

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/16/2012	
NAME OF PROVIDER OR SUPPLIER GRACE HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 5838 WEST BRICK RD, SUITE 106B SOUTH BEND, IN 46628			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0000	<p>This visit was for a initial state hospice licensure survey.</p> <p>Survey date: 3/14/12 - 3/16/12</p> <p>Facility #: 012733</p> <p>Medicaid vendor #:</p> <p>Surveyor: Ingrid Miller PHNS, RN Tonya Tucker PHNS, RN</p> <p>Skilled Unduplicated Census: 7</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 23, 2012</p>			S0000			

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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S0501	<p>418.52 PATIENTS' RIGHTS The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.</p> <p>Based on home visit observation, clinical record review, interview, and policy review, the hospice failed to ensure patient's medical record was protected and kept confidential for 1 of 2 home visit observed (patient #1) and the registered nurse protected the patient's right to privacy and dignity for 1 of 2 home visits observed (patient #5).</p> <p>Findings</p> <p>1. On 3/15/12 at 10 AM, a document from Clinical record #1, start of care 3/8/12, was found in the home record of patient #6. Patient #1 and #6 do not live at the same residence. The document from Clinical record #1 found in the home chart of patient #6 was titled "Grace Hospice Physician's orders" with a date of 3/12/12 and time 9:30 AM with Employee D Registered Nurse's (RN) signature on the verbal order and Employee F's, medical director, signature. This document stated, "Patient: [name of patient was written], MRN [medical record number], dx [diagnosis]: debility ... Medication / Treatment / Lab / Diagnostic Orders ... Lidoderm Patch 5 % apply 1 patch q [every] am [morning] and</p>	S0501	<p>S 0501 Beginning April 4, 2012, 100% of home records will be reviewed by the RN Case Manager every 2 weeks, for a period of 2 months, to ensure all documents are exclusive to the individual patient. After 2 months of consistent compliance, the agency will review 10% of all active client's home records, or at least 5 active client home records, whichever is greater, on a quarterly basis. These will be documented on a spreadsheet for compliance and kept with the home chart. See ATTACHMENT A.Beginning April 4, 2012, 100% of active office charts will be reviewed by the Administrator every 2 weeks, for a period of 2 months, to ensure compliance. After 2 months of consistent compliance, the agency will review 10% of all active records, or at least 5 active records, whichever is greater, on a quarterly basis. These will be documented on a spreadsheet for compliance and kept in the agencies QAPI binder. See ATTACHMENT B.Education was provided to all staff related to HIPPA, Patient Bill of Rights and Confidentiality on 3/22/12 and 3/27/12. See ATTACHMENT C.2. Education was provided to all staff by the Administrator related</p>	04/04/2012			

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	<p>remove q hs [bedtime] daily."</p> <p>A. On 3/15/12 at 10 AM, Employee E, home health aide, indicated the document from clinical record #1 should not have been in Clinical record #6's home record.</p> <p>B. Clinical record #1's record evidenced a document titled, "Patient Bill of Rights" and signed by the power of attorney for patient #1 with no date noted. This document stated, "The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The hospice agency must protect and promote the exercise of these rights and shall do the following: a. Provide the patient with a written notice of the patient right: Confidentiality of the clinical records maintained by the hospice agency."</p> <p>C. Clinical record #1 record evidenced a document titled, "Grace Hospice Consent to Treat" with the legal representative's signature dated 3/6/12. This document stated, "Patient Rights and Responsibilities ... I hereby acknowledge and/or written receipt of the agency policy and procedures for Hospice patient rights and responsibilities."</p>		<p>to patient's right to dignity and privacy on 3/29/12. See ATTACHMENT D.</p>				

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	<p>D. On 3/16/12 at 1:40 PM, Employee A, the administrator, and Employee D indicated the rights of patient #1 to confidentiality were not protected.</p> <p>2. Patient #5's home visit observation failed to evidence the patient's right to dignity and privacy were protected. On March 15, 2012, at 1:38 PM at a home visit observation, Employee D, RN, was observed to assess patient #5 in an assisted living facility in the patient's private room. The RN failed to shut the door of the room during this time. To assess the patient's buttocks area, the RN called for assist on a call light and a certified nursing assistant arrived to assist. The patient was transferred to bed with two people assisting. The RN removed the patient's pants to check the patency of a Foley catheter and the skin integrity in the peri area and buttocks area without covering the patient's private areas.</p> <p>A. On March 16, 2012, at 1:35 PM, Employees A and D indicated the rights of dignity and personal privacy of patient #5 were not protected.</p> <p>B. The agency policy titled "Patient Rights and Responsibilities" with no effective date stated, "Assure patient privacy and promote patients' security ...</p>						

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	protect and promote patient's rights."			

