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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151554 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/28/2015 |
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| NAME OF PROVIDER OR SUPPLIER COMMUNITY HOME HEALTH | STREET ADDRESS, CITY, STATE, ZIP CODE 9894 E 121ST ST FISHERS, IN 46037 |
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| L 0000 Bldg. 00 | <p>This was a Federal Hospice Recertification and State Hospice Relicensure and complaint survey.</p> <p>Survey Dates: August 21, 2015 to August 28, 2015</p> <p>Complaint number: IN00159144 - Substantiated. Federal and State deficiencies are cited. Unrelated Deficiencies also cited.</p> <p>Facility Number: 009501</p> <p>Medicaid Number: 200121620A</p> <p>Clinical Records Reviewed: 17 Home Visits: 4</p> <p>Census: 95</p> <p>Community Home Health and Hospice was found not to be in compliance with the Conditions of Participation 418.54: Initial and Comprehensive Assessment of Patient and Conditions of Participation 418.56: Interdisciplinary Group, Care Planning, and Coordination of Services.</p> | L 0000 | | |
| L 0520 | | | | |

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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| Bldg. 00 | <p>Based on record review and interview, the agency failed to ensure members of the Interdisciplinary Group completed a chaplain initial assessment and / or initial bereavement assessment within 5 calendar days after the election statement of hospice care for 16 of 17 clinical records reviewed (See L 523) and failed to ensure that the Interdisciplinary Group, (in collaboration with the individual's attending physician, if any), updated the comprehensive assessment at least every 15 days for 3 of 17 clinical records reviewed (See L 533).</p> <p>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.</p> | L 0520 | <p>1.Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>1.Provided MSW (9.23.2015) and Chaplain (9.22.2015) education regarding CoP requirements and agency policy for Chaplain and Medical Social Services initial assessment and initial bereavement assessment to be completed within 5 calendar days of the election of hospice care.</p> <p>2.Provided staff education regarding CoP requirements and agency policy regarding the plan of care review with the IDG team must be no less frequently than every 15 days with all changes made to the plan of care during that time including medication reconciliation and visit frequency..</p> <p>3.Initial Comprehensive Assessment and Plan of Care policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2015.</p> <p>4.Patient Case Conferences policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2015.</p> <p>5.Hospice Bereavement</p> | 09/25/2015 | |

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| | | | <p>Program policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015 and via hard copy at MSW team meeting on 9.23.2015.</p> <p>6.Social Work Assessment and Services policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015 and via hard copy at MSW team meeting on 9.23.2015.</p> <p>7.Spiritual Assessment and Services policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015 and via hard copy to be provided at team meeting on 9.30.2015.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>1.On 9.21.2015 hospice management reviewed all Chaplain and MSW forms, policies and work flows regarding the completion of the initial assessment and initial BV assessment within 5 calendar days after the election of hospice care.</p> <p>2.On 9.21.2015 hospice management reviewed all forms, policies and work flows regarding the plan of care review with the IDG team must be no less frequently than every 15 days with all changes made to the plan of care during that time including</p> | |

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| | | | <p>medication reconciliation and visit frequency..</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>1.All forms, policies and work flows regarding the Chaplains and MSW completion of the comprehensive assessment and the initial BV assessment were reviewed on 9.21.2015. Chaplain education occurred on 9.22.2015, MSW education occurred 9.23.2015. Information emailed to all staff on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2105.</p> <p>2.All forms, policies and work flows regarding the plan of care review with the IDG team must be no less frequently than every 15 days with all changes made to the plan of care during that time including medication reconciliation and visit frequency were reviewed on 9.21.2015. Information emailed to all staff on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2105.</p> <p>4 . Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality</p> | |

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| L 0523 Bldg. 00 | 418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT 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. Based on record review and interview, the agency failed to ensure members of the Interdisciplinary Group completed a | L 0523 | assurance program will be put into place. 1. Who is responsible Hospice leadership 2. The system by which the responsible person(s) will monitor Clinical record review will consist of a random sample of 10% of admissions gathered from the monthly admissions report. 3. Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Monthly monitoring beginning in November for October admissions 4. Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Monitoring will be for 12 months 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. 1. Provided MSW (9.23.2015) and Chaplain (9.22.2015) education regarding | 09/25/2015 | |

