

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2015
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NAME OF PROVIDER OR SUPPLIER HOSPICE FRANCISCAN COMMUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
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L 000 Bldg. 00	<p>This visit was for a federal and state hospice complaint survey.</p> <p>Complaint IN0000159309 - Substantiated: Federal and state deficiencies related to the allegations are cited.</p> <p>Survey date: 5/13/15 -5/15/15</p> <p>Facility #: 008300</p> <p>Medicaid vendor: 200141550</p> <p>QR: JE 5/21/15</p>	L 000		
L 543 Bldg. 00	<p>418.56(b) PLAN OF CARE All hospice care and services furnished to</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.</p> <p>Based on interview, clinical record review, and policy review, the hospice failed to ensure the individualized written care plan was followed for 2 of 4 records reviewed (#1 and #4).</p> <p>Findings</p> <p>1. The hospice policy titled "Staff Registered Nurse" with an effective date of 10/02/2000 stated, "Utilizes the nursing process to provide skilled care for a specific group of patients according to a written physician plan of care ... Specific task / duties: Implements the plan of care with actions that provide for patient / family participation in decision making, and to determine the need for special care."</p> <p>2. The hospice policy titled "Review of Plan of Treatment" with an effective date of 11/94 and reviewed dates of 3/05 and 11/08 stated, "Program staff reassesses the patient periodically during the course of care. A reassessment is the ongoing</p>	L 543	L 543- The QI Educator has in-serviced the nursing staff on 5/28/15 on following and updating "Individualized Written Care Plan" Policy. Employee B directly involved no longer works for Hospice Franciscan Communities. Supervisor of Clinical Services and the QI/Education Coordinator will develop an educational program to review the standards in relation to a comprehensive assessment and development of a collaborative plan of care; Patient and interdisciplinary group. Education of all nurses will be completed by 6/14/15. Nurses will comply with policy titled "Review of Plan of Treatment" on all patients. Starting June 4, 2015, 100% of active charts will be audited x 30 days or until compliance is greater or equal to 95%. Then 50% of active charts will be audited x 30 days until compliance is greater than or equal to 95%. Then 50% of active charts will be audited for 60 days until compliance is greater than or equal to 95%. Then 20% of active charts will be audited ongoing thereafter. Ongoing evaluation of nursing will be the responsibility	06/14/2015

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	<p>evaluation of the patient's condition and serves to 1. facilitate continuous data collection in order to make changes to the plan of care 2. reevaluate the need for continued services prior to recertification 3. evaluate and revise the plan of care when there is an unexpected change ... The reassessment of the patient and family is appropriate to the care services being provided and may include ... the patient's pain and other symptoms ... Each discipline assesses the patient according to practice standards and provides care as appropriate at every visit."</p> <p>3. Clinical record #1, with an established plan of care (POC) dated 6/25/12 and diagnosis of end stage lung cancer, failed to evidence the skilled nurse followed the written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician, the patient, and the primary caregiver in accordance with the patient's needs. The POC stated, "Skilled nursing: 2 -3 X wk [times per week] for 60 days and PRN [as needed] for status change and exacerbation of symptoms. Monitor health status, bowel status, hydration and nutrition, respiratory status, skin integrity, pain and symptom management and teach patient and family self care and safety measures." The medication,</p>		of Supervisor of Clinical Services and QI/Education Coordinator during supervised field visits. Any concerns will be addressed as they are identified.	

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	<p>Valium, was not ordered on the plan of care and was administered on 5/4/15 by Employee B, Registered Nurse (RN).</p> <p>A. A clinical document titled "Community Nursing Note" with a date of 4/9/14 and time of 10:15 - 10:55 AM completed by Employee B, RN, failed to show that the GI [gastrointestinal] system was assessed completely. The bowel sounds were not assessed.</p> <p>B. A clinical document titled "Community Nursing Note" with a date of 4/14/14 and time of 10:45 - 11:45 AM completed by Employee B, RN, failed to show a complete pain assessment occurred at the visit. The pain level of 2 was documented but the location of the pain and description of the pain was not documented.</p> <p>C. A clinical document titled "Community Nursing Note" with a date of 4/18/14 and time of 4:10 PM - 4:45 PM completed by Employee B, RN, failed to show that a complete assessment of the GI system occurred at this visit. The document failed to show that bowel sounds were assessed.</p> <p>D. A clinical document titled "Community Nursing Note" with a date of 4/21/14 and time of 9:20 AM - 10 AM</p>			