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S0505	<p>418.52(b)(1) EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON (1) The patient has the right: (i) To exercise his or her rights as a patient of the hospice; (ii) To have his or her property and person treated with respect; (iii) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and (iv) To not be subjected to discrimination or reprisal for exercising his or her rights.</p> <p>Based on clinical record review and interview, the hospice failed to ensure that 2 of 7 patients were provided with (Clinical record #1 and #4) the Indiana toll-free number for voicing complaints to the state department.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 3/8/12, evidenced a document titled "Consent to Treat" and signed by the patient's caregiver on 3/6/12. This document had the Michigan State Department of Health Department phone number instead of the Indiana Department of Health phone number. This document stated, "I hereby acknowledge that I may file a complaint or questions regarding services with the State. I understand that I may call the State Hotline phone number</p>	S0505	<p>S 0505 Grace Hospice of Indiana's Consent to Treat was corrected on 2/17/12 by the Regional Director of Operations, to include the correct Indiana State Hotline Number (SEE PAGE 1 OF THE ATTACHED CONSENT TO TREAT). All blank forms that were in the office were corrected by hand and the correction was sent to the printer on 2/17/12 for all future orders. There were 2 packets that were in the automobile of the RN Case Manager that were inadvertently missed. The RN Case Manager delivered the corrected p.1 of the Consent to Treat form for Patient #4 on 2/20/12. A Coordination of Communication form reflecting this was discovered, and accordingly updated with the patient on 2/20/12, was written as a late entry on 3/19/12 by the RN Case Manager (SEE ATTACHMENT K), and a corrected copy was put</p>	03/28/2012			

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	<p>7 days per week / hours per day at: Hotline toll-free number 1-800-882-6006 [Michigan Department of Health].</p> <p>2. Clinical record #4, SOC 2/28/12, evidenced a document titled "Consent to Treat" and signed by the patient's caregiver on 2/18/12. This document had the Michigan State Department of Health Department phone number instead of the Indiana Department of Health phone number. This document stated, "I hereby acknowledge that I may file a complaint or questions regarding services with the State. I understand that I may call the State Hotline phone number 7 days per week/24 Hours per day at: Hotline toll-free number 1-800-882-6006 [Michigan Department of Health]."</p> <p>3. The Indiana State Department of Health number is 1-800-227-6334.</p> <p>4. On 3/16/12 at 1:40 PM, Employees D and H, both Registered Nurses, indicated the Michigan Hotline number was used instead of the Indiana Hotline number in record #1 and #4.</p>		<p>in the office clinical record on 3/19/12. The corrected Consent to Treat for Patient #1 was scanned to the POA on 3/12/12 and a corrected copy was put in the office clinical record on 3/19/12. A late entry Coordination of Communication was filled out on 3/28/12 by the RN Case Manager reflecting that the corrected version was scanned to the POA and a copy was later placed in the office clinical record (SEE ATTACHMENT L).</p>				

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S0516	<p>418.52(c)(5) RIGHTS OF THE PATIENT [The patient has a right to the following:] (5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.</p> <p>Based on home visit observation, clinical record review, interview, and policy review, the hospice failed to ensure patient's medical record was protected and kept confidential for 1 of 2 home visit observed (patient #1).</p> <p>Findings</p> <p>1. On 3/15/12 at 10 AM, a document from Clinical record #1, start of care 3/8/12, was found in the home record of patient #6. Patient #1 and #6 do not live at the same residence. The document from Clinical record #1 found in the home chart of patient #6 was titled "Grace Hospice Physician's orders" with a date of 3/12/12 and time 9:30 AM with Employee D Registered Nurse's (RN) signature on the verbal order and Employee F's, medical director, signature. This document stated, "Patient: [name of patient was written], MRN [medical record number], dx [diagnosis]: debility ... Medication / Treatment / Lab / Diagnostic Orders ... Lidoderm Patch 5 % apply 1 patch q [every] am [morning] and</p>	S0516	S 0516 Beginning April 4, 2012, 100% of active office charts will be reviewed by the Administrator every 2 weeks, for a period of 2 months, to ensure compliance. After 2 months of consistent compliance, the agency will review 10% of all active records, or at least 5 active records, whichever is greater, on a quarterly basis. These will be documented on a spreadsheet for compliance and kept in the agencies QAPI binder. See ATTACHMENT B Education was provided to all staff related to HIPPA, Patient Bill of Rights and Confidentiality on 3/22/12 and 3/27/12. See ATTACHMENT C.	04/09/2012			

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	<p>remove q hs [bedtime] daily."</p> <p>2. On 3/15/12 at 10 AM, Employee E, home health aide, indicated the document from clinical record #1 should not have been in Clinical record #6's home record.</p> <p>3. Clinical record #1's record evidenced a document titled, "Patient Bill of Rights" and signed by the power of attorney for patient #1 with no date noted. This document stated, "The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The hospice agency must protect and promote the exercise of these rights and shall do the following: a. Provide the patient with a written notice of the patient right: Confidentiality of the clinical records maintained by the hospice agency."</p> <p>4. Clinical record #1 record evidenced a document titled, "Grace Hospice Consent to Treat" with the legal representative's signature dated 3/6/12. This document stated, "Patient Rights and Responsibilities ... I hereby acknowledge and/or written receipt of the agency policy and procedures for Hospice patient rights and responsibilities."</p> <p>5. On 3/16/12 at 1:40 PM, Employee A,</p>						

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	the administrator, and Employee D indicated the rights of patient #1 to confidentiality were not protected.			

