

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2016
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NAME OF PROVIDER OR SUPPLIER PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032
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L 0000 Bldg. 00	<p>This was a Federal Hospice Recertification and State Hospice Relicensure survey.</p> <p>Survey Dates: August 8, 2016 to August 15, 2016</p> <p>Facility Number: 007409</p> <p>Medicaid Number: 200990000A</p> <p>Clinical Records Reviewed: 16 Home Visits: 4</p> <p>Census: 243</p> <p>State of the Heart Hospice was found not to be in compliance with the Conditions of Participation 481:54 Initial and comprehensive assessment of the patient, Condition of Participation 418.56: Interdisciplinary Group, Care Planning, and Coordination of Services, Condition of Participation 418.58: Quality Assessment and Performance Improvement (QAPI) and Condition of Participation 418.64: Core Services.</p>	L 0000		
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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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L 0520 Bldg. 00	Based on record review and interview, the hospice failed to ensure the admitting Registered Nurse had conducted a complete physical assessment of a patient's physical needs in 2 of 4 records reviewed of patients identified with wounds and 1 of 1 records reviewed of patients with intravenous access in a sample of 16 (See L 522); failed to ensure that the comprehensive assessment was completed no later than 5 calendar days after the election of hospice care in 1 of 13 active records reviewed in a sample of 16 (See L 523); failed to ensure the registered nurse updated the comprehensive assessment in relation to assessment of wounds in 4 of 5 records reviewed of patients with wounds and 2 of 2 records reviewed of patients with an intravenous site in a sample of 16 (See L 533); failed to ensure that data elements identified had measurable goals and measurement of outcomes (See L 534); and failed to ensure that the data elements identified in the comprehensive assessments were incorporated into each hospice patients care planning and coordination of services (See L 535).	L 0520	L520 418.54 Condition of Participation: INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT On 09/13/16, 09/14/16, 09/15/16, and 09/16/16, the Administrator conducted training sessions for all staff that addressed: (i) Policy No. H:2-045, "InitialAssessment" (see Attachment Group A; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i> , 2016) which sets forth that an assessment must be done with 48hours of election of hospice care that addresses all areas of hospice carerelated to the palliation and management of the terminal illness and relatedconditions and identifies the patient's need for hospice care and services, andthe patient's need for physical, psychosocial, emotional, and spiritual care; (ii) Policy No. H:2-046 "Comprehensive Assessment" (seeAttachment Group A; policy from <i>PremierHospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i> ,2016), which sets forth that the hospice interdisciplinary group, inconultation with the individual's attending physician (if any), will completethe comprehensive	09/27/2016

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	The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance the Condition of Participation 418.54: Initial and Comprehensive Assessment of Patient.		assessment that identifies the patient's need for hospice care and services, and the need for physical, psychosocial, emotional, and spiritual care; (iii) Policy No. H:2-047, "Ongoing Comprehensive Assessments" (see Attachment Group A; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i> , 2016), which sets forth during each home visit, the Case Manager or other discipline will evaluate the patient according to the problems identified during the initial assessment and thereafter, the ongoing comprehensive assessment; and (iv) Policy No. C:2-038, "Patient Focused Performance Improvement" (see Attachment Group A; policy from <i>Premier Hospice & Palliative Care CHAP Core Policy and Procedure Manual</i> , 2016), and the software verbal orders process to allow for edits/the addition of patient-specific goal text in verbal orders that address data elements including but not limited to: pain, dyspnea, nausea, vomiting, diarrhea, constipation, emotional distress, and spiritual needs; (v) Each discipline will evaluate the patient's and their caregivers goal needs according to the problems identified during the initial comprehensive assessment and thereafter during the ongoing comprehensive assessment(s); (vi) The hospice	

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			<p>will conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care; (vii) This assessment will include all areas of hospice care related to the palliation and management of the terminal illness and related conditions, including, but not limited to, an assessment of any drain site and how the drain is to be operated as well as measurement of abdominal girth to monitor for ascites, as appropriate to liver patients, wound assessment upon admission or within the 5-day window, and assessment of any subclavian medi-port; (viii) The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), will complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24, including but not limited to, documentation of attempted contact to schedule and make visits within the 5-day window; (ix) The update of the comprehensive assessment will 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 will be</p>	

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			<p>accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. Updates to the comprehensive assessment shall include, but are not limited to; ongoing assessments of all wounds, including skin grafts and necrotic wounds, that include the specific appearance of the wound bed, surrounding tissue, and measurements of each wound; ongoing assessment of any drain site, including any drainage that may have been removed from the abdominal cavity, and measurements of abdominal girth, as appropriate to abdominal ascites for liver patients; ongoing assessment of any IV site to include the location, any leakage from the site, signs and symptoms of infection, and when the IV site and tubing were last changed; and ongoing assessment of any medi-port site, even when covered by a dressing; (x) Staff were instructed that data elements from the comprehensive assessment, including but not limited to the following examples: pain, dyspnea, nausea, vomiting, diarrhea, constipation, emotional distress, and spiritual needs, shall be incorporated into patient centered and measurable goals. Each discipline shall evaluate the patient's and their caregivers goal needs according to the problems identified during the</p>	

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			<p>initial comprehensive assessment and thereafter, the ongoing comprehensive assessment. The comprehensive assessment includes data elements that allow for measurement of outcomes. The hospice measures and documents data in the same way for all patients. The data elements take into consideration aspects of care related to hospice and palliation; and (xi) Data elements shall be incorporated into patient centered and measurable goals using software goal text edits. This data collection is used to coordinate services toward meeting patient and caregiver-centered goals and is used in the hospice's quality assessment and performance improvement program. Over the last two weeks, the agency implemented a new software documentation enhancement for wounds entitled the Integumentary Command Center; on 9/6/2016, 09/08/16, 09/09/16, 09/14/16, 09/15/16, and 09/16/2016, clinical trainings occurred on the Integumentary Command Center, along with a new Wound Care policy, IV Care protocols, and training on software verbal orders process for plan of care updates. Beginning 9/19/2016, clinical managers will review 100% of Admission records, 100% of Initial and Comprehensive Assessments, and on a twice monthly basis, 100% of IDG</p>	

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			<p>Update and Comprehensive Assessments using focused Hospice Clinical Record Audit Tool elements to assess met/not met compliance % with L521, L523, L533, L534 and L535. The results of these reviews will be maintained in the QAPI Audit Tracker. As needed, staff will receive individual re-education, documented on the QA Education Form, which will be maintained by the Administrator. This level of review will continue for 90 days. If 95% compliance is met, then on a going forward basis, 10% of records will be audited by clinical managers monthly using the Hospice Clinical Record Audit Tool. If 95% compliance is not maintained after the initial 60 days or any subsequent time periods, the audit methodology will revert back to 100% of records being reviewed monthly until 95% compliance is met. The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body. Completion Date: All Staff education shall be completed by 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016, the organization will have implemented the Audit Tracker of</p>	

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L 0521 Bldg. 00	<p>418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.</p> <p>Based on record review and interview, the hospice failed to ensure the admitting Registered Nurse had conducted a complete physical assessment of a patient's physical needs in 2 of 5 records reviewed of patients identified with wounds and 1 of 1 records reviewed of patients with intravenous access in a sample of 16. (# 11 and 16)</p> <p>Findings include:</p> <p>1. Clinical record number 11, Election date 06/08/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 06/08/16 to 09/05/16. The patient's hospice diagnosis indicated malignant neoplasm of colon with secondary diagnoses of malignant neoplasm of liver and sever protein -</p>			L 0521	<p>100% Admission Recordand Initial and Comprehensive Assessment Record Review.</p> <p>L521 418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT</p> <p>On 09/13/16, 09/14/16, 09/15/16, and 09/16/16, the Administrator conducted training sessions for all staff that specifically addressed: Policy No. H:2-045, "Initial Assessment", (see Attachment Group A; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual, 2016</i>) which sets forth that an assessment must be done within 48 hours of election of hospice care that addresses all areas of hospice care related to the palliation and management of the terminal illness and related conditions and identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial,</p>		09/27/2016

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	<p>calorie malnutrition.</p> <p>A. A client coordination note dated 06/08/16, indicated the patient had a peritoneal drain placed on 05/25/16, due to the patient's increased malignant ascites and required drainage. The patient has had multiple hospitalizations with the most recent due to worsening of abdominal pain, nausea, vomiting, and diarrhea. The patient had been put on antibiotics for sepsis. The integumentary and gastrointestinal sections of the start of care assessment failed to include an assessment of the drain site and how the drain was to be operated as well as a measurement of abdominal girth to monitor for ascites.</p> <p>2. Clinical record number 16, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to 10/04/16, with treatment orders to wrap lower extremity wounds three times a week with kerlix and to apply antimicrobial pressure dressing to the coccyx wound when soiled. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary diagnoses of dementia, hypertension, and stage III chronic kidney disease. The patient was also a diabetic.</p>		<p>emotional, and spiritual care; <u>Policy No. H:2-046, "Comprehensive Assessment"</u>, (see Attachment Group A; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016) which sets forth that the hospice interdisciplinary group, in consultation with the individual's attending physician (if any), will complete the comprehensive assessment that identifies the patient's need for hospice care and services and to determine the data elements that allow for measurement of outcomes, development of an individualized plan of care, coordination of services and, in the aggregate, for the hospice's quality assessment and performance improvement program. Data elements are to be incorporated into patient centered and measurable goals by using software goal text edits; <u>Policy No. H:2-047, "Ongoing Comprehensive Assessments"</u>, (see Attachment Group A; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016) which sets forth during each home visit, the Case Manager or other discipline will evaluate the patient according to the problems identified during the initial assessment and thereafter, the ongoing comprehensive assessment and are to: a. focus on the patient's</p>		

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	<p>A. Discharge instructions dated 07/05/16, was faxed to the office on 07/07/16. The instructions indicated the following treatment orders: Right dorsal superficial wound and bilateral heel wounds: Aquacel AG on bilateral heels, Adaptic to right dorsal wound. Allyn heel cup to left heel. Wrap both feet with kerlix. Change dressing daily.</p> <p>B. The start of care assessment dated 07/07/16, indicated the patient had 4 wounds, 3 to the bilateral feet and one on the coccyx. The wounds failed to be assessed upon admission. The wound assessment was not conducted within the 5 day window.</p> <p>C. A nursing visit note dated 07/12/16, indicated the patient had a right. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>3. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>4. A policy titled "Initial Assessment" Policy No. H:2 - 045.1 revised 06/2014, indicated " ... Admitting registered nurse</p>		<p>response to care, changes in patient condition, level of deterioration, and changes in patient diagnoses or prognosis;</p> <p>b. be accomplished by the hospice IDG (in collaboration with the individual's attending physician, if any);</p> <p>c. consider changes that have taken place since the initial assessment;</p> <p>d. include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care; and</p> <p>e. be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days; In addition to in-servicing on these policies, training also included the following:</p> <p>a. Each discipline is to evaluate the patient's and their caregivers goal needs according to the problems identified during the initial comprehensive assessment and thereafter during the ongoing comprehensive assessment(s);</p> <p>b. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions, including, but not limited to, an assessment of any drain site and how the drain is to be operated as well as a measurement of abdominal girth to monitor for ascites, wound</p>				

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	uses an assessment scale / rating tool to assess for problems and to establish a baseline status of each symptom related "		assessment upon admission or within the 5-day window, and assessment of any subclavian medi-port. Beginning 9/19/2016, clinical managers will review 100% of Admission records, 100% of Initial and Comprehensive Assessments, and on a twice monthly basis, 100% of IDG Update and Comprehensive Assessments using focused Hospice Clinical Record Audit Tool elements to assess met/not met compliance %. The results of these reviews will be maintained in the QAPI Audit Tracker. As needed, staff will receive individual re-education which will be documented on the QA Education Form, and maintained by the Administrator. This level of review will continue for 90 days. If 95% is met, then on a going forward basis, 10% of records will be audited by clinical managers monthly using the Hospice Clinical Record Audit Tool. If 95% compliance is not maintained after the initial 60 days or any subsequent time periods, the audit methodology will revert back to 100% of records being reviewed monthly until 95% compliance is met. The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected	

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L 0523 Bldg. 00	<p>418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT</p> <p>The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.</p> <p>Based on record review and interview, the agency failed to ensure members of the Interdisciplinary Group completed a medical social service assessment within 5 calendar days after the election statement of hospice care in 1 of 13 active records reviewed in a sample of 16. (# 13)</p> <p>Findings include:</p> <p>1. Clinical record number 13, Election date 08/01/16, included a form called</p>	L 0523	<p>and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed by 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016, the organization will have implemented the Audit Tracker of 100% Admission Record and Initial and Comprehensive Assessment Record Review.</p> <p>L 523 418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT</p> <p>As part of the Administrator's training on 09/13/16, 09/14/16, 09/15/16, and 09/16/16, staff were re-educated on Policies No. H:2-045 "Initial Assessment" (see Attachment Group A; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016) and No. H:2-046 "Comprehensive Assessment", (see Attachment Group A; policy from <i>Premier Hospice & Palliative Care CHAP</i></p>	09/27/2016	

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	<p>"Hospice Certification and Plan of Care" for the certification period of 08/01/16 to 10/29/16.</p> <p>A. A physician order dated 08/05/16, indicated patient was rescheduled and outside 5 day time frame for social worker due to family request related to birth of a grandchild. Family requested visit following week.</p> <p>B. Review of the missed visit log, the log failed to include documentation of the social worker speaking with the family and obtaining the request from the family to move evaluation visit to the following week.</p> <p>C. Review of the coordination log, the log failed to include documentation of the social worker attempting contact to make scheduled visits within the 5 day window.</p> <p>2. During a home visit with Employee B, social worker, on 08/08/16 at 3:45 PM, Employee B indicated that he / she had a conference with the case manager the previous Friday (day 5) and was informed that the patient would not be home due to birth of great grandchildren. Employee indicated he / she had not made contact with the patient / caregiver until today.</p>		<p><i>Hospice Policy and Procedure Manual, 2016</i>) which set forth the timing of when such assessments must be completed.</p> <p>Along with in-servicing on these policies, training reinforced that the hospice interdisciplinary group, in consultation with the individual's attending physician (if any), will complete the comprehensive assessment no later than 5 calendar days after the election of hospice care. Documentation must include worker attempts to contact and make scheduled visits within the 5-day window and updated orders as necessary.</p> <p>Beginning 9/19/2016, clinical managers will review 100% of Admission records using the Hospice Clinical Record Audit Tool elements to ensure that all patient records include sufficient documentation of the scheduling efforts and timing of when such assessments were completed after the election of hospice care in accordance with §418.24, including but not limited to, documentation of attempted contacts to make scheduled assessment visits within the 5-day window.</p> <p>The results of these reviews will be maintained in the QAPI Audit Tracker. Staff shall add IDG Notes to communicate attempted contacts, decline the visit if appropriate, and document</p>				

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	<p>3. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>4. A policy titled "Comprehensive Assessment" Policy No. H:2 - 046.1 revised 10/2014, indicated " ... The hospice interdisciplinary group, in consultation with the individuals' attending physician (if any), will complete the comprehensive assessment no later than 5 calendar days after the election of hospice care "</p>		<p>physician's orders for the rescheduled assessment. As needed, staff will receive individual re-education which will be documented on the QA Education Form, which will be maintained by the Administrator. This level of review will continue for 90 days. If 95% is met, then on a going forward basis, 10% of admission records will be audited by clinical managers monthly using the Hospice Clinical Record Audit Tool. If 95% compliance is not maintained after the initial 90 days or any subsequent time periods, the audit methodology will revert back to 100% of admission records being reviewed monthly until 95% compliance is met.</p> <p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization will have implemented the Audit Tracker of 100% Admission Record Review.</p>	

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L 0533 Bldg. 00	<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 record review and interview, the hospice failed to ensure the registered nurse updated the comprehensive assessment in relation to assessment of wounds in 4 of 5 records reviewed of patients with wounds (# 2, 9, 11, 16) and 2 of 2 records reviewed of patients with an intravenous site (# 12 and 16) in a sample of 16.</p> <p>Findings include:</p> <p>1. Clinical record number 2, Election date 05/12/16, included a written plan of care for the certification period 05/12/16 to 08/09/16.</p> <p>A. A skilled nursing visit note dated</p>	L 0533	<p>L 533 418.54(d)UPDATE OF COMPREHENSIVE ASSESSMENT</p> <p>As part of the in-service performed 09/13/16, 09/14/16,09/15/16, and 09/16/16, staff were re-educated on Policy No. H:2-047,"Ongoing Comprehensive Assessments", (see Attachment Group A; policyfrom <i>Premier Hospice & PalliativeCare CHAP Hospice Policy and Procedure Manual</i>, 2016) which sets forthduring each home visit, the Case Manager or other discipline will evaluate thepatient according to the problems identified during the initial assessment andthereafter, the ongoing comprehensive assessment. This policy (and the</p>	09/27/2016
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	<p>06/09/16, the integumentary section indicated patient had a wound. Review of the form called "Wound Assessment Tool Report," the report failed to include an assessment of the wound bed and surrounding tissue. A physician order dated 06/09/16, indicated "Duoderm to Stage 2 pressure ulcer to left buttocks." The skilled nurse failed to update the comprehensive assessment to include appearance of the wound bed and surrounding tissue as well as measurements of the wound.</p> <p>B. Review of a skilled nursing visit note dated 06/13/16, the skilled nurse failed to update the comprehensive assessment to include appearance of the wound bed and surrounding tissue.</p> <p>2. Clinical record number 9, Election date 07/11/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/11/16 to 10/08/16.</p> <p>A. A nursing visit note dated 08/05/16, indicated the patient had a diabetic ulcer to the left heel and a blister to the right heel. The hospice nurse documented "discussed wounds with FSN [facility skilled nurse] and blister has popped with skin still intact ... Discussed current wound dressing with</p>		<p>trainingexamples) also address that these ongoing comprehensive assessments:</p> <p>(i) are to focus on the patient's response to care, changes in patient condition, level of deterioration, and changes in patient diagnoses or prognosis;</p> <p>(ii) must be accomplished by the hospice IDG (in collaboration with the individual's attending physician, if any);</p> <p>(iii) must consider changes that have taken place since the initial assessment;</p> <p>(iv) include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care;</p> <p>(v) must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days; and</p> <p>(vi) updates must include, but are not limited to; ongoing assessments of all wounds, including skin grafts and necrotic wounds, that include the specific appearance of the wound bed, surrounding tissue, and measurements of each wound; ongoing assessment of any drain site, including any drainage that may have been removed from the abdominal cavity, and measurements of abdominal girth, as appropriate to abdominal ascites; ongoing</p>	

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	<p>staff and added to orders ... " The skilled nurse failed to update the comprehensive assessment to include appearance of the wound bed and surrounding tissue as well as measurements of the wound</p> <p>B. A nursing visit note dated 08/09/16, indicated the patient had a diabetic ulcer to the left heel and a blister to the right heel. The skilled nurse failed to update the comprehensive assessment to include appearance of the wound bed and surrounding tissue as well as measurements of the wound</p> <p>3. Clinical record number 11, Election date 06/08/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 06/08/16 to 09/05/16. The patient's hospice diagnosis indicated malignant neoplasm of colon with secondary diagnoses of malignant neoplasm of liver and sever protein - calorie malnutrition.</p> <p>A. A client coordination note dated 06/08/16, indicated the patient had a peritoneal drain placed on 05/25/16, due to the patient's increased malignant ascites and required drainage. The patient has had multiple hospitalizations with the most recent due to worsening of abdominal pain, nausea, vomiting, and diarrhea. The patient had been put on</p>		<p>assessment of any IV site to include the location, any leakage from the site, signs and symptoms of infection, and when the IV site and tubing have last been changed; and ongoing assessment of any medi-port site, even when covered by a dressing.</p> <p>Beginning 09/19/2016, clinical managers will review on a twice monthly basis, 100% of IDG Update and Comprehensive Assessment records using the Hospice Clinical Record Audit Tool elements to determine whether written documentation exists that the hospice updated the comprehensive assessment, which includes verbal orders, during each home visit. Staff shall add late entry IDG Notes and verbal orders to remediate any findings of noncompliance and will receive individual re-education documented on the QA Education Form. Staff reeducation Forms and documentation will be maintained by the Administrator. After 90 days, if 95% met compliance threshold goal for any given month, then 10% of IDG Update and Comprehensive Assessment records will be audited monthly by clinical managers using the Hospice Clinical Record Audit Tool to maintain compliance. If 95% compliance is not maintained the audit methodology will increase to</p>		

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	<p>antibiotics for sepsis.</p> <p>B. Review of the hospice nurse visit notes dated 06/09, 06/10, 06/11, 06/14, 06/15, 06/17, 06/21, 06/24, 06/29, 07/01, 07/05, 07/08, 07/13, 07/15, 07/19, 07/22, 07/28, and 08/03/16, the hospice nurse failed to update the comprehensive to include an assessment of the drain site, including any drainage that may have been removed from the abdominal cavity and any measurements of abdominal girth due to the abdominal ascites.</p> <p>C. A hospice visit note dated 08/04/16, indicated that the peritoneal drain had been removing 1200 milliliters of fluid per day and the nurse notified the physician to increase the amount of bags delivered per month from 15 to 30. The hospice nurse failed to update the comprehensive to include an assessment of the drain site and any measurements of abdominal girth due to the abdominal ascites.</p> <p>4. Clinical record number 12, Election date 04/14/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 04/04/16 to 07/02/16. The patient's primary diagnosis indicated malignant neoplasm of overlapping sites of colon, with secondary diagnoses of malignant</p>		<p>100% of IDG Update and Comprehensive Assessment records monthly until 95% compliance is met. The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization will have implemented the Audit Tracker of 100% Admission Record Review.</p>		

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	<p>neoplasm of the liver and intrahepatic bile duct, digestive organs, retroperitoneal / peritoneum, and lung.</p> <p>A. A physician order dated 06/13/16, indicated an intravenous infusion was initiated. The infusion was initiated on 06/14/16.</p> <p>B. A nursing visit note dated 07/05/16, indicated the patient's abdomen was firm and tender and the patient complained of pain to the abdomen. The comprehensive assessment failed to be updated to include an assessment of the IV site such as location, if there was any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p> <p>C. A nursing visit note dated 07/12/16, indicated the patient's abdomen was firm, nodule in right lower quadrant from sub q button. The comprehensive assessment failed to be updated to include an assessment of the IV site in the abdomen such as any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p> <p>D. A nursing visit note dated 07/14/16, indicated the patient's abdomen</p>			

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	<p>was firm and non-tender. The comprehensive assessment failed to be updated to include an assessment of the IV site such as location, any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p> <p>E. A nursing visit note dated 07/19/16, indicated the nurse provided the patient with a few skin prep pads to help make his / her CADD pump dressing stay on due to sweat. The comprehensive assessment failed to be updated to include an assessment of the IV site such as location, any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p> <p>F. A nursing visit note dated 07/21/16, the comprehensive assessment failed to be updated to include include an assessment of the IV site site such as location, any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p> <p>G. A nursing visit dated 08/04/16, indicated the LPN arrived to the patient's home with the CADD pump alarming high pressure. The note indicated the LPN changed the tubing and silenced the</p>			

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	<p>alarm. No further documentation in regards to the follow up of changing the tubing, assessment of the sub q site and location, any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p> <p>5. Clinical record number 16, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to 10/04/16, with treatment orders to wrap lower extremity wounds three times a week with kerlix and to apply antimicrobial pressure dressing to the coccyx wound when soiled. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary diagnoses of dementia, hypertension, and stage III chronic kidney disease. The patient was also a diabetic.</p> <p>A. Discharge instructions dated 07/05/16, was faxed to the office on 07/07/16. The instructions indicated the following treatment orders: Right dorsal superficial wound and bilateral heel wounds: Aquacel AG on bilateral heels, Adaptic to right dorsal wound. Allyvn heel cup to left heel. Wrap both feet with kerlix. Change dressing daily.</p> <p>B. The start of care assessment dated</p>			

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	<p>07/07/16, indicated the patient had 4 wounds, 3 to the bilateral feet and one on the coccyx. The wounds failed to be assessed upon admission.</p> <p>C. A nursing visit note dated 07/12/16, the comprehensive assessment failed to be updated to include an assessment of the coccyx wound. The nursing visit also indicated the patient had a right subclavian mediport that had a dressing covering the site which was not indicated on the admission assessment.</p> <p>D. A nursing visit note dated 07/14/16, the comprehensive assessment failed to be updated to include an assessment of the coccyx wound. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>E. A nursing visit note dated 07/15/16, the comprehensive assessment failed to be updated to include an assessment of the coccyx wound. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>F. A nursing visit note dated 07/18/16, the comprehensive assessment / wound assessment tool failed to be</p>			

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	<p>updated to include measurements of the skin graft, necrotic wound to the left 4th toe and failed to include an assessment of all the wounds, including the coccyx wound. The comprehensive assessment failed to be updated to include an assessment of the patient's right subclavian mediport.</p> <p>G. A nursing visit note dated 07/20/16, the comprehensive assessment failed to be updated to include an assessment of the coccyx wound and an assessment of the patient's right subclavian mediport.</p> <p>H. A nursing visit note dated 07/22/16, the integumentary assessment indicated the patient had two wounds to the left lower extremity, an assessment was provided for 2 of 3 wounds, but the note failed to be specific as to which wound (left toe, left heel or left lower leg) he / she were describing. The comprehensive assessment failed to be updated to include an assessment to 1 of 3 wounds to the left lower extremity, failed to include an assessment of the skin graft on the right leg, and failed to include an assessment of the coccyx. The comprehensive assessment failed to be updated to include an assessment of the patient's right subclavian mediport.</p>			