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	<p>failed to show that a complete gastrointestinal assessment was completed. This note was completed by Employee B, RN. The documentation showed that the patient had no bowel movement for more than 1 week. The physician had not been notified. The psychosocial and musculoskeletal part of the assessment had not been completed.</p> <p>E. A clinical document titled "Community Nursing Note" with a date of 4/24/14 and time of 2 PM - 2:40 PM completed by Employee B, RN, failed to show that a complete assessment of the GI system occurred at this visit. The document failed to show that bowel sounds were assessed.</p> <p>F. A clinical document titled "Community Nursing Note" with a date of 4/27/14 and time of 9:20 AM - 10 AM completed by Employee B, RN, failed to show that a complete assessment of the GI system occurred at this visit. The document failed to show the bowel sounds were assessed or when the last bowel movement occurred.</p> <p>G. A clinical document titled "Community Nursing Note" with a date of 5/1/15 and time of 9:50 AM - 10:35 AM completed by Employee B, RN, failed to show that a complete assessment</p>			

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	<p>of the GI system occurred at this visit. The document failed to show the last date of a bowel movement.</p> <p>H. A clinical document titled "Community Nursing Note" with a date of 5/2/15 and time of 11:05 AM - 11:45 AM completed by Employee B, RN, failed to show that a complete assessment of the GI system occurred at this visit. The document failed to show that bowel sounds were assessed. A pain assessment was not completed at this visit.</p> <p>I. A clinical document titled "Nursing addendum progress notes " with a date of 5/4/14 and time of 9:25 AM - 11 AM completed by Employee B, RN, failed to show that a pain assessment was completed. This visit note stated, "Gave 1/2 dose (Valium 15 mg [milligrams] due to concerns ... previous reactions [hallucinations, anger ... with ativan and haldol.]"</p> <p>J. A clinical document titled "Nursing addendum progress notes " with a date of 5/5/14 and time of 2 PM - 7:30 PM completed by Employee B, RN, failed to show that a pain assessment or any other physical assessment was completed.</p> <p>K. On 5/14/15 at 1:45 PM, the</p>			

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	<p>director of nursing indicated the clinical notes completed by Employee B, RN, were not complete and did not follow the policies of the hospice.</p> <p>4. Clinical record #4, with an established POC dated 4/14/15, failed to evidence the skilled nurse followed the written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician, the patient, and the primary caregiver in accordance with the patient's needs. The POC stated, "Skilled nursing 2 times a week for 60 days and PRN for status change and exacerbation of symptoms. Monitor health status, bowel status, hydration and nutrition, respiratory status, skin integrity, pain and symptom management and teach patient and family self care and safety measures."</p> <p>A. A clinical document titled "Community Nursing Note" with a date of 4/16/15 and time of 12:35 PM - 1:30 PM completed by Employee B, RN, failed to show a complete GI assessment had occurred. Bowel sounds were not assessed.</p> <p>B. A clinical document titled "Community Nursing Note" with a date of 4/20/15 and time of 3:05 PM - 3:55 PM completed by Employee B, RN,</p>			

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L 672 Bldg. 00	<p>failed to show a complete GI assessment had occurred. Bowel sounds were not documented.</p> <p>C. A clinical document titled "Community Nursing Note" with a date of 4/23/15 and time of 2:05 PM - 2:55 PM completed by Employee B, RN, failed to show a complete GI assessment had occurred. Bowel sounds were not documented.</p> <p>D. On 5/15/15 at 10:30 AM, the director of nursing and the quality assurance manager indicated the assessments were not complete for clinical record #4.</p> <p>418.104(a)(1) CONTENT Each patient's record must include the following: (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.</p>			