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S0530	<p>418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:</p> <ul style="list-style-type: none"> (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. <p>Based on clinical record review, policy review, facility document review, and interview, the hospice failed to ensure an accurate drug profile for 1 of 7 patient records (File #5).</p> <p>Findings</p> <p>1. Clinical record #5, start of care 2/18/12 failed to ensure comprehensive assessment included an accurate medication profile for 1 of 7 records reviewed. On 3/15/12 at 12:45 PM, the facility medication administration record was requested at a home visit observation. This document titled "Settlers House Medication administration record" for the dates of 3/1/12 -- 3/31/12 stated, "Synthroid 112 mcg [micrograms] give 1</p>	S0530	S 0530 Beginning 4/9/12, medication reconciliation will occur at every visit by the hospice nurse for patients residing in a facility. The Facility Care Plan Coordination form will be utilized (SEE ATTACHMENT E). The hospice nurse will request a current copy of the facility medication administration record and compare that with Grace Hospice of Indiana's Hospice Medication Profile (SEE ATTACHMENT F) to ensure all written and verbal medication orders are transcribed correctly for the hospice patient. Any changes will be reflected on the Hospice Medication Profile and Facility Care Plan Coordination form. A copy of the facility care plan coordination form will be left with the facility for placement in the patient chart.	04/09/2012			

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	<p>tablet orally every morning start 2/28/12, furosemide 20 mg [milligrams] give 1 tab [tab]orally in the am [morning] for edema, and furosemide 20 mg take 1 tab po [by mouth] at noon if edema persists." These medications were signed by staff at the appropriate times each day between the dates of March 1st to March 15th.</p> <p>b. Clinical record #5 evidenced a document titled "Hospice Medication Profile" and signature of Employee D, Registered Nurse (RN), on 2//218/12, 2/24/12, and 3/2/12. This medication profile stated, "Levothyroxine 100 mcg [micrograms] po daily." No orders for furosemide were included on this document.</p> <p>c. On 3/15/12 at 1:45 PM, Employee D indicated the medication profile had not been updated as required by the agency policy below.</p> <p>2. The agency policy titled "Medication Orders" with no effective date stated, "To ensure all written and verbal medication orders are transcribed correctly for the patient. The agency will take steps to reduce the potential for error or misinterpretation when orders are written or verbally communicated."</p>						

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S0543	<p>418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.</p> <p>Based on clinical record review, interview, and policy review, the hospice failed to ensure 1 of 5 patients (patient #3) received the frequency of home health aide visits listed on the individualized written plan of care.</p> <p>Findings</p> <p>1. Clinical record #3, start of care 2/17/12, failed to evidence home health aide visits followed the individualized written plan of care. The clinical document titled "IDT Care Plan" with a certification period of 2/17/12 - 5/16/12 stated, "Visit orders: start 2/17/12 stop 2/29/12 3 X 13 [times in the 13 days]. Status: New."</p> <p>Aide visits were made on 2/24/12 and 2/28/12. No third visit was made in this time frame as required by the plan of care.</p> <p>2. On 3/14/12 at 3:30 PM, Employee J, Registered Nurse, indicated one HHA visit had been missed between 2/17/12</p>	S0543	S 0543 On 3/29/2012, the Administrator provided education on documentation, including correction of errors and missed visit documentation. ATTACHMENT D. The Administrator will run a visit order compliance report, obtained by the agencies EMR system, and all orders that are not in compliance will be rectified. As of 4/9/2012, the agency will save a copy of the weekly visit order compliance reports that have been pulled from the agencies EMR system. A copy of any orders that have been rectified as a result of the visit order compliance report will be filed behind the actual report.	04/09/2012			

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	<p>and 2/29/12.</p> <p>3. The agency policy titled "Interdisciplinary Group Plan of Care" with no effective date stated, "A comprehensive patient Interdisciplinary Plan of Care will be established and maintained for each individual admitted to the hospice program, and the care provided to the individual must be in accordance with the plan."</p>			

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NAME OF PROVIDER OR SUPPLIER GRACE HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 5838 WEST BRICK RD, SUITE 106B SOUTH BEND, IN 46628			
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S0557	<p>418.56(e)(4) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.</p> <p>Based on clinical record review, home visit observation, interview, and policy review, the hospice failed to ensure coordination of care ocured between hospice staff (Employee A) and facility staff of an assisted living facility in 1 of 1 home observations for skilled nurse services (patient #5).</p> <p>Findings</p> <p>1. On 3/15/12 at 1:45 PM, a certified nursing assistant (CNA) employed by an assisted living facility delivered care to Patient #5 with Employee D, Registered Nurse, from the hospice. The CNA assisted Employee D transfer the patient to bed. While transferring the patient, the CNA threw Patient #5's foley bag on the floor. Employee D did not educate this caregiver of Patient #5 on infection control or hospice philosophy.</p> <p>2. On 3/15/12 at 2:10 PM, the CNA of the assisted living facility indicated no</p>	S0557	<p>S 0557 For any facility wherein Grace Hospice patients reside, the facility employees will be given an orientation on the hospice philosophy by the Grace Hospice Administrator. This education will be completed with the applicable staff by 4/13/12 and a sign in sheet will be completed.</p> <p>See ATTACHMENT G.The Grace Hospice Administrator will conference with the facility Administrator regarding the infection control incident that ocured with the assisted living facility CNA on 3/15/12 by 4/13/12 This will be documented on the Facility Care Plan Coordination form. See ATTACHMENT E.The Grace Hospice Administrator will provide education to our agency's nursing staff on 3/29/12 in regards to the following:a. providing patient caregivers, including facility staff, with instructions regarding personal hygiene, universal precautions and infection control procedures relative to patient careb. what to do when a</p>	04/13/2012			

