</p> <p>Surveyor: Ingrid Miller RN, PHNS</p> <p>Census: 135 skilled unduplicated admissions</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: right;">April 9, 2012</p>	L0000		

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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L0512	<p>418.52(c)(1) RIGHTS OF THE PATIENT The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;</p> <p>Based on clinical record review, document review, observation, and interview, the hospice failed to ensure the patient's right to effective pain management was observed during wound care in 1 of 1 home visits (# 2) with a skilled nurse (employee J).</p> <p>Findings</p> <p>1. On 3/28/12 at 11:15 AM, Employee J, Registered Nurse, was observed to perform wound care on patient #2 who was lying in bed with the head of bed elevated 15 degrees. Patient #2 lived in an assisted living facility and had a diagnosis of unspecified renal tumor. Prior to performing the wound care, the nurse did not assess the patient for pain or ask the staff of the assisted living facility who administered the pain medications about the patient's pain level or time the last pain medication was given. Employee J turned the patient onto his/her left side and the patient complained of pain at this time. As the wound care was completed on the patient's coccyx area, the patient continued to complain of pain at a medium level. The nurse did not</p>	L0512	L512Administrator and Patient Care Coordinator will inservice hospice clinical staff regarding patient's right to receive effective pain management and symptom control for conditions related to terminal illness, by April 17, 2012. Pain and symptom management will be addressed at each Interdisciplinary Group. 20% of all active/discharge clinical records will be audited by Patient Care Coordinator/designee for evidence that pain and symptoms are assessed and acted upon as necessary, beginning April 17, 2012 and ongoing. Any issue regarding symptom management will be addressed with staff as indicated and any necessary education provided. Patient Care Coordinator will be responsible for monitoring clinical practice to ensure that pain and symptom management is conducted and effective. Findings will be forwarded to Administrator with Outcome Based Quality Improvement Reports quarterly.	04/17/2012			

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	<p>offer any pain medication at this time. After completion of the wound care, the patient was transferred to a wheelchair. The patient continued to complain of pain. The nurse stated, "You have a pain pill coming up at noon."</p> <p>2. The record evidenced the patient's medications included Lortab 5-500 tablet take 1 tablet by mouth every six hours while awake and Norco 5-325 tablet take 1 tablet every 6 hours as needed for pain.</p> <p>3. On 9/2/10 patient #2 signed the document titled "Patient rights and responsibilities." This document stated, "I have received a verbal explanation and written copy of St. Anthony Hospice, Franciscan Community Services, Inc. Patient Rights and Responsibilities." This document was included in the "Patient and Family Handbook."</p> <p>4. The document titled "Patient Bill of Rights" included in the "Patient and Family Handbook" stated, "Patients have the right to receive effective pain management and symptom control from hospice for conditions related to the terminal illness."</p> <p>5. On 3/28/12 at 11:45 AM, Employee C, the patient care coordinator, indicated the patient complained of pain during the</p>				

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	skilled nurse visit.			

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L0533	<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 home visit observation, policy review, interview, and clinical record review, the hospice failed to ensure the IDG (interdisciplinary group) updated the comprehensive assessment in 1 of 8 records reviewed of patients who had been on service more than 15 days (patient #3).</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) 9/30/11, with a diagnosis of adult failure to thrive failed to evidence that nutritional needs and swallowing problems noted in the updates to the comprehensive assessment had been discussed by the IDG and then updated to the care plan.</p>	L0533	L533Administrator and Patient Care Coordinator will inservice staff regarding the update of a comprehensive assessment by the hospice team to consider changes in patient status that may have occurred since last assessment, and the frequency of the updates required. Inservice by April 17, 2012. 20% of active/discharge clinical records and Interdisciplinary Group documentation will be audited monthly by Patient Care Coordinator/designee for evidence that the Comprehensive Assessment has been reviewed/discussed and changed as necessary with hospice team members. Begins April 17, 2012. Patient Care Coordinator will be responsible for monitoring clinical practice to ensure Comprehensive Assessments are timely and involve hospice team. Findings will be forwarded to	04/17/2012			