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	<p>I. A nursing visit note dated 07/25/16, review of the wound assessment tool, measurements were performed to the left toe, left heel and left leg. The wound assessment tool and the comprehensive assessment failed to be updated to include an assessment of the left heel and left leg wounds and failed to be updated to include an assessment of the coccyx wound. The comprehensive assessment failed to be updated to include an assessment of the patient's right subclavian mediport.</p> <p>J. A nursing visit note dated 07/29/16, indicated the patient had one wound, indicated the left heel, and the 'dressings' had been changed to the left lower extremity. The comprehensive assessment failed to be updated to include an assessment of the coccyx wound and the left 4th toe. The comprehensive assessment failed to be updated to include an assessment of the patient's right subclavian mediport.</p> <p>K. A nursing visit note dated 08/01/16, indicated the patient reported the right 4th toe and the left 3rd toe opened up over the weekend. Review of the wound assessment tool, the left heel, left toe, and right toe were measured but the comprehensive assessment failed to be updated to include an assessment of</p>			

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	<p>the wounds. The comprehensive assessment failed to be updated to include an assessment of the coccyx wound and an assessment of the patient's right subclavian mediport.</p> <p>L. A nursing visit note dated 08/05/16, indicated the patient had wounds to the bilateral toes and left heel. Review of the wound assessment tool, the tool failed to include measurements and assessments of the bilateral big toes and left 5th toe. The comprehensive assessment failed to be updated to include an assessment of all wounds and failed to include an assessment of the coccyx wound. The comprehensive assessment failed to be updated to include an assessment of the patient's right subclavian mediport.</p> <p>M. A nursing visit note dated 08/08/16, the wounds were measured, assessed and entered into the wound assessment tool. Review of the wound assessment tool, the right toe, left toe, and left heel was measured only. The wound assessment tool failed to specify which toes were measured, and failed to include the assessment of the wounds that were measured. The assessment tool failed to include the remaining treated toes. The comprehensive assessment failed to include an assessment of the</p>			

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L 0534 Bldg. 00	<p>coccyx wound and an assessment of the patient's right subclavian mediport.</p> <p>6. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>7. A policy titled "Ongoing Comprehensive Assessments" Policy No. H:2 0 047.1 revised 06/2014, indicated " ... During each home visit, the Case Manager or other discipline will evaluate the patient according to the problems identified during the initial assessment and thereafter the comprehensive assessment ... Current treatment related to the identified symptoms and the patient's response ... Progress toward hospice goals and patient needs and problems ... Ongoing comprehensive assessments should focus on ... Patient's response to care ... Changes in patient condition, level of deterioration ... Changes in patient diagnoses / prognosis "</p> <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</p>				

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	<p>same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.</p> <p>Based on record review and interview, the agency failed to ensure that data elements identified had measurable goals and measurement of outcomes in 9 of 16 patients sampled (Patient #2, 3, 4, 7, 8, 11, 13, 15 and 16).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A policy titled "Hospice Item Set" Policy No. H:2 - 091.1 revised 08/2014, indicated " ... The HIS is NOT an assessment instrument and does not replace a thorough and ongoing assessment of each patient required by the Medicare Conditions of Participation " 2. The patient plan of care for patient #2, 3, 4, 7, 8, 11, 13, 15, and 16 were reviewed and all failed to include measurable goals or measurement of outcomes. 3. On 08/22/16 at 3:00 PM, the Director of Clinical Services demonstrated on the computer how the admission nurse completes an admission assessment and answers the appropriate questions for the data elements using the HIS (Hospice Item Set) program. Once a second visit 	L 0534	<p>L 534 418.54(e)(1)PATIENT OUTCOME MEASURES</p> <p>As part of the in-service performed by the Administrator on 09/13/16, 09/14/16, 09/15/16, and 09/16/16, staff were re-educated on Policy No. C:2-038, "Patient Focused Performance Improvement", (see Attachment Group A; policy from <i>Premier Hospice & Palliative Care CHAP Core Policy and Procedure Manual</i>, 2016) and the software verbal orders process to allow for edits/the addition of patient-specific goal text in verbal orders. Staff were instructed that data elements from the comprehensive assessment, including but not limited to the following examples: pain, dyspnea, nausea, vomiting, diarrhea, constipation, emotional distress, and spiritual needs, shall be incorporated into patient centered and measurable goals. Each discipline shall evaluate the patient's and their caregivers goal needs according to the problems identified during the initial comprehensive assessment and thereafter, the ongoing comprehensive assessment. The comprehensive assessment includes data elements that allow for measurement of outcomes.</p>	09/27/2016

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	<p>had been made, usually within 48 hours, the information would be transmitted to CMS (Centers for Medicare and Medicaid). The Director of Clinical Services indicated the agency had not been measuring the data throughout the patient's course of care and had not verified that the data elements identified in the comprehensive assessments assisted in the development of the plan of care which included measurable goals and measurement of outcomes.</p> <p>4. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p>		<p>The hospice measures and documents data in the sameway for all patients. The data elements take into consideration aspects of carerelated to hospice and palliation. 100% of Initial and Comprehensive assessments will bereviewed by clinical managers using the Hospice Clinical Record Audit Toolelements after admission and then twice monthly for 90 days and met/not met compliance % tracked on the QAPI AuditTracker for evidence the hospice measured data elements as part of the initialand comprehensive assessment, including but not limited to: measures on pain,dyspnea, nausea, vomiting, diarrhea, constipation, emotional distress, andspiritual needs, and incorporateddistinct measures into patient centered and measurable goals that allow formeasurement of outcomes. Staff shall add late entry IDG Notes and edited plan of careverbal orders to remediate any findings of noncompliance and will receiveindividual re-education documented on the QA Education Form. Staff reeducationForms and documentation will be maintained by the Administrator. After 90 days,if 95% met compliance threshold goal for any given month, then 10% of Initialand Comprehensive assessment records will be audited monthly by</p>		

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L 0535 Bldg. 00	418.54(e)(2) PATIENT OUTCOME MEASURES (2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program. Based on record review and interview, the agency failed to ensure that the data elements identified in the comprehensive assessments were incorporated into each hospice patients care planning and coordination of services in 9 of 16	L 0535	clinicalmanagers using the Hospice Clinical Record Audit Tool to maintain compliance. The Director of Hospice services will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur. The results will be reported to the QAPI committee andGoverning Body. Completion Date: All Staff education was completed on 9/16/2016. Any staff members who have beenon vacation or medical leave will receive the above mentioned training prior toreturning to work. By no later than09/27/2016 the organization will have implemented the Audit Tracker of 100%Admission Record Review. L 535 418.54(e)(2)PATIENT OUTCOME MEASURES As part of the in-serviceperformed by the Administrator on 09/13/16, 09/14/16, 09/15/16, and	09/27/2016	

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	<p>patients sampled (Patient #2, 3, 4, 7, 8, 11, 13, 15 and 16).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A policy titled "Hospice Item Set" Policy No. H:2 - 091.1 revised 08/2014, indicated " ... The HIS is NOT an assessment instrument and does not replace a thorough and ongoing assessment of each patient required by the Medicare Conditions of Participation " 2. The plan of care for patient #2, 3, 4, 7, 8, 11, 13, 15, and 16 were reviewed and all failed to indicate data elements were used to develop an individualized plan of care and to coordinate services. 2. On 08/22/16 at 3:00 PM, the Director of Clinical Services demonstrated on the computer how the admission nurse completes an admission assessment and answers the appropriate questions for the data elements using the HIS (Hospice Item Set) program. Once a second visit had been made, usually within 48 hours, the information would be transmitted to CMS (Centers for Medicare and Medicaid). The Director of Clinical Services indicated the agency had not been measuring the data throughout the 		<p>09/16/16, staff were re-educated on Policy No. C:2-038, "Patient Focused Performance Improvement", (see Attachment Group A; policy from <i>Premier Hospice & Palliative Care CHAPCore Policy and Procedure Manual</i>, 2016), and the software verbal orders process to allow for edits/the addition of patient-specific goal text in verbal orders. Staff were instructed that data elements from the comprehensive assessment, including but not limited to the following examples: pain, dyspnea, nausea, vomiting, diarrhea, constipation, emotional distress, and spiritual needs, shall be incorporated into patient centered and measurable goals using goal text edits. Each discipline shall evaluate the patient's and their caregivers goal needs according to the problems identified during the initial comprehensive assessment and thereafter, the ongoing comprehensive assessment. The comprehensive assessment includes data elements that allow for measurement of outcomes and coordination of services toward meeting patient and caregiver-centered goals. The hospice measures and documents data in the same way for all patients. The data elements take into consideration aspects of care related to hospice and palliation.</p>	

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	<p>patient's course of care and had not verified that the data elements identified in the comprehensive assessments assisted in the development of the plan of care which included measurable goals and measurement of outcomes.</p> <p>3. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p>		<p>100% of Initial and Comprehensive assessments will be reviewed by clinical managers using the Hospice Clinical Record Audit Tool elements after admission and then twice monthly for 90 days and met/not met compliance % results tracked on the QAPI Audit Tracker for evidence the hospice measured data elements as part of the initial and comprehensive assessment, including but not limited to: measures on pain, dyspnea, nausea, vomiting, diarrhea, constipation, emotional distress, and spiritual needs, and incorporated distinct measures, as appropriate, into patient centered and measurable goals that allow for measurement of outcomes.</p> <p>Staff shall add late entry IDG Notes and edited plan of care verbal orders to remediate any findings of noncompliance and will receive individual re-education documented on the QA Education Form. Staff reeducation Forms and documentation will be maintained by the Administrator. After 90 days, if 95% met compliance threshold goal for any given month, then 10% of Initial and Comprehensive assessment records will be audited monthly by clinical managers using the Hospice Clinical Record Audit Tool to maintain compliance.</p>		

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L 0536 Bldg. 00	Based on record review and interview, the hospice failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems identified in the initial comprehensive assessments in 9 of 13 records reviewed in a sample of 16 (See L 545); failed to ensure interventions were appropriate for the management of pain and failed to address other symptoms that were identified through initial and	L 0536	<p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization will have implemented the Audit Tracker of 100% Admission Record Review.</p> <p>L536 418.56 Condition of participation: IDG, CARE PLANNING, COORDINATION OF SERVICES CONDITION.</p> <p>On 09/13/16, 09/14/16, 09/15/16, and 09/16/16, the Administrator conducted training sessions for all staff that addressed new software documentation enhancement for wounds entitled, the Integumentary Command Center, new Wound Care Policy H:2-095 (see Attachment Group B; policy from <i>Premier Hospice & Palliative</i></p>	09/27/2016

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	<p>comprehensive assessments 1 of 13 active records reviewed (See L 546); failed to ensure that goals and outcomes anticipated from implementing and coordinating the plan of care were patient specific and measurable in 9 of 10 records reviewed of patients in the first certification period in a sample of 16 (See L 548); failed to ensure all members of IDG (Interdisciplinary Group) had participated in the review and updates of the plan of care in 5 of 13 active records reviewed in a sample of 16 (See L 552); and failed to update the initial plan of care with information obtained from the updated comprehensive assessments and note the patient's response to care, any changes in care, and progress toward desired outcomes and goals in 11 of 13 active records reviewed of patient's who had been on service for more than 15 days in a sample of 16 (See L 553).</p> <p>The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance the Condition of Participation 418.56: Interdisciplinary Group, Care Planning, and Coordination of Services.</p>		<p>Care CHAPHospice Policy and Procedure Manual, 2016) , IV Care protocols, software verbal orders process forupdates. This training also addressed: (1) PolicyNo. H:2-003, "Interdisciplinary Group Membership and Responsibilities", (seeAttachment Group B; policy from PremierHospice & Palliative Care CHAP Hospice Policy and Procedure Manual,2016) and; (2) PolicyNo. H:2-030 "The Plan of Care", (see Attachment Group B;policy from Premier Hospice &Palliative Care CHAP Hospice Policy and Procedure Manual, 2016) that directs a writtenindividualized patient and family/caregiver plan of care will be establishedand maintained for each patient. (3) PolicyNo. C:2-038, "Patient Focused Performance Improvement" (see AttachmentGroup B; policy from Premier Hospice& Palliative Care CHAP Core Policy and Procedure Manual, 2016) which directs theInterdisciplinary Group that goals and outcomes anticipated from implementingand coordinating the plan of care are patient centered and measurable goalsthat allow for the measurement of outcomes and that the IDG shall update theinitial plan of care with information obtained from the updated comprehensiveassessments document assessment/</p>	

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			<p>reassessment of the patient's response to care and note the patient's response to care, any changes in care, and progress toward desired outcomes and goals.</p> <p>The hospice medical directors also received re-education on Policy No. H:2-013 "Physician Services – Medical Director" (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016). These policies and these training sessions focused on how the plan of care is to be based on the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group (in collaboration with the individuals attending physician, if any) and will be reviewed and revised on a regular basis but no less than frequently than every fifteen [15] days. Staff were instructed that they must develop an individualized written plan of care for each patient that reflects 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 but not limited</p>	

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			<p>tointerventions to manage pain and symptoms.</p> <p>100% of Initial Plans of Care and Update records will be reviewed by clinical managers using the Hospice Clinical Record Clinical Audit Tool elements after admission and then twice monthly for 90 days and tracked on the QAPI Audit Tracker form/not met compliance % a written individualized patient and family/caregiver plan of care was established and maintained for each patient which includes verbal orders. Staff shall add late entry IDG Notes and verbal orders to remediate any findings of noncompliance and will receive individual re-education documented on the QA Education Form. Staff reeducation Forms and documentation will be maintained by the Administrator.</p> <p>After 90 days, if 95% met compliance threshold goal for any given month, then 10% of Initial Plan of Care and Update records will be audited monthly by clinical managers using the Hospice Clinical Record Audit Tool to maintain compliance.</p> <p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed on</p>	

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L 0545 Bldg. 00	<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: Based on record review and interview, the hospice failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems identified in the initial comprehensive assessments in 9 of 13 records reviewed in a sample of 16. (# 2, 3, 4, 7, 8, 11, 13, 15, and 16)</p>	L 0545	<p>9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization will have implemented the Audit Tracker of 100% Initial Plans of Care and Update Record Review. See additional detail in the Plan of Correction descriptions in Tags L545, L546, L548, L552 and L553.</p> <p>L 545 418.56(c) CONTENT OF PLAN OF CARE</p> <p>On 09/13/16, 09/14/16, 09/15/16, and 09/16/16, the Administrator conducted training sessions for all staff that addressed Policy No. H:2-030 entitled "The Plan of Care" (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016) that directs a written</p>	09/27/2016

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	<p>Findings include:</p> <p>1. Clinical record number 2, Election date 05/12/16, included a physician's plan of care for the certification dates of 05/12/16 to 08/09/16. The patient diagnoses included but not limited to heart failure, hypertension, edema, low back pain, and lumbago.</p> <p>A. The start of care nursing assessment dated 05/12/16, identified the patient had 1 - 2 falls in the past 3 months and required an assistive device for ambulation. The assessment indicated the patient was alert and oriented to person, place, and time, forgetful at times. The assessment indicated the patient had reddened areas under the bilateral breasts, and that the patient had a pain in the bilateral lower extremities with a pain level of 5 on a scale of 1 - 10 (ten being worse pain). The patient pain was described as continuous, interferes with patient's activity daily (but not constantly), weight bearing and activity made the pain worse. The assessment also indicated the patient had 3+ bilateral lower extremity edema, diminished breath sounds, and no oxygen use / treatments.</p> <p>B. Review of the initial plan of care, the nursing interventions included but not</p>		<p>individualized patient and family/caregiver plan of care which is established and maintained for each patient and is to include all services necessary for the palliation and management of the terminal illness and related conditions, including but not limited to interventions to manage pain and symptoms. This policy and the training establishes that the plan of care will be based on the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group (in collaboration with the individuals attending physician, if any) and will be reviewed and revised on a regular basis but no less than frequently than every fifteen [15] days. The hospice medical director is required to evidence participation in the review and update of the plan of care.</p> <p>100% of Initial Plans of Care and Update records will be reviewed by clinical managers using the Hospice Clinical Record Audit Tool elements after admission and then twice monthly for 90 days and tracked on the QAPI Audit Tracker for met/not compliance % that a written individualized patient and family/caregiver plan of care was established and maintained for each patient which includes verbal orders. Staff shall add late entry IDG Notes and verbal orders</p>	

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	<p>limited to hospice nurse for observation and assessment of cardiac / circulatory system each visit; observation and assessment of respiratory status; observation and assessment of integumentary status for early identification of complications; hospice nurse observation and assessment of patient safety, instruct safety measures as needed; skilled nurse for observation / assessment of patient's ability to perform ADLs (activities of daily living) and related complications; skilled nurse to obtain oxygen saturations via pulse oximetry as needed; and skilled nurse to prefill medi-planner every week.</p> <p>The initial plan of care failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems identified in the initial comprehensive assessments.</p> <p>2. Clinical record number 3, Election date 7/14/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/14/16 to 10/11/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated malignant pancreatic cancer with metastasis to the lung mediastinum, and liver with secondary diagnoses of hypertension and</p>		<p>to remediate any findings of noncompliance and will receive individual re-education documented on the QA Education Form. Staff reeducation Forms and documentation will be maintained by the Administrator. After 90 days, if 95% met compliance threshold goal met for any given month, then 10% of Initial Plan of Care and Update records will be audited monthly by clinical managers using the Hospice Clinical Record Audit Tool to maintain compliance. The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization will have implemented the Audit Tracker of 100% Initial Plans of Care and Update Record Review.</p>	

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	<p>diabetes.</p> <p>A. The start of care nursing assessment dated 07/14/16, indicated the patient's past medical history included congestive heart failure, congestive / obstructive, and asthma and he / she would wear a c-pap at night and he / she would wear it during the day if he / she would become overly short of breath. The patient was incontinent of bowel and bladder. Appetite varies from good to very poor daily. The patient would become very fatigued with ambulation at short distances. The patient had diminished visual activity, diminished breath sounds, blood sugars range in the 300's, requires assistance with toileting, dressing, and grooming.</p> <p>B. Review of the initial plan of care, the nursing interventions included but not limited to hospice nurse to monitor pain level using pain scale each visit and report changes in pain level to physician; hospice nurse observation and assessment of respiratory status; skilled nurse to provide instructions / reinforcement related to urinary incontinence; skilled nurse to provide instructions / reinforcement regarding care of the bowel incontinent patient; instruct bowel protocol as needed; skilled nurse of observation and assessment of patient's</p>			

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	<p>ability to perform ADLs and related complications; skilled nurse to obtain oxygen saturations via pulse oximetry as needed; skilled nurse to review home safety, instruct patient / caregiver in measures to improve home safety and prevent falls; skilled nurse for observation and assessment of of cardiac / circulatory system each visit; hospice nurse to instruct and monitor use of oxygen; and skilled nurse for observation of knowledge base to identify knowledge deficits for early intervention of complications.</p> <p>The initial plan of care failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems identified in the initial comprehensive assessments.</p> <p>3. Clinical record number 4, Election dated 05/18/16, included a form called "Hospice Certificating and Plan of Care" for the certification period of 05/18/16 to 08/15/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated Alzheimer's disease with secondary diagnoses of atherosclerosis, dementia, esophageal reflux, and hypertension.</p> <p>A. Review of the initial plan of care,</p>			

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	<p>the nursing interventions included but not limited to hospice nurse to evaluate patient and develop plan of care to be signed by physician, hospice nurse observation and assessment of sensory / neurological status, nutrition and hydration status, genitourinary pattern, signs and symptoms of declining status / imminent death, instruct bowel protocol as needed, skilled nurse to obtain oxygen saturations via pulse oximetry as needed, to coordinate plan of care with facility staff, patient may have general hospice comfort kit, hospice aide service for assistance with personal care and ADLs secondary to functional limitations, which prevent self - care due to "no willing or able caregiver to provide for hygiene needs", volunteer services as needed, music therapy evaluation, and hospice nurse to instruct and monitor use of oxygen.</p> <p>B. The Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated 05/24/16, the case manager provided a synopsis of the patient's admission from 05/18/16. The synopsis indicated the patient resides in a memory care unit, no respiratory issues but has oxygen and nebulizer treatments as needed. Incontinent of bowel and bladder. Fed by staff and eats less than 75% of meals. Had a weight loss of 16</p>			

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	<p>pounds in the last 5 months. Had 2 falls in the last 6 weeks. Decreased level of consciousness with nonsensical speech. Had a recent urinary tract infection and aspiration pneumonia, both treated with antibiotics. Patient was now non ambulatory, chair bound, requiring assistance of 1 - 2 for transfers, wheelchair propelled by staff. Family desires comfort care only.</p> <p>The initial plan of care failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems identified in the initial comprehensive assessments.</p> <p>4. Clinical record number 7, Election date 07/25/16, included a form called "Hospice Certifying and Plan of Care" for the certification period of 07/25/16 to 10/22/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated malignant neoplasm of ovary with secondary diagnoses of malaise and fatigue, difficulty walking, lack of coordination, muscle weakness, and depressive disorder.</p> <p>A. The start of care nursing assessment dated 07/25/16, indicated the patient had gone from doing most all of</p>			

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	<p>personal care independently to being completely bedfast and dependent on family for all ADLs within the last 6 months, the patient had impaired learning and physical limitations, diminished visual acuity, 3+ edema to left lower extremity, diminished breath sounds, incontinence of bowel and bladder, nausea, poor appetite, as needed opioid use, hypoactive bowel sounds but reported several bowel movements a day, the patient was discharged from a skilled nursing facility same day of hospice admission and the facility nurse reported the patient had passed a large amount of blood in the bowels 4 to 5 times, the patient was anemic with excessive bleeding or bruising, lab results from 07/02/16 indicated a hemoglobin of 5.9 and the patient received 2 units of packed red blood cells, the patient was lethargic, difficulty answering most questions and required assistance of family, the patient had 1 - 2 falls in the past 3 months, required assistance with toileting / bathing / dressing / grooming, balance problem while standing, walking, decreased muscle coordination,unstable when turning, and required an assistive device with ambulation, decreased strength with neck, back, upper and lower extremities. The patient had "excellent" social support system that included 3 or more family and friends.</p>			

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	<p>B. Review of the initial plan of care, the nursing interventions included but not limited to hospice nurse to evaluate patient and develop plan of care to be signed by physician, to monitor pain level using pain scale each visit and report changes in pain level to physician, to instruct / reinforce new and changed medications and medication regimen, observation and assessment of cardiac / circulatory system each visit, sensory / neurological status, nutrition and hydration status, respiratory status, genitourinary pattern, integumentary status for early identification of complications, patient safety, instruct safety measures as needed, signs and symptoms of declining status / imminent death, patient's ability to perform ADLs and related complications, knowledge base to identify knowledge deficits for early intervention of complications, skilled nurse to provide instructions / reinforcement related to urinary incontinence, regarding care of the bowel incontinent patient bowel protocol as needed, caregiver(s) on how to assist with ADLs, hospice aide to assist with ADLs and personal care needs, skilled nurse to obtain oxygen saturations via pulse oximetry as needed, patient may have general hospice comfort kit, hospice aide service for assistance with personal</p>			

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	<p>care and ADLs secondary to functional limitations, which prevent self - care. There was no willing or able caregiver to provide for hygiene needs, and hospice nurse to instruct and monitor use of oxygen.</p> <p>The initial plan of care failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems identified in the initial comprehensive assessments.</p> <p>5. Clinical record number 8, Election date 05/18/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 05/18/16 to 09/05/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated idiopathic pulmonary fibrosis with secondary diagnosis of hypertension.</p> <p>A. The start of care nursing assessment dated 05/18/16, indicated the patient's severe chronic lung diseases was evidenced by disabling dyspnea at rest, poor or unresponsive to bronchodilators resulting in decreased functional capacity (bed to chair existence, fatigue, cough), increasing visits to the hospital for respiratory infections or respiratory failure, oxygen saturations at <88% on</p>			

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	<p>room air, unintentional progressive weight loss of >10% of body weight over previous 6 months. The assessment indicated a hearing deficit in both ears, shortness of breath at night and with mobility, 1 - 2 + edema to the bilateral lower extremities, expiratory wheezing at rest, continuous oxygen at 4 liters and other treatments for shortness of breath were opioids and other medication; urinary incontinence, immune compromised, anxiety treated with ativan as needed, balance problems while standing, walking, turning, and required human assistance and an assistive device to assist with ambulation, requires assistance with toileting, bathing, and grooming,</p> <p>B. Review of the initial plan of care, the nursing interventions included but not limited to hospice nurse to evaluate patient and develop plan of care to be signed by physician; skilled nurse to instruct / reinforce new and changed medications and medication regimen; hospice nurse to monitor pain level using pain scale each visit and report changes in pain level to physician; hospice nurse observation and assessment of cardiac / circulatory system each visit, patient's ability to perform ADLs and related complications, signs and symptoms of declining status / imminent death,</p>			

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	<p>knowledge base to identify knowledge deficits for early intervention of complications; hospice nurse to instruct and monitor use of oxygen, hospice nurse observation and assessment of nutrition and hydration, respiratory status, genitourinary pattern; skilled nurse to provide instructions / reinforcement related to urinary incontinence; instruct bowel protocol as needed, hospice nurse observation and assessment of patient safety, instruct safety measures as needed; skilled nurse to obtain oxygen saturations via pulse oximetry as needed; instruct patient / family on signs and symptoms of dying and plan for managing symptoms, patient may have general hospice comfort kit; and skilled nurse to review home safety, instruct patient / caregiver in measures to improve home safety and prevent falls.</p> <p>The initial plan of care failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems identified in the initial comprehensive assessments.</p> <p>6. Clinical record number 11, Election date 06/08/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 06/08/16 to 09/05/16, contained interventions and</p>			

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	<p>non-measurable goals. The patient's hospice diagnosis indicated malignant neoplasm of colon with secondary diagnoses of malignant neoplasm of liver and severe protein calorie deficiency.</p> <p>A. The start of care nursing assessment dated 06/08/16, identified the patient was having moderate abdominal pain rated at a 6 on a scale of 1 - 10 (with 10 being the worse). The patient's reported goal for pain was zero. The assessment indicated the patient had 1+ edema to the right and left lower extremity / ankle, diminished breath sounds but no shortness of breath. The rated nausea a 7 on a scale of 1 - 10 (with 10 being the worse) in the past 24 hours. The patient's reported goal for nausea was zero. There were no abnormal dress / grooming / personal hygiene identified. Decreased strength in back and lower extremities, but the patient was not rated as a fall risk. Equipment needs indicated bed with rails, bedside commode, over bed table, oxygen concentrator, oxygen cylinder, walker, and shower chair.</p> <p>B. A form titled "Client Coordination Note Report" dated 06/08/16, indicated the note was a summary of the patient's admission. The note indicated, " ... Dx. [diagnosis] of malignant neoplasm of colon, unspecified</p>			