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	<p>hospice staff had ever discussed the hospice philosophy.</p> <p>3. On 3/16/12 at 11:35 PM, Employee A indicated no caregiver education or coordination of services had occurred with the Assisted Living CNA caring for Patient #5.</p> <p>4. The agency policy titled "Hospice Coordination of Services" with no effective date stated, "The hospice shall designate a RN to coordinate the implementation of the plan of care for each client. Agency staff will coordinate care to assure that patients receive appropriate care and that the actions and goals of interdisciplinary services are complementary and reflect cooperative care planning. The methods of communicating are appropriate to the needs and abilities of the patient, inclusive of all staff, or agencies providing care, relevant to care or services provided, timely ... ongoing communication with patients and caregivers will receive information to help achieve care or service goals."</p> <p>5. The agency policy titled "Infection Control Exposure Program" with no effective date stated, "The organization implements prevention and control processes throughout the organization ...</p>		caregiver is not ensuring infection control. how to appropriately document once education is conductedSee ATTACHMENT D.				

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	<p>The organization shall develop and implement polices and procedures in compliance with current applicable local public health, state, federal, accrediting bodies, and OSHA regulations ...</p> <p>Education 2. Patient caregivers will be provided with instructions regarding personal hygiene, universal precautions and infection control procedures involving care of the patient (i.e. handwashing, disinfection, etc.) by the nursing staff."</p> <p>6. The agency policy titled "Patient and Caregiver Education" stated, "To ensure the patient and/or caregivers obtain information regarding self/patient care, safety, pain management, infection control ... identified as a knowledge deficit ... the RN and other staff, as appropriate, will reevaluate the identified needs, educate patient and caregivers and document information appropriately. Identified education needs may include the following: basic health practices and safety ... infection prevention and control. The education process will be coordinated among the staff members who are providing care to the patient."</p>						

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S0579	<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.</p> <p>Based on home visit observation, clinical record review, policy review, and interview, the hospice agency failed to ensure 1 of 1 registered nurse (Employee D) who provided care followed infection control practices including educating patients and caregivers on Foley catheter bag care while providing direct patient care in 1 of 1 home visit observations (patient #5) with skilled nurse services.</p> <p>Findings</p> <p>1. On 3/15/12 at 1:45 PM, Employee D, a registered nurse (RN) was observed to perform an assessment to Patient #5 in his/her residence without ensuring or providing education to assisted living staff when standard infection control policies were not followed. On 3/15/12 at 1:48 PM, Employee D assessed Patient #5 in the patient's room. Before completing a skin assessment on the patient's buttocks area, the nurse called for assist. A certified nursing assistant (CNA) employed by the assisted living facility where the patient resided arrived and then</p>	S0579	S 0579 The Grace Hospice Administrator will conference with the facility Administrator regarding the infection control incident that occurred with the assisted living facility CNA on 3/15/12 by 4/13/12. This will be documented on the Facility Care Plan Coordination form. See ATTACHMENT E. The Grace Hospice Administrator will provide education to our agency's nursing staff on 3/29/12 in regards to the following: a. providing patient caregivers, including facility staff, with instructions regarding personal hygiene, universal precautions and infection control procedures relative to patient care b. what to do when a caregiver is not ensuring infection control c. how to appropriately document once education is conducted See ATTACHMENT D.	04/13/2012			

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	<p>proceeded to assist the nurse with transferring the patient to bed. Employee D and the CNA removed the patient's Foley catheter bag from the patient's storage bag under the seat of the wheelchair. [The Foley bag is used to collect urine from the patient's bladder.] The CNA threw the Foley bag and tubing onto the floor by the patient's bed. At this time the CNA and nurse transferred the patient into bed. At this time the CNA removed the patient's pants by lifting the catheter bag above the patient's bladder level and allowing urine to run back towards the pelvic area. The Foley bag was then attached to the bed frame by the hook on the bag. Then the patient was rolled over onto the left side and the nurse assessed the patient's buttocks area and applied a barrier cream. After finishing all these tasks, the nurse and CNA positioned the patient with pillows and covered him/her with a blanket. The nurse did not educate the CNA about the care required for the Foley to ensure infection control during or after this visit observed.</p> <p>A. The clinical document titled "Nursing assessment" with a date of 3/15/12 and time in of 1 PM and time out of 2:10 PM and signature of Employee D failed to evidence the nurse had provided teaching to the CNA.</p>						