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	<p>Based on interview, clinical record review, and policy review, the hospice failed to ensure clinical records included complete updated comprehensive assessments and clinical notes for 2 of 4 records (1 and 4) reviewed.</p> <p>Findings</p> <p>1. The hospice policy titled "Staff Registered Nurse" with an effective date of 10/02/2000 stated, "Utilizes the nursing process to provide skilled care for a specific group of patients according to a written physician plan of care ... Specific task / duties: Implements the plan of care with actions that provide for patient / family participation in decision making, and to determine the need for special care."</p> <p>2. The hospice policy titled "Review of Plan of Treatment" with an effective date of 11/94 and reviewed date of 3/05 and 11/08 stated, "Program staff reassesses the patient periodically during the course of care. A reassessment is the ongoing evaluation of the patient's condition and serves to 1. facilitate continuous data collection in order to make changes to the plan of care 2. reevaluate the need for continued services prior to recertification 3. evaluate and revise the plan of care</p>	L 672	L 672- The QI Educator has inserviced the nursing staff on 5/28/15 on policy titled "Content and Format of Clinical Records". Employee Bdirectly involved no longer works for Hospice Franciscan Communties. Supervisor of Clinical Services and QI/Education Coordinator will develop an educational program to review the standards and policy titled "Content and Format of Clinical Records" to maintain a complete comprehensive updated assessment and accurate clinical record for every patient admitted to hospice services. Education of all nurses will be completed by 6/14/15 Nurses will comply with policy titled "Content and Format of Clinical Record" on all patients. Starting June 4, 2015, 100% of active charts will be audited x 30 days or until compliance is greater or equal to 95%.Then 50% of active charts will be audited x 30 days until compliance is greater than or equal to 95%.Then 50% of active charts will be audited for 60 days until compliance is greater than or equal to 95%.Then 20% of active charts will be audited ongoing thereafter. Ongoing evaluation of nursing will be the responsibility of Supervisor of Clinical Services and QI/EducationCoordinator during supervised field visits. Any concerns will be addressed as they are identified. L 672- The QI Educator has inserviced the nursing staff on 5/28/15 on policy	06/14/2015			

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	<p>when there is an unexpected change ... The reassessment of the patient and family is appropriate to the care services being provided and may include ... the patient's pain and other symptoms ... Each discipline assesses the patient according to practice standards and provides care as appropriate at every visit."</p> <p>3. The agency policy titled "Content and Format of Clinical Record" with a revision dated of 11/08 stated, "The program initiates and maintains a comprehensive and accurate clinical record for every patient admitted to hospice services ... B. information / documentation of the following ... patient / family / caregiver initial and ongoing comprehensive assessment ... regular pain assessments, interventions and outcomes ... clinical staff documentation is clear, concise, and includes the following 1. Services and treatments provided ... physicians orders and oversight activities."</p> <p>4. Clinical record #1, with an established plan of care (POC) dated 6/25/12 and diagnosis of end stage lung cancer, failed to evidence the skilled nurse followed the written plan of care established by the hospice interdisciplinary group in collaboration with the attending</p>		<p>titled " Review of Plan of Treatment". Employee B directly involved no longer works for Hospice Franciscan Communities. Nurses will comply with policy titled "Review of Plan of Treatment" on all patients. Supervisor of Clinical Services and QI/Education Coordinator will develop an educational program to review the standards and policy titled "Content and Format of Clinical Records"to maintain a complete comprehensive updated assessment and accurate clinical record for every patient admitted to hospice services. Education of all nurses will be completed by 6/14/15 Starting June 4, 2015, 100% of active charts will be audited x 30 days or until compliance is greater or equal to 95%. Then 50% of active charts will be audited x 30 days until compliance is greater than or equal to 95%. Then 50% of active charts will be audited for 60 days until compliance is greater than or equal to 95%. Then 20% of active charts will be audited ongoing thereafter. Ongoing evaluation of nursing will be the responsibility of Supervisor of Clinical Services and QI/Education Coordinator during supervised field visits. Any concerns will be addressed as they are identified.</p>	

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	<p>physician, the patient, and the primary caregiver in accordance with the patient's needs. The POC stated, "Skilled nursing: 2 -3 X wk [times per week] for 60 days and PRN [as needed] for status change and exacerbation of symptoms. Monitor health status, bowel status, hydration and nutrition, respiratory status, skin integrity, pain and symptom management and teach patient and family self care and safety measures." The medication, Valium, was not ordered on the plan of care and was administered on 5/4/15 by Employee B, Registered Nurse (RN).</p> <p>A. A clinical document titled "Community Nursing Note" with a date of 4/9/14 and time of 10:15 - 10:55 AM completed by Employee B, RN, failed to show that the GI [gastrointestinal] system was assessed completely. The bowel sounds were not assessed.</p> <p>B. A clinical document titled "Community Nursing Note" with a date of 4/14/14 and time of 10:45 - 11:45 AM completed by Employee B, RN, failed to show a complete pain assessment occurred at the visit. The pain level of 2 was documented but the location of the pain and description of the pain was not documented.</p> <p>C. A clinical document titled</p>			