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	<p>This was evidenced by the following:</p> <p>A. On 3/28/12 at 1:25 PM, the patient's caregiver indicated the patient had continued weight loss and was having swallowing problems in the past week and Employee J was aware.</p> <p>B. A nursing visit note dated 3/26/12 and signed by Employee J, Registered Nurse, stated, "Respiratory ... diminished breath sounds ... cough aspirated with water."</p> <p>C. The Interdisciplinary group meeting notes dated 3/27/12 and signed by Employee J stated, "Regular diet ... Weight continues to lose."</p> <p>D. Patient #3's clinical record evidenced a document titled "The Interdisciplinary Group/Nursing Care plan." This document had not been updated since 2/20/12."</p> <p>2. On 3/30/12 at 2:55 PM, Employee C, the patient care coordinator and RN, indicated the comprehensive assessment and care plan had not been updated and the patient had not had his / her nutritional needs updated on the care plan.</p> <p>3. The hospice policy titled "Initial Assessment" with an effective date of</p>		Administrator beginning April 23, 2012 with Outcome Based Quality Improvement Report.		

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	11/94 and revision date of 11/08 stated, "The update of the comprehensive assessment must be accomplished by the Interdisciplinary Team ... and consider changes that have taken place since the initial assessment."			

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L0534	<p>418.54(e)(1) PATIENT OUTCOME MEASURES (1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.</p> <p>Based on clinical record, policy, and hospice document review and staff interview, the hospice failed to ensure the measurable data elements, collected in the same manner for all patients, had been completed on the comprehensive assessments for 3 of 11 clinical records reviewed (#2, #8, and #10).</p> <p>Findings include</p> <p>1. The policy titled "Initial Assessment" dated 11/94 and reviewed 11/08 stated, "D. The update of the comprehensive assessment must be accomplished by the Interdisciplinary Team (in collaboration with the individual attending physician, if applicable) and: a. Consider changes that have taken place since the initial assessment, b. include information on the patient's progress toward desired outcomes, c. Reassessment of patient's response to care."</p> <p>2. Clinical records #2, 8, and 10 evidenced the hospice had used the same</p>	L0534	L534Administrator and Patient Care Coordinator will inservice staff regarding the comprehensive assessment must be conducted and documented to evaluate any changes that may have taken place since last assessment and patient progress towards desired outcomes, by April 17, 2012. 20% of active/discharge clinical records will be audited by Patient Care Coordinator/designee monthly for evidence that a comprehensive assessment is conducted, that changes are documented and addressed as necessary, and progress toward patient desired goals and also evaluated and addressed as necessary, by April 17, 2012. Patient Care Coordinator will be responsible for monitoring clinical practice and documentation to ensure that comprehensive assessments are conduced and complete and include hospice team. Findings will be forwarded to Administrator beginning April 23, 2012.	04/17/2012	

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	<p>standardized forms at each comprehensive nursing visit for the completion of the comprehensive assessment and updates to the assessments. The pain scale was being used to assess measurable outcome data elements and had not been completed at the visits.</p> <p>a. Clinical record #2, start of care (SOC) 9/2/10, included comprehensive assessments on 1/24/12, 2/1/12, 2/8/12, 3/1/12, 3/7/12, 3/17/12, and 3/23/12. Each of these assessments indicated the patient complained of pain at the time of this visit. However, the pain severity scale, a part of the pain assessment, was not completed at this visit.</p> <p>b. Clinical record #8, start of care (SOC) 12/6/11, included comprehensive assessments on 3/2/11, 3/3/11, 3/8/11, and 3/14/11. Each of these assessments indicated the patient complained of pain at the time of this visit. However, the pain severity scale, a part of the pain assessment, was not completed at this visit.</p> <p>c. Clinical record #10, SOC 12/14/11, included comprehensive assessments on 12/15/11, 12/21/11, and 12/23/11. Each of these assessments indicated the patient complained of pain at the time of this</p>				

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	<p>visit. However, the pain severity scale, a part of the pain assessment, was not completed at this visit.</p> <p>3. A hospice document titled "Hospice Care Franciscan Community Based Services monthly survey results stated, "Each patient admitted to services will be monitored for effective management 100%."</p> <p>4. On 2/28/12 at 4:10 PM, the administrator indicated the pain scale was not used to measure symptom management for the measurable data elements at the above visits.</p>				