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| | <p>chaplain initial assessment and/or medical social service and/or initial bereavement assessment within 5 calendar days after the election statement of hospice care for 16 of 17 clinical records reviewed. (# 1 - 16)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, Election date of 07/23/15. Review of the medical social worker initial assessment indicated the licensed medical social worker failed to complete and document the initial bereavement evaluation section within 5 days of the skilled nurse initial assessment dated 07/23/15. 2. Clinical record #2, Election date of 01/26/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial assessment dated 01/26/15. 3. Clinical record #3, Election date of 08/09/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial | | <p>CoP requirements and agency policy for Chaplain and Medical Social Services initial assessment and initial bereavement assessment to be completed within 5 calendar days of the election of hospice care.</p> <ol style="list-style-type: none"> 2. Initial Comprehensive Assessment and Plan of Care policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2015. 3. Hospice Bereavement Program policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015 and via hard copy at MSW team meeting on 9.23.2015. 4. Social Work Assessment and Services policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015 and via hard copy at MSW team meeting on 9.23.2015. 5. Spiritual Assessment and Services policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015 and via hard copy to be provided at team meeting on 9.30.2015. <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <ol style="list-style-type: none"> 1. On 9.21.2015 hospice management reviewed all Chaplain and MSW forms, policies and work flows regarding the completion of the initial assessment and initial BV assessment within 5 calendar days after the election of hospice care <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> | |

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| | <p>assessment dated 08/09/15.</p> <p>4. Clinical record #4, Election date of 11/18/14. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial assessment dated 11/18/14.</p> <p>5. Clinical record #5, Election date of 05/29/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial assessment dated 05/29/15. Review of the communication notes, the chaplain did not attempt to make patient contact until day 5 (06/02/15) of the skilled nurse initial assessment. Review of the chaplain initial assessment dated 06/05/15, the chaplain did failed to complete and document the spiritual initial assessment within 5 days of the skilled nurse initial assessment.</p> <p>6. Clinical record #6, Election date of 09/29/14. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial</p> | | <p>1.All forms, policies and work flows regarding the Chaplains and MSW completion of the comprehensive assessment and the initial BV assessment were reviewed on 9.21.2015. Chaplain education occurred on 9.22.2015, MSW education occurred 9.23.2015. Information emailed to all staff on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2105.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>1. Who is responsible Hospice leadership</p> <p>2. The system by which the responsible person(s) will monitor Clinical record review will consist of a random sample of 10% of admissions gathered from the monthly admissions report.</p> <p>3. Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Monthly monitoring beginning in November for October admissions</p> <p>4. Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Monitoring will be for 12 months</p> | | |

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| | <p>bereavement assessment section within 5 days of the skilled nurse initial assessment dated 09/29/14.</p> <p>7. Clinical record #7, Election date of 08/13/14. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial assessment dated 08/13/14. Review of the chaplain initial assessment dated 08/19/14, indicated the chaplain failed to complete and document the spiritual initial assessment within 5 days of the skilled nurse initial assessment.</p> <p>8. Clinical record #8, Election date of 01/20/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial assessment dated 01/20/15.</p> <p>9. Clinical record #9, Election date of 03/09/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial</p> | | | |

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| | <p>assessment dated 03/09/15.</p> <p>10. Clinical record #10, Election date of 07/14/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial assessment dated 07/14/15.</p> <p>11. Clinical record #11, Election date of 05/12/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial assessment dated 05/12/15.</p> <p>12. Clinical record #12, Election date of 03/31/15. Review of the medical social worker initial evaluation indicated a licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial assessment dated 03/31/15.</p> <p>13. Clinical record #13, Election date of 01/29/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial</p> | | | |