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	<p>B. On 3/16/12 at 11:35 AM, the administrator indicated Employee D did not follow the infection control policy.</p> <p>2. The agency policy titled "Infection Control Exposure Program" with no effective date stated, "The organization implements prevention and control processes throughout the organization ... The organization shall develop and implement polices and procedures in compliance with current applicable local public health, state, federal, accrediting bodies, and OSHA regulations ... Education 2. Patient caregivers will be provided with instructions regarding personal hygiene, universal precautions and infection control procedures involving care of the patient (i.e. handwashing, disinfection, etc.) by the nursing staff."</p> <p>3. The agency policy titled "Patient and Caregiver Education" stated, "To ensure the patient and/or caregivers obtain information regarding self/patient care, safety, pain management, infection control ... identified as a knowledge deficit ... the RN and other staff, as appropriate, will reevaluate the identified needs, educate patient and caregivers and document information appropriately. Identified education needs may include the following: basic health practices and</p>						

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	safety ... infection prevention and control. The education process will be coordinated among the staff members who are providing care to the patient."			

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S0582	<p>418.60(c) EDUCATION The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.</p> <p>Based on home visit observation, clinical record review, policy review, and interview, the hospice agency failed to ensure 1 of 1 registered nurse (Employee D) who provided care followed infection control practices including educating patients and caregivers on Foley catheter bag care while providing direct patient care in 1 of 1 home visit observations (patient #5) with skilled nurse services.</p> <p>Findings</p> <p>1. On 3/15/12 at 1:45 PM, Employee D, a registered nurse (RN) was observed to perform an assessment to Patient #5 in his/her residence without ensuring or providing education to assisted living staff when standard infection control policies were not followed. On 3/15/12 at 1:48 PM, Employee D assessed Patient #5 in the patient's room. Before completing a skin assessment on the patient's buttocks area, the nurse called for assist. A certified nursing assistant (CNA) employed by the assisted living facility where the patient resided arrived and then</p>	S0582	<p>S 0582 The Grace Hospice Administrator will conference with the facility Administrator regarding the infection control incident that occurred with the assisted living facility CNA on 3/15/12 by 4/13/12. This will be documented on the Facility Care Plan Coordination form. See ATTACHMENT E. The Grace Hospice Administrator will provide education to our agencies nursing staff on 3/29/12 in regards to the following: a. providing patient caregivers, including facility staff, with instructions regarding personal hygiene, universal precautions and infection control procedures relative to patient care b. what to do when a caregiver is not ensuring infection control c. how to appropriately document once education is conducted See ATTACHMENT D.</p>	04/13/2012			

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	<p>proceeded to assist the nurse with transferring the patient to bed. Employee D and the CNA removed the patient's Foley catheter bag from the patient's storage bag under the seat of the wheelchair. [The Foley bag is used to collect urine from the patient's bladder.] The CNA threw the Foley bag and tubing onto the floor by the patient's bed. At this time the CNA and nurse transferred the patient into bed. At this time the CNA removed the patient's pants by lifting the catheter bag above the patient's bladder level and allowing urine to run back towards the pelvic area. The Foley bag was then attached to the bed frame by the hook on the bag. Then the patient was rolled over onto the left side and the nurse assessed the patient's buttocks area and applied a barrier cream. After finishing all these tasks, the nurse and CNA positioned the patient with pillows and covered him/her with a blanket. The nurse did not educate the CNA about the care required for the Foley to ensure infection control during or after this visit observed.</p> <p>A. The clinical document titled "Nursing assessment" with a date of 3/15/12 and time in of 1 PM and time out of 2:10 PM and signature of Employee D failed to evidence the nurse had provided teaching to the CNA.</p>			

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	<p>B. On 3/16/12 at 11:35 AM, the administrator indicated Employee D did not follow the infection control policy.</p> <p>2. The agency policy titled "Infection Control Exposure Program" with no effective date stated, "The organization implements prevention and control processes throughout the organization ... The organization shall develop and implement polices and procedures in compliance with current applicable local public health, state, federal, accrediting bodies, and OSHA regulations ... Education 2. Patient caregivers will be provided with instructions regarding personal hygiene, universal precautions and infection control procedures involving care of the patient (i.e. handwashing, disinfection, etc.) by the nursing staff."</p> <p>3. The agency policy titled "Patient and Caregiver Education" stated, "To ensure the patient and/or caregivers obtain information regarding self/patient care, safety, pain management, infection control ... identified as a knowledge deficit ... the RN and other staff, as appropriate, will reevaluate the identified needs, educate patient and caregivers and document information appropriately. Identified education needs may include the following: basic health practices and</p>						

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	safety ... infection prevention and control. The education process will be coordinated among the staff members who are providing care to the patient."			