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	<p>and past medical history of secondary malignant neoplasm of liver and intrahepatic bile duct, GERDS [gastro-esophageal reflux disease], tachycardia, malignant ascites, unspecified severe protein - calorie malnutrition, sepsis secondary to E coli bacterium and C diff ... Patient had peritoneal drain placed 05/25/16 given her increased malignant ascites requiring drainage. Multiple hospitalizations over past six months. Most recent ... for worsening abdominal pain, nausea / vomiting and diarrhea. Recent antibiotic tx [treatment] for sepsis ... Spanish speaking only, increased weakness and fatigue, requiring increased assistance with ADL's ... gait unsteady, nausea and vomiting. Appetite decreased. Recent weight gain r/t [related to] ascites "</p> <p>C. Review of the initial plan of care, the nursing interventions included but not limited to hospice nurse to evaluate the patient and develop plan of care to be signed by physician; hospice nurse to monitor pain level using pain scale each visit and report changes in pain level to physician; skilled nurse for observation and assessment of integumentary status for early identification of complications; hospice nurse observation and assessment of patient safety, instruct safety measures as needed; skilled nurse for observation</p>			

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	<p>and assessment of patient's ability to perform ADLs and related complications; hospice nurse to ensure interpreter will be used for communication of plan of care, instructions and concerns; patient may have general hospice comfort kit; hospice nurse observation and assessment of nutrition and hydration status; instruct bowel protocol as needed; hospice nurse to instruct and monitor use of oxygen; Skilled nurse to obtain oxygen saturations via pulse oximetry as needed; skilled nurse to instruct / reinforce new and changed medications and medication regimen; hospice nurse to ensure interpreter will be used for communication of plan of care, instructions and concerns.</p> <p>The initial plan of care failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems identified in the initial comprehensive assessments.</p> <p>7. Clinical record number 13, Election date 08/01/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 08/01/16 to 10/29/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary</p>			

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	<p>diagnoses of diabetes, stroke, and hypertension.</p> <p>A. The start of care nursing assessment dated 08/01/16, the assessment indicated the patient had an ejection fraction of < 20 %, the patient had diminished visual acuity, pain score of 8 on a scale of 1 - 10 (with 10 being the worse), the pain generalized and was described as aching, continuous, interferes with activity all the time, weight bearing and certain positions made the pain worse. The goal for pain was a score of 5. The patient was observed to have 2 + edema to the bilateral lower extremities, the patient had coarse sounds in the left lung, the patient was on continuous oxygen at 4 liters. The patient was incontinent of bowel and bladder. The patient was a diabetic and blood sugars were checked in the morning and at bedtime. The patient's blood sugars ranged in the high range of 200's. The assessment indicated the patient was dependent on the family member for ADLs. The patient was chair bound and required assistance with toileting. The patient had decreased strength in the upper and lower extremities, and also ambulated with an assistive device.</p> <p>B. Review of the initial plan of care,</p>			

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	<p>the nursing interventions included but not limited to hospice nurse to evaluate the patient and develop plan of care to be signed by physician; hospice nurse to monitor pain level using pain scale each visit and report changes in pain level to physician; hospice nurse observation and assessment of cardiac / circulatory system each visit; hospice nurse to instruct and monitor use of oxygen; hospice nurse observation and assessment of respiratory status; hospice nurse to observe and assess genitourinary pattern; skilled nurse to provide instructions / reinforcement regarding care of the bowel incontinent patient; instruct bowel protocol as needed; hospice nurse observation and assessment of patient safety, instruct safety measures prn; hospice nurse observation and assessment of signs and symptoms of declining status / imminent death; the skilled nurse will assess the spiritual needs of the patient; patient may have general hospice comfort kit; skilled nurse to obtain oxygen saturations via pulse oximetry as needed; and skilled nurse to instruct / reinforce new and changed medications and medication regimen.</p> <p>The initial plan of care failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems</p>			

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	<p>identified in the initial comprehensive assessments.</p> <p>8. Clinical record number 15, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to 10/04/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated atherosclerotic heart disease with secondary diagnoses of dementia, hypertension, and stage III chronic kidney disease.</p> <p>A. The start of care nursing assessment dated 07/07/16, identified the patient had irregular frequency of chest pain, shortness of breath during sleep, the chest pain occurred at rest and with exertion, the chest pain was relieved with nitroglycerin, and the pain was described as pressure, sharp, and radiating. The assessment indicated no abnormal respiratory findings identified, but dyspnea significantly affected the patient on a score of 5 on a scale from 1 - 10 with 10 being the worse. The patient's reported goal was a 2 and the patient's worst level of shortness of breath was a 7. The assessment indicated the patient had appetite problems with a score of 4 on a scale from 1 - 10 with 10 being the worse. The patient's reported goal was 2</p>			

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	<p>and the worst level in the last 24 hours was a 6. The assessment indicated the patient had abnormal thought process, described as incoherence and found to have an abnormal recent memory. The functional status indicated the patient had bilateral knee replacements, gait ambulation disturbance, and ambulated with an assistive device. The assessment indicated the family burdens include administering medications and experiencing increased time demands.</p> <p>B. Review of the initial plan of care, the nursing interventions included but not limited to hospice nurse to evaluate patient and develop plan of care to be signed by physician; hospice nurse observation and assessment of cardiac / circulatory system each visit; hospice nurse to provide instructions related to cardiac / circulatory system each visit; hospice nurse to instruct and monitor use of oxygen; hospice nurse observation and assessment of sensory / neurological status; instruct caregiver(s) on levels of consciousness and to report changes to hospice nurse; hospice nurse observation and assessment of patient safety, instruct safety measures as needed; patient may have general hospice comfort kit; skilled nurse to review home safety, instruct patient / caregiver in measures to improve home safety and prevent falls,</p>			

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	<p>skilled nurse to obtain oxygen saturations via pulse oximetry; skilled nurse for observation and assessment of knowledge base to identify knowledge deficits for early intervention of complications; skilled nurse to instruct / reinforce new and changed medications and medication regimen; and hospice nurse to monitor pain level using pain scale each visit and report changes in pain level to physician.</p> <p>The initial plan of care failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems identified in the initial comprehensive assessments.</p> <p>9. Clinical record number 16, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to 10/04/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary diagnoses of dementia, hypertension, and stage III chronic kidney disease.</p> <p>A. The start of care nursing assessment dated 07/07/16, identified that the patient resided in a community residential setting, the patient indicated severe aching, pressured, continuous pain</p>			

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	<p>to the lower extremities scoring an 8 on a scale of 1 - 10 (with 10 being the worse). Patient's goal for pain was a 5. Weight bearing made the pain worse. The pain affected the patient's ability to enjoy activities, mobility, and sleep. The assessment indicated the patient had four wounds "x 3" on bilateral feet and one on the coccyx. The nurse indicated he / she was not able to assess due to the patient had went to bed. The assessment indicated the patient and dyspnea at night, shortness of breath with ambulation, and the patient was receiving inhalation treatments. The assessment indicated the patient was incontinent of urine at night. The assessment indicated the patient was alert and oriented to person, place, and time but was unable to recall recent events. The patient had balance problems while standing / walking and required an assistive device. The functional assessment indicated the patient had pain / stiffness, decreased strength, amputation and ambulation disturbance. The reason for the pain and stiffness was due to the bilateral lower extremity wounds. The assessment indicated the patient had poor social support, no willing family members or friends, and was basically alone.</p> <p>B. Review of the initial plan of care, the nursing interventions included but not</p>			

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	limited to hospice nurse to evaluate patient and develop plan of care to be signed by physician; hospice nurse to monitor pain level using pain scale each visit and report changes in pain level to physician; hospice nurse to instruct patient / caregiver(s) on use of pain scale, administration and side effects of pain medications; hospice nurse observation and assessment of cardiac / circulatory system each visit; hospice nurse to provide instructions related to cardiac / circulatory system each visit; instruct caregiver(s) on seizure precautions and the need to report seizure activity; hospice nurse observation and assessment of sensory / neurological status; hospice nurse observation and assessment of respiratory status; hospice nurse to provide instructions for performing inhalation therapy and care for equipment; skilled nurse for observation and assessment of integumentary status for early identification of complications; skilled nurse to provide instructions / reinforcement related to complications of integumentary status including related to bilateral lower extremity wounds and coccyx wound; skilled nurse for administration of decubitus wound care, wrapped lower extremity wounds three times per week with kerlix, coccyx wound apply antimicrobial pressure dressing when soiled; skilled nurse to			

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	<p>provide instructions related to decubitus ulcer care; instruct bowel protocol as needed; hospice nurse observation and assessment of patient safety, instruct safety measures as needed; skilled nurse for observation / assessment of patient's ability to perform ADLs and related complications; skilled nurse for observation and assessment of patient's social isolation and provide assistance to patient in development of planned activities; skilled nurse to prefill medi-planner every week; and patient may have general hospice comfort kit.</p> <p>The initial plan of care failed to develop an individualized plan of care that reflected the patient and family goals and interventions based on the problems identified in the initial comprehensive assessments.</p> <p>10. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>11. A policy titled "The Plan of Care" Policy No. H:2 - 030.1 revised 03/2016, indicated " ... A written individualized patient and family / caregiver plan of care will be established and maintained ... The</p>			

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L 0546 Bldg. 00	<p>plan of care will be based on the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group and will be reviewed on a regular basis but no less than every fifteen [15] days ...The plan of care will identify the patient's needs and services to meet those needs "</p> <p>418.56(c)(1) 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:] (1) Interventions to manage pain and symptoms.</p> <p>Based on record review and interview, the Interdisciplinary Team failed to ensure interventions were appropriate for the management of pain and failed to address other symptoms that were identified through initial and comprehensive assessments in 1 of 13 active records reviewed in a sample of 16 (Patient #2).</p> <p>Findings include:</p> <p>1. Clinical record number 2, Election date 05/12/16, included a physician's plan</p>	L 0546	<p>L 546 418.5 (c)(1)CONTENT OF PLAN OF CARE. Interventions to manage pain and symptoms.</p> <p>On 09/13/16, 09/14/16,09/15/16, and 09/16/16, the Administrator conducted training sessions for allstaff that addressed: thenew software documentation enhancement for wounds entitled, the IntegumentaryCommand Center, new Wound Care Policy No. H:2-095 (see Attachment GroupB; policy from <i>Premier Hospice &Palliative Care CHAP Hospice Policy and Procedure Manual, 2016</i>) , IV Care protocols, softwareverbal orders</p>	09/27/2016			

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	<p>of care for the certification dates of 05/12/16 to 08/09/16. The patient diagnoses included but not limited to heart failure, hypertension, edema, low back pain, and lumbago.</p> <p>A. A comprehensive start of care assessment dated 05/12/16, indicated the patient had reddened areas under the bilateral breasts, and that the patient had a pain in the bilateral lower extremities with a pain level of 5 on a scale of 1 - 10 (ten being worse pain). The patient pain was described as continuous, interferes with patient's activity daily (but not constantly), weight bearing and activity made the pain worse. The assessment also indicated the patient had 3+ bilateral lower extremity edema, diminished breath sounds, and no oxygen use / treatments.</p> <p>B. The Certificate of Terminal Illness dated 05/12/16, indicated the patient's oxygen saturations were 91% on room air but dropped to the mid 80's with any exertion. The patient was short of breath with exertion greater than walking 20 feet. The patient complained of pain in bilateral lower extremities and used tramadol for pain management. The patient had 3+ lower extremity edema.</p> <p>C. Review of the initial plan of care,</p>		<p>process for updates, Interdisciplinary Group Membership and Responsibilities" Policy No. H:2-003 (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016), and policy titled "ThePlan of Care", No.H:2-030 (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAPHospice Policy and Procedure Manual</i>, 2016), that directs a written individualized patient andfamily/caregiver plan of care will be established and maintained for eachpatient. The plan of care will be based on the initial, comprehensive andongoing comprehensive assessments performed by members of the interdisciplinarygroup (in collaboration with the individuals attending physician, if any) andwill be reviewed and revised on a regular basis but no less than frequentlythan every fifteen [15] days. The hospice medical director shall evidenceparticipation in the review and update of the plan of care. The plan of carewill identify the patient's needs and services to meet those needs. Staff wereinstructed that they must develop an individualized written plan of care for each patient that reflects patient and family goals and interventions based onthe problems identified in the initial,</p>	

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	<p>the nursing interventions included but not limited to skilled nurse for observation and assessment of cardiac / circulatory system each visit, observation and assessment of respiratory status, and observation and assessment of integumentary status for early identification of complications, and the skilled nurse to obtain oxygen saturations via pulse oximetry as needed.</p> <p>The initial plan of care failed to include interventions for pain management, failed to include parameters for obtaining oxygen saturations, and failed to include specific interventions for the management of cardiopulmonary distress.</p> <p>2. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>3. A policy titled "Plan of Care" Policy No. H:2 - 030.1 revised 03/2016, indicated " ... The plan of care will identify the patient needs and services to meet those needs, including the management of pain and discomfort and symptom relief. It must state, in detail, the scope and frequency of services needed to meet the patient's and family /</p>		<p>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 but not limited to, interventions to manage pain and symptoms, parameters for obtaining oxygen saturations as needed, and specific interventions for the management of cardiopulmonary distress.</p> <p>100% of Initial Plans of Care and Update records will be reviewed by clinical managers using the Clinical records Audit Tool elements after admission and then twice monthly for 90 days and tracked on the QAPI Audit Tracker for met/not compliance % that a written individualized patient and family/caregiver plan of care, which includes verbal orders, was established and maintained for each patient that includes all services necessary for the palliation and management of the terminal illness and related conditions, including but not limited to, interventions to manage pain and symptoms. Staff shall add late entry IDG Notes and verbal orders to remediate any findings of noncompliance and will receive individual re-education documented on the QA Education Form. Staff re-education Forms</p>	

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	<p>caregiver needs ... The written plan of care will contain, but will not be limited to the following ... Pain and symptom management interventions ... Measurable outcomes anticipated from implementing and coordinating the plan of care "</p> <p>s</p>		<p>and documentation will be maintained by the Administrator. After 90 days, if 95% met compliance threshold goal for any given month, then 10% of Initial Plan of Care and Update records will be audited monthly by clinical managers using the Hospice Clinical Record Audit Tool to maintain compliance.</p> <p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>The Director of Compliance and the Director of Hospice will train all staff on Pain and Symptom Management using the nationally recognized ELNEC curriculum by no later than 09/27/16. An attendance record will document participation. With this additional knowledge, the clinicians will be able to incorporate this training into Plan of Care development.</p> <p>Completion Date: All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization will have implemented the Audit Tracker of 100% Initial Plans of Care and Update Record Review.</p>	

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L 0548 Bldg. 00	<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 record review and interview, the Interdisciplinary Group failed to ensure that goals and outcomes anticipated from implementing and coordinating the plan of care were patient specific and measurable in 9 of 10 records reviewed of patients in the first certification period in a sample of 16. (# 2, 3, 4, 7, 8, 11, 13, 15, 16)</p> <p>Findings include:for the management of the identified problems.</p> <p>1. Clinical record number 2, Election date 5/12/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 05/12/16 to 08/09/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated heart failure with secondary diagnoses hypertension, edema, low back pain, and lumbago.</p>	L 0548	<p>L 548 418.56(c)(3) CONTENT OFPLAN OF CARE. Measurable outcomes anticipated from implementing andcoordinating the plan of care.</p> <p>On 09/13/16, 09/14/16,09/15/16, and 09/16/16, the Administrator conducted training sessions for allstaff that addressed PolicyNo. C-2.038 "PatientFocused Performance Improvement" (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAP CorePolicy and Procedure Manual, 2016</i>) andPolicy No. H:2-030 "The Plan of Care" (see Attachment Group B;policy from <i>Premier Hospice &Palliative Care CHAP Hospice Policy and Procedure Manual, 2016</i>), which that directs a writtenindividualized patient and family/caregiver plan of care will be establishedand maintained for each patient.</p> <p>The plan of care will identify the patient's needs andservices to meet those needs. Staff were</p>	09/27/2016

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	A. The plan of care included the following goals: A nursing plan of care will be established that meets the patient's needs; Patient will maintain optimal cardiac function within constraints of disease; Patient's respiratory status will be stabilized to comfort as possible; Skin breakdown will be identified and measures to resolve breakdown implemented promptly; Patient will have safety needs met; Patient will receive personal care and hygiene, including other activities of daily living to their optimal level; Patient will demonstrate oxygen saturation to patient's optimal level as established by physician; Knowledge deficits will be identified and appropriate instruction provided; Patient / Caregiver will demonstrate ability to administer medications via planner device; General Hospice comfort kit will be provided to the patient; A medical social worker plan of care will be established that meets the patient's needs; A chaplain plan of care will be established that meets the patient's needs; Patient will receive personal care and hygiene, including other activities of daily living to their optimal level; Music therapy evaluation and plan of care developed to meet patient / caregiver needs; and Patient / caregiver will verbalize understanding of oxygen use related to uses and safety.		instructed that they must develop an individualized written plan of care for each patient that reflects patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The Interdisciplinary Group shall ensure that goals and outcomes anticipated from implementing and coordinating the plan of care are patient centered and measurable goals that allow for the measurement of outcomes. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions. The hospice medical director shall evidence participation in the review and update of the plan of care 100% of Initial Plans of Care and Update records will be reviewed by clinical managers using the Hospice Clinical Record Audit Tool elements after admission and then twice monthly for 60 days and tracked on the QAPI Audit Tracker for met/not compliance % that a written individualized patient and family/caregiver plan of care was established and maintained for each patient which demonstrates measurable outcomes anticipated from implementing and coordinating the plan of				

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	<p>The goals and outcomes anticipated from implementing and coordinating the plan of care failed to be patient specific and measurable.</p> <p>2. Clinical record number 3, Election date 7/14/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/14/16 to 10/11/16, contained interventions and non-measurable goals. The patient's hospice diagnoses indicated malignant pancreatic cancer with metastasis to the lung mediastinum, and liver with secondary diagnoses of hypertension and diabetes.</p> <p>A. The plan of care included the following goals: A nursing plan of care will be established that meets the patient's needs; Patient / caregiver will administer medications as prescribed as evidenced by no adverse effects from medication error; Patient / caregiver will understand the pain scale, how to manage pain and report changes to hospice; Patient's respiratory status will be stabilized to comfort as possible; Patient / caregiver will verbalize understanding of effects of urinary incontinence; Patient / caregiver will verbalize understanding of care required secondary to bowel incontinence; Patient will have an</p>		<p>care.Staffshall add late entry IDG Notes and verbal orders to remediate any findings ofnoncompliance and will receive individual re-education documented on the QAEducation Form. Staff reeducation Forms and documentation will be maintained bythe Administrator. After 90 days, if 95% met compliance threshold goal forany given month, then 10% of Initial Plan of Care and Update records will beaudited monthly by clinical managers using the Hospice Clinical Record AuditTool to maintain compliance.</p> <p>The Director of Hospice services will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur. The results will be reported to the QAPI committee andGoverning Body.</p> <p>Completion Date:All Staff education was completed on 9/19/2016. Any staff members who have beenon vacation or medical leave will receive the above mentioned training prior toreturning to work. By no later than09/27/2016 the organization will have implemented the Audit Tracker of 100%Initial Plans of Care and Update Record Review.</p>	

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	<p>effective bowel program; patient will receive personal care and hygiene, including other activities of daily living to their optimal level; Patient will demonstrate oxygen saturation to patient's optimal level as established by physician; Patient will receive personal care and hygiene, including other activities of daily living to their optimal level; patient / caregiver will verbalize / demonstrate understanding of fall prevention / safety; Knowledge deficits will be identified and appropriate instruction provided; Patient / caregiver will verbalize understanding of oxygen use related to uses and safety; and Patient will maintain optimal cardiac function within constraints of disease.</p> <p>The goals and outcomes anticipated from implementing and coordinating the plan of care failed to be patient specific and measurable.</p> <p>3. Clinical record number 4, Election date of 05/18/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 05/18/16 to 08/15/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated Alzheimer disease.</p> <p>A. The plan of care included the</p>			

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	<p>following goals: A nursing plan of care will be established that meets the patient's needs; Caregiver(s) are knowledgeable of care and need to report changes of level of consciousness; Caregivers(s) verbalize understanding of anorexia and / or dehydration in the dying patient and demonstrate comfort with the plan of care; Patient will be free of signs / symptoms of discomfort related to genitourinary system; Patient will have an effective bowel program; Patient will transition peacefully through the dying process; Patient will demonstrate oxygen saturation to patient's optimal level as established by physician; Facility staff is knowledgeable and involved in hospice plan of care for patient; A medical social worker plan of care will be established that meets the patient's needs; Patient will receive personal care and hygiene, including other activities of daily living to their optimal level; Music therapy evaluation and plan of care developed to meet patient / caregiver needs; and Patient / caregiver will verbalize understanding of oxygen use related to uses and safety.</p> <p>The goals and outcomes anticipated from implementing and coordinating the plan of care failed to be patient specific and measurable.</p>			

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	<p>4. Clinical record number 7, Election date 07/25/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/25/16 to 10/22/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated Malignant neoplasm of ovary with secondary diagnoses of malaise, fatigue, muscle weakness, difficulty in walking, lack of coordination, and atypical depressive disorder.</p> <p>A. The plan of care included the following goals: A nursing plan of care will be established that meets the patient's needs; Patient / caregiver will administer medications as prescribed as evidenced by no adverse effects from medication error; Patient / caregiver will understand the pain scale, how to manage pain and report changes to hospice; Patient will maintain optimal cardiac function within constraints of disease; Caregiver(s) are knowledgeable of care and need to report changes of level of consciousness; Caregivers(s) verbalize understanding of anorexia and / or dehydration in the dying patient and demonstrate comfort with the plan of care; Patient's respiratory status will be stabilized to comfort as possible; Patient will be free of signs / symptoms of discomfort related to genitourinary</p>			

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	<p>system; Patient / caregiver will verbalize understanding of care required secondary to urinary incontinence; Skin breakdown will be identified and measures to resolve breakdown implemented promptly; Patient / caregiver will verbalize understanding of care required secondary to bowel incontinence; Patient will have an effective bowel program; Patient will have safety needs met; Patient will transition peacefully through the dying process; Caregiver(s) verbalize understanding of signs / symptoms imminent death; Patient will receive personal care and hygiene, including other activities of daily living to their optimal level; Caregiver will demonstrate ability to assist patient with ADLs; Patient's personal care needs will be met; Patient will demonstrate oxygen saturation to patient's optimal level as established by physician; Knowledge deficits will be identified and appropriate instruction provided; General hospice comfort kit will be provided to the patient; A medical social worker plan of care will be established that meets the patient's needs; A chaplain plan of care will be established that meets the patient's needs; Patient will receive personal care and hygiene, including other activities of daily living to their optimal level; and Patient / caregiver will verbalize understanding of oxygen use</p>			

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	<p>related to uses and safety.</p> <p>The goals and outcomes anticipated from implementing and coordinating the plan of care failed to be patient specific and measurable.</p> <p>5. Clinical record number 8, Election date 5/18/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 05/18/16 to 08/15/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated idiopathic pulmonary fibrosis with secondary diagnosis of hypertension.</p> <p>A. The plan of care included the following goals: A nursing plan of care will be established that meets the patient's needs; Patient / caregiver will administer medications as prescribed as evidenced by no adverse effects from medication error; Patient / caregiver will understand the pain scale, how to manage pain and report changes to hospice; Patient will maintain optimal cardiac function within constraints of disease; Patient / caregiver will verbalize understanding of oxygen use related to uses and safety; Caregivers(s) verbalize understanding of anorexia and / or dehydration in the dying patient and demonstrate comfort with the plan of</p>			

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	<p>care; Patient's respiratory status will be stabilized to comfort as possible; Patient will be free of signs / symptoms of discomfort related to genitourinary system; Patient / caregiver will verbalize understanding of care required secondary to urinary incontinence; Patient will have an effective bowel program; Patient will have safety needs met; Patient will receive personal care and hygiene, including other activities of daily living to their optimal level; Patient will demonstrate oxygen saturation to patient's optimal level as established by physician; Patient will transition peacefully through the dying process; Caregiver(s) verbalize understanding of signs / symptoms imminent death; Knowledge deficits will e identified and appropriate instruction provided; General hospice comfort kit will be provided to the patient; A medical social worker plan of care will be established that meets the patient's needs; A chaplain plan of care will be established that meets the patient's needs; and Patient / caregiver will verbalize / demonstrate understanding of fall prevention / safety.</p> <p>The goals and outcomes anticipated from implementing and coordinating the plan of care failed to be patient specific and measurable.</p>			

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	<p>6. Clinical record number 11, Election date 06/08/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 06/08/16 to 09/05/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated malignant neoplasm of colon with secondary diagnoses of malignant neoplasm of liver and severe protein calorie deficiency.</p> <p>A. The plan of care included the following goals: A nursing plan of care will be established that meets the patient's needs; Patient / caregiver will understand the pain scale, how to manage pain and report changes to hospice; Patient / caregiver will understand the pain scale, how to manage pain and report changes to hospice; Skin breakdown will be identified and measures to resolve breakdown implemented promptly; Patient will have safety needs met; Patient will receive personal care and hygiene, including other activities of daily living to their optimal level; Patient / Caregiver understands instructions given by hospice staff through the use of the interpreter; General hospice comfort kit will be provided to the patient; A medical social worker plan of care will be established that meets the patient's needs; A chaplain plan of care will be established that meets</p>			