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L0562	<p>418.58(a)(2) PROGRAM SCOPE (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.</p> <p>Based on clinical record, policy, and hospice document review and staff interview, the hospice failed to ensure the measurable data elements, collected in the same manner for all patients, had been completed on the comprehensive assessments for 3 of 11 clinical records reviewed (#2, #8, and #10).</p> <p>Findings include</p> <p>1. The policy titled "Initial Assessment" dated 11/94 and reviewed 11/08 stated, "D. The update of the comprehensive assessment must be accomplished by the Interdisciplinary Team (in collaboration with the individual attending physician, if applicable) and: a. Consider changes that have taken place since the initial assessment, b. include information on the patient's progress toward desired outcomes, c. Reassessment of patient's response to care."</p> <p>2. Clinical records #2, 8, and 10 evidenced the hospice had used the same standardized forms at each</p>	L0562	L562Administrator and Patient Care Coordinator will inservice nursing staff regarding patient's rights to receive effective pain management and symptom control for conditions related to terminal illness, by April 17, 2012. Pain and symptom management will be addressed at each Interdisciplinary Group. 20% of all active/discharge clinical records will be audited by Patient Care Coordinator/designee for evidence that pain and symptoms are assessed and acted upon as necessary, beginning April 21, 2012 and ongoing, and any necessary education provided. Patient Care Coordinator will be responsible for monitoring clinical practice to ensure that deficiencies are corrected, findings will be forwarded to Administrator by April 23, 2012.	04/17/2012			

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	<p>comprehensive nursing visit for the completion of the comprehensive assessment and updates to the assessments. The pain scale was being used to assess measurable outcome data elements and had not been completed at the visits.</p> <p>a. Clinical record #2, start of care (SOC) 9/2/10, included comprehensive assessments on 1/24/12, 2/1/12, 2/8/12, 3/1/12, 3/7/12, 3/17/12, and 3/23/12. Each of these assessments indicated the patient complained of pain at the time of this visit. However, the pain severity scale, a part of the pain assessment, was not completed at this visit.</p> <p>b. Clinical record #8, start of care (SOC) 12/6/11, included comprehensive assessments on 3/2/11, 3/3/11, 3/8/11, and 3/14/11. Each of these assessments indicated the patient complained of pain at the time of this visit. However, the pain severity scale, a part of the pain assessment, was not completed at this visit.</p> <p>c. Clinical record #10, SOC 12/14/11, included comprehensive assessments on 12/15/11, 12/21/11, and 12/23/11. Each of these assessments indicated the patient complained of pain at the time of this visit. However, the pain severity scale, a</p>				

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	<p>part of the pain assessment, was not completed at this visit.</p> <p>3. A hospice document titled "Hospice Care Franciscan Community Based Services monthly survey results stated, "Each patient admitted to services will be monitored for effective management 100%."</p> <p>4. On 2/28/12 at 4:10 PM, the administrator indicated the pain scale was not used to measure symptom management for the measurable data elements at the above visits.</p>				

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L0581	<p>418.60(b)(2) CONTROL [The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that-] (2) Includes the following: (i) A method of identifying infectious and communicable disease problems; and (ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.</p> <p>Based on record and document review, interview and policy review, the hospice failed to ensure the infection control program monitored 1 of 11 patient records (Clinical record 1).</p> <p>Findings</p> <ol style="list-style-type: none"> Clinical record #1, start of care (SOC) 1/17/11, evidenced interdisciplinary group meeting notes on 10/11/11 and signed by employee I, Registered Nurse, that stated, "Changes in the plan of care: Fever, drainage from skin tears, Septra SS." The infection control log failed to include documentation of this infection for patient #6. On 3/7/12 at 3:05 PM, Employee N, the patient care coordinator, indicated the infection control log failed to monitor 	L0581	L581Administrator and Patient Care Coordinator will inservice hospice staff regarding coordination of infection control surveillance, identification, prevention, control and investigation of infectious and communicable disease by April 17, 2012. 20% of active/discharge clinical records and infectious discharge log will be audited by Patient Care Coordinator/designee for clinical documentation or lab results to indicate presence of infectious disease and evidence of actions taken, beginning April 21, 2012 and ongoing. Patient Care Coordinator will be responsible for monitoring clinical practice to ensure that deficiency is corrected. Findings will be forwarded to Administrator beginning by April 23, 2012 with Outcome Based Quality Improvement Report.	04/17/2012			

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	<p>patient #6's documentation of this antibiotic treatment, fever, and drainage from skin tears.</p> <p>4. The hospice policy titled "Interdisciplinary Team Policies Infection 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>			