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S0626	<p>418.76(g)(2) HOSPICE AIDE ASSIGNMENTS AND DUTIES</p> <p>(2) A hospice aide provides services that are:</p> <p>(i) Ordered by the interdisciplinary group.</p> <p>(ii) Included in the plan of care.</p> <p>(iii) Permitted to be performed under State law by such hospice aide.</p> <p>(iv) Consistent with the hospice aide training.</p> <p>Based on clinical record review, job description review, and interview, the hospice failed to ensure the hospice aide followed the aide care plan for 1 of 5 active records reviewed of patients with hospice aide services (Clinical record #6).</p> <p>Findings</p> <p>1. Clinical record #6, start of care 2/29/12, failed to evidence Employee E, Hospice Aide (HA) followed the aide assignment sheet as directed by the registered nurse (RN) on the hospice aide care plan and as required on the HA's job description.</p> <p>A. Employee E HHA signed the job description titled "Hospice Aide" on 2/14/12. This document was co-signed by Employee A, the administrator, and stated, "The Hospice Aide ... will follow the plan of care (instruction sheet) as instructed by Agency's health care professional."</p>	S0626	S 0626 Beginning April 9, 2012, the RN Case Manager will review the Hospice Aide notes for each patient receiving hospice aide services every 14 days to ensure compliance with the Hospice aide Plan of Care. The RN Case Manager will initial the bottom of each hospice aide note showing that it was compared with the hospice aide plan of care. If it is determined that an update is needed to the hospice aide plan of care, the RN Case Manager will fill out an updated hospice aide plan of care, and educate the assigned hospice aide to the new plan. The hospice aide will sign off on the updated plan of care. Beginning April 9, 2012, 100% of the Hospice Aide Plans of Care will be reviewed by the Administrator every 2 weeks, for a period of 2 months, to ensure compliance. After 2 months of consistent compliance, the agency will review 10% of all active Hospice Aide Plans of Care, or at least 5 active Hospice Aide Plans of Care, whichever is greater, on a quarterly basis. These will be documented on a spreadsheet for	04/09/2012			

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	<p>B. The clinical record document titled "Hospice Aide Care Plan" with a date of 2/29/12 and signed by Employee D, RN, stated, "Services provided this visit ... bed bath, shampoo, nail care, skin care, oral care, assist with transfer, reposition patient, emotional support/socialization, pericare, incontinence care, offer fluids, assist with feeding, and linen change."</p> <p>C. The clinical record document titled "Hospice Aide Daily visit note" signed by Employee E, HA, and the patient's caregiver on 3/2/12 stated the following were performed: "Bed Bath .. skin care, oral care, reposition patient, pericare, and incontinence check." The aide failed to perform the shampoo, nail care, assist with transfer, emotional support / socialization, offer fluids, and assist with feeding.</p> <p>D. The clinical record document titled "Hospice Aide Daily visit note" signed by Employee E and the patient's caregiver on 3/5/12 stated the following tasks were performed: "Bath .. nail care, skin care, oral care, reposition patient, pericare, and incontinence check." The aide failed to perform the shampoo, assist with transfer, emotional support / socialization, offer fluids, and assist with feeding.</p>		compliance. See ATTACHMENT J.				

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	<p>E. The clinical record document titled "Hospice Aide Daily visit note" signed by Employee E and the patient's caregiver on 3/8/12 stated, "Bath, nail care, skin care, oral care, reposition patient, emotional support / socialization, pericare, incontinence check and linen check." The aide failed to offer fluids and assist with fluids as required on the aide care plan.</p> <p>2. On 3/14/12 at 3:55 PM, Employee J, RN, indicated Employee E had not followed the aide care plan as required per signed job description below:</p> <p>3. The document titled "Hospice Aide" with a signature of Employee E on 2/14/12 and the administrator stated, "Will follow the aide care plan (instruction sheet) as instructed by the agency's health care professional."</p>						

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S0642	<p>418.78 VOLUNTEERS</p> <p>The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.</p> <p>Based on clinical record review, interview, and policy review, the hospice failed to ensure 1 of 1 patients (patient #5) requesting a volunteer had the service available.</p> <p>Findings</p> <p>1. Clinical record #5, start of care 2/8/12, evidenced a family request for volunteer services on 3/1/12. No volunteer visit was documented through 3/15/12. The clinical document titled "Volunteer Assessment / Assignment" signed by Employee A, the administrator / volunteer coordinator, on 3/1/12 stated, "Volunteer requested on to 3/1/12 ... [family member] stated [he/she] would like to try volunteer to sit with [his/her family member] when available."</p> <p>On 3/15/12 at 3:35 PM, the administrator indicated the hospice had no volunteer actively working in administrative or direct patient care at this time.</p>	S0642	S 0642 When no volunteer is available, staff from Grace Hospice will fill in until a volunteer can be found. Grace Hospice will not count those hours as volunteer hours or billable hours, but will record in the clinical record that the requested service was completed. The Agency will recruit and train volunteers as an ongoing basis. See ATTACHMENT M.	03/27/2012			

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NAME OF PROVIDER OR SUPPLIER GRACE HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 5838 WEST BRICK RD, SUITE 106B SOUTH BEND, IN 46628
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	2. The agency policy titled "Volunteer Services" with no effective date stated, "It is the policy of this agency to hire volunteers and to train volunteers prior to their assignment ... The agency will show retention."			