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	<p>the patient's needs; Caregiver verbalize understanding of anorexia and / or dehydration in the dying patient and demonstrate comfort with the plan of care; Patient will have an effective bowel program; Patient / Caregiver will verbalize understanding of oxygen use related to uses and safety; Patient will demonstrate oxygen saturation to patient's optimal level as established by physician; Patient / caregiver will administer medications as prescribed as evidenced by no adverse effects from medication error; and Patient / caregiver understands instructions given by hospice staff through the use of the interpreter</p> <p>B. A physician order dated 08/03/16, indicated in the "Goals" portion of the order "A chaplain plan of care will be established that meets the patient's needs. Patient will have an increased sense of security, peacefulness, ability to express love / forgiveness. Plans for funeral / memorial will be completed.</p> <p>The goals and outcomes anticipated from implementing and coordinating the plan of care failed to be patient specific and measurable.</p> <p>8. Clinical record number 13, Election date 08/01/16, included a form called "Hospice Certification and Plan of Care"</p>			

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	<p>for the certification period of 08/01/16 to 10/29/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary diagnoses of diabetes, stroke, and hypertension.</p> <p>A. The plan of care included the following goals: A nursing plan of care will be established that meets the patient's needs; Patient / caregiver will understand the pain scale, how to manage pain and report changes to hospice; Patient will maintain optimal cardiac function within constraints of disease; Patient / caregiver will verbalize understanding of oxygen use related to uses and safety; Patient respiratory status will be stabilized to comfort as possible; Patient will be free of signs / symptoms of discomfort related to genitourinary system; Patient / caregiver(s) will verbalize understanding of care required secondary to bowel incontinence; Patient will have an effective bowel program; Patient will have safety needs met; Patient will transition peacefully through the dying process; General hospice comfort kit will be provided to the patient; Patient will receive personal care and hygiene, including other activities of daily living to their optimal level; Patient will demonstrate oxygen saturation to</p>			

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	<p>patient's optimal level as established by physician; and Patient / caregiver will administer medications as prescribed as evidenced by no adverse effects from medication error.</p> <p>B. A physician order dated 08/03/16, indicated in the "Goals" portion of the order "A chaplain plan of care will be established that meets the patient's needs. Patient will have an increased sense of security, peacefulness, ability to express love / forgiveness. Plans for funeral / memorial will be completed;</p> <p>C. A physician order dated 08/08/16, indicated in the "Goals" portion of the order "A medical social worker plan of care will be established that meets the patient's needs. Patient will transition peacefully through the dying process. Patient and caregiver will have decreased fear / anxiety regarding death and dying process. Patient / caregiver will express an increased sense of closure and peacefulness at the end of life. Caregiver will experience a sense of accomplishments at having supported the dying person. Patient / caregiver will have knowledge of the stages of grief and the grief cycle.</p> <p>The goals and outcomes anticipated from implementing and coordinating the plan</p>			

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	<p>of care failed to be patient specific and measurable.</p> <p>9. Clinical record number 15, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to 10/04/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated atherosclerotic heart disease with secondary diagnoses of dementia - Lewey bodies, hypertension, and stage III chronic kidney disease.</p> <p>A. The plan of care included the following goals: A nursing plan of care will be established that meets the patient's needs; Patient will maintain optimal cardiac function within constraints of disease; Patient / caregiver will verbalize understanding of oxygen use related to uses and safety; Caregiver(s) are knowledgeable of care and need to report changes of level of consciousness; Patient / caregiver are knowledgeable of change in level of consciousness as it relates to disease process and / or are approaching end of life; Patient will have safety needs met; General hospice comfort kit will be provided to the patient; Patient / caregiver will verbalize / demonstrate understanding of fall prevention / safety;</p>			

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	<p>Patient will demonstrate oxygen saturation to patient's optimal level as established by physician; Knowledge deficits will be identified and appropriate instruction provided; Patient / caregiver will administer medications as prescribed as evidenced by no adverse effects from medication error; Patient / caregiver will understand the pain scale, how to manage pain and report changes to hospice.</p> <p>B. A physician order dated 07/08/16, indicated in the "Goals" portion of the order "A chaplain plan of care will be established that meets the patient's needs. Patient will have an increased sense of security, peacefulness, ability to express love / forgiveness. Plans for funeral / memorial will be completed.</p> <p>C. The Hospice IDG Comprehensive Assessment and plan of care update report dated 07/12/16, indicated on 07/07/16, that the hospice social worker was to evaluate patient / caregiver(s) ability to cope with impending death and provide appropriate support based on assessment, evaluate patient's personal business problems. Provide assistance in resolving identified personal business problems. Assess for grieving issues / complications, provide supportive counseling.</p>				

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	<p>The goals and outcomes anticipated from implementing and coordinating the plan of care failed to be patient specific and measurable.</p> <p>10. Clinical record number 16, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to 10/04/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary diagnoses of dementia, hypertension, and stage III chronic kidney disease.</p> <p>A. The plan of care included the following goals: A nursing plan of care will be established that meets the patient's needs; Patient / caregiver will understand the pain scale, how to manage pain and report changes to hospice; Patient / caregiver will understand pain medication administration and side effects; Patient will maintain optimal cardiac function within constraints of disease; Caregiver(s) are knowledgeable of seizure precautions; Caregiver(s) are knowledgeable of care and need to report changes of level of consciousness; Patient's respiratory status will be stabilized to comfort as possible; Patient / caregiver able to verbalize measures to promote comfort related to respiratory</p>			

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	<p>system in the terminal patient; Patient / caregiver will demonstrate independence in administration of ordered inhalation therapy and care for equipment as a result of skilled instruction; Skin breakdown will be identified and measures to resolve breakdown implemented promptly; Patient / caregiver will verbalize / demonstrate adequate knowledge of integumentary status; Patient will demonstrate improved decubitus ulcer status as evidenced by decrease in size / drainage of wound, absence of infection, and decreased pain as a result of skilled intervention; Caregiver will be able to demonstrate proper care for decubitus healing and verbalize / demonstrate preventive measures to include pressure relief, nutrition, skin care and signs / symptoms to report to physician; Patient will have an effective bowel program; Patient will have safety needs met; Patient will receive personal care and hygiene including other activities of daily living to their optimal level; Patient will demonstrate an increased interest in socialization and activities; Patient / caregiver will demonstrate ability to administer medications via planner device; and General hospice comfort kit will be provided to the patient.</p> <p>B. A physician order dated 07/11/16, indicated in the "goals" portion of the</p>			

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	<p>order "A medical social worker plan of care will be established that meets the patient's needs. Patient will have safety needs met. Patient and caregiver will have decreased fear / anxiety regarding death and dying process. Personal business problems will be resolved. Patient / caregiver will express an increased sense of closure and peacefulness at the end of life. Caregiver will experience a sense of accomplishments at having supported the dying person. Patient / caregiver will have knowledge of the stages of grief and the grief cycle.</p> <p>The goals and outcomes anticipated from implementing and coordinating the plan of care failed to be patient specific and measurable.</p> <p>11. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>12. A policy titled "Plan of Care" Policy No. H:2 - 030.1 revised 03/2016, indicated " ... The plan of care will identify the patient needs and services to meet those needs, including the management of pain and discomfort and</p>			

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L 0552 Bldg. 00	<p>symptom relief ... The written plan of care will contain, but will not be limited to the following ... Measurable outcomes anticipated from implementing and coordinating the plan of care "</p> <p>418.56(d) REVIEW OF THE PLAN OF CARE The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. Based on record review and interview, the hospice failed to ensure all members of IDG (Interdisciplinary Group) had participated in the review and updates of the plan of care in 5 of 13 active records reviewed in a sample of 16. (# 4, 7, 8, 9, and 13) Findings include: 1. Clinical record number 4, Election date of 05/18/16, included forms called "Hospice Certification and Plan of Care Update Report" for 05/24/16, 06/07/16, and 08/02/16. The update failed to evidence that the hospice social worker, had participated in the reviews and updates. 2. Clinical record number 7, Election</p>	L 0552	<p>L552 418.56(d)REVIEW OF THE PLAN OF CARE</p> <p>The Administrator has in-serviced staff on the new software documentation enhancement for wounds entitled, the Integumentary CommandCenter, new Wound Care Policy H:2-095 (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual, 2016</i>), IV Care protocols, "Patient Focused PerformanceImprovement", policy No. C:2-038 (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAPCore Policy and Procedure Manual, 2016</i>), the software verbal orders process to allow for edits/theaddition of patient-specific goal text in verbal orders, InterdisciplinaryGroup</p>	09/27/2016

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NAME OF PROVIDER OR SUPPLIER PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032		
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	<p>date 07/25/16, included a form called "Hospice Certification and Plan of Care Update Report" for 07/27/16 and 08/10/16, failed to evidence that the medical director had participated in the review and updates.</p> <p>3. Clinical record number 8, Election date 5/18/16, included a form called "Hospice Certification and Plan of Care Update Report" for 06/01/16, 06/15/16, and 06/29/16. The update failed to evidence that the hospice medical director had participated in the review and update.</p> <p>4. Clinical record number 9, Election date 07/11/16, included a form called "Hospice Certification and Plan of Care Update Report" for 07/27/16 and 08/10/16. The update failed to evidence that the hospice medical director had participated in the review and update.</p> <p>5. Clinical record number 13, Election date 08/01/16, included a form called "Hospice Certification and Plan of Care Report" for 08/09/16.</p> <p>1. During a home visit with the hospice social worker on 08/08/16 at 3:45 PM, the family member had expressed being overwhelmed with the multiple visits and had declined for the</p>		<p>Membership and Responsibilities" Policy No. H:2-003 (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016), "Interdisciplinary Group Meeting" Policy No. H:2-036 (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016), and policy titled "The Plan of Care", No. H:2-030 (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016), that directs a written individualized patient and family/caregiver plan of care will be established and maintained for each patient. The plan of care will be based on the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group (in collaboration with the individual's attending physician, if any) and will be reviewed and revised on a regular basis but no less than frequently than every fifteen [15] days. The hospice medical director shall evidence participation in the review and update of the plan of care. The plan of care will identify the patient's needs and services to meet those needs. Staff were instructed that they must develop an individualized written plan</p>		

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	<p>home health aide to come to the home. The family member had expressed that she doesn't feel the need of a home health aide at this time. The family member provided the hospice social worker of the name and phone number of the patient's case worker with Medicaid, for possible assistance with home delivery of food / meals. The family member expressed going out of state for vacation in the following month and had set up a place for the patient to go while the family member was on vacation. The family member indicated he / she was not aware of who the primary nurse was due to all the different nurse coming into the home.</p> <p>2. The hospice social worker was observed in the office during the IDG meeting which took place from 9:00 AM to 11:30 AM, with all disciplines involved in the patient care, but did not participate in the meeting.</p> <p>3. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 08/09/16, included the following the hospice social worker summary: For past 2 weeks indicated "Assess complete. Pt [patient] appears A/Ox 3 [alert and oriented x 3], pleasant and conversational. Lives with [family member] who is primary cg [caregiver].</p>		<p>ofcare for each patient that reflects patient and family goals and interventionsbased on the problems identified in the initial, comprehensive, and updatedcomprehensive assessments. The plan of care must include all services necessaryfor the palliation and management of the terminal illness and relatedconditions. In addition, the Interdisciplinary Group shall ensure that goalsand outcomes anticipated from implementing and coordinating the plan of careare patient centered and measurable goals that allow for the measurement ofoutcomes. The revised plan of care must include information from the patient'supdated comprehensive assessment and must note the patient's progress towardoutcomes and goals as specified in the plan of care.</p> <p>As related to the documentation software, trainingdiscussion included directions on selecting the IDG communication note typeversus Narrative note to ensure IDG communication of ongoing progress, patientchanges, and updates of the comprehensive assessment. This will allow the IDGbetter oversee care plan updates per patient and caregiver needs.</p> <p>100% of Initial Plans of Care andIDG Update records will be reviewed by clinical managers</p>		

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	<p>Interested in home delivered meals, Has emergency button. Advance directives and funeral arrangements in place. Code status DNR [do not resuscitate]." Plans for patient care and frequency of visits for the upcoming 2 weeks: "Visits 1 x / month to provide support and comfort."</p> <p>6. Employee C, chaplain, was interviewed after the IDG meeting on 08/09/16 at 11:30 AM. Employee C indicated that the IDG forms were to be filled out prior to the meeting and that he / she only speaks during the meetings when necessary, that the IDG meetings were more for the nurses then social workers.</p> <p>7. An interview with the Clinical Director on 08/09/16 at 1:15 PM, both indicated that they didn't know why the hospice social worker did not participate in the IDG meeting and that the social worker should have participated until he / she needed to leave for their scheduled appointment at 11:00 AM.</p> <p>8. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p>		<p>using the HospiceClinical Record Audit Tool elements after admission and then twice monthly for90 days and tracked on the QAPI Audit Tracker for met/not met compliance % thata writtenindividualized patient and family/caregiver plan of care that includes verbalorders was established and maintained by the IDG for each patient. Staff shalladd late entry IDG Notes and verbal orders to remediate any findings ofnoncompliance and will receive individual re-education documented on the QAEducation Form. Staff reeducation Forms and documentation will be maintained bythe Administrator. After 90 days, if 95% met compliance threshold goal forany given month, then 10% of Initial Plan of Care and Update records will beaudited monthly by clinical managers using the Hospice Clinical Record AuditTool to maintain compliance.</p> <p>The Director of Hospice services will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur. The results will be reported to the QAPI committee andGoverning Body. The Chief Compliance Officer and the Director of Compliancewill attend each IDG meeting for the next 90 days for observation and educationin real time. A form to document the</p>		

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L 0553	<p>9. A policy titled "Physician Services - Medical Director" Policy No. H:2-013.1 revised 10/2014, indicated " ... Reviewing patients' medical eligibility for hospice services, in accordance with hospice program policies and procedures, and establishing the plan of care in conjunctions with attending physician and interdisciplinary group prior to providing care ... Attending interdisciplinary group meetings and working in a team approach with the group. In conjunction with the attending physician and interdisciplinary group, reviewing and updating the plan of care every 15 days, or more frequently as needed "</p> <p>10. A policy titled "Interdisciplinary Group Membership and Responsibilities" Policy No. H:2-003.1 revised 11/2013, indicated " ... The interdisciplinary group responsibilities include but are not limited not to, Participation in the establishment of the plan of care for each patient admitted to the hospice services. Participation in the periodic review and updating of the plan of care for each patient receiving hospice services "</p> <p>418.56(d) REVIEW OF THE PLAN OF CARE</p>		<p>progress of the IDG team education has been developed. Completion Date:All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization will have implemented the Audit Tracker of 100% Initial Plans of Care and Update Record Review.</p>				

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Bldg. 00	<p>A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.</p> <p>Based on observation, record review, and interview, the IDG (Interdisciplinary Group) failed to update the initial plan of care with information obtained from the updated comprehensive assessments and note the patient's response to care, any changes in care, and progress toward desired outcomes and goals in 11 of 13 active records reviewed of patient's who had been on service for more than 15 days in a sample of 16. (# 1, 2, 3, 4, 7, 8, 9, 11, 12, 13, 14, and 16)</p> <p>Findings include:</p> <p>1. Clinical record number 1, Election date 01/26/16, included A physician's hospice recertification order dated 07/10/16. The patient's hospice diagnosis indicated chronic obstructive pulmonary disease with secondary diagnoses of arthropathy, osteoporosis, and protein calorie malnutrition.</p> <p>A. The Hospice recertification order dated 07/08/16, indicated the following goals that had been met:</p> <p>1. "Patient / Caregiver will understand the pain scale, how to manage</p>	L 0553	<p>L553 418.56(d)REVIEW OF THE PLAN OF CARE</p> <p>The Administrator has in-serviced staff 09/06/16, 09/08/16, 09/09/16,09/13/16, 09/14/16, 09/15/16, and 09/16/16 on the new software documentation enhancement for woundsentitled, the Integumentary Command Center, new Wound Care Policy No. H:2-095 (seeAttachment Group B; policy from <i>PremierHospice & Palliative Care CHAP Hospice Policy and Procedure Manual,2016</i>), IV Care protocols,"Patient Focused Performance Improvement", policy No. C:2-038 (seeAttachment Group B; policy from <i>PremierHospice & Palliative Care CHAP Core Policy and Procedure Manual, 2016</i>), the software verbal ordersprocess to allow for edits/the addition of patient-specific goal text in verbalorders, Interdisciplinary Group Membership and Responsibilities" PolicyNo. H:2-003 (see Attachment Group B; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and ProcedureManual, 2016</i>),"Interdisciplinary Group Meeting" Policy No. H:2-036 (seeAttachment Group B; policy from <i>PremierHospice & Palliative</i></p>	09/27/2016
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	<p>pain and report changes to hospice. Patient / Caregiver understands need to report changes in pain level to hospice RN. Patient / Caregivers understands the cause of pain. Patient / Caregiver verbalizes understanding of the administration and side effects of pain medication. Cardiac exacerbations are identified promptly and interventions initiated quickly to minimize associated risks. Patient / Caregiver verbalizes understanding of anorexia and cachexia in the dying process. Patient / Family verbalizes understanding of issues related to decreased appetite. Patient's respiratory status is stabilized to comfort within realms of disease. Patient has minimal problems with respiratory comfort. Patient / Caregiver able to verbalize / demonstrate how to position patient for comfort and to assist in decrease in respiratory secretions. Patient is free from exacerbations of integumentary status since last visit. Patient / caregiver verbalizes the importance and rationale for use of support surfaces to prevent skin breakdown. Patient / Caregiver demonstrates routine skin inspections, as evidenced by no skin breakdown. Patient / Caregiver demonstrates frequent change and proper positioning to prevent skin breakdown. Patient / Caregiver verbalizes dietary and fluid required to</p>		<p>Care CHAP Hospice Policy and Procedure Manual, 2016), and policy titled "The Plan of Care", No. H:2-030 (see Attachment Group B; policy from Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual, 2016), that directs a written individualized patient and family/caregiver plan of care will be established and maintained for each patient. The plan of care will be based on the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group (in collaboration with the individual's attending physician, if any) and will be reviewed and revised on a regular basis but no less than frequently than every fifteen [15] days. The hospice medical director shall evidence participation in the review and update of the plan of care and has been re-educated on policy "Physician Services – Medical Director", Policy No. H:2-013. The plan of care will identify the patient's needs and services to meet those needs. Staff were instructed that they must develop an individualized written plan of care for each patient that reflects patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The Interdisciplinary Group shall</p>	

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	<p>promote healing process and health skin. Patient / Caregiver verbalizes understanding of proper safety measures related to fall awareness. Patient / Caregiver administers prescribed medication properly as a result of nurse filled planner device. Patient / Family verbalizes proper use of comfort kit. Patient verbalizes tolerance to pulse oximetry procedure. Facility staff is knowledgeable and involved in hospice plan of care for patient.</p> <p>B. A physician's order dated 07/12/16, indicated the patient was started on "Doxycycline 100 milligrams twice a day for ten days and prednisone 60 milligrams x 4 days, then 40 milligrams x 4 days, then 20 milligrams x 4 days, then 10 milligrams x 4 days."</p> <p>C. A hospice nursing visit note dated 07/15/16, indicated the patient tripped over oxygen tubing the previous day and fell obtaining a small scratch to the right elbow.</p> <p>D. An extra hospice nursing visit note dated 07/17/16, indicated the patient had an increased in confusion.</p> <p>1. Review of the "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/26/16, the</p>		<p>ensure that goals and outcomes anticipated from implementing and coordinating the plan of care are patient centered and measurable goals that allow for the measurement of outcomes. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions. The revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. The IDG (Interdisciplinary Group) shall to update the initial plan of care with information obtained from the updated comprehensive assessments document assessment/ reassessment of the patient's response to care and note the patient's response to care, any changes in care, and progress toward desired outcomes and goals.</p> <p>As related to the documentation software, training discussion included directions on selecting the IDG communication note type versus Narrative note to ensure IDG communication of ongoing progress, patient changes, and updates of the comprehensive assessment. This will allow the IDG better oversee care plan updates per</p>		

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	<p>case manager indicated "... Pt [patient] has had two falls resulting in minor bruises. Educated on fall precautions. ATB [antibiotic] and prednisone helpful with recent increase in SOB [shortness of breath] and confusion ..." Plans for patient's care and frequency for the next two weeks only indicated skilled nursing and home health aide frequencies. The IDG report failed to include any changes in care and desired outcomes and goals.</p> <p>E. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/12/16, 07/26/16, and 08/09/16, included the following identified problems:</p> <p>1. Coping, declining status / imminent death. Impaired quality of life. Music Therapy evaluation performed for hospice patient / additional visit will be performed, altered home safety, need for facility staff care coordination, need for general hospice comfort kit, need for observation and assessment of nutrition / hydration, need for observation / assessment of respiratory status, need for oxygen saturations, need for observation and assessment of altered comfort, need for observation and assessment of cardiac / circulatory system, need for observation and assessment of skin, need for skilled</p>		<p>patient and caregiver needs.</p> <p>100% of Initial Plans of Care andIDG Update records will be reviewed by clinical managers using the HospiceClinical Record Audit Tool elements after admission and then twice monthly for90 days and tracked on the QAPI Audit Tracker for met/not met for compliance %that a writtenindividualized patient and family/caregiver plan of care was established andmaintained for each patient which includes the verbal orders. The plan of carewill be based on the initial, comprehensive and ongoing comprehensiveassessments performed by members of the interdisciplinary group (incollaboration with the individual's attending physician, if any) and will bereviewed and revised on a regular basis but no less than frequently than everyfifteen [15] days. The hospice medical director shall evidence participation inthe review and update of the plan of care. The plan of care will identify thepatient's needs and services to meet those needs. Staff were instructed thatthey must develop an individualized written plan of care for each patient thatreflects patient and family goals and interventions based on the problemsidentified in the initial, comprehensive, and updated comprehensiveassessments. The Interdisciplinary Group shall</p>				

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	<p>teaching of altered comfort, need for skilled teaching of respiratory status, need for skilled teaching related to preservation of skin integrity, need for wound care not otherwise specified, need to prefill planner device. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>2. Clinical record number 2, Election date 05/12/16, included a physician's plan of care for the certification dates of 05/12/16 to 08/09/16. The patient's hospice diagnosis indicated heart failure with secondary diagnoses hypertension, edema, low back pain, and lumbago.</p> <p>A. A physicians recertification order dated 07/26/16, indicated the following goals that had been met:</p> <p>1. Patient / Caregiver will understand the pain scale, how to manage pain and report changes to hospice. Cardiac exacerbations are identified promptly and interventions initiated quickly to minimize associated risks. Patient's respiratory status is stabilized to comfort within realms of disease. Patient has minimal problems with respiratory</p>		<p>ensure that goals and outcomes anticipated from implementing and coordinating the plan of care are patient centered and measurable goals that allow for the measurement of outcomes. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions.</p> <p>Staff shall add late entry IDG Notes and verbal orders to remediate any findings of noncompliance and will receive individual re-education documented on the QA Education Form. Staff reeducation Forms and documentation will be maintained by the Administrator. After 90 days, if 95% met compliance threshold goal for any given month, then 10% of Initial Plan of Care and Update records will be audited monthly by clinical managers using the Hospice Clinical Record Audit Tool to maintain compliance.</p> <p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or</p>				

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	<p>comfort. Patient is free from exacerbations of integumentary status since last visit. Patient / Caregiver verbalizes understanding of proper safety measures related to fall awareness. Patient's non-skilled care needs are achieved safely. Patient / Caregiver verbalizes prescribed treatment / medications regimen related to knowledge deficits since last visit. Patient / Caregiver administers prescribed medication properly as a result of nurse filled planner device. Patient / Family verbalizes proper use of comfort kit. Patient verbalizes tolerance to pulse oximetry procedure.</p> <p>B. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 05/17/16, 05/31/16, 06/14/16,06/28/16, 07/12/16, and 07/26/16, included the following identified problems:</p> <p>1. Spiritual issues and life values, coping, grieving, impaired quality of life, music therapy evaluation performed for hospice patient, additional visit will be performed, altered home safety, need for general hospice comfort kit, need for observation and assessment of respiratory status, need for oxygen saturations, need for observation and assessment of</p>		<p>medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization will have implemented the Audit Tracker of 100% Initial Plans of Care and Update Record Review.</p>				

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	<p>knowledge deficits not otherwise specified, need for observation / assessment of patient's ability to perform ADLs, Need for observation and assessment of altered comfort, need for observation and assessment of cardiac / circulatory system, need for observation and assessment of skin, and need to prefill planner device. The IDG report failed to document assessment / reassessment of the patient's response to care, any changes in care, and progress toward desired outcomes and goals.</p> <p>C. The IDG updated reports dated 05/17/16, 05/31/16, 06/14/16, indicated that patient used Tramadol for pain management. The IDG failed to update the plan of care report to include Tramadol on the medication profile and failed to document assessment / reassessment of the patient's response to care, any changes in care, and progress toward desired outcomes and goals.</p> <p>D. The IDG updated report dated 05/17/16, indicated "Chaplain [HSC-Hospice spiritual care] has evaluated the patient and the plan of care to be signed by physician calls for follow up HSC visits to be made The patient's spiritual needs, concerns, and life questions will be addressed. [sic] The patient's faith and life values will be</p>			

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	<p>affirmed."</p> <p>1. The chaplain visit note dated 05/16/16, indicated sacramental support arranged with local parish, and notify priest for rites if the patient had a change in condition. The visit note indicated the patient's spouse had died. Special needs / issues indicated bereavement support and plans / follow up included offer prayer / devotional readings / religious ritual ministry, provide opportunities for active listening / spiritual conversations, provide spiritual support and presence. The visit note included specific interventions provided and not provided as well as goals met and not met. The IDG failed to revise the plan of care to include interventions specific to the patient and family needs with measurable goals.</p> <p>E. The social worker visit note dated 05/17/16, indicated the patient was at home with daughter, patient and daughter coping with the loss of the patient's spouse, and reported being sad from the loss. The social worker indicated the hospice social worker care plan had been established.</p> <p>1. The social service section on the IDG updated report dated 05/31/16, indicated "No changes made at this time"</p>			