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| | <p>bereavement assessment section within 5 days of the skilled nurse initial assessment dated 01/29/15.</p> <p>14. Clinical record #14, Election date of 05/21/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete the assessment within 5 days of the skilled nurse initial assessment dated 05/21/15. The social work also failed to complete the initial bereavement assessment section of the evaluation.</p> <p>15. Clinical record #15, Election date of 04/18/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial assessment dated 04/18/15.</p> <p>16. Clinical record #16, Election date of 02/10/15. Review of the medical social worker initial evaluation indicated the licensed medical social worker failed to complete and document the initial bereavement assessment section within 5 days of the skilled nurse initial assessment dated 02/10/15.</p> <p>17. The Director of Nursing, was interviewed on 08/24/15 at 11:15 AM.</p> | | | |

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| | <p>The Director of Nursing stated the social worker should have been doing the bereavement assessment upon admission. The Director of Nursing stated it was the expectation for social service to be completing the initial bereavement assessment section of the evaluation.</p> <p>18. The Director of Nursing was interviewed on 08/27/15 at 10:40 AM. The Director of Nursing stated the expectation was that the chaplain would do the initial assessment within the five day window or document otherwise.</p> <p>19. An updated policy titled Initial Comprehensive Assessment and Plan of Care dated 4/28/14, indicated " ... The assessment must be completed no later than 5 calendar days after the election of hospice care "</p> <p>20. An updated policy titled Hospice Bereavement Program dated 04/28/14, indicated " ... Bereavement care planning will begin on admission as part of the comprehensive assessment. It will identify risk factors for the grieving process and will be developed by the Hospice Interdisciplinary Group (IDG) with input from the patient, family, and attending physician when applicable "</p> <p>21. An updated policy titled Social Work</p> | | | |

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| L 0533 Bldg. 00 | <p>Assessment and Services dated 04/28/14, indicated " ... Will complete the social work comprehensive assessment within 5 days of election of hospice care ... Anticipatory grief issues and bereavement assessment for the patient and or guardian / family / significant other "</p> <p>22. An updated policy titled Spiritual Assessment and Services dated 04/28/14, indicated " ... Hospice chaplain will monitor referral notices each working day and assess the spiritual care needs of the patient and or guardian within 5 calendar days of the election of hospice care unless requested otherwise by patient / guardian or family "</p> <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</p> | | | |

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| | <p>than every 15 days.</p> <p>Based on record review and interview, the agency failed to ensure that the Interdisciplinary Group, (in collaboration with the individual's attending physician, if any), updated the comprehensive assessment at least every 15 days for 3 of 17 clinical records reviewed. (#5, 6 and 14)</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care (SOC) 05/29/15, included an initial comprehensive assessment with orders for Dobutamine (vasopressor - increase blood pressure) 1000 milligrams / 250 milliliters, (4,000 micrograms / milliliter), inject 2 - 20 micrograms / kilogram / minute into the vein continuously.</p> <p>a. On 08/25/15 at 12:30 PM, the patient was observed to have an infusion pump in a black pouch that was connected by a tubing going to the patient's arm. The patient stated that the medication infusing in his arm was Dobutamine.</p> <p>b. Review of the IDG plan of care updates on 07/21, 08/04, and 08/18. Each updated plans of cares indicated that the Dobutamin continuous infusion</p> | L 0533 | <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>1.Provided staff education regarding CoP requirements and agency policy regarding the plan of care review with the IDG team must be no less frequently than every 15 days with all changes made to the plan of care during that time including medication reconciliation and visit frequency..</p> <p>2.Initial Comprehensive Assessment and Plan of Care policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2015.</p> <p>3.Patient Case Conferences policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2015.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>1.On 9.21.2015 hospice management reviewed all forms, policies and work flows regarding the plan of care review with the</p> | 09/25/2015 | |