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L0591	<p>418.64(b)(1) NURSING SERVICES</p> <p>(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.</p> <p>Based on home visit observation, policy review, document review, interview, and clinical record review, the hospice failed to ensure nursing services (File #J) met the nursing needs of 2 of 11 clinical records (files 2 and 3) reviewed.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC 9/30/11), with a diagnosis of unspecified renal tumor failed to evidence nursing services met the patient's needs for pain control. This was evidenced by the following:</p> <p>A. On 3/28/12 at 11:15 AM, Employee J, Registered Nurse, was observed to perform wound care on patient #2 who was lying in bed with the head of bed elevated 15 degrees. Patient #2 lived in an assisted living facility and had a diagnosis of unspecified renal tumor. Prior to performing the wound care, the nurse did not assess the patient</p>	L0591	L591Administrator and Patient Care Coordinator will inservice nursing staff regarding patient's rights to receive effective pain management and symptom control for conditions related to terminal illness, by April 17, 2012. Pain and symptom management will be addressed at each Interdisciplinary Group. 20% of all active/discharge clinical records will be audited by Patient Care Coordinator/designee for evidence that pain and symptoms are assessed and acted upon as necessary, beginning April 21, 2012 and ongoing, and any necessary education provided. Patient Care Coordinator will be responsible for monitoring clinical practice to ensure that deficiencies are corrected, findings will be forwarded to Administrator by April 23, 2012.	04/17/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151515		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/30/2012	
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	<p>for pain or ask the staff of the assisted living facility who administered the pain medications about the patient's pain level or time the last pain medication was given. Employee J turned the patient onto his/her left side and the patient complained of pain at this time. As the wound care was completed on the patient's coccyx area, the patient continued to complain of pain at a medium level. The nurse did not offer any pain medication at this time. After completion of the wound care, the patient was transferred to a wheelchair. The patient continued to complain of pain. The nurse stated, "You have a pain pill coming up at noon."</p> <p>B. The record evidenced the patient's medications included Lortab 5-500 tablet take 1 tablet by mouth every six hours while awake and Norco 5-325 tablet take 1 tablet every 6 hours as needed for pain.</p> <p>C. On 9/2/10 patient #2 signed the document titled "Patient rights and responsibilities." This document stated, "I have received a verbal explanation and written copy of St. Anthony Hospice, Franciscan Community Services, Inc. Patient Rights and Responsibilities." This document was included in the "Patient and Family Handbook."</p>						

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	<p>D. The document titled "Patient Bill of Rights" included in the "Patient and Family Handbook" stated, "Patients have the right to receive effective pain management and symptom control from hospice for conditions related to the terminal illness."</p> <p>E. On 3/28/12 at 11:45 AM, Employee C, the patient care coordinator, indicated the patient complained of pain during the skilled nurse visit.</p> <p>2. Clinical record #3, SOC 9/30/11, with a diagnosis of adult failure to thrive failed to evidence that nutritional needs and swallowing problems noted in the updates to the comprehensive assessment had been updated by the registered nurse (Employee J) and discussed by the IDG and then updated to the care plan. This was evidenced by the following:</p> <p>A. On 3/28/12 at 1:25 PM, the patient's caregiver indicated the patient had continued weight loss and was having swallowing problems in the past week and Employee J was aware.</p> <p>B. A nursing visit note dated "3/26/12" and signed by Employee J, Registered Nurse, stated, "Respiratory ... diminished breath sounds ... cough aspirated with water."</p>			

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	<p>C. The Interdisciplinary group meeting notes dated 3/27/12 and signed by Employee J stated, "Regular diet ... Weight continues to lose."</p> <p>D. Patient #3's clinical record evidenced a document titled "The Interdisciplinary Group/Nursing Care plan." This document had not been updated since 2/20/12."</p> <p>E. On 3/30/12 at 2:55 PM, Employee C, the patient care coordinator and RN, indicated the registered nurse had not updated the comprehensive assessment and care plan had not been updated and the patient had not had his / her nutritional needs updated on the care plan.</p> <p>3. The agency policy titled "Staff Registered Nurse" with an effective date of 10/02/2000 stated, "Position summary: utilizes the nursing process to provide skilled care for a specific group of patients according to a written Physician Plan of care ... demonstrates a complete knowledge of a variety of diagnosis and age groups as evidenced by accurate and complete assessments."</p>				