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	<p>when asked to list any changes to the patient's plan of care since the last IDT/IDG meeting. Summary of care for the past 2 weeks indicated "no visits." Plans for patient's care and frequency of visits for the upcoming 2 weeks indicated "HSW [hospice social worker] visits scheduled for 1 x monthly." The IDG failed to revise the plan of care to include interventions specific to the patient and family needs with measurable goals.</p> <p>F. Review of the Medical Director entries on "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 05/31/16, 06/14/16, 06/28/16, 07/12/16, and 07/26/16, the medical director indicated "Patient is a 97 year old white male / female with hospice diagnosis of congestive heart failure. He/ she has comorbidities of hypertension, heart murmur, lower back pain and fatigue. Patient currently lives at home with his / her spouse in [name of city]. Patient is short of breath with any exertion. Patient continues to be appropriate for hospice care." On 08/09/16, the medical director continued to indicate the patient lived with his / his spouse and failed to identify that the patient's spouse had died at the start of services. The medical director also failed to update the plan of care reports in relation to changes that had taken place</p>			

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	<p>since the initial assessment.</p> <p>G. A physician's order dated 05/23/16, indicated to discontinue Music Therapy. Review of the 05/31/16, 06/14/16, 6/28/16, 07/12/16, 07/26/16, and 08/09/16, continued to include "Music Therapy Evaluation performed for hospice patient. Additional visit will be performed" on the "Current Problem List" portion. The IDG failed to revise the plan of care.</p> <p>H. A form titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 06/14/16, indicated a new order dated 06/09/16, for "duoderm to stage 2 pressure ulcer to left buttocks" The agency failed update the plan of care to include progress toward desired outcome and the reassessment of the patient's response to current care / treatment being provided between 06/09/16 to 06/14/16, as well as measurable goals.</p> <p>I. A form titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 06/28/16, indicated a new order dated 06/16/16, the duoderm to the pressure ulcer was discontinued, tramadol 50 milligram to be given every 6 hours as needed, and lasix was increased from 20 milligrams</p>			

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	<p>to 40 milligrams daily. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>3. Clinical record number 3, Election date 7/14/16, included a form called "Hospice Certification and Plan of Care Updated Report" for the certification period of 07/14/16 to 10/11/16. The patient diagnoses included but were not limited to Malignant pancreatic cancer, with metastasis to the lung mediastinum, and liver, hypertension, and diabetes.</p> <p>A. Review of the Medical Director entries on "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/26/16 and 08/09/16, the medical director indicated "The patient is a 68 - year old white male / female with hospice diagnosis of pancreatic carcinoma with metastatic diseases. Patient has comorbidities of hypertension, diabetes, hyperlipidemia, insomnia, CHF [congestive heart failure], COPD [chronic obstructive pulmonary disease] and wears cpap at night for his / her sleep apnea. Patient diagnosed with pancreatic cancer in May of 2016. Patient also has history of heart valve</p>			

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	<p>replacement in May of 2016. Patient is incontinent of bowel and bladder. Appetite is varied. Patient can ambulate independently however becomes very fatigued quickly. Patient requires assistance with ADLs. KPPS score is 40/40. Patient appears to be appropriate for hospice care. The medical director also failed to update the plan of care reports in relation to changes that had taken place since the initial assessment.</p> <p>B. A physician order dated 07/25/16, indicated the patient was started on prednisone 60 milligrams x 4 days, 40 milligrams x 4 days, and 20 milligrams x 4 days. The patient was also started on zithromax z-pak for respiratory infection.</p> <p>1. The Case Manager note indicated, "New Admit. See Admit Note."</p> <p>2. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/26/16, included the following identified problems:</p> <p>a. Coping, personal business, need for observation and assessment of respiratory status, need for oxygen saturations, need for observation /</p>			

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	<p>assessment of patient's ability to perform ADLs, need for observation and assessment of altered comfort, need for skilled teaching and observe / assess of bowel protocol, need for skilled teaching teaching related to bowel incontinence, need for skilled teaching related to prescribed medications, and need for skilled teaching related to urinary incontinence. The IDG report failed to document assessment / reassessment of the patient's response to care, any changes in care, and progress toward desired outcomes and goals.</p> <p>C. A physician order dated 08/01/16, indicated the patient was started on Plavix 75 milligrams by the VA and the hydrocodone was increased to 10 milligrams for pain.</p> <p>1. The Case Manager note indicated, the patient had increased abdominal pain and started taking morphine, complains of nausea at times and takes phenergan.</p> <p>2. The "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 08/09/16, included the following identified problems:</p> <p>a. Coping, personal business,</p>			

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	<p>need for observation and assessment of respiratory status, need for oxygen saturations, need for observation / assessment of patient's ability to perform ADLs, need for observation and assessment of altered comfort, need for skilled teaching and observe / assess of bowel protocol, need for skilled teaching related to bowel incontinence, need for skilled teaching related to prescribed medications, and need for skilled teaching related to urinary incontinence. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>4. Clinical record number 4, Election date of 05/18/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 05/18/16 to 08/15/16. The patient's hospice diagnosis indicated Alzheimer disease.</p> <p>A. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 05/24/16, 06/07/16, 06/21/16, 07/5/16, 07/19/16, and 08/02/16, included the following identified problems:</p>			

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	<p>1. Spiritual issues and life values, impaired quality of life, music therapy evaluation performed for hospice patient / additional visit will be performed, need for facility staff care coordination, need for general hospice comfort kit, need for observation and assessment of declining status / imminent death, need for observation of nutrition / hydration, need for observation and assessment of sensory / neurological status, need for observation and assessment of genitourinary status, need for oxygen saturations, and need for skilled teaching and observe / assess of bowel protocol. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>5. Clinical record number 7, Election date 07/25/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/25/16 to 10/22/16. The patient's hospice diagnosis indicated Malignant neoplasm of ovary with secondary diagnoses of malaise, fatigue, muscle weakness, difficulty in walking, lack of coordination, and atypical depressive disorder.</p>			

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	<p>A. A skilled nursing visit note dated 08/09/16, indicated the patient had sheering on the buttocks, bowel incontinence, 4 + pitting edema to the left lower extremity ankle, and complains of pain to the left lower extremity when moved.</p> <p>B. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/27/16 and 08/10/16, included the following identified problems:</p> <p>1. Declining status / imminent death, spiritual issues and life values,grieving, altered home safety, need for general hospice comfort kit, need for observation need for observation of nutrition / hydration, need for observation and assessment of respiratory status, need for observation and assessment of sensory / neurological status, need for observation and assessment of genitourinary status, need for oxygen saturations, need for observation and assessment of knowledge deficits not otherwise specified, need for observation / assessment of patient's ability to perform ADLs, need for observation and assessment of altered comfort, need for observation and</p>			

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	<p>assessment of cardiac / circulatory system, need for observation and assessment of skin, need for skilled teaching and monitoring use of oxygen, need for skilled, need for skilled teaching and observe / assess of bowel protocol, need for skilled teaching regarding declining status / imminent death, need for skilled teaching related to bowel incontinence, need for skilled teaching related to prescribed medications, need for skilled teaching related to self care deficits, and need for skilled teaching related to urinary incontinence. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>6. Clinical record number 8, Election date 5/18/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 05/18/16 to 08/15/16. The patient's hospice diagnosis indicated idiopathic pulmonary fibrosis with secondary diagnosis of hypertension.</p> <p>A. Review of the start of care hospice nurse visit note dated 05/18/16, the hospice nurse identified the following problems: potential alteration for pain,</p>			

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	<p>knowledge deficit related to pain medications, altered cardiac / circulatory system, altered respiratory status with oxygen at 4 liters per minute flowing continuously per nasal cannula, knowledge deficit on oxygen use, alteration in nutrition, alteration in elimination related to bladder incontinence, potential alteration in bowel elimination, altered home safety, alteration in grief, and knowledge deficit in the the dying process.</p> <p>1. A nursing visit note dated 05/23/16, indicated the patient had 2 + pitting edema to bilateral feet and ankles, oxygen saturations dropped to 86% with 2 liters of oxygen after ambulating to the bathroom, and the patient had a non-productive cough.</p> <p>2. An on-call nursing visit note dated 05/23/16, the assessment indicated the patient was having shallow respirations at 40 breaths per minute, use of accessory muscles, crackles in the right and left lower lobes, and oxygen flowing at 4 liters per minute. A physician's order obtained during the visit indicated for the patient to receive a morphine nebulizer treatment 5 milligrams / 3 milliliters every four hours as needed for shortness of breath.</p>			

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	<p>3. A nursing phone call report dated 05/26/16, indicated the patient was using a rollator due to weakness and shortness of breath, the patient was sleeping off and on during the day, more restless at night, reports using ativan 0.5 milligrams during the day and an unknown dose at night every four hours. The spouse was educated to use the morphine nebulizer more frequently and to stretch out the ativan doses so that the patient could be more awake during the day.</p> <p>4. An on-call nursing visit note dated 05/28/16, the assessment indicated the patient was having labored and shallow respirations at 60 breaths per minute, oxygen saturations at 82%, use of accessory muscles, productive cough, crackles heard in the right and left lower lobes, and continued to have 4 liters of oxygen flowing continuously. A physician order had been obtained with orders to increase morphine to 5 milligrams every hour and to increase ativan to 1 milligram every hour as needed.</p> <p>5. A second on-call nursing visit note dated 05/28/16, the assessment indicated the patient was having labored respirations at 66 breaths per minute, oxygen saturations at 78%, and irregular</p>			

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	<p>apical heart rate at 110 beats per minute, use of accessory muscles, periods of apnea, and continuous oxygen increased to 10 liters per minute. A new order was obtained to increase skilled nursing visits to daily.</p> <p>6. An evening nursing phone call dated 05/28/16, indicated the patient's family member reported oxygen saturations at 98% with oxygen at 12 liters per minute continuously. The on-call nurse advised the family member to decrease the both oxygen concentrators down to 4 liters (to equal 8 liters) and if the patient's respirations become labored or the patient becomes anxious, to increase oxygen back up to 12 liters.</p> <p>7. A nursing visit note dated 05/29/16, indicated the patient's breathing was normal at 20 breaths per minute and oxygen saturations at 97% with 8 liters of oxygen flowing continuously. The note indicated the family made a point board to help with communication with the patient. Urine was concentrated and family educated on encouraging fluid intake. Patient was constipated and nursing advised Miralax daily until patient had a bowel movement.</p> <p>a. The clinical record included a form called "Hospice IDG</p>				

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	<p>Comprehensive Assessment and Plan of Care Update Report" dated 06/01/16 (1st IDG update). The form reiterated the problems identified upon admission, but failed to include the events that had taken place since admission. The IDG updated report failed to document assessment / reassessment of the patient's response to care, any changes in care, and progress toward desired outcomes and goals.</p> <p>8. Review of Coordination Notes, the patient / family denied nursing visits on 06/01/16, 06/03/16, 06/07/16, and 06/09/16. The missed visits were related to patient feeling well and didn't feel the need of a nurse or fear of patient catching an illness from the nurse. The 06/07/16 coordination note indicated the patient had shingles.</p> <p>9. A hospice social worker note dated 06/03/16, indicated the patient had some periods of confusion, expressed anxiety, and fear of death.</p> <p>10. A nursing visit note dated 06/14/16, indicated the patient's oxygen was up to 9 liters per minute and lung sounds diminished. The note indicated the patient was taking benedryl for insomnia. The patient requested weekly nursing visits.</p>			

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	<p>a. A "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 06/15/16 and 06/29/16, continued to identify the following problems: coping, declining status / imminent death, grieving, personal business, altered home safety, need for general hospice comfort kit, need for observation and assessment of nutrition / hydration, observation and assessment of respiratory status, need for observation of the genitourinary status, need for oxygen saturations, need for observation / assessment of knowledge deficits not otherwise specified, need for observation / assessment of patient's ability to perform ADLs, need for observation and assessment of altered comfort, need for observation and assessment of cardiac / circulatory system, need for skilled teaching and monitoring use of oxygen, need for skilled teaching and observe / assess of bowel protocol, and need for skilled teaching related to prescribed medications. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>7. Clinical record number 9, Election</p>			

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	<p>date 07/11/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/11/16 to 10/08/16. The patient's hospice diagnosis indicated late effect intracranial injury with secondary diagnoses of Parkinson disease, diabetes, depressive disorder.</p> <p>A. The initial Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated 07/13/16, contained the following problems:</p> <p>1. Declining status / imminent death, grieving, personal business, altered home safety, need for facility staff coordination, need for observation need for observation of nutrition / hydration, need for observation and assessment of respiratory status, need for observation and assessment of sensory / neurological status, need for observation and assessment of genitourinary status, need for oxygen saturations, need for observation / assessment of patient's ability to perform ADLs, need for observation and assessment of altered comfort, need for observation and assessment of cardiac / circulatory system, need for observation and assessment of skin, need for skilled teaching and monitoring use of oxygen, need for skilled teaching related to bowel incontinence, and need for skilled</p>			

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	<p>teaching related to urinary incontinence.</p> <p>B. A nursing visit note dated 08/05/16, indicated the patient had a diabetic ulcer to the left heel and a blister to the right heel. The hospice nurse documented "discussed wounds with FSN [facility skilled nurse] and blister has popped with skin still intact ... Discussed current wound dressing with staff and added to orders ... " The visit note failed to include measurements, appearance of wounds, and appearance of surrounding tissue.</p> <p>C. A nursing visit note dated 08/09/16, indicated the patient had a diabetic ulcer to the left heel and a blister to the right heel. The hospice nurse also indicated the patient was started on an antibiotic on 08/08/16, for a urinary tract infections after the facility labs had been drawn. The note went on to indicate that the facility nurse indicated that eschar remained to the left ankle wound.</p> <p>D. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 08/10/16, included the following:</p> <p>1. Orders which indicated the patient was started on ativan twice a day</p>			

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	<p>as needed on 07/29/16, the patient was switched from pureed diet to mechanical soft diet on 08/03/16, treatment orders to the left heel, to be cleansed with normal saline, apply santyl and cover with dry dressing daily and to apply skin prep, foam padding, and kerlix to the right heel.</p> <p>2. The case manager indicated the patient was more alert since admission and had been placed in a lock down memory care unit, mumbles nonsensical words, occasionally make sense. Facility staff continued to state that the patient doesn't have pain and utilizes ativan to reduce anxiety. Patient was incontinent of bowel and bladder. Pt had decreased appetite since moving to the locked unit. The patient was dependent on all ADLs and a two max assistance transfer. The facility nurse reported a diabetic ulcer to the left ankle and a healing blister to the right ankle, and that the patient was currently on Cipro for a urinary tract infection.</p> <p>E. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 08/10/16, included the following identified problems:</p> <p>1. Declining status / imminent</p>						

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	<p>death, grieving, personal business, altered home safety, need for facility staff coordination, need for observation need for observation of nutrition / hydration, need for observation and assessment of respiratory status, need for observation and assessment of sensory / neurological status, need for observation and assessment of genitourinary status, need for oxygen saturations, need for observation / assessment of patient's ability to perform ADLs, need for observation and assessment of altered comfort, need for observation and assessment of cardiac / circulatory system, need for observation and assessment of skin, need for skilled teaching and monitoring use of oxygen, need for skilled teaching related to bowel incontinence, and need for skilled teaching related to urinary incontinence. The IDG updated report / orders failed to be consistent with the location of the wounds. The order failed to include the days the facility nurses were to perform dressings and the number of days the hospice nurses were to perform the dressing. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p>			

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	<p>8. Clinical record number 11, Election date 06/08/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 06/08/16 to 09/05/16. The patient's hospice diagnosis indicated malignant neoplasm of colon with secondary diagnoses of malignant neoplasm of liver and severe protein calorie deficiency.</p> <p>A. A physician's order dated 08/03/16, indicated hospice chaplain was reducing visits to "prn" (as needed).</p> <p>ar B. A hospice visit note dated 08/04/16, indicated that the peritoneal drain had been removing 1200 milliliters of fluid per day and the nurse notified the physician to increase the amount of bags delivered per month from 15 to 30. The hospice nurse failed to include an assessment of the drain site and any measurements of abdominal girth due to the abdominal ascites.</p> <p>C. During IDG meeting on 08/09/16 from 9:00 AM to 11:30 AM, Employee A, a registered nurse / case manager, had indicated difficulty with nursing visits and needing an interpreter. Employee S, a hospice social worker, had provided information to Employee A to contact for an interpreter.</p>			

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	<p>D. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 06/14/16, 06/28/16, 07/12/16, 07/26/16, and 08/09/16, included the following identified problems:</p> <p>1. Spiritual issues and life values, coping, cultural and language issues, grieving, personal business, altered home safety, cultural and language issues, need for general hospice comfort kit, need for observation and assessment of nutrition / hydration, need for observation / assessment of patient's ability to perform ADLs, need for observation and assessment of skin, and need for skilled teaching and observe / assess of bowel protocol. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>9. Clinical record number 12, Election date 04/14/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 04/04/16 to 07/02/16. The patient's primary diagnosis indicated malignant neoplasm of overlapping sites of colon, with</p>						

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	<p>secondary diagnoses of malignant neoplasm of the liver and intrahepatic bile duct, digestive organs, retroperitoneal / peritoneum, and lung.</p> <p>A. Review of the Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 06/14/16, the new medication order section indicated the patient was started on a dilaudid drip for pain, the hospice chaplain indicated the patient discontinued spiritual care, hospice social worker indicated no new psychosocial needs identified, and the case manager indicated the patient was having increase in shortness of breath, utilizing oxygen as needed, abdomen slightly distended, complains of pain at a 6 out of 10, with Fentanyl patches (narcotic pain medication) increased to 150 micrograms every 48 hours. Plans for the next two weeks included for the case manager to change the patches every 48 hours, assess vital signs, pain level, and respiratory comfort.</p> <p>B. Review of the Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 06/28/16, the case manager indicated the patient was now receiving dilaudid for pain via cadd pump, continued pain in abdomen, lower back, and rectum, remained continent of bowel and bladder, independent in ADLs,</p>			

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	<p>fair appetite, and had issues with insomnia due to loud neighbors but trivializing ear plugs and taking trazodone. Plans for the next two weeks included assess vital signs, pain level, functional status, and cadd pump.</p> <p>C. Review of the Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/12/16, the case manager indicated the patient was having hypertension, continues to use oxygen as needed, remains continent of bowel and bladder, physical pain decreasing, but case manager felt emotional pain was exacerbating the physical pain, appetite decreasing, increase in nausea and taking promethazine, slight edema in bilateral lower extremities, and increase weakness. Plans for the next two weeks included assess vital signs, pain, new concerns / declines. The hospice social worker continued to indicate no new psychosocial needs.</p> <p>D. Review of the Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/26/16, the case manager indicated the patient continued to not sleep well due to loud neighbors and intermittent pain. Dilaudid infusing at 20 milligrams / hour with 6 milligram bolus every 30 minutes, no</p>			

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	<p>shortness of breath, abdomen firm and nontender, remains continent of bowel and bladder, and increase fatigue due to increase in dilaudid. Plans for the next two weeks included assess vital signs, pain, respiratory comfort, bowel pattern, new changes / concerns. The hospice social worker continued to indicate no new psychosocial needs.</p> <p>E. Review of the Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/26/16, the case manager indicated the patient was feeling weak and tired, sleeping more throughout the day, pain level a 6 out of 10, patient had increased pain and discomfort when trying to have a bowel movement, appetite continued to decrease, lungs clear, abdomen was firm and tender, sub q button (infusion site) in left lower quadrant and the patient reported it was tender to touch. Plans for the next two weeks included assessment of vitals, pain, and changes / concerns. The hospice social worker continued to indicate no new psychosocial needs.</p> <p>F. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 06/14/16, 06/28/16, 07/12/16, 07/26/16, and 08/09/16, included the following identified</p>			

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	<p>problems:</p> <p>1. Spiritual issues and life values, grieving, coping, altered home safety, altered comfort, need for general hospice comfort kit, need for observation and assessment of nutrition / hydration, need for observation / assessment of patient's ability to perform ADLs, need for observation and assessment of altered comfort, and need for observation and assessment of skin. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>10. Clinical record number 13, Election date 08/01/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 08/01/16 to 10/29/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary diagnoses of diabetes, stroke, and hypertension</p> <p>A. During a home visit with the hospice social worker on 08/08/16 at 3:45 PM, the family member had expressed being overwhelmed with the multiple</p>						

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	<p>visits and had declined for the home health aide to come to the home. The family member had expressed that she doesn't feel the need of a home health aide at this time. The family member provided the hospice social worker of the name and phone number of the patient's case worker with Medicaid, for possible assistance with home deliver of food / meals. The family member expressed going out of state for vacation in the following month and had set up a place for the patient to go while the family member was on vacation. The family member indicated he / she was not aware of who the primary nurse was due to all the different nurse coming into the home. The family indicated the chaplain was planning to make weekly visits and nursing starting two times a week. The social worker failed to discuss a visit schedule with the patient and family member.</p> <p>B. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 08/09/16, included the following identified problems:</p> <p>1. Spiritual issues and life values; coping; declining status / imminent death; grieving; altered home safety; grieving; need for general hospice comfort kit;</p>			

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	<p>need for observation and assessment of respiratory status; need for observation and assessment of the genitourinary status; need for observation and assessment of altered comfort; need for observation and assessment of cardiac / circulatory system; need for skilled teaching and monitoring use of oxygen; need for skilled teaching and observe / assess of bowel protocol; and need for skilled teaching related to bowel incontinence.</p> <p>2. The hospice spiritual care summary for past 2 weeks indicated "assessment complete. Baptist. Good fam [family] support ... Welcomes SC [spiritual care]." Plans for patient care and frequency of visits for the upcoming 2 weeks: "Provided SC 2xM [two times a month]."</p> <p>3. The hospice social worker summary for past 2 weeks indicated "Assess complete. Pt [patient] appears A/Ox3 [alert and oriented x3], pleasant and conversational. Lives with [family member] who is primary cg [caregiver]. Interested in home delivered meals, Has emergency button. Advance directives and funeral arrangements in place. Code status DNR [do not resuscitate]." Plans for patient care and frequency of visits for the upcoming 2 weeks: "Visits 1 x /</p>			

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	<p>month to provide support and comfort."</p> <p>4. The case manager summary provided the patient diagnoses, complaints of generalized pain with a rate of 8 / 10 (10 being worse pain), left lung coarse, right lung slightly diminished, oxygen saturations 91% on 4 liters via mask or cannula, no complaints of incontinence of bowel and bladder, poor appetite, dependent for ADLs. [Family member] noticed decline in patient in past 2 weeks. The summary failed to include plans for care for the upcoming 2 weeks but provided a frequency of 2 times a week and home health aide 2 times a week. The IDG updated reports failed to include plans of care for the upcoming 2 weeks by all perspective disciplines.</p> <p>11. Clinical record number 14, Election date 04/13/16, included A physician's hospice recertification order dated 06/27/16. The patient's hospice diagnosis indicated heart failure with secondary diagnoses of myocardial infarction, type 2 diabetes, and unspecified protein - calorie malnutrition.</p> <p>A. The Hospice recertification order dated 06/27/16, indicated the following goals that had been met:</p>			

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	<p>1. "Patient / caregiver will understand the pain scale, how to manage pain and report changes to hospice. Cardiac exacerbations are identified promptly and interventions initiated quickly to minimize associated risks. Patient / caregiver(s) verbalizes understanding of anorexia and cachexia in the dying process. Patient / family verbalizes understanding of issues related to decreased appetite. Patient's respiratory status is stabilized to comfort within realms of disease. Patient is free from exacerbations of integumentary status since last visit. Patient / caregiver(s) verbalizes understanding of proper safety measures related to fall awareness. Patient is free from exacerbations of genitourinary disease since last visit. Facility staff is knowledgeable and involved in hospice plan of care for patient."</p> <p>B. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/12/16, included the following:</p> <p>1. The case manager summary indicated the patient had no skin or pain issues, no edema, remained on oxygen at 2 liters per minute continuously. The summary of care for the past 2 weeks</p>			

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	<p>indicated "routine visits done, monitored for changes in condition." The plans for patient's care for the upcoming 2 weeks indicated to continue with scheduled visits and monitor for changes, work with facility staff, patient and IDG team to provide appropriate care for patient.</p> <p>2. The hospice chaplain summary indicated the summary of care for the past two weeks were working to build trust and relationship and also provided socialization. The plans for the patient's care for the upcoming 2 weeks indicated to continue plan of care 1 x per month.</p> <p>3. The hospice social worker summary indicated no new psychosocial needs identified and will continue to follow plan of care. The plan for patient's care for the upcoming 2 weeks indicated the hospice social worker would continue to the meet the patient 1 x / month to continue providing support for psychosocial needs. Hospice social worker would follow up with patient's guardian regarding funeral arrangements as previous efforts had been unsuccessful.</p> <p>C. A skilled nursing visit note dated 07/15/16, indicated the patient was returning from a shower and was out of breath due to portable tank being out. The note indicated that the facility nurse</p>			

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	<p>requested the hospice team encourage the The patient to leave the room and that the patient only leaves the room for showers.</p> <p>D. The "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/26/16, indicated the following:</p> <ol style="list-style-type: none"> 1. The case manager summary indicated the patient was short of breath at rest, used his / her oxygen continuously at 2 liters per minute, oxygen saturations drop into 70 / 80's if oxygen was off for even a few minutes. The summary of care for the past 2 weeks indicated "no changes." The plans for patient's care for the upcoming 2 weeks indicated to continue to monitor for shortness of breath and changes in condition, work with facility, physician, and IDG to provide the appropriate care according to established plan of care. 2. The hospice chaplain summary indicated the patient had not been seen since last IDG and the plans for patient's care for the upcoming 2 weeks indicated "continue poc [plan of care] 1xM [one time a month]. 3. The hospice social worker summary indicated no new psychosocial needs identified and will continue to 			