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| | <p>had been discontinued on 07/21/15.</p> <p>c. Review of the patient's physician orders indicated a physician office had discontinued the patient's Dobutamine medication on 07/21/15.</p> <p>d. An interview with the Director of Nursing, on 08/26/15 at 2:00 PM, stated that Employee A and the IDG should have recognized that the medication had been discontinued in error by the physician's office during IDG meetings. The medication section of the plan of care failed to be updated to include the Dobutamine infusion.</p> <p>2. Clinical record #6, Election date of 09/24/14, with an updated established plan of care dated 07/26/15, with orders for social services one time a month for three months with 12 prn (as needed) visits for psychosocial support. Review of the social worker visit notes, the social worker had been making weekly visits on 8/7, 8/14, and 8/21/15. The IDG met on 08/04 and on 08/18/15. The plan of care failed to be updated to reflect the increase in social service frequencies.</p> <p>3. Clinical record #14, Election date of 05/21/15, with orders for skilled nursing services two times a week for 14 weeks with 30 prn visits for pain and symptom</p> | | <p>IDG team must be no less frequently than every 15 days with all changes made to the plan of care during that time including medication reconciliation and visit frequency.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>1.All forms, policies and work flows regarding the plan of care review with the IDG team must be no less frequently than every 15 days with all changes made to the plan of care during that time including medication reconciliation and visit frequency were reviewed on 9.21.2015. Information emailed to all staff on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2105.</p> <p>4 . Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>1. Who is responsible Hospice leadership</p> <p>2. The system by which the responsible person(s) will monitor Clinical record review will consist of a random sample of 10% of admissions gathered from the</p> | | |

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| L 0536 Bldg. 00 | <p>management. Review of the skilled nursing visit notes evidenced that the skilled nurse made weekly visits on 05/26, 06/03, 06/10, 06/17, 06/23, 07/01, 08/08, and 08/15/15. The IDG met on 05/28, 6/11, 06/25, 07/09, 07/23, and 08/06/15. The plan of care failed to be updated to reflect the decrease in skilled nursing service frequencies.</p> <p>4. An updated policy titled Initial Comprehensive Assessment and Plan of Care dated 04/28/15, indicated " ... The plan of care must be reviewed with the interdisciplinary team no less frequently than every 15 days. The update must include information related to changes in the patient condition ... medications ... and reassessment to the response in care."</p> <p>5. An updated policy titled Patient Case Conferences dated 04/28/14, indicated " ... Subjects discussed in patient case conferences may include, but are not limited to ... frequency of home health care visits, patient prognosis "</p> <p>Based on interview and review of record review, the hospice failed to ensure the care provided to the patient followed the</p> | | | L 0536 | <p>monthly admissions report.</p> <p>3.Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc.</p> <p>Monthly monitoring beginning in November for October admissions</p> <p>4.Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped.</p> <p>Monitoring will be for 12 months</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>1.Provided RN education</p> | | 09/25/2015 |

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| | <p>written plan of care in 9 of 17 records reviewed (See L 543); failed to ensure all hospice care and services furnished to patients and their families followed an individualized written plan of care established by the hospice interdisciplinary group with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs in 15 of 17 clinical records reviewed (See L 547); and failed to ensure a intravenous medication was included on the medication profile for 3 of 17 records reviewed (See L 549).</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>regarding CoP requirements and agency policy regarding intravenous medication inclusion on the medication profile and infusion site care as ordered. Medication reconciliation completed.</p> <p>2. Provided staff education regarding CoP requirements and agency policy regarding documentation, visit frequency matching plan of care, appropriate use of PRN visits and reporting of missed visits.</p> <p>3. Provided staff education regarding CoP requirements and agency policy regarding all hospice care and services furnished to patients and their families follow an individualized written plan of care utilizing appropriate visit frequencies established by the hospice IDG with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs</p> <p>4. Initial Comprehensive Assessment and Plan of Care policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>5. Medication Reconciliation policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>6. Missed Visits policy</p> | | |

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| | | | <p>reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2015.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>1.On 9.21.2015 hospice management reviewed all forms, policies and work flows regarding intravenous medication inclusion on the medication profile and infusion site care as ordered.</p> <p>2.Medication reconciliation completed on all active patients.</p> <p>3.On 9.21.2015 hospice management reviewed all forms, policies and work flows regarding documentation, visit frequency matching plan of care, appropriate use of PRN visits and reporting of missed visits.</p> <p>4.On 9.21.2015 hospice management reviewed all forms, policies and work flows related to all hospice care and services furnished to patients and their families follow an individualized written plan of care utilizing appropriate visit frequencies established by the hospice IDG with the attending physician (if any), the patient or</p> | |