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	<p>"Community Nursing Note" with a date of 4/18/14 and time of 4:10 PM - 4:45 PM completed by Employee B, RN, failed to show that a complete assessment of the GI system occurred at this visit. The document failed to show that bowel sounds were assessed.</p> <p>D. A clinical document titled "Community Nursing Note" with a date of 4/21/14 and time of 9:20 AM - 10 AM failed to show that a complete gastrointestinal assessment was completed. This note was completed by Employee B, RN. The documentation showed that the patient had no bowel movement for more than 1 week. The physician had not been notified. The psychosocial and musculoskeletal part of the assessment had not been completed.</p> <p>E. A clinical document titled "Community Nursing Note" with a date of 4/24/14 and time of 2 PM - 2:40 PM completed by Employee B, RN, failed to show that a complete assessment of the GI system occurred at this visit. The document failed to show that bowel sounds were assessed.</p> <p>F. A clinical document titled "Community Nursing Note" with a date of 4/27/14 and time of 9:20 AM - 10 AM completed by Employee B, RN, failed to</p>			

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	<p>show that a complete assessment of the GI system occurred at this visit. The document failed to show the bowel sounds were assessed or when the last bowel movement occurred.</p> <p>G. A clinical document titled "Community Nursing Note" with a date of 5/1/15 and time of 9:50 AM - 10:35 AM completed by Employee B, RN, failed to show that a complete assessment of the GI system occurred at this visit. The document failed to show the last date of a bowel movement.</p> <p>H. A clinical document titled "Community Nursing Note" with a date of 5/2/15 and time of 11:05 AM - 11:45 AM completed by Employee B, RN, failed to show that a complete assessment of the GI system occurred at this visit. The document failed to show that bowel sounds were assessed. A pain assessment was not completed at this visit.</p> <p>I. A clinical document titled "Nursing addendum progress notes " with a date of 5/4/14 and time of 9:25 AM - 11 AM completed by Employee B, RN, failed to show that a pain assessment was completed. This visit note stated, "Gave 1/2 dose (Valium 15 mg [milligrams] due to concerns ... previous reactions [hallucinations, anger ... with ativan and</p>			

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	<p>haldol.]"</p> <p>J. A clinical document titled "Nursing addendum progress notes " with a date of 5/5/14 and time of 2 PM - 7:30 PM completed by Employee B, RN, failed to show that a pain assessment or any other physical assessment was completed.</p> <p>K. On 5/14/15 at 1:45 PM, the director of nursing indicated the clinical notes completed by Employee B, RN, were not complete and did not follow the policies of the hospice.</p> <p>5. Clinical record #4, with an established POC dated 4/14/15, failed to evidence the skilled nurse followed the written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician, the patient, and the primary caregiver in accordance with the patient's needs. The POC stated, "Skilled nursing 2 times a week for 60 days and PRN for status change and exacerbation of symptoms. Monitor health status, bowel status, hydration and nutrition, respiratory status, skin integrity, pain and symptom management and teach patient and family self care and safety measures."</p> <p>A. A clinical document titled</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151532	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2015
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NAME OF PROVIDER OR SUPPLIER HOSPICE FRANCISCAN COMMUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
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	<p>"Community Nursing Note" with a date of 4/16/15 and time of 12:35 PM - 1:30 PM completed by Employee B, RN, failed to show a complete GI assessment had occurred. Bowel sounds were not assessed.</p> <p>B. A clinical document titled "Community Nursing Note" with a date of 4/20/15 and time of 3:05 PM - 3:55 PM completed by Employee B, RN, failed to show a complete GI assessment had occurred. Bowel sounds were not documented.</p> <p>C. A clinical document titled "Community Nursing Note" with a date of 4/23/15 and time of 2:05 PM - 2:55 PM completed by Employee B, RN, failed to show a complete GI assessment had occurred. Bowel sounds were not documented.</p> <p>D. On 5/15/15 at 10:30 AM, the director of nursing and the quality assurance manager indicated the assessments were not complete for clinical record #4.</p>			

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