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	<p>follow plan of care. The plan for patient's care for the upcoming 2 weeks indicated the hospice social worker would continue to the meet the Surveyor: Ford, Shannon Based on observation, record review, and interview, the IDG (Interdisciplinary Group) failed to update the plan of care to document assessment / reassessment of the patient's response to care, any changes in care, and progress toward desired outcomes and goals in 13 of 13 active records reviewed of patient's who had been on service for more than 15 days in a sample of 16. (# 1 - 13)</p> <p>Findings include:</p> <p>1. Clinical record number 1, Election date 01/26/16, included A physician's hospice recertification order dated 07/10/16. The patient's hospice diagnosis indicated chronic obstructive pulmonary disease with secondary diagnoses of arthropathy, osteoporosis, and protein calorie malnutrition.</p> <p>A. The Hospice recertification order dated 07/08/16, indicated the following goals that had been met:</p> <p>1. "Patient / Caregiver will understand the pain scale, how to manage pain and report changes to hospice. Patient / Caregiver understands need to</p>			

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	<p>report changes in pain level to hospice RN. Patient / Caregivers understands the cause of pain. Patient / Caregiver verbalizes understanding of the administration and side effects of pain medication. Cardiac exacerbations are identified promptly and interventions initiated quickly to minimize associated risks. Patient / Caregiver verbalizes understanding of anorexia and cachexia in the dying process. Patient / Family verbalizes understanding of issues related to decreased appetite. Patient's respiratory status is stabilized to comfort within realms of disease. Patient has minimal problems with respiratory comfort. Patient / Caregiver able to verbalize / demonstrate how to position patient for comfort and to assist in decrease in respiratory secretions. Patient is free from exacerbations of integumentary status since last visit. Patient / caregiver verbalizes the importance and rationale for use of support surfaces to prevent skin breakdown. Patient / Caregiver demonstrates routine skin inspections, as evidenced by no skin breakdown. Patient / Caregiver demonstrates frequent change and proper positioning to prevent skin breakdown. Patient / Caregiver verbalizes dietary and fluid required to promote healing process and health skin. Patient / Caregiver verbalizes</p>			

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	<p>understanding of proper safety measures related to fall awareness. Patient / Caregiver administers prescribed medication properly as a result of nurse filled planner device. Patient / Family verbalizes proper use of comfort kit. Patient verbalizes tolerance to pulse oximetry procedure. Facility staff is knowledgeable and involved in hospice plan of care for patient.</p> <p>B. A physician's order dated 07/12/16, indicated the patient was started on "Doxycycline 100 milligrams twice a day for ten days and prednisone 60 milligrams x 4 days, then 40 milligrams x 4 days, then 20 milligrams x 4 days, then 10 milligrams x 4 days."</p> <p>C. A hospice nursing visit note dated 07/15/16, indicated the patient tripped over oxygen tubing the previous day and fell obtaining a small scratch to the right elbow.</p> <p>D. An extra hospice nursing visit note dated 07/17/16, indicated the patient had an increased in confusion.</p> <p>1. Review of the "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/26/16, the case manager indicated "... Pt [patient] has had two falls resulting in minor</p>			

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	<p>bruises. Educated on fall precautions. ATB [antibiotic] and prednisone helpful with recent increase in SOB [shortness of breath] and confusion ..." Plans for patient's care and frequency for the next two weeks only indicated skilled nursing and home health aide frequencies. The IDG report failed to include any changes in care and desired outcomes and goals.</p> <p>E. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/12/16, 07/26/16, and 08/09/16, included the following identified problems:</p> <p>1. Coping, declining status / imminent death. Impaired quality of life. Music Therapy evaluation performed for hospice patient / additional visit will be performed, altered home safety, need for facility staff care coordination, need for general hospice comfort kit, need for observation and assessment of nutrition / hydration, need for observation / assessment of respiratory status, need for oxygen saturations, need for observation and assessment of altered comfort, need for observation and assessment of cardiac / circulatory system, need for observation and assessment of skin, need for skilled teaching of altered comfort, need for skilled teaching of respiratory status,</p>			

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	<p>need for skilled teaching related to preservation of skin integrity, need for wound care not otherwise specified, need to prefill planner device. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>2. Clinical record number 2, Election date 05/12/16, included a physician's plan of care for the certification dates of 05/12/16 to 08/09/16. The patient's hospice diagnosis indicated heart failure with secondary diagnoses hypertension, edema, low back pain, and lumbago.</p> <p>A. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 05/17/16, 05/31/16, 06/14/16,06/28/16, 07/12/16, and 07/26/16, included the following identified problems:</p> <p>1. Spiritual issues and life values, coping, grieving, impaired quality of life, music therapy evaluation performed for hospice patient, additional visit will be performed, altered home safety, need for general hospice comfort kit, need for observation and assessment of respiratory</p>			

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	<p>status, need for oxygen saturations, need for observation and assessment of knowledge deficits not otherwise specified, need for observation / assessment of patient's ability to perform ADLs, Need for observation and assessment of altered comfort, need for observation and assessment of cardiac / circulatory system, need for observation and assessment of skin, and need to prefill planner device. The IDG report failed to document assessment / reassessment of the patient's response to care, any changes in care, and progress toward desired outcomes and goals.</p> <p>B. A physicians recertification order dated 07/26/16, indicated the following goals that had been met:</p> <p>1. Patient / Caregiver will understand the pain scale, how to manage pain and report changes to hospice. Cardiac exacerbations are identified promptly and interventions initiated quickly to minimize associated risks. Patient's respiratory status is stabilized to comfort within realms of disease. Patient has minimal problems with respiratory comfort. Patient is free from exacerbations of integumentary status since last visit. Patient / Caregiver verbalizes understanding of proper safety measures related to fall awareness.</p>			

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	<p>Patient's non-skilled care needs are achieved safely. Patient / Caregiver verbalizes prescribed treatment / medications regimen related to knowledge deficits since last visit. Patient / Caregiver administers prescribed medication properly as a result of nurse filled planner device. Patient / Family verbalizes proper use of comfort kit. Patient verbalizes tolerance to pulse oximetry procedure.</p> <p>2. Spiritual issues and life values, coping, grieving, impaired quality of life, music therapy evaluation performed for hospice patient, additional visit will be performed, altered home safety, need for general hospice comfort kit, need for observation and assessment of respiratory status, need for oxygen saturations, need for observation and assessment of knowledge deficits not otherwise specified, need for observation / assessment of patient's ability to perform ADLs, Need for observation and assessment of altered comfort, need for observation and assessment of cardiac / circulatory system, need for observation and assessment of skin, and need to prefill planner device. The IDG report failed to document assessment / reassessment of the patient's response to care, any changes in care, and progress toward desired outcomes and goals.</p>				

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	<p>C. The IDG updated reports dated 05/17/16, 05/31/16, 06/14/16, indicated that patient used Tramadol for pain management. The IDG failed to update the plan of care report to include Tramadol on the medication profile and failed to document assessment / reassessment of the patient's response to care, any changes in care, and progress toward desired outcomes and goals.</p> <p>D. The IDG updated report dated 05/17/16, indicated "Chaplain [HSC-Hospice spiritual care] has evaluated the patient and the plan of care to be signed by physician calls for follow up HSC visits to be made The patient's spiritual needs, concerns, and life questions will be addressed. [sic] The patient's faith and life values will be affirmed."</p> <p>1. The chaplain visit note dated 05/16/16, indicated sacramental support arranged with local parish, and notify priest for rites if the patient had a change in condition. The visit note indicated the patient's spouse had died. Special needs / issues indicated bereavement support and plans / follow up included offer prayer / devotional readings / religious ritual ministry, provide opportunities for active listening / spiritual conversations, provide</p>			

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	<p>spiritual support and presence. The visit note included specific interventions provided and not provided as well as goals met and not met. The IDG failed to revise the plan of care to include interventions specific to the patient and family needs with measurable goals.</p> <p>E. The social worker visit note dated 05/17/16, indicated the patient was at home with daughter, patient and daughter coping with the loss of the patient's spouse, and reported being sad from the loss. The social worker indicated the hospice social worker care plan had been established.</p> <p>1. The social service section on the IDG updated report dated 05/31/16, indicated "No changes made at this time" when asked to list any changes to the patient's plan of care since the last IDT/IDG meeting. Summary of care for the past 2 weeks indicated "no visits." Plans for patient's care and frequency of visits for the upcoming 2 weeks indicated "HSW [hospice social worker] visits scheduled for 1 x monthly." The IDG failed to revise the plan of care to include interventions specific to the patient and family needs with measurable goals.</p> <p>F. Review of the Medical Director entries on "Hospice IDG Comprehensive</p>			

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	<p>Assessment and Plan of Care Update Report" dated 05/31/16, 06/14/16, 06/28/16, 07/12/16, and 07/26/16, the medical director indicated "Patient is a 97 year old white male / female with hospice diagnosis of congestive heart failure. He/ she has comorbidities of hypertension, heart murmur, lower back pain and fatigue. Patient currently lives at home with his / her spouse in [name of city]. Patient is short of breath with any exertion. Patient continues to be appropriate for hospice care." On 08/09/16, the medical director continued to indicate the patient lived with his / his spouse and failed to identify that the patient's spouse had died at the start of services. The medical director also failed to update the plan of care reports in relation to changes that had taken place since the initial assessment.</p> <p>G. A physician's order dated 05/23/16, indicated to discontinue Music Therapy. Review of the 05/31/16, 06/14/16, 6/28/16, 07/12/16, 07/26/16, and 08/09/16, continued to include "Music Therapy Evaluation performed for hospice patient. Additional visit will be performed" on the "Current Problem List" portion. The IDG failed to revise the plan of care.</p> <p>H. A form titled "Hospice IDG</p>			

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	<p>Comprehensive Assessment and Plan of Care Update Report" dated 06/14/16, indicated a new order dated 06/09/16, for "duoderm to stage 2 pressure ulcer to left buttocks" The agency failed update the plan of care to include progress toward desired outcome and the reassessment of the patient's response to current care / treatment being provided between 06/09/16 to 06/14/16, as well as measurable goals.</p> <p>I. A form titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 06/28/16, indicated a new order dated 06/16/16, the duoderm to the pressure ulcer was discontinued, tramadol 50 milligram to be given every 6 hours as needed, and lasix was increased from 20 milligrams to 40 milligrams daily. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>3. Clinical record number 3, Election date 7/14/16, included a form called "Hospice Certification and Plan of Care Updated Report" for the certification period of 07/14/16 to 10/11/16. The patient diagnoses included but were not</p>			

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	<p>limited to Malignant pancreatic cancer, with metastasis to the lung mediastinum, and liver, hypertension, and diabetes.</p> <p>A. Review of the Medical Director entries on "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/26/16 and 08/09/16, the medical director indicated "The patient is a 68 - year old white male / female with hospice diagnosis of pancreatic carcinoma with metastatic diseases. Patient has comorbidities of hypertension, diabetes, hyperlipidemia, insomnia, CHF [congestive heart failure], COPD [chronic obstructive pulmonary disease] and wears cpap at night for his / her sleep apnea. Patient diagnosed with pancreatic cancer in May of 2016. Patient also has history of heart valve replacement in May of 2016. Patient is incontinent of bowel and bladder. Appetite is varied. Patient can ambulate independently however becomes very fatigued quickly. Patient requires assistance with ADLs. KPPS score is 40/40. Patient appears to be appropriate for hospice care. The medical director also failed to update the plan of care reports in relation to changes that had taken place since the initial assessment.</p> <p>B. A physician order dated 07/25/16, indicated the patient was started on</p>						

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	<p>prednisone 60 milligrams x 4 days, 40 milligrams x 4 days, and 20 milligrams x 4 days. The patient was also started on zithromax z-pak for respiratory infection.</p> <p>1. The Case Manager note indicated, "New Admit. See Admit Note."</p> <p>2. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/26/16, included the following identified problems:</p> <p>a. Coping, personal business, need for observation and assessment of respiratory status, need for oxygen saturations, need for observation / assessment of patient's ability to perform ADLs, need for observation and assessment of altered comfort, need for skilled teaching and observe / assess of bowel protocol, need for skilled teaching teaching related to bowel incontinence, need for skilled teaching related to prescribed medications, and need for skilled teaching related to urinary incontinence. The IDG report failed to document assessment / reassessment of the patient's response to care, any changes in care, and progress toward desired outcomes and goals.</p>			

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	<p>C. A physician order dated 08/01/16, indicated the patient was started on Plavix 75 milligrams by the VA and the hydrocodone was increased to 10 milligrams for pain.</p> <p>1. The Case Manager note indicated, the patient had increased abdominal pain and started taking morphine, complains of nausea at times and takes phenergan.</p> <p>2. The "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 08/09/16, included the following identified problems:</p> <p>a. Coping, personal business, need for observation and assessment of respiratory status, need for oxygen saturations, need for observation / assessment of patient's ability to perform ADLs, need for observation and assessment of altered comfort, need for skilled teaching and observe / assess of bowel protocol, need for skilled teaching teaching related to bowel incontinence, need for skilled teaching related to prescribed medications, and need for skilled teaching related to urinary incontinence. The IDG updated reports failed to document assessment /</p>			

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NAME OF PROVIDER OR SUPPLIER PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032
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	<p>reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>4. Clinical record number 4, Election date of 05/18/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 05/18/16 to 08/15/16. The patient's hospice diagnosis indicated Alzheimer disease.</p> <p>A. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 05/24/16, 06/07/16, 06/21/16, 07/5/16, 07/19/16, and 08/02/16, included the following identified problems:</p> <p>1. Spiritual issues and life values, impaired quality of life, music therapy evaluation performed for hospice patient / additional visit will be performed, need for facility staff care coordination, need for general hospice comfort kit, need for observation and assessment of declining status / imminent death, need for observation of nutrition / hydration, need for observation and assessment of sensory / neurological status, need for observation and assessment of genitourinary status, need for oxygen saturations, and need for</p>			

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	<p>skilled teaching and observe / assess of bowel protocol. The IDG updated reports failed to document assessment / reassessment of the patient's response to care, any changes in care / new specific interventions / measurable goals, and progress toward current desired outcomes and goals.</p> <p>5. Clinical record number 7, Election date 07/25/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/25/16 to 10/22/16. The patient's hospice diagnosis indicated Malignant neoplasm of ovary with secondary diagnoses of malaise, fatigue, muscle weakness, difficulty in walking, lack of coordination, and atypical depressive disorder.</p> <p>A. A skilled nursing visit note dated 08/09/16, indicated the patient had sheering on the buttocks, bowel incontinence, 4 + pitting edema to the left lower extremity ankle, and complains of pain to the left lower extremity when moved.</p> <p>B. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 07/27/16 and 08/10/16, included the following identified problems:</p>						

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L 0559 Bldg. 00	<p>1. Declining status / imminent death, spiritual issues and life values, grieving, altered home safety, need for general hospice comfort kit, need for observation need for observation of nutrition / hydration, need for observation and assessment of respiratory status, need for observation and assessment of sensory / neurological status, need for observation and assessment of genitour</p> <p>418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT</p> <p>Based on observation, record review, and interview, the agency failed to provide documentation in the development and implementation of an ongoing QAPI program involving all hospice services focusing on quality indicators related to improving palliative outcomes and actions taken to demonstrate improvement in hospice performance (See L 560); failed to show measurable improvement in the quality indicators related to improved palliative outcomes and hospice services (See L 561); failed to analyze and track quality indicators that enable the hospice to assess processes of care, hospice services, and operations (See L 562); failed to ensure quality indicator data, including patient care, was used in the QAPI (Quality Assessment and Performance</p>	L 0559	<p>L559 418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT CONDITION</p> <p>In response to these findings, the agency performed are assessment of its Quality Assurance and Performance Improvement (QAPI) Program and determined that the QAPI Plan Meeting Template will be revised and approved (by no later than September 29, 2016) to expand specific compliance monitoring for QAPI action and minutes reporting to the Professional Advisory Committee and then the Governing Body on the following L Tags to be tracked on the QAPI Audit Tracker and also as part of the ongoing Hospice Clinical Records Audit Tool: L521, L523, L533, L534, L535, L545, L546, L548, L552, L553, L590, and</p>	09/27/2016

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	Improvement) program (See L 563). The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with Condition of Participation 42 CFR 418.58 Quality Assessment and Performance Improvement.		L591. The Administrator has in-serviced staff 09/13/16, 09/14/16,09/15/16, and 09/16/16 on Policy No. H:1-015 "Quality Assessment andPerformance Improvement Program" (see Attachment Group C; policyfrom <i>Premier Hospice & PalliativeCare CHAP Hospice Policy and Procedure Manual</i> , 2016), which addresses that the agencydocument the development and implementation of an ongoing QAPI programinvolving all hospice services focusing on quality indicators related toimproving palliative outcomes and actions taken to demonstrate improvement inhospice performance. The hospicemeasures, analyzes, and tracks quality indicators, including adverse patientevents, and other aspects of performance that enable the hospice to assessprocesses of care, hospice services, and operations. The program uses qualityindicator data, including patient care, and other relevant data, in the designof its program. As part of the 2016 Hospice Compliance Plan/QAPI targets,100% of all Admission records, Care Plans, and IDG Updates will be reviewed by clinical managers using the Hospice Clinical Record Audit	

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			<p>Tool elements for 90 days and results tracked on the QAPI Audit Tracker for met/not met compliance %for L521, L523, L533, L534, L535, L545, L546, L548, L552, L590, and L591. Any non-compliance findings will be remediated and staff shall add late entry IDG Notes for assessment of noncompliance and will receive individual re-education documented on the QA Education Form.</p> <p>After 90 days, if 95% compliance threshold has been met for any given month, 10% of all Admission records, Care Plans, and IDG Updates will be audited by clinical managers monthly using the Hospice Clinical Audit Tool to maintain compliance. Ongoing, QAPI trends will be identified by the QAPI committee for any finding below 95% in any quarter and a Performance Improvement Plan developed and initiated. Trending of all QAPI Plan audit results will be ongoing each quarter. QAPI minutes and Performance Improvement Plans will be audited by the Director of Compliance each quarter ongoing.</p> <p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI</p>	

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L 0560 Bldg. 00	418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS. Based on observation, record review, and interview, the agency failed to provide	L 0560	committee and Governing Body. Completion Date: All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than September 27,2016, the QAPI Plan Meeting Template will be revised and approved. Review of QAPI program results will be ongoing. See additional detail in the Plan of Correction descriptions in Tags L560, L561, L562, and L563. L560 418.58QUALITY ASSESSMENT & PERFORMANCE	09/27/2016	

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	<p>documentation in the development and implementation of an ongoing QAPI program involving all hospice services focusing on quality indicators related to improving palliative outcomes and actions taken to demonstrate improvement in hospice performance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A policy titled "Hospice Item Set" Policy No. H:2 - 091.1 revised 08/2014, indicated " ... The HIS is NOT an assessment instrument and does not replace a thorough and ongoing assessment of each patient required by the Medicare Conditions of Participation " 2. The QAPI information was reviewed on 08/08/16 at 11:00 AM. 3. On 08/22/16 at 3:00 PM, the Director of Clinical Services demonstrated on the computer how the admission nurse completes an admission assessment and answers the appropriate questions for the data elements using the HIS (Hospice Item Set) program. Once a second visit had been made, usually within 48 hours, the information would be transmitted to CMS (Centers for Medicare and Medicaid). The data elements would be measured again upon discharge / death. 		<p>IMPROVEMENT</p> <p>In response to these findings, the agency conducted a thorough review of its QAPI program to determine additional items to add to our current QAPI program to ensure compliance to regulations.</p> <p>As part of the 2016 Hospice Compliance Plan/QAPI targets, 100% of all Admission records, Care Plans, and IDG Updates will be reviewed by clinical managers using the Hospice Clinical Record Audit Tool elements for 60 days and results tracked on the QAPI Audit Tracker for met/not met compliance % for L521, L523, L533, L534, L535, L545, L546, L548, L552, L590, and L591. Any non-compliance findings will be remediated and staff shall add late entry IDG Notes for assessment of non-compliance and will receive individual re-education documented on the QA Education Form. After 90 days, if 100% compliance threshold has been met for any given month, 10% of all Admission records, Care Plans, and IDG Updates will be audited by clinical managers monthly using the Hospice Clinical Audit Tool to maintain compliance. Ongoing, QAPI trends will be identified by the QAPI committee for any finding below 95% in any quarter and a Performance Improvement Plan developed and</p>	

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L 0561 Bldg. 00	<p>The Director of Clinical Services indicated the agency had not been measuring the data throughout the patient's course of care and had not verified that the data elements identified in the comprehensive assessments assisted in the development of the plan of care which included measurable goals and measurement of outcomes.</p> <p>4. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>418.58(a)(1) PROGRAM SCOPE (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services. Based on observation, record review, and interview, the agency failed to show measurable improvement in the quality indicators related to improved palliative outcomes and hospice services.</p> <p>Findings include:</p>	L 0561	<p>initiated. Trending of allQAPI Plan audit results will be ongoing each quarter. QAPI minutes andPerformance Improvement Plans will be audited by the Director of Complianceeach quarter ongoing.</p> <p>The Director of Hospice services will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur. The results will be reported to the QAPI committee andGoverning Body.</p> <p>Completion Date: By no later than September 27,2016, the QAPI Plan Meeting Template will be revised and approved. Review of QAPI program results will beongoing.</p> <p>L 561 418.58(a)(1)PROGRAM SCOPE</p> <p>The QAPI program scope was development based §418.58(a). Ourpolicy H:1-015 "Quality Assessment Performance Improvement Program (seeAttachment Group C; policy from <i>PremierHospice & Palliative</i></p>	09/27/2016

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	<p>1. A policy titled "Hospice Item Set" Policy No. H:2 - 091.1 revised 08/2014, indicated " ... The HIS is NOT an assessment instrument and does not replace a thorough and ongoing assessment of each patient required by the Medicare Conditions of Participation "</p> <p>2. On 08/22/16 at 3:00 PM, the Director of Clinical Services demonstrated on the computer how the admission nurse completes an admission assessment and answers the appropriate questions for the data elements using the HIS (Hospice Item Set) program. Once a second visit had been made, usually within 48 hours, the information would be transmitted to CMS (Centers for Medicare and Medicaid). The data elements would be measured again upon discharge / death. The Director of Clinical Services indicated the agency had not been measuring the data throughout the patient's course of care and had not verified that the data elements identified in the comprehensive assessments assisted in the development of the plan of care which included measurable goals and measurement of outcomes.</p> <p>3. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation /</p>		<p>Care CHAP Hospice Policy and Procedure Manual, 2016) has stated indicators which are measured, reported to the QAPI Committee, Professional Advisory Committee and the Governing Body. Performance Improvement Projects have commenced. All aspects of the QAPI Program have been extensively reviewed.</p> <p>As part of the 2016 Hospice Compliance Plan/QAPI targets, 100% of all Admission records, Care Plans, and IDG Updates will be reviewed by clinical managers using the Hospice Clinical Record Audit Tool elements for 90 days and results tracked on the QAPI Audit Tracker for met/not met compliance % for L521, L523, L533, L534, L535, L545, L546, L548, L552, L590, and L591. Any non-compliance findings will be remediated and staff shall add late entry IDG Notes for assessment of noncompliance and will receive individual re-education documented on the QA Education Form. After 90 days, if 100% compliance threshold has been met for any given month, 10% of all Admission records, Care Plans, and IDG Updates will be audited by clinical managers monthly using the Hospice Clinical Audit Tool to maintain compliance. Ongoing, QAPI trends will be identified by the QAPI committee for any finding below 90% in any</p>	

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L 0562 Bldg. 00	<p>information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <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. Based on observation, record review, and interview, the agency failed to analyze and track quality indicators that enable the hospice to assess processes of care, hospice services, and operations.</p>	L 0562	<p>quarter and a Performance Improvement Plan developed and initiated. Trending of all QAPI Plan audit results will be ongoing each quarter. QAPI minutes and Performance Improvement Plans will be audited by the Director of Compliance each quarter ongoing.</p> <p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: By no later than September 27, 2016, the QAPI Plan Meeting Template will be revised and approved. Review of QAPI program results will be ongoing.</p> <p>L 562 418.58(a) (2) IMPLEMENTATION</p> <p>The implementation of the QAPI program has and will continue to audit, monitor and correct items based on the Governing Body's approved Compliance Plan. The</p>	09/27/2016	

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. A policy titled "Hospice Item Set" Policy No. H:2 - 091.1 revised 08/2014, indicated " ... The HIS is NOT an assessment instrument and does not replace a thorough and ongoing assessment of each patient required by the Medicare Conditions of Participation " 2. On 08/22/16 at 3:00 PM, the Director of Clinical Services demonstrated on the computer how the admission nurse completes an admission assessment and answers the appropriate questions for the data elements using the HIS (Hospice Item Set) program. Once a second visit had been made, usually within 48 hours, the information would be transmitted to CMS (Centers for Medicare and Medicaid). The data elements would be measured again upon discharge / death. The Director of Clinical Services indicated the agency had not been measuring the data throughout the patient's course of care and had not verified that the data elements identified in the comprehensive assessments assisted in the development of the plan of care which included measurable goals and measurement of outcomes. 3. The Administrator, Clinical Director, 		<p>Compliance Plandocuments the specific data collection, stated methodology, standardized audittools, oversight and reporting responsibilities. All aspect of theimplementation has and will be documented. The reporting of this activities are archived and were available duringSurvey.</p> <p>As part of the 2016 Hospice Compliance Plan/QAPI targets,100% of all Admission records, Care Plans, and IDG Updates will be reviewed byclinical managers using the Hospice Clinical Record Audit Tool elements for 60days and results tracked on the QAPI Audit Tracker for met/not compliance % forL521, L523, L533, L534, L535, L545, L546, L548, L552, L590, and L591. Anynon-compliance findings will be remediated and staff shall add late entry IDGNotes for assessment of noncompliance and will receive individual re-educationdocumented on the QA Education Form. After 90 days, if 100% compliancethreshold has been met for any given month, 10% of all Admission records, CarePlans, and IDG Updates will be audited by clinical managers monthly using theHospice Clinical Audit Tool to maintain compliance. Ongoing, QAPI trends willbe identified by the QAPI committee for any finding below 95% in any quarterand a Performance</p>		