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| | | | <p>representative, and the primary caregiver in accordance with the patient's needs.</p> <p>3 . Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>1.All forms, policies and work flows regarding intravenous medication inclusion on the medication profile and infusion site care as ordered were reviewed on 9.21.2015. Information emailed to RNs on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>2.All forms, policies and work flows regarding documentation, visit frequency matching plan of care, appropriate use of PRN visits and reporting of missed visits were reviewed on 9.21.2015. Information emailed to all staff on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2105.</p> <p>3.All forms, policies and work flows regarding all hospice care and services furnished to patients and their families follow an individualized written plan of care utilizing appropriate visit frequencies established by the hospice IDG with the attending physician (if any), the patient or</p> | | |

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| | | | <p>representative, and the primary caregiver in accordance with the patient's needs were reviewed on 9.21.2015. Information emailed to all staff on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2105.</p> <p>4 . Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>1. Who is responsible Hospice leadership</p> <p>2. The system by which the responsible person(s) will monitor Clinical record review will consist of a random sample of 10% of admissions gathered from the monthly admissions report.</p> <p>3. Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Monthly monitoring beginning in November for October admissions</p> <p>4. Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Monitoring will be for 12 months</p> | |

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| L 0543 Bldg. 00 | <p>418.56(b) PLAN OF CARE</p> <p>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 interview and review of record review, the hospice failed to ensure the care provided to the patient followed the written plan of care in 9 of 17 records reviewed. (#1, 2, 5, 6, 12, 13, 14, 15 and 16)</p> <p>Findings include:</p> <p>1. Clinical record #1, Election date of 07/23/15, with an established plan of care for skilled nursing frequency two times a week for 14 weeks with 30 prn visits for pain and symptom management and social services one time a month for three months with 12 prn visits for emotional and psychosocial support.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse made two extra visits on week two and three extra visits during week four. Review of the updated plan of care dated 08/04 and 08/18, indicated that there were no changes in the care provided by the agency. The</p> | L 0543 | <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>1. Provided staff education regarding CoP requirements and agency policy regarding documentation, visit frequency matching plan of care, appropriate use of PRN visits and reporting of missed visits.</p> <p>2. Initial Comprehensive Assessment and Plan of Care policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2015.</p> <p>3. Missed Visits policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2015.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the</p> | 09/25/2015 | |

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| | <p>skilled nurse failed to follow the plan of care.</p> <p>b. Review of the social service visit notes, the social worker made an initial visit on week two, one extra visit on week three, and three extra visits on week four. Review of the updated plan of care dated 08/04 and 08/18, indicated that there were no changes in the care provided by the agency. The social worker failed to follow the plan of care.</p> <p>2. Clinical record #2, Election date of 01/26/15, with an established plan of care for skilled nursing frequency two times a week for 13 weeks with 30 prn visits for pain and symptom management and social services one time a month for three months with 12 prn visits for emotional and psychosocial support.</p> <p>a. Review of the updated plan of care dated 02/12, indicated skilled nursing visits five times a week for one week starting 2/9 to 2/13, one time a week for one week 2/14, then two times a week for 10 weeks starting 2/15 to 4/15 with 30 prn visits for pain and symptom management. Review of the skilled nursing visit notes evidenced four routine skilled nursing visits between 02/16 to 02/20. The skilled nurse failed to follow the plan of care.</p> | | <p>same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>1. On 9.21.2015 hospice management reviewed all forms, policies and work flows regarding documentation, visit frequency matching plan of care, appropriate use of PRN visits and reporting of missed visits.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>1. All forms, policies and work flows regarding documentation, visit frequency matching plan of care, appropriate use of PRN visits and reporting of missed visits were reviewed on 9.21.2015. Information emailed to all staff on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2105.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>1. Who is responsible Hospice leadership 2. The system by which the</p> | | |