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L0594	<p>418.64(c) MEDICAL SOCIAL SERVICES Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.</p> <p>Based on personnel file review and interview, the hospice failed to ensure the services for 11 of 11 records (#1-#11) were provided by a qualified medical social worker in 1 of 1 medical social worker file reviewed (Employee #E) with the potential to affect all the patients of the hospice.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Personnel file E evidenced a date of hire 8/2/07 and a first patient contact of 8/28/07. The personnel record included a Diploma that evidenced the employee was a graduate of Bachelor of Arts in Psychology / Sociology from Calumet College in Hammond, Indiana in 1980. 2. On 3/27/12 at 12 noon, Employee E indicated he/she had a Bachelor of Arts in Psychology and Sociology. 3. On 3/28/12 at 2:05 PM, the administrator indicated Employee E was not a graduate of a Master's Program in Social Work. 	L0594	L594Administrator and Patient Care Coordinator will inservice Social Worker regarding oversight of practice by Master prepared Social Worker. Pair will discuss care plan on a scheduled basis for evidence of appropriate intervention. 20% of all active/discharge clinical records will be audited by Patient Care Coordinator/designee weekly for evidence that care is assessed and acted upon as necessary, beginning April 21, 2012 and ongoing. Patient Care Coordinator will be responsible for monitoring Social Worker oversight by MSW to ensure that deficiencies are corrected, findings will be forwarded to Administrator by April 23, 2012.	04/17/2012			

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L0597	<p>418.64(d)(2) COUNSELING SERVICES (2) Dietary counseling. Dietary counseling, when identified in the plan of care, must be performed by a qualified individual, which include dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met.</p> <p>Based on clinical record review, home visit observation, policy review, and interview, the hospice failed to ensure the dietician (Employee Q) provided dietary counseling when needs were identified for patients (Clinical record # 3) in 1 of 1 record reviewed of patients with dietary needs.</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) 9/30/11, with a diagnosis of adult failure to thrive failed to evidence that nutritional needs and swallowing problems noted in the updates to the comprehensive assessment had been discussed by the IDG and the dietician consulted. This was evidenced by the following:</p> <p>A. On 3/28/12 at 1:25 PM, the patient's caregiver indicated the patient had continued weight loss and was having swallowing problems in the past week and Employee J was aware.</p>	L0597	L597Administrator and Patient Care Coordinator will inservice staff in relation to nursing role in a nutritional assessment and utilization of dietary counseling, as necessary. 20% of all active/discharge records will be audited quarterly for evidence that a nutritional assessment is conducted and acted upon as necessary. Patient Care Coordinator will be responsible for monitoring clinical practice to ensure that deficiencies are corrected, findings will be forwarded to Administrator by April 23, 2012.	04/23/2012			

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	<p>B. A nursing visit note dated 3/26/12 and signed by Employee J, Registered Nurse, stated, "Respiratory ... diminished breath sounds ... cough aspirated with water."</p> <p>C. The Interdisciplinary group meeting notes dated 3/27/12 and signed by Employee J stated, "Regular diet ... Weight continues to lose."</p> <p>D. Patient #3's clinical record evidenced a document titled "The Interdisciplinary Group/Nursing Care plan." This document had not been updated since 2/20/12."</p> <p>E. The record failed to evidence the registered dietician had been consulted.</p> <p>2. On 3/30/12 at 2:55 PM, Employee C, the patient care coordinator and RN, indicated the nutritional needs of patient #3 had not been updated on the care plan.</p> <p>3. The hospice policy titled "Registered Dietician" with no effective date listed stated, "The registered dietician is responsible for coordination of the hospice nutrition program. Provides direct service to patient for nutritional assessment and counseling as prescribed by the physician, act as consultant to the</p>						

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L0625	<p>interdisciplinary team on matters related to nutritional counseling."</p> <p>418.76(g)(1) HOSPICE AIDE ASSIGNMENTS AND DUTIES (1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.</p> <p>Based on observation and interview, the agency failed to ensure an aide assignment sheet was present in the home record for 1 of 3 home visits (clinical record # 8) of patients with aide services.</p> <p>Findings</p> <ol style="list-style-type: none"> On 3/28/12 at 10:50 AM, the home folder of patient #8 failed to evidence an aide assignment sheet. On 3/28/12 at 3:20 PM, the administrator indicated the aide care plan was not in the home folder. 	L0625	<p>L625Administrator and Patient Care Coordinator will inservice nursing staff and nursing assistants on contents of assignment and how necessary updates completed. Will educate staff that aide is to carry a current assignment with him/her for reference and to provide care as assigned. 20% of all active/discharge clinical records will be audited quarterly for initial and updated HHA assignment, beginning April 17, 2012 and ongoing. Patient Care Coordinator will be responsible for monitoring clinical practice to ensure that deficiencies are corrected, findings will be forwarded to Administrator by April 23, 2012.</p>	04/17/2012	