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L 0563 Bldg. 00	<p>and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>418.58(b)(1) PROGRAM DATA (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program. Based on observation, record review, and interview, the agency failed to ensure quality indicator data, including patient care, was used in the QAPI (Quality Assessment and Performance Improvement) program.</p> <p>Findings include:</p>	L 0563	<p>Improvement Plan developed and initiated. Trending of all QAPI Plan audit results will be ongoing each quarter. QAPI minutes and Performance Improvement Plans will be audited by the Director of Compliance each quarter ongoing.</p> <p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: By no later than September 27, 2016, the QAPI Plan Meeting Template will be revised and approved. Review of QAPI program results will be ongoing.</p> <p>L 563 418.58(b)(1) PROGRAM DATA</p> <p>The agency will continue to provide documentation in the development and implementation of an ongoing QAPI program involving all hospice services focusing on quality indicators related to</p>	09/27/2016	

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NAME OF PROVIDER OR SUPPLIER PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032
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	<p>1. A policy titled "Hospice Item Set" Policy No. H:2 - 091.1 revised 08/2014, indicated " ... The HIS is NOT an assessment instrument and does not replace a thorough and ongoing assessment of each patient required by the Medicare Conditions of Participation "</p> <p>2. On 08/22/16 at 3:00 PM, the Director of Clinical Services demonstrated on the computer how the admission nurse completes an admission assessment and answers the appropriate questions for the data elements using the HIS (Hospice Item Set) program. Once a second visit had been made, usually within 48 hours, the information would be transmitted to CMS (Centers for Medicare and Medicaid). The data elements would be measured again upon discharge / death. The Director of Clinical Services indicated the agency had not been measuring the data throughout the patient's course of care and had not verified that the data elements identified in the comprehensive assessments assisted in the development of the plan of care which included measurable goals and measurement of outcomes.</p> <p>3. The Administrator, Clinical Director, and Compliance Officer were unable to</p>		<p>improving palliative outcomes and actions taken to demonstrate improvement in hospice performance.</p> <p>The hospice will continue to 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>The program will continue to use quality indicator data, including patient care, and other relevant data, in the design of its program. The Quality Assessment and Performance Improvement (QAPI) Plan and Meeting Template will be revised and approved to expand specific compliance monitoring for QAPI action and reporting to the Professional Advisory Committee and then the Governing Body on the following L Tags now being tracked on the QAPI Audit Tracker and also as part of the ongoing Hospice Clinical Records Audit Tool: L521, L523, L533, L534, L535, L545, L546, L548, L552, L553, L590, and L591.</p> <p>As part of the 2016 Hospice Compliance Plan/QAPI targets, 100% of all Admission records, Care Plans, and IDG Updates will be reviewed by clinical managers using the Hospice Clinical Record Audit</p>	

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	provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.		<p>Tool elements for 90days and results tracked on the QAPI Audit Tracker for met/not compliance % for L521, L523, L533, L534, L535, L545, L546, L548, L552, L590, and L591. Any non-compliance findings will be remediated and staff shall add late entry IDG Notes for assessment of noncompliance and will receive individual re-education documented on the QA Education Form. After 90 days, if 100% compliance threshold has been met for any given month, 10% of all Admission records, Care Plans, and IDG Updates will be audited by clinical managers monthly using the Hospice Clinical Audit Tool to maintain compliance. Ongoing, QAPI trends will be identified by the QAPI committee for any finding below 95% in any quarter and a Performance Improvement Plan developed and initiated. Trending of all QAPI Plan audit results will be ongoing each quarter. QAPI minutes and Performance Improvement Plans will be audited by the Director of Compliance each quarter ongoing.</p> <p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p>	

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L 0579 Bldg. 00	<p>418.60(a) PREVENTION</p> <p>The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. Based on medical record review and interview, the agency failed to ensure the employees tuberculosis skin test forms included a time of when the tuberculosis skin test were given and a time of when the skin test were read so that there would be verification that the skin tests were read after 48 hours and before 72 hours of the time of the injection.</p> <p>Findings include:</p> <p>1. Review of Employee C's medical personnel record, a tuberculosis skin test form indicated a tuberculosis skin test was administered on 01/05/16 at 11:40 AM and read on 01/08/16. The clinical record failed to evidence a time of when the skin test was read and if it was read between 48 and 72 hours after the initial administration of the skin test.</p>	L 0579	<p>Completion Date: By no later than September 27,2016, the QAPI Plan Meeting Template will be revised and approved. Review ofQAPI program results will be ongoing.</p> <p>L 579 418.60(a) PREVENTION The agency reviewed Policy No. C:2-041" TuberculosisExposure and Control Plan" (see Attachment Group D; policy from <i>Premier Hospice & Palliative Care CHAPHospice Policy and Procedure Manual, 2016</i>), which directs agency staff to follow Centers for DiseaseControl (CDC) procedures for Mantoux/TB skin test documentation <i>to include the times</i>, as well as thedates of administration and reading of TB skin tests.</p> <p>During the in-service sessions that took place 09/13/16,09/14/16, 09/15/16, and 09/16/16, the Administrator re-educated all nursingstaff that not only must TB skin tests be read between 48 to 72 hours after administrationbut the records must indicate the time when they</p>	09/27/2016

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	<p>2. Review of Employee F's medical personnel record, a tuberculosis skin test was administered on 07/08/16 and read on 07/10/16. The record failed to evidence a time for administration of the skin test and failed to evidence a time for when the skin test was read.</p> <p>3. Review of Employee H's medical personnel record, a tuberculosis skin test was administered on 12/02/15 and read on 12/04/16 at 12:30 PM. The record failed to evidence a time for the administration of the skin test.</p> <p>4. Review of Employee I's medical personnel record, a tuberculosis skin test was administered on 01/19/16 and read on 01/21/16. The record failed to evidence a time for the administration of the skin test and failed to evidence a time for when the skin test was read.</p> <p>5. Review of Employee J's, medical personnel record, a tuberculosis skin test was administered on 04/05/16 and read on 04/07/16 at 2:00 PM. The record failed to evidence a time for the administration of the skin test.</p> <p>6. Review of Employee K's medical personnel record, a tuberculosis skin test was administered on 02/02/16 at 1:45 PM</p>		<p>were administered and read.</p> <p>For 90 days, 100% of all HR records will be reviewed for and results tracked for evidence of skin test documentation, as applicable, that includes the times (as well as the dates) of administration and readings of tests. Employee/Contractor/Volunteer human resource files lacking documentation of TB skin test times or tests read outside the 48 to 72-hour time frame will result in the worker being scheduled for retesting. Further, the employee will not be allowed patient contact until an appropriate TB test and documentation is in their file. After 90 days, if 100% compliance threshold has been met for any given month, 10% of HR records will be audited monthly to maintain compliance.</p> <p>The Director of Human Resources will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or medical leave will receive</p>	

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	<p>and read on 02/04/16 at 10:00 AM. The employee failed to have the tuberculosis skin test read 48 hours after the initial administration.</p> <p>7. Employee R, Human Resource Director, was interviewed on 08/22/16 at 1:30 PM. Employee R indicated that the agency nurses provides the tuberculosis skin test and that he assumed the nurses were providing and documenting the skin test appropriately.</p> <p>8. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>9. A web site for Centers for Disease Control (CDC) www.CDC.gov/.../mantoux indicated, " ... Record all the information required for documentation by you institution ... date and time of administration, injection site location, lot number of tuberculin. The skin test should be read between 48 - 72 hours after administration. A patient who does not return within 72 hours will probably need to be rescheduled for another skin test "</p>		<p>theabove mentioned training prior to returning to work. The review of all 100% of all HR Files for valid TB tests was completed and reschedules began on September 13, 2016.</p>				

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L 0587 Bldg. 00	<p>Based on record review and interview, the Registered Nurse failed to notify the patient's physician for changes in condition and treatment in 3 of 13 active records reviewed in a sample of 16 (See L 590); failed to ensure Registered Nurse appropriately assessed and identified patients with wounds, mediport, peritoneal drain for abdominal ascites, and failed to properly start a peripheral IV to infuse fluids in 6 of 13 active patient patients in a sample of 16 (See L 591),</p> <p>The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with the Condition of Participation 418.64: Core Services.</p>	L 0587	<p>L587 418.64 CORESERVICES CONDITION.</p> <p>On 09/13/16, 09/14/16, 09/15/16, and 09/16/16, the Administrator conducted training sessions for all staff that addressed Policy No. H:2-038 "Monitoring Patient's Response/Reporting to Physician" (see Attachment Group E; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual, 2016</i>). Staff were instructed the hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness. All physician employees and those under contract, must function under the supervision of the hospice medical director. All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician. If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the</p>	09/27/2016	

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			<p>medical needs of the patient. The Administrator's in-service training also addressed Policy No. H:2-004 "Hospice Nursing Care" (see Attachment Group E; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016), the hospice's new Wound Care Policy No. H:2-095 (see Attachment Group E; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016), IV Care protocols, and Policy No. H:2-032 "Verification of Physician Orders (see Attachment Group E; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016). Nursing staff were retrained that and that the hospice must provide nursing care and services by or under the supervision of a registered nurse and such services must meet the patient's needs as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. 20% of patient records will be reviewed by clinical managers using the hospice clinical audit tool for the next 90 days and results tracked to achieve 95% compliance with nursing care and employees and those under contract coordinating patient care with the attending physician. Staff shall add late entry IDG Notes and verbal orders to remediate any findings.</p>	

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L 0590 Bldg. 00	418.64(a) PHYSICIAN SERVICES The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's		<p>ofnoncompliance and will receive individual re-education documented on the QA Education Form. Staff reeducation Forms and documentation will be maintained bythe Administrator. After 90 days, if 95% compliance threshold has been met forany given month, then 10% of patient records will be audited monthly tomaintain compliance.</p> <p>The Director of Hospice services will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur. The results will be reported to the QAPI committee andGoverning Body.</p> <p>Completion Date:All Staff education was completed on 9/19/2016. Any staff members who have beenon vacation or medical leave will receive the above mentioned training prior toreturning to work. By no later than 09/27/2016 the organization will haveimplemented the Audit Tracker of 20% of patient records using the clinical audittool. See additional detail in the Plan of Correction descriptions in TagsL590 and L591.</p>		

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	<p>attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.</p> <p>(1) All physician employees and those under contract, must function under the supervision of the hospice medical director.</p> <p>(2) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician.</p> <p>(3) If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.</p> <p>Based on record review and interview, the Registered Nurse failed to notify the patient's physician for changes in condition and treatment in 3 of 13 active records reviewed in a sample of 16. (# 12, 15, and 16)</p> <p>Findings include:</p> <p>1. Clinical record number 12, Election date 04/14/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 04/04/16 to 07/02/16. The patient's primary diagnosis indicated malignant neoplasm of overlapping sites of colon, with secondary diagnoses of malignant neoplasm of the liver and intrahepatic bile duct, digestive organs, retroperitoneal / peritoneum, and lung.</p>	L 0590	<p>L590 418.64(a)PHYSICIAN SERVICES</p> <p>On 09/13/16, 09/14/16, 09/15/16, and 09/16/16, the Administrator conducted training sessions for all staff that addressed Policy No. H:2-038 "Monitoring Patient's Response/Reporting to Physician" (see Attachment Group E; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016). Staff were instructed the hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness. All physician employees and those under contract, must function under the</p>	09/27/2016

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	<p>A. A nursing visit note dated 07/28/16, indicated the patient's abdomen was firm and tender. The sub q site was in the left lower quadrant and reported that the site was tender to touch. The clinical record failed to indicate if the physician had been notified of the patient's sub q site.</p> <p>2. Clinical record number 15, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to 10/04/16. The patient's hospice diagnosis indicated atherosclerotic heart disease with secondary diagnoses of dementia - Lewey bodies, hypertension, and stage III chronic kidney disease.</p> <p>A. A physician's order dated 07/27/16, indicated 1 liter of 0.9% Normal Saline to be infused over 24 hours intravenously due to the patient was vomiting and diarrhea on 07/26/16.</p> <p>B. A nursing visit note dated 07/27/16 at 2:44 PM, the skilled nurse attempted two times to start an IV without success. The case manager notified a patient care coordinator in the office. The visit note failed to indicate if the case manager had notified the physician of the attempts and inability to</p>		<p>supervision of the hospice medicaldirector. All physician employees and those under contract shall meet thisrequirement by either providing the services directly or through coordinatingpatient care with the attending physician. If the attending physician isunavailable, the medical director, contracted physician, and/or hospicephysician employee is responsible for meeting the medical needs of the patient. 20% of patient records will be reviewed by clinical managersusing the hospice clinical audit tool for the next 90 days and results trackedto achieve 95% compliance with nursing care and employees and those undercontract coordinating patient care with the attending physician. Staff shalladd late entry IDG Notes and verbal orders to remediate any findings ofnoncompliance and will receive individual re-education documented on the QAEducation Form. Staff reeducation Forms and documentation will be maintained bythe Administrator. After 90 days, if 95% compliance threshold has been met forany given month, then 10% of patient records will be audited monthly tomaintain compliance.</p> <p>The Director of Hospice services will be responsible formonitoring these corrective actions to ensure that this deficiency is</p>		

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	<p>start an IV.</p> <p>C. A coordination note dated 07/28/16, indicated another registered nurse had went to the patient's home to place a peripheral IV for infusion of the normal saline. The registered was unable to locate any angiocatheters in the office, and "was going to utilize butterfly [sic] or vacutainer needle for infusion." The registered nurse continued to indicate that a butterfly needle was placed, started the infusion, the fluids were "barely dripping and then vein started to show signs of potential intolerance." The registered nurse discussed with spouse and patient that the "we" would wait until another angiocatheter from [name of company] "tomorrow." The note failed to indicate if the nurse had notified the physician of the inability to start an IV and the plan to reattempt the following day.</p> <p>6. Clinical record number 16, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to 10/04/16, with treatment orders to wrap lower extremity wounds three times a week with kerlix and to apply antimicrobial pressure dressing to the coccyx wound when soiled. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary</p>		<p>corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization will have implemented the Audit Tracker of 20% of patient records using the clinical audit tool.</p>				

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	<p>diagnoses of dementia, hypertension, and stage III chronic kidney disease. The patient was also a diabetic.</p> <p>A. A nursing visit note dated 07/18/16, indicated the patient appeared to be developing a necrotic area on 4th left toe. Left lower leg had some redness and warmth. The visit note failed to indicate if the physician had been notified of the necrotic 4th toe as well as the redness and warmth to the left lower leg.</p> <p>B. A nursing visit note dated 07/25/16, indicated the dressings were changed to the left lower extremity and the left 4th toe was becoming more necrotic. The note failed to indicate if the physician had been notified of the increase in necrosis to the 4th toe.</p> <p>C. A nursing visit note dated 07/29/16, indicated the patient's right big toe was bloody under the toenail from the patient stubbing it in the bathroom. The note failed to indicated if the physician had been notified of the injury to the right big toe.</p> <p>D. A nursing visit note dated 08/01/16, indicated the patient reported the right 4th toe and the left 3rd toe opened up over the weekend. The visit note failed to indicate if the physician had</p>			

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L 0591 Bldg. 00	<p>been notified of the status of the right and left toes and if an order had been obtained prior to providing treatment.</p> <p>7. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>8. A policy titled "Physician Responsibility in Managing Hospice Patients" revised 10/2014, indicated " ...The physician has the right to be an active participant in the development of the plan of care in the provision of hospice orders ... Be provided with timely information regarding his / her patient. Notification and contact will occur with ... Changes in the patient's condition ... Changes needed regarding ... treatments, medications "</p> <p>418.64(b)(1) NURSING SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.</p>			

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	<p>Based on record review and interview, the hospice failed to ensure Registered Nurse appropriately assessed and identified patients with wounds, mediport, peritoneal drain for abdominal ascites, and failed to properly start a peripheral IV to infuse fluids in 6 of 13 active patient patients in a sample of 16. (# 2, 9, 11, 12, 15, and 16)</p> <p>Findings include:</p> <p>1. Clinical record number 2, Election date 05/12/16, included a physician's plan of care for the certification dates of 05/12/16 to 08/09/16.</p> <p>A. A physician order dated 05/26/16, indicated "Pt [patient] to be seen for 1 visit during the week of May 28th to June 4th." The order failed to include disciplines involved with the visit.</p> <p>B. Review of a skilled nursing visit note dated 06/09/16, the integumentary section indicated patient had a wound.</p> <p>1. Review of a form called "Wound Assessment Tool Report," the report failed to include an assessment of the wound bed and surrounding tissue.</p> <p>2. A physician order dated 06/09/16, indicated "Duoderm to Stage 2</p>	L 0591	<p>L 591 418.64(b)(1)NURSING SERVICES</p> <p>On 09/13/16, 09/14/16,09/15/16, and 09/16/16, the Administrator conducted training sessions for allnursing staff that addressed PolicyNo. H:2-004 "Hospice Nursing Care",Policy No. H:2-004 (see Attachment Group E; policy from <i>Premier Hospice & Palliative Care CHAPHospice Policy and Procedure Manual</i>, 2016), Policy No. H:2-032 "Verificationof Physician Orders (see Attachment Group E; policy from <i>Premier Hospice & Palliative Care CHAPHospice Policy and Procedure Manual</i>, 2016), the new Wound Care Policy No.H:2-095 (see Attachment Group E; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and ProcedureManual</i>, 2016), IV Care protocols, and that thehospice must provide nursing care and services by or under the supervision of aregistered nurse.</p> <p>This re-education addressed how nursing services are toensure that the nursing needs of the patient are met as identified in thepatient's initial assessment, comprehensive assessment, and updatedassessments.</p> <p>Training examples included: visit orders must include thediscipline involved, wound orders must include specific instructions on</p>	09/27/2016			

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	<p>pressure ulcer to left buttocks." The order failed to include frequency of changes / management by the agency and / or family / caregivers.</p> <p>C. Review of a skilled nursing visit note dated 06/13/16, the note failed to include documentation that the wound on the left buttock had been assessed.</p> <p>2. Clinical record number 9, Election date 07/11/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/11/16 to 10/08/16. The patient's hospice diagnosis indicated late effect intracranial injury with secondary diagnoses of Parkinson disease, diabetes, depressive disorder.</p> <p>A. A nursing visit note dated 08/05/16, indicated the patient had a diabetic ulcer to the left heel and a blister to the right heel. The hospice nurse documented "discussed wounds with FSN [facility skilled nurse] and blister has popped with skin still intact ... Discussed current wound dressing with staff and added to orders ... " The visit note failed to include measurements, appearance of wounds, and appearance of surrounding tissue.</p> <p>B. A nursing visit note dated 08/09/16, indicated the patient had a</p>		<p>thefrequency of changes by the agency and or family/caregivers or facility staff,visit documentation must include detailed wound assessment of every wound/skingraft at comprehensive assessment and ongoing, including measurements,appearance of wound bed and surrounding tissue, IDG Update must be consistentwith the number and location of the wounds reported in visit notes, start ofcare assessments must include an assessment of any drain site , how the drainis to be operated, any drainage that may have been removed from the abdominalcavity, and measurements of abdominal girth due to abdominal ascites,assessment of an IV site shall include location, if there was any leakage from thesite, any signs and symptoms of infection, and when the IV site or tubing hadbeen last changed, staff shall report to the physician on changes of condition,such as if an IV or wound site is red, warm, or tender to touch, documentationmust include the physician had been notified of any new wound/injury and ordersmust be obtained prior to treatment, documentation and orders shall includeinitial and ongoing medi-port assessments, and charted wound care must exactlyfollow the ordered treatment/care,.</p>		

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	<p>diabetic ulcer to the left heel and a blister to the right heel. The note went on to indicate that the facility nurse indicated that eschar remained to the left ankle wound.</p> <p>C. The clinical record included forms called "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 08/10/16, the case manager indicated the facility nurse reported a diabetic ulcer to the left ankle and a healing blister to the right ankle. The IDG updated report indicated the patient's treatment orders to the left heel was to cleanse with normal saline, apply santyl and cover with dry dressing daily and to the right heel, apply skin prep, foam padding, and kerlix. The order failed to include the days the facility nurses were to perform dressings and the number of days the hospice nurses were to perform the dressing. The IDG updated report / orders and the skilled nursing visit notes failed to be consistent with the number and / or location of the wounds.</p> <p>3. Clinical record number 11, Election date 06/08/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 06/08/16 to 09/05/16. The patient's hospice diagnosis indicated malignant neoplasm of colon</p>		<p>20% of patient records will be reviewed by clinical managers using the hospice clinical audit tool for the next 90 days and results tracked to achieve 95% compliance with nursing care and employees and those under contract coordinating patient care with the attending physician. Staff shall add late entry IDG Notes and verbal orders to remediate any findings of noncompliance and will receive individual re-education documented on the QA Education Form. Staff reeducation Forms and documentation will be maintained by the Administrator. After 90 days, if 95% compliance threshold has been met for any given month, then 10% of patient records will be audited monthly to maintain compliance.</p> <p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed on 9/19/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization</p>		

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	<p>with secondary diagnoses of malignant neoplasm of liver and sever protein - calorie malnutrition.</p> <p>A. A client coordination note dated 06/08/16, indicated the patient had a peritoneal drain placed on 05/25/16, due to the patient's increased malignant ascites and required drainage. The patient has had multiple hospitalizations with the most recent due to worsening of abdominal pain, nausea, vomiting, and diarrhea. The patient had been put on antibiotics for sepsis. The integumentary and gastrointestinal sections of the start of care assessment failed to include an assessment of the drain site and how the drain was to be operated.</p> <p>B. Review of the hospice nurse visit notes dated 06/09, 06/10, 06/11, 06/14, 06/15, 06/17, 06/21, 06/24, 06/29, 07/01, 07/05, 07/08, 07/13, 07/15, 07/19, 07/22, 07/28, and 08/03/16, the hospice nurse failed to update the comprehensive to include an assessment of the drain site, including any drainage that may have been removed from the abdominal cavity and any measurements of abdominal girth due to the abdominal ascites.</p> <p>C. A hospice visit note dated 08/04/16, indicated that the peritoneal drain had been removing 1200 milliliters</p>		will have implemented the Audit Tracker of 20% of patient records using the clinical audit tool.	

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	<p>of fluid per day and the nurse notified the physician to increase the amount of bags delivered per month from 15 to 30. The hospice nurse failed to include an assessment of the drain site and any measurements of abdominal girth due to the abdominal ascites.</p> <p>4. Clinical record number 12, Election date 04/14/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 04/04/16 to 07/02/16. The patient's primary diagnosis indicated malignant neoplasm of overlapping sites of colon, with secondary diagnoses of malignant neoplasm of the liver and intrahepatic bile duct, digestive organs, retroperitoneal / peritoneum, and lung.</p> <p>A. A physician order dated 06/13/16, indicated an intravenous infusion was initiated. The infusion was initiated on 06/14/16.</p> <p>B. A nursing visit note dated 07/05/16, indicated the patient's abdomen was firm and tender and the patient complained of pain to the abdomen. The nursing visit note failed to include an assessment of the IV site such as location, if there was any leakage from the site, signs and symptoms of infection. The note failed to include when the last</p>			

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	<p>IV site had been changed.</p> <p>C. A nursing visit note dated 07/12/16, indicated the patient's abdomen was firm, nodule in right lower quadrant from sub q button. The nursing note failed to include an assessment of the IV site in the abdomen such as any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p> <p>D. A nursing visit note dated 07/14/16, indicated the patient's abdomen was firm and nontender. The nursing visit note failed to include an assessment of the IV site such as location, any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p> <p>E. A nursing visit note dated 07/19/16, indicated the nurse provided the patient with a few skin prep pads to help make his / her CADD pump dressing stay on due to sweat. The nursing visit note failed to include an assessment of the IV site such as location, any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p>			

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	<p>F. A nursing visit note dated 07/21/16, failed to include an assessment of the IV site site such as location, any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p> <p>G. A nursing visit note dated 07/28/16, indicated the patient's abdomen was firm and tender. The sub q site was in the left lower quadrant and reported that the site was tender to touch. The clinical record failed to indicate if the physician had been notified of the patient's sub q site.</p> <p>H. A nursing visit dated 08/04/16, indicated the LPN arrived to the patient's home with the CADD pump alarming high pressure. The note indicated the LPN changed the tubing and silenced the alarm. No further documentation in regards to the follow up of changing the tubing, assessment of the sub q site and location, any leakage from the site, signs and symptoms of infection. The note failed to include when the last IV site had been changed.</p> <p>5. Clinical record number 15, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to</p>			

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	<p>10/04/16. The patient's hospice diagnosis indicated atherosclerotic heart disease with secondary diagnoses of dementia - Lewey bodies, hypertension, and stage III chronic kidney disease.</p> <p>A. A physician's order dated 07/27/16, indicated 1 liter of 0.9% Normal Saline to be infused over 24 hours intravenously due to the patient was vomiting and diarrhea on 07/26/16.</p> <p>B. A nursing visit note dated 07/27/16 at 2:44 PM, the skilled nurse attempted two times to start an IV without success. The case manager notified a patient care coordinator in the office. The visit note failed to indicate if the case manager had notified the physician of the attempts and inability to start an IV.</p> <p>C. A coordination note dated 07/28/16, indicated another registered nurse had went to the patient's home to place a peripheral IV for infusion of the normal saline. The registered was unable to locate any angiocatheters in the office, and "was going to utilize butterfly [sic] or vacutainer needle for infusion." The registered nurse continued to indicate that a butterfly needle was placed, started the infusion, the fluids was "barely dripping and then vein started to show signs of</p>						

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	<p>potential intolerance." The registered nurse discussed with spouse and patient that the "we" would wait until another angiocatheter from [name of company] "tomorrow."</p> <p>D. A coordination note dated 08/10/16, indicated "this note pertains to phone conversation with pt's [patient's] wife on 07/29/16." The note indicated the patient was feeling better, drinking liquids and keeping them down. Order was received to discontinue IV fluids. The registered nurses failed to meet the patient needs and failed to</p> <p>E. An interview with the Clinical Director on 08/11/16 at 11:30 AM, indicated the IV medication and supplies were not kept in the office but obtained by a pharmacy.</p> <p>6. Clinical record number 16, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to 10/04/16, with treatment orders to wrap lower extremity wounds three times a week with kerlix and to apply antimicrobial pressure dressing to the coccyx wound when soiled. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary diagnoses of dementia, hypertension, and</p>			