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| | <p>b. Review of the updated plan of care dated 02/12, indicated home health aide to assist the patient with bathing and hygiene two times a week for 10 weeks starting the week of 02/15. The clinical record failed to evidence home health aide visit notes or documentation of missed visits the week of 02/15 to 02/21.</p> <p>c. Review of the updated plan of care dated 02/12 and 02/26, indicated social service visits one time a week for one week starting 02/09 to 02/13, then one visit monthly starting 02/14 to 04/25 for three months with 30 visits as needed for emotional and psychosocial support. The clinical record evidenced six routine social service visits between 02/08 to 02/14, one routine visit week four, five, seven, eight, nine; two visits on week 10 and 11; and one visit on week 12. The social worker failed to follow the plan of care.</p> <p>3. Clinical record #5, Election date of 05/29/15, with an established plan of care for home health aide two times a week for 14 weeks. Review of the home health aide visit notes evidenced that the home health aide did not start until 06/11/15. The home health aide failed to follow the plan of care.</p> | | <p>responsible person(s) will monitor Clinical record review will consist of a random sample of 10% of admissions gathered from the monthly admissions report.</p> <p>3.Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Monthly monitoring beginning in November for October admissions</p> <p>4.Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Monitoring will be for 12 months</p> | |

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| | <p>4. Clinical record #6, Election date of 09/24/14, with an established plan of care for skilled nursing one time a week for 13 weeks with 30 prn visits for pain and symptom management and social services one time a month for three months with 12 prn visits.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse had been making extra routine visits weekly on 8/7, 8/14, and 8/21/15. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the social worker visit notes, the social worker had been making weekly visits on 8/7, 8/14, and 8/21/15. The social worker failed to follow the plan of care.</p> <p>5. Clinical record #12, Election date of 03/31/15, with an established plan of care for chaplain services one time a month for three months with 12 prn visits for spiritual support. Review of the chaplain visit notes, the chaplain had been making bi-weekly visits on 04/09, 04/23, and 05/08, and 05/21/15. The chaplain failed to follow the plan of care.</p> <p>6. Clinical record #13, Election date of 01/29/15, included an initial comprehensive assessment and updates, titled "IDG Update" dated 07/14, 07/28,</p> | | | |

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| | <p>08/11/2015 with orders for chaplain services one time a month for two months with 12 prn visits for spiritual support.</p> <p>Review of the chaplain visit notes, the chaplain had been making bi-weekly visits on 07/03, 07/17, 07/31, and 08/14/15. The chaplain failed to follow the plan of care.</p> <p>7. Clinical record #14, Election date of 05/21/15, with orders for skilled nursing services two times a week for 14 weeks with 30 prn visits for pain and symptom management and chaplain services one time a month for three months with 12 prn visits for spiritual support.</p> <p>a. Review of the skilled nursing visit notes evidenced that the skilled nurse made weekly visits on 05/26, 06/03, 06/10, 06/17, 06/23, 07/01, 08/08, and 08/15/15. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the home health aide visit notes failed to evidence a second home health aide visit between 06/07/15 to 06/13/15.</p> <p>8. Clinical record #15, Election date of 04/18/15, which included an updated comprehensive assessment dated 07/07/15 to 08/17/15 with orders for</p> | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151554 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 08/28/2015 |
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| NAME OF PROVIDER OR SUPPLIER COMMUNITY HOME HEALTH | STREET ADDRESS, CITY, STATE, ZIP CODE 9894 E 121ST ST FISHERS, IN 46037 |
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| | <p>orders for skilled nursing two times a week for 14 weeks and 30 prn visits for pain and symptom management. Review of the skilled nursing visit notes failed to evidence a skilled nursing visit between 07/12/15 to 07/18/15.</p> <p>14. Clinical record #16, Election date of 02/10/15, which included an updated comprehensive assessment dated 05/21/15 to 07/29/15, with orders for skilled nursing one time a week for 14 weeks with 30 prn visits for pain and symptom management and home health aide services two times a week for 14 weeks.</p> <p>a. Review of the skilled nursing visit notes failed to evidence a skilled nursing visit between 05/21/15 to 05/23/15.</p> <p>b. Review of the home health aide visit notes failed to evidence a second home health visit between 05/21/15 to - 5/23/15 and two home health aide visits between 05/31/15 and 06/06/15.</p> <p>15. The Director of Nursing was interviewed on 08/24/15 at 11:30 AM. The Director of Nursing stated that the clinical staff should have been filling out missed visit notes and notifying the physician. The Director of Nursing also stated that the staff should be</p> | | | |