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S0644	<p>418.78(b) ROLE Volunteers must be used in day-to-day administrative and/or direct patient care roles.</p> <p>Based on clinical record review interview, and policy review, the hospice failed to ensure a volunteer was used in day-to-day administrative and / or direct patient care roles for 1 of 1 hospice with the potential to affect all of the patients of the hospice.</p> <p>Findings</p> <p>1. Clinical record #5, start of care 2/8/12, evidenced a family request for volunteer services on 3/1/12. No volunteer visit was documented through 3/15/12. The clinical document titled "Volunteer Assessment / Assignment" signed by Employee A, the administrator / volunteer coordinator, on 3/1/12 stated, "Volunteer requested on to 3/1/12 ... [family member] stated [he/she] would like to try volunteer to sit with [his/her family member] when available."</p> <p>On 3/15/12 at 3:35 PM, the administrator indicated the hospice had no volunteer actively working in administrative or direct patient care at this time.</p>	S0644	S 0644 When no volunteer is available, staff from Grace Hospice will fill in until a volunteer can be found. Grace Hospice will not count those hours as volunteer hours or billable hours, but will record in the clinical record that the requested service was completed. The Agency will recruit and train volunteers as an ongoing basis. See ATTACHMENT M.	03/27/2012

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	2. The agency policy titled "Volunteer Services" with no effective date stated, "It is the policy of this agency to hire volunteers and to train volunteers prior to their assignment ... The agency will show retention."			

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S0646	<p>418.78(d) COST SAVING The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following: (1) The identification of each position that is occupied by a volunteer. (2) The work time spent by volunteers occupying those positions. (3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section.</p> <p>Based on interview and review of policies, the hospice failed to ensure cost savings was achieved through the use of volunteers for 1 of 1 hospice.</p> <p>Findings</p> <p>1. On 3/15/12 at 3:35 PM the administrator indicated the hospice had no volunteer actively working in administrative or direct patient care at this time and no cost savings at this time.</p> <p>2. The agency policy titled "Volunteer Coordinator" with no effective date stated, "The volunteer coordinator provides supervision of the volunteers ... Supervise volunteer staff and intervade with all levels of management regarding volunteer activity, monitors and evaluates</p>	S0646	S 0646 Grace Hospice of Indiana will recruit and train volunteers on an ongoing basis. The Administrator will estimate the cost savings directly attributable to that of the administrative or direct patient care volunteer positions each month (SEE ATTACHMENT H). This amount will, at a minimum, equal 5 percent of the total patient care hours of all paid hospice employees and contract staff. Grace Hospice of Indiana will maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked. SEE ATTACHMENT I. These cost saving sheets will be completed by the Administator of Grace Hospice of Indiana and sent to the agencies Director of Volunteer Services on a monthly basis.	04/09/2012			

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S0647	<p>the effectiveness of volunteers performance."</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.</p> <p>Based on interview, the hospice failed to ensure volunteers were available to provide services to patients or for administrative services for 1 of 1 hospice.</p> <p>Findings</p> <p>On 3/15/12 at 3:35 PM, the administrator indicated the hospice had no volunteer actively working in administrative or direct patient care at this time.</p>	S0647	<p>S 0647 Grace Hospice of Indiana will recruit and train volunteers on an ongoing basis. The Administrator will estimate the cost savings directly attributable to that of the administrative or direct patient care volunteer positions each month (SEE ATTACHMENT H). This amount will, at a minimum, equal 5 percent of the total patient care hours of all paid hospice employees and contract staff. Grace Hospice of Indiana will maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked. See ATTACHMENT I. These cost saving sheets will be completed by the Administrator of Grace Hospice of Indiana and sent to the agencies Director of Volunteer Services on a monthly basis.</p>	04/09/2012

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S0650	<p>418.100(a) SERVING THE HOSPICE PATIENT AND FAMILY The hospice must provide hospice care that-</p> <p>(1) Optimizes comfort and dignity; and (2) Is consistent with patient and family needs and goals, with patient needs and goals as priority.</p> <p>Based on home visit observation, policy review, and interview, the hospice failed to ensure the patient's (#5) right to dignity was protected for 1 of 1 home visit with nursing services (Employee D) with the potential to affect all the patients of the hospice.</p> <p>Findings</p> <p>1. Patient #5's home visit observation failed to evidence the patient's right to dignity and privacy were protected. On March 15, 2012, at 1:38 PM at a home visit observation, Employee D, RN, was observed to assess patient #5 in an assisted living facility in the patient's private room. The RN failed to shut the door of the room during this time. To assess the patient's buttocks area, the RN called for assist on a call light and a certified nursing assistant arrived to assist. The patient was transferred to bed with two people assisting. The RN removed the patient's pants to check the patency of a Foley catheter and the skin</p>	S0650	S 0650 On 3/29/12, education was provided to all staff by the Administrator related to patient's right to dignity and privacy. Upon hire, all new staff will be educated as to the organizational policy related to patient's right to dignity and privacy titled Patient Privacy, Security, and Property (SEE ATTACHMENT D). Each new hire will sign a copy of the policy verifying understanding of company expectation. A signed copy of the policy will be kept in each new hire and current staff personnel file.	03/29/2012			