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	<p>stage III chronic kidney disease. The patient was also a diabetic.</p> <p>A. Discharge instructions dated 07/05/16, was faxed to the office on 07/07/16. The instructions indicated the following treatment orders: Right dorsal superficial wound and bilateral heel wounds: Aquacel AG on bilateral heels, Adaptic to right dorsal wound. Allyn heel cup to left heel. Wrap both feet with kerlix. Change dressing daily.</p> <p>B. The start of care assessment dated 07/07/16, indicated the patient had 4 wounds, 3 to the bilateral feet and one on the coccyx. The wounds failed to be assessed upon admission.</p> <p>C. A nursing visit note dated 07/12/16, indicated the patient had a diabetic ulcer to the left heel and right heel, a skin graft to the right lower extremity, and a stasis ulcer to the left leg. The visit note failed to include an assessment of the coccyx wound and failed to include the type of wound care provided. The nursing visit also indicated the patient had a right subclavian mediport that which was not indicated on the admission assessment.</p> <p>D. A nursing visit note dated 07/14/16, indicated the patient's dressings</p>			

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	<p>had been performed per physician orders. The visit note failed to include an assessment of the coccyx wound and failed to include the type of wound care provided. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>E. A nursing visit note dated 07/15/16, indicated the patient's dressings had been performed to the bilateral foot/ankle. The visit note failed to include an assessment of the coccyx wound and failed to include the type of wound care provided. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>F. A nursing visit note dated 07/18/16, indicated the patient's dressings had been performed to the bilateral lower extremities. The note indicated the patient appeared to be developing a necrotic area on 4th left toe. Left lower leg had some redness and warmth. Review of the wound assessment tool, the tool failed to include measurements of the skin graft and failed to include an assessment of all the wounds. The visit note failed to include an assessment of the coccyx wound and failed to include the type of wound care provided. The visit note failed to measure the necrotic wound to the left 4th toe and failed to</p>			

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	<p>indicate if the physician had been notified of the necrotic 4th toe as well as the redness and warmth to the left lower leg. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>G. A nursing visit note dated 07/20/16, indicated new treatment orders from the foot doctor. The treatment orders indicated to apply betadine and cover with gauze to the left 4th toe; apply Aquacel AG and cover with dry gauze, and secure with roll gauze to the left heel and left anterior leg; apply layer of tubigrip to left lower extremity; and the patient to wear heel cups bilaterally. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>H. A nursing visit note dated 07/22/16, indicated the left lower extremity dressings had been changed per orders and the integumentary assessment indicated the patient had two wounds to the left lower extremity, an assessment was provided for 2 of 3 wounds, but the note failed to be specific as to which wound (left toe, left heel or left lower leg) he / she were describing. The visit note failed to include an assessment to 1 of 3 wounds to the left lower extremity, failed to include an assessment of the</p>			

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	<p>skin graft on the right leg, and failed to include an assessment of the coccyx wound as well as the type of wound care provided. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>I. A nursing visit note dated 07/25/16, indicated the dressings were changed to the left lower extremity and the left 4th toe was becoming more necrotic. Review of the wound assessment tool, measurements were performed to the left toe, left heel and left leg. The wound assessment tool and the visit note failed to include an assessment of the left heel and left leg wounds. The visit note failed to include an assessment of the coccyx wound and failed to include the type of wound care provided. The note also failed to indicate if the physician had been notified of the increase in necrosis to the 4th toe. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>J. A treatment update from the wound clinic dated 07/27/16, was faxed to the agency on 08/10/16. The visit note indicated the patient had a wound to the left 4th digit toe, anterior left leg was healed, left heel, left big toe, and right 2nd digit toe. The treatment orders</p>			

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NAME OF PROVIDER OR SUPPLIER PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032
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	<p>included to continue to put betadine wet to dry on 4th left toe, continue with Aquacel AG to the left heel ulcer, follow with bacitracin ointment and bandaid with padding to 2nd right toe. Continue heel protector to left heel.</p> <p>K. A nursing visit note dated 07/29/16, indicated the patient had one wound, indicated the left heel, and the 'dressings' had been changed to the left lower extremity. The note failed to include an assessment of the coccyx and the left 4th toe. The visit note indicated the right big toe was bloody under the toenail from the patient stubbing it in the bathroom. The note indicated iodine was applied to the left toe. The visit note failed to include an assessment of the coccyx wound and failed to include the type of wound care provided to the left heel. The nurse failed to use betadine for treatment of the left toe. The note failed to indicated if the physician had been notified of the injury to the right big toe. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>L. A nursing visit note dated 08/01/16, indicated the dressings were changed to the left lower extremity, the patient reported the right 4th toe and the left 3rd toe opened up over the weekend</p>			

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	<p>and the wounds were cleansed and covered with calcium AG and gauze. Review of the wound assessment tool, the left heel, left toe, and right toe were measured but failed to include an assessment. The visit note and clinical record failed to indicate if the physician had been notified of the status of the right and left toes and if an order had been obtained prior to providing treatment. The note failed to include an assessment of the coccyx wound. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>M. A treatment update from the wound clinic dated 08/03/16, was faxed to the agency on 08/10/16. The visit note indicated the patient had a wound to the left 4th digit toe, left heel, left big toe, right 2nd digit toe, two wounds located on the distal nail bed (the visit note failed to indicate which distal nail bed), and a wound located on the left 5th toe. The treatment orders included to continue with Aquacel AG to the left heel ulcer and apply to the left 4th digit toe and to apply bacitracin ointment and plain gauze to bilateral hallux nail beds, 2nd right toe, and left 5th nail bed. Continue heel protector to left heel. The clinical record failed to include if the nurse obtained a clarification order to continue to wrap left lower extremity with tubigrip stocking.</p>			

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	<p>N. A nursing visit note dated 08/05/16, indicated the patient had wounds to the bilateral toes and left heel. The note indicated new treatment orders had been received. The orders indicated to apply bacitracin to bilateral great toes and left 5th toe and cover with a bandaid; discontinue bacitracin to the left 4th toe and begin covering with Aquacel AG, cover with gauze, and secure with a bandaid; continue Aquacel AG to the left heel, over with plain gauze and secure with paper tape; wrap bilateral lower extremities from toes to below knees with kerlix and coban; and to change the dressing Monday, Wednesday, and Friday with exception to the days the patient would go to the wound clinic. Review of the wound assessment tool, the tool failed to include measurements and assessments of the bilateral big toes and left 5th toe. The visit note failed to include an assessment of all wounds and failed to include an assessment of the coccyx wound. The clinical record failed to include a written order that was obtained on this date. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>O. A nursing visit note dated 08/08/16, the wounds were measured, assessed and entered into the wound</p>			

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	<p>assessment tool. Review of the wound assessment tool, the right toe, left toe, and left heel was measured only. The wound assessment tool failed to specify which toes were measured, and failed to include the assessment of the wounds that were measured. The assessment tool failed to include the remaining treated toes. The visit note failed to include the treatment provided to the wounds. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>P. During a home visit with Employee A, a registered nurse and case manager of the patient, on 08/12/16 at 9:15 AM, the patient was observed to have bilateral lower extremities wrapped with coban with netting on the outside, foam heel cups observed in the patient's walking shoe, and gauze wrapped around bilateral big toes, the right 2nd toe, and the left 4th digit toe. Employee A was observed to provide wound treatments to all areas including the left lower leg stasis ulcer area that was noted and observed to be healed by the physician on 07/27/16. Employee A applied Aquacel AG to the right and left big toe, left 4th digit toe, left heel, and left lateral shin area, and right 2nd toe. The nurse applied roll gauze to bilateral lower extremities followed by coban and</p>			

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	<p>netting. The nurse applied gauze to the toes and secured with tape. The nurse failed to provide wound treatment per physician orders and provided treatment to a wound that was healed. The nurse was interviewed after the visit. The nurse indicated he / she did not have much experience with wound care and had only been a nurse for a short time. The nurse indicated his / her experience was in long term care, but did not provide much wound care. The visit note also failed to include an assessment of the patient's right subclavian mediport.</p> <p>7. A policy for wound treatments was requested on 08/22/16 at 3:00 PM. The Director of Clinical Services indicated the agency did not have a policy and procedure for wound care, that they agency follows Lippincott Nursing Procedure book.</p> <p>8. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>9. A website www.hcib.org/docs/subq-medication.pdf titled "Hospice and Palliative Nurses Association" included a patient</p>			

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	<p>instruction sheet titled "Subcutaneous Medication Administration Infusions." The form indicated "... The Sub Q insertion site may be on the abdomen, chest wall, upper outer thigh, or the upper outer arm. The sites are generally changed every 3 to 5 days, but may need to stay in place longer ... check site twice a day ... leaking, pain, redness, bruising, burning, or swelling at the site "</p> <p>10. A website www.health.qld.gov.au titled Guidelines for Subcutaneous Infusion Device Management in Palliative Care, 2nd Edition" indicated on page 11, "Principles to include in patient assessment, recording, and documentation include: Asking the patient how they feel ... are their pain and other symptoms under controlled? Documentation of symptom control and efficiency of interventions; Careful inspection of site ... for signs of inflammation and site reaction, and documentation of findings; ... Careful inspection of tubing for patency; Site inspection should be performed as part of routine care and includes principles such as checking for: tenderness at the site, presence of a hematoma and leaking at the insertion site." Page 20 indicated in "Summary Statement: ... The longevity of a site can vary considerably from 1 - 14 days. Many variables influence the</p>			

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L 0647 Bldg. 00	<p>longevity of the site, such as the type of medication and type of cannula / needle used; Select and use sites on a rotating basis "</p> <p>11. A policy titled "Intravenous Administration of Medications / Solutions" Policy No. H:2-060.1 revised 10/2014, indicated " ... IV medications and solutions will only be administered through a peripheral or central venous line ... A physician must be notified if any of the follow circumstances occur ... If repeated difficulty occurs in establishing a peripheral line."</p> <p>418.78(e) LEVEL OF ACTIVITY Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked. Based on document review and interview, the hospice failed to ensure volunteers were providing a minimum of 5 percent of the total patient care hours of all paid hospice employees and contract staff for 1 of 1 hospice reviewed.</p> <p>The findings include:</p>	L 0647	<p>L647 418.78(e)LEVEL OF ACTIVITY</p> <p>The hospice has had ongoing PerformanceImprovement Plan (PIP) focusing on new programs for increasing patient contact,and the recruitment, recognition, and retention of Volunteers, such as</p>	09/27/2016	

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	<p>1. The Agency document titled "Volunteer Monthly Status Report" indicated the following:</p> <p>A. The agency form dated January, 2015, failed to evidence that 5% of care had been provided by volunteers.</p> <p>B. The agency form dated February, 2015, failed to evidence that 5% of care had been provided by volunteers.</p> <p>C. The agency form dated May, 2015, failed to evidence that 5% of care had been provided by volunteers.</p> <p>D. The agency form dated June, 2015, failed to evidence that 5% of care had been provided by volunteers.</p> <p>E. The agency form dated July, 2015, failed to evidence that 5% of care had been provided by volunteers.</p> <p>F. The agency form dated August, 2015, failed to evidence that 5% of care had been provided by volunteers.</p> <p>G. The agency form dated September, 2015, failed to evidence that 5% of care had been provided by volunteers.</p>		<p>RetiredPersons, College Students, Employee Friends, Church Congregations, High SchoolSeniors (18 years of age), and Previous Patient Family Members at Open Houses,Blood Drives, Food Donations, Community Health Fairs, Internships, IndianaAreas on Aging, Advertisement on Social Media, Church Bulletins, and MonthlyActive Aging Coalition meetings. As aresult of these efforts, the hospice has met the 5% goal for the months ofJuly 2016 and August 2016 and shall continue to strive to meet or exceed 5% inVolunteer utilization requirements.</p> <p>The VolunteerCoordinator will continue to compile and analyze the data monthly and submitreports to the Administrator, which will then be reported to the QAPICommittee on a quarterly basis.Monthly and annual statistical reports will determine the percentage ofservices given by volunteers in relationship to the direct care hours.Volunteers must provide day-to-day administrative and/or direct patient careservices in an amount that, at a minimum, equals 5 percent of the total patientcare hours of all paid hospice employees and contract staff. The hospice willcontinue to maintain records on the use of volunteers for patient care andadministrative services, including the type of services and</p>		

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	<p>H. The agency form dated October, 2015, failed to evidence that 5% of care had been provided by volunteers.</p> <p>I. The agency form dated November, 2015, failed to evidence that 5% of care had been provided by volunteers.</p> <p>J. The agency form dated December, 2015, failed to evidence that 5% of care had been provided by volunteers.</p> <p>K. The agency form dated January, 2016, failed to evidence that 5% of care had been provided by volunteers.</p> <p>L. The agency form dated February, 2016, failed to evidence that 5% of care had been provided by volunteers.</p> <p>M. The agency form dated March, 2016, failed to evidence that 5% of care had been provided by volunteers.</p> <p>N. The agency form dated April, 2016, failed to evidence that 5% of care had been provided by volunteers.</p> <p>O. The agency form dated May, 2016, failed to evidence that 5% of care had been provided by volunteers.</p> <p>P. The agency form dated June, 2016, failed to evidence that 5% of care</p>		<p>time worked. Non-compliance with the 5% goal for any given month, will result in reassessment of the PIP in a QAPI subcommittee meeting the next month.</p> <p>On 09/13/16, 09/14/16, 09/15/16, and 09/16/16, the Administrator conducted training sessions for all staff on Policy No. H:3-014 "Documentation of Volunteer Utilization" (see Attachment Group F; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016) that indicates the hours of volunteer services will meet or exceed 5% of the total patient care hours of paid and contracted hospice personnel.</p> <p>The Director of Hospice services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion Date: All Staff education was completed on 9/16/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. Satisfying the 5% goal was completed in July 2016.</p>				

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	<p>had been provided by volunteers.</p> <p>Q. The agency form dated July, 2016, failed to evidence that 5% of care had been provided by volunteers.</p> <p>2. Employee P, Volunteer Coordinator, was interviewed on 08/22/16 at 10:45 AM. Employee P indicated it had been difficult finding volunteers. Employee P indicated most of the volunteers were ages mid 30's and younger with other commitments such as paying jobs and school. Employee P indicated the older generation were not volunteering as much anymore. Employee P indicated that people were volunteering for places that did not require the training like hospice. Employee P also indicated that the Seymour branch had been without a Volunteer Coordinator for a while.</p> <p>3. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>4. A policy titled "Documentation of Volunteer Utilization" revised 10/2014, indicated " ... The hours of volunteer services will exceed 5% of the total patient care hours of paid and contracted</p>			

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L 0671 Bldg. 00	<p>hospice personnel ... The Volunteer Coordinator will compile and analyze the data monthly ... Monthly and annual statistical reports will determine the percentage of services given by volunteers in relationship to the other volunteers "</p> <p>418.104 CLINICAL RECORDS A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. Based on record review and interview, the hospice failed to ensure clinical record information was accurate in 4 of 13 active records reviewed in a sample of 16. (#2, 11, 12, 13)</p> <p>Findings include:</p> <p>1. Clinical record number 2, Election date 05/12/16, included a physician's plan of care for the certification dates of 05/12/16 to 08/09/16.</p> <p>A. A physician order dated 05/26/16, indicated "Pt [patient] to be seen for 1 visit during the week of May 28th to June 4th." The order failed to include disciplines involved with the visit.</p>	L 0671	<p>L671 418.104CLINICAL RECORDS</p> <p>On 09/13/16, 09/14/16,09/15/16, and 09/16/16, the Administrator conducted training sessions for allstaff that addressed:</p> <ul style="list-style-type: none"> •□□□□□□□□ Policy No. H:2-032 "Verification of Physician Orders" (see Attachment Group G;policy from <i>Premier Hospice &Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016); •□□□□□□□□ PolicyNo. C:2-033 "Clinical Service/Data Collection" (see Attachment Group G;policy from <i>Premier Hospice &Palliative Care CHAP Core Policy and Procedure Manual</i>, 2016), which defines guidelines forvalid verbal 	09/27/2016

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	<p>B. A hospice chaplain assessment visit note dated 05/16/16, indicated "Pt [patient] appears to be emotionally stable and coping well with spouse's passing."</p> <p>1. A hospice social worker assessment visit note dated 05/17/16, indicated "Pt and dtr [daughter] coping RT [related to] his / her loss of spouse / dad ... "</p> <p>2. A form titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 05/31/16, 06/14/16, 06/28/16, 07/12/16, and 07/26/16, the medical director indicated "Patient is a 97 year old white male / female with hospice diagnosis of congestive heart failure. He/ she has comorbidities of hypertension, heart murmur, lower back pain and fatigue. Patient currently lives at home with his / her spouse in [name of city]. Patient is short of breath with any exertion. Patient continues to be appropriate for hospice care." On 08/09/16, the medical director continued to indicate the patient lived with his / his spouse.</p> <p>C. A physician order dated 06/09/16, indicated "Duoderm to Stage 2 pressure ulcer to left buttocks." The order failed to include frequency of changes /</p>		<p>orders and clinical data collection and Staff were trained thatthe clinical record containing past and current findings must be maintained foreach hospice patient and that the clinical record must contain correct clinicalinformation that is available to the patient's attending physician and hospicestaff. The clinical record will be maintained electronically;</p> <p>●□□□□□□□□ PolicyNo. H:2-087 "Contents of Clinical Record" (see AttachmentGroup G; policy from <i>Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual</i>, 2016), which indicates the clinicalrecord will contain sufficient information to identify the patient, describe the patient's problems and needs, justify care, and accurately document careprovided and results in detail. Training examples included: visit orders must include the disciplineinvolved with the visit, the IDG Medical Director must be updated on changes tocaregiver status, wound orders shall specify the frequency of changes andmanagement by the agency and or family/caregivers, physician notification ofchanges and follow up in demonstrated in coordination notes and visit charting,charting on home health aide and LPN supervisory visits occurs only when thosedisciplines exist in the case, IV orders must</p>	

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	<p>management by the agency and / or family / caregivers.</p> <p>D. A skilled nursing visit note dated 06/16/16, indicated in the "Medication Reconciliation" section that there were no new medication ordered during the visit.</p> <p>1. The "Narrative" section indicated the physician had been notified of the patient's edema and a new order to increase lasix from 20 milligrams to 40 milligrams. The visit note failed to provide accurate / consistent information.</p> <p>2. Clinical record number 11, Election date 06/14/16, included a physician's plan of care for the certification dates of 05/12/16 to 08/09/16.</p> <p>A. Review of the skilled nursing visit notes dated 06/10/16, 06/13/16, 06/14/16, 06/17/16, 07/01/16, 07/05/16, 07/15/16, the notes indicated a home health aide supervisory had been completed and that the patient was satisfied with services and the home health aide was following the plan of care. The visit notes failed to include accurate information for the plan of care did not evidence home health aide services.</p> <p>B. Review of the skilled nursing visit notes dated 07/08/16 and 07/13/16,</p>		<p>include if the drip is givensubcutaneous, peripherally, or through an implanted port (if a port is used,then must include size of needle), or through a central catheter, and how oftenthe IV site is to be changed. IV orders must include if bolus dose may begiven.</p> <p>20% of patient records will bereviewed by clinical managers using the hospice clinical audit tool for thenext 90 days and results tracked to achieve 95% compliance with a clinical record containing pastand current findings is being maintained for each hospice patient. The clinicalrecord must contain correct clinical information and orders so that it isavailable to the patient's attending physician and hospice staff. Staff shalladd late entry IDG Notes and verbal orders to remediate any findings ofnoncompliance and will receive individual re-education documented on the QAPIEducation Form. Staff reeducation Forms and documentation will be maintained bythe Administrator. After 90 days, if 95% compliance threshold has been metfor any given month, then 10% of patient records will be audited monthly tomaintain compliance.</p> <p>The Director of Hospice services will be responsible formonitoring these corrective actions to ensure</p>	

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	<p>the notes indicated a licensed practical nurse supervisory had been completed and that the patient was satisfied with the services and the licensed practical nurse was following the plan of care. The visit note failed to provide accurate information for all nursing visits had been made by a Registered Nurse.</p> <p>3. Clinical record number 12, Election date 04/14/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 04/04/16 to 07/02/16.</p> <p>A. Review of skilled nursing visit notes dated 06/13/16 and 06/14/16, the notes indicated a licensed practical nurse supervisory had been completed and that the patient was satisfied with the services and the licensed practical nurse was following the plan of care. The visit note failed to provide accurate information for all nursing visits had been made by a Registered Nurse.</p> <p>B. A nursing visit note dated 06/14/16, indicated the nurse initiated a dilaudid CADD pump. The dilaudid was being infused via sub q button.</p> <p>1. The clinical record included a physician order dated 06/13/16, for Dilaudid drip 1.5 milligrams per hour</p>		<p>that this deficiency is corrected and will not recur. The results will be reported to the QAPI committee and Governing Body.</p> <p>Completion Date: All Staff education was completed on 9/16/2016. Any staff members who have been on vacation or medical leave will receive the above mentioned training prior to returning to work. By no later than 09/27/2016 the organization will have implemented the Audit Tracker of 20% of patient records using the clinical audit tool.</p>				

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	<p>basal rate, 1.5 milligrams every 30 minutes as needed. The order failed to include if the drip was to be given subcutaneous, peripherally, or through an implanted port or through a central catheter. The order also failed to include how often the IV site was to be changed.</p> <p>2. The clinical record included a physician order dated 06/17/16, for hydromorphone 3 milligrams per hour basal rate with 2 milligram bolus. The order failed to include if the drip was to be given subcutaneous, peripherally, or through an implanted port or through a central catheter. The order failed to include how often the bolus dose may be given.</p> <p>3. The clinical record included a physician order dated 06/28/16, for Dilaudid intravenous 5 milligram / hour continuous with a 3 milligram bolus dose every 30 minutes as needed. The order failed to include if the drip was to be given subcutaneous, peripherally, or through an implanted port or through a central catheter.</p> <p>4. The clinical record included a physician order dated 07/07/16, for hydromorphone 10 milligrams every hour continuously with 3 milligram bolus. The order failed to include if the drip was</p>			

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	<p>to be given subcutaneous, peripherally, or through an implanted port or through a central catheter. The order failed to include how often the bolus dose may be given.</p> <p>4. Clinical record number 13, Election date 08/01/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 08/01/16 to 10/29/16, contained interventions and non-measurable goals. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary diagnoses of diabetes, stroke, and hypertension.</p> <p>A. Review of the skilled nursing visit notes dated 08/02/16, 08/06/16, and 08/09/16, the notes indicated a home health aide supervisory had been completed and that the patient was satisfied with services and the home health aide was following the plan of care. The visit notes failed to include accurate information for the plan of care did not evidence that a home health aide had not started services during those time periods.</p> <p>5. Clinical record number 15, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to</p>			

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	<p>10/04/16. The patient's hospice diagnosis indicated atherosclerotic heart disease with secondary diagnoses of dementia - Lewey bodies, hypertension, and stage III chronic kidney disease.</p> <p>A. A physician's order dated 07/27/16, indicated 1 liter of 0.9% Normal Saline to be infused over 24 hours intravenously due to the patient was vomiting and diarrhea on 07/26/16. The order failed to include orders if the fluids were to be given intravenously via implanted port (include size of needle to be used), peripherally, or buy an peripheral central catheter.</p> <p>6. Clinical record number 16, Election date 07/07/16, included a form called "Hospice Certification and Plan of Care" for the certification period of 07/07/16 to 10/04/16, with treatment orders to wrap lower extremity wounds three times a week with kerlix and to apply antimicrobial pressure dressing to the coccyx wound when soiled. The patient's hospice diagnosis indicated ischemic cardiomyopathy with secondary diagnoses of dementia, hypertension, and stage III chronic kidney disease. The patient was also a diabetic.</p> <p>A. Discharge instructions dated 07/05/16, was faxed to the office on</p>			

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	<p>07/07/16. The instructions indicated the following treatment orders: Right dorsal superficial wound and bilateral heel wounds: Aquacel AG on bilateral heels, Adaptic to right dorsal wound. Allyvn heel cup to left heel. Wrap both feet with kerlix. Change dressing daily.</p> <p>B. The start of care assessment dated 07/07/16, indicated the patient had 4 wounds, 3 to the bilateral feet and one on the coccyx. The wounds failed to be assessed upon admission.</p> <p>C. A nursing visit note dated 07/12/16, indicated the patient had a diabetic ulcer to the left heel and right heel, a skin graft to the right lower extremity, and a stasis ulcer to the left leg. The visit note failed to include an assessment of the coccyx wound and failed to include the type of wound care provided. The clinical record failed to include accurate information for the development of the plan of care.</p> <p>6. The Administrator, Clinical Director, and Compliance Officer were unable to provide any further documentation / information in reference to the above findings by the conclusion of the exit conference on 08/22/16 at 3:20 PM.</p> <p>7. A policy titled "Contents of Clinical</p>			

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	<p>Record" Policy No. H:2 - 087.1 revised 10/2014, indicated " ... A clinical record will contain sufficient information to identify the patient, describe the patient's problems and needs, justify care, accurately document care provided and results in detail "</p> <p>8. A website www.hcib.org/docs/sub-q-medication.pdf titled "Hospice and Palliative Nurses Association" included a patient instruction sheet titled "Subcutaneous Medication Administration Infusions." The form indicated "... The Sub Q insertion site may be on the abdomen, chest wall, upper outer thigh, or the upper outer arm. The sites are generally changed every 3 to 5 days, but may need to stay in place longer "</p> <p>9. A website www.health.qld.gov.au titled Guidelines for Subcutaneous Infusion Device Management in Palliative Care, 2nd Edition" indicated on page 20 "Summary Statement: ... The longevity of a site can vary considerably from 1 - 14 days. Many variables influence the longevity of the site, such as the type of medication and type of cannula / needle used; Select and use sites on a rotating basis "</p> <p>10. A policy titled "Intravenous</p>			

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	Administration of Medications / Solutions" Policy No. H:2-060.1 revised 10/2014, indicated " ... All orders for IV medications and solutions will specify dilutions, route, frequency of administration, and rate of infusion "				