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| L 0547 Bldg. 00 | <p>documenting and updating the plan of care when there is a change in frequency.</p> <p>16. A policy titled Missed Visits dated 04/28/14, indicated " ... The agency shall appropriately document missed patient visits and inform the patient's physician of messed visits "</p> <p>17. A policy titled Initial Comprehensive Assessment and Plan of Care dated 04/28/14, indicated " ... 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 ... the scope and frequency of services necessary to meet the specific patient / guardian and family needs ... the update must include information related to changes in the patient condition "</p> <p>418.56(c)(2) 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:] (2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. Based on record review and interview, the hospice failed to ensure all hospice care and services furnished to patients</p> | L 0547 | <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>1. Provided staff education regarding CoP requirements and agency policy</p> | 09/25/2015 | | | |

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| | <p>and their families followed an individualized written plan of care established by the hospice interdisciplinary group with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs in 15 of 17 clinical records reviewed. (#1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15 and 16)</p> <p>Findings include:</p> <p>1. Clinical record #1, Election date of 07/23/15, with an established plan of care for skilled nursing two times a week for 14 weeks with 30 prn (as needed) visits for pain and symptom management; chaplain services one time a month for three months with 12 prn visits for spiritual support; and social services one time a month for three months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>2. Clinical record #2, Election date of 01/26/15, with an established updated plan of care dated 04/26/15 for chaplain services one time a month for three months with 12 prn visits for spiritual support and social services one time a month for three months with 12 prn visits</p> | | <p>regarding all hospice care and services furnished to patients and their families follow an individualized written plan of care utilizing appropriate visit frequencies established by the hospice IDG with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs</p> <p>2. Initial Comprehensive Assessment and Plan of Care policy reviewed 9.21.2015 and distributed to staff electronically on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2015.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>1. On 9.21.2015 hospice management reviewed all forms, policies and work flows related to all hospice care and services furnished to patients and their families follow an individualized written plan of care utilizing appropriate visit frequencies established by the hospice IDG with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs.</p> <p>☐</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>☐</p> <p>1. All forms, policies and work flows regarding all hospice care and services furnished to patients and their families follow an individualized written plan of care utilizing appropriate visit frequencies established by the hospice IDG with the attending physician (if any), the patient or representative, and the primary caregiver</p> | |

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| NAME OF PROVIDER OR SUPPLIER COMMUNITY HOME HEALTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 9894 E 121ST ST FISHERS, IN 46037 | | | |
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| | <p>for emotional and psychosocial support. The range of prn visits (1 - 12) is not detailed to support an individualized need.</p> <p>3. Clinical record #3, Election date of 08/09/15, with an established plan of care for skilled nursing two times a week for 13 weeks with 30 prn visits for pain and symptom management; chaplain services one time a month for three months with 12 prn visits for spiritual support; and social services one time a month for three months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>4. Clinical record #4, Election date of 11/13/14, with an established updated plan of care dated 07/07/15 with chaplain services one time a month for two months with 12 prn visits for spiritual support and social services one time a month for two months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12) is not detailed to support an individualized need.</p> <p>5. Clinical record #5, Election date of 05/29/15, with an established plan of care for skilled nursing two times a week for</p> | | <p>in accordance with the patient's needs were reviewed on 9.21.2015. Information emailed to all staff on 9.25.2015. Hard copy distributed to MSW on 9.23.2015 and to be provided to all other staff at team meeting on 9.30.2105.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>1. Who is responsible Hospice leadership</p> <p>2. The system by which the responsible person(s) will monitor Clinical record review will consist of a random sample of 10% of admissions gathered from the monthly admissions report.</p> <p>3. Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Monthly monitoring beginning in November for October admissions</p> <p>4. Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Monitoring will be for 12 months</p> | | | | |

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| | <p>14 weeks with 30 prn visits for pain and symptom management; home health aide services two times a week for 14 weeks; chaplain services one time a month for three months with 12 prn visits for spiritual support; and social services one time a month for three months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>6. Clinical record #6, Election date of 09/24/14, with an established updated plan of care dated 07/26/15 for skilled nursing two times a week for 8 weeks with 30 prn visits for pain and symptom management; home health aide services two times a week for 8 weeks; chaplain services one time a month for two months with 12 prn visits for spiritual support; and social services one time a month for two months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>7. Clinical record #7, Election date of 08/13/15, with an established plan of care for skilled nursing two times a week for 14 weeks with 30 prn visits for pain and symptom management; chaplain services one time a month for three months with</p> | | | |

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| | <p>12 prn visits for spiritual support; and social services one time a month for three month with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>8. Clinical record #8, Election date of 01/20/15, with an established updated plan of care dated 05/02/15 with chaplain services one time a month for two months with 12 prn visits for spiritual support and social services one time a month for two month with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12) is not detailed to support an individualized need.</p> <p>9. Clinical record #9, Election date of 03/09/15, with an established plan of care for skilled nursing two times a week for 13 weeks with 30 prn visits for pain and symptom management; home health aide services two times a week for 13 weeks; chaplain services one time a month for three months with 12 prn visits for spiritual support; and social services one time a month for three months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> | | | |

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| | <p>10. Clinical record #11, Election date of 05/12/15, with an established plan of care for skilled nursing two times a week for 14 weeks with 30 prn visits for pain and symptom management; home health aide services two times a week for 14 weeks; chaplain services one time a month for three months with 12 prn visits for spiritual support; and social services one time a month for three months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>11. Clinical record #12, Election date of 03/31/15, with an established plan of care for skilled nursing one time a week for 14 weeks with 30 prn visits for pain and symptom management; chaplain services one time a month for three months with 12 prn visits for spiritual support and social services one time a month for three months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>13. Clinical record #13, Election date of 01/29/15, with an established updated plan of care dated 07/28/15 for skilled nursing one time a week for nine weeks</p> | | | |

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|--------------------|--|---------------|---|----------------------|
| | <p>with 30 prn visits for pain and symptom management; home health aide services two times a week for nine weeks; chaplain services one time a month for two months with 12 prn visits for spiritual support and social services one time a month for three months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>14. Clinical record #14, Election date of 05/21/15, with an established plan of care for skilled nursing services two times a week for 14 weeks with 30 prn visits for pain and symptom management; home health aide services two times a week for 14 weeks; chaplain services one time a month for three months with 12 prn visits for spiritual support and social services one time a month for three months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>15. Clinical record #15, Election date of 04/18/15, with an established plan of care for skilled nursing two times a week for 14 weeks and 30 prn visits for pain and symptom management; home health aide services two times a week for 14 weeks; chaplain services one time a month for</p> | | | |

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| | <p>three months with 12 prn visits for spiritual support and social services one time a month for three months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>14. Clinical record #16, Election date of 02/10/15, which included an established updated plan of care dated 05/21/15, with orders for skilled nursing one time a week for 14 weeks with 30 prn visits for pain and symptom management and home health aide services two times a week for 14 weeks; chaplain services one time a month for three months with 12 prn visits for spiritual support and social services one time a month for three months with 12 prn visits for emotional and psychosocial support. The range of prn visits (1 - 12 and 1 - 30) is not detailed to support an individualized need.</p> <p>15. The Director of Nursing was interviewed on 08/26/15 at 9:55 AM. The Director of Nursing had stated the reason for the large amount of prn visits was so the patient / caregivers would have more of a say in their care and more visits could be provided upon the patient / caregiver request.</p> | | | |

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| L 0549 Bldg. 00 | <p>16. An policy titled Initial Comprehensive Assessment and Plan of Care dated 04/28/14, indicated " ... Hospice must conduct and document in writing a patient specific comprehensive assessment that identifies the patient needs for hospice care and services "</p> <p>418.56(c)(4) 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:] (4) Drugs and treatment necessary to meet the needs of the patient. Based on observation, record review, and interview, the agency failed to ensure a intravenous medication was included on the medication profile for 3 of 17 records reviewed. (# 5, 9, and 12)</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care (SOC) 05/29/15, included an initial comprehensive assessment and updates dated 07/21/15, 08/04/15, and 08/18/15. Each updated plans of cares indicated that the Dobutamine (vasopressor - increase blood pressure