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	<p>integrity in the peri area and buttocks area without covering the patient's private areas.</p> <p>2. On March 16, 2012, at 1:35 PM, Employees A and D indicated the rights of dignity and personal privacy of patient #5 were not protected.</p> <p>3. The agency policy titled "Patient Rights and Responsibilities" with no effective date stated, "Assure patient privacy and promote patients' security ... protect and promote patient's rights."</p>			

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S9996	<p>IC 16-25-7 Disclosure Requirements</p> <p>Sec. 1. Each hospice program licensed or approved under this article shall prepare and update as necessary a disclosure document to be presented to each potential patient of the hospice program.</p> <p>Sec. 2. The disclosure document required under section 1 of this chapter must contain at least the following:</p> <p>(1) A description of all hospice services provided by the hospice program, including the</p> <p style="padding-left: 20px;">(A) types of nursing services;</p> <p style="padding-left: 20px;">(B) other service;</p> <p style="padding-left: 20px;">(C) specific services available during the progressive stages of the terminal illness and thereafter; and</p> <p style="padding-left: 20px;">(D) a statement that the extent of the hospice services and supplies are dispensed based on the hospice program patient's individual needs as determined by the interdisciplinary team.</p> <p>(2) An explanation of the hospice program's internal complaint resolution process.</p> <p>(3) A statement that the hospice program patient has the right to participate in the planning of the patient's care.</p> <p>(4) A statement that a hospice program patient may refuse any component of hospice services offered by the hospice program.</p> <p>(5) A statement that a hospice employee may provide supplies to a:</p> <p style="padding-left: 20px;">(A) hospice program patient; or</p> <p style="padding-left: 20px;">(B) hospice program patient's family;</p> <p>in addition to the supplies provided by the hospice program, but the employee may only be reimbursed for the supplies by providing a written receipt to the hospice program patient or the hospice program patient's family.</p> <p>(6) A statement that the hospice program</p>						

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	<p>patient may request the hospice program to provide, on a monthly basis, an itemized statement of services and supplies delivered to the patient, as submitted to the patient's payer</p> <p>(7) The toll free number established by the state department under IC 16-25-5-4 to receive complaints from hospice program patients and the family members of hospice program patients regarding the hospice program.</p> <p>Based on clinical record review, agency policy review, and interview, the hospice failed to ensure that 2 of 7 clinical records (Clinical record #1 and #4) had a disclosure document that included the Indiana Department of Health toll-free number to receive complaints.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 3/8/12, evidenced a document titled "Consent to Treat" and signed by the patient's caregiver on 3/6/12. This document had the Michigan State Department of Health Department phone number instead of the Indiana Department of Health phone number. This document stated, "I hereby acknowledge that I may file a complaint or questions regarding services with the State. I understand that I may call the State Hotline phone number 7 days per week / hours per day at: Hotline toll-free number 1-800-882-6006</p>	S9996	S 9996 Grace Hospice of Indiana's Consent to Treat was corrected on 2/17/12 by the Regional Director of Operations, to include the correct Indiana State Hotline Number (SEE PAGE 1 OF THE ATTACHED CONSENT TO TREAT). All blank forms that were in the office were corrected by hand and the correction was sent to the printer on 2/17/12 for all future orders. There were 2 packets that were in the automobile of the RN Case Manager that were inadvertently missed. The RN Case Manager delivered the corrected p.1 of the Consent to Treat form for Patient #4 on 2/20/12. A Coordination of Communication form reflecting this was discovered, and accordingly updated with the patient on 2/20/12, was written as a late entry on 3/19/12 by the RN Case Manager (SEE ATTACHMENT K), and a corrected copy was put in the office clinical record on 3/19/12. The corrected Consent to Treat for Patient #1 was scanned to the POA on 3/12/12	04/09/2012			

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	<p>[Michigan Department of Health].</p> <p>2. Clinical record #4, SOC 2/28/12, evidenced a document titled "Consent to Treat" and signed by the patient's caregiver on 2/18/12. This document had the Michigan State Department of Health Department phone number instead of the Indiana Department of Health phone number. This document stated, "I hereby acknowledge that I may file a complaint or questions regarding services with the State. I understand that I may call the State Hotline phone number 7 days per week/24 Hours per day at: Hotline toll-free number 1-800-882-6006 [Michigan Department of Health].</p> <p>3. The Indiana State Department of Health Hotline number is 1-800-227-6334.</p> <p>4. The agency policy titled "Patient Rights and Responsibilities" with no effective date stated, "This agency recognizes and supports patient rights and will provide patients with sufficient information regarding their responsibilities in the care process by informing each patient of his/her rights and responsibilities in both verbal and written form during the admission process in a language they can understand ... Employees will receive information</p>		and a corrected copy was put in the office clinical record on 3/19/12. A late entry Coordination of Communication was filled out on 3/28/12 by the RN Case Manager reflecting that the corrected version was faxed to the POA and a copy was later placed in the office clinical record (SEE ATTACHMENT L).				

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	<p>during orientation and the employee's role in promoting patient understanding and self-determination."</p> <p>5. On 3/16/12 at 1:40 PM, Employees D and H, both Registered Nurses indicated the Michigan Hotline number was used instead of the Indiana Hotline number for record #1 and #4.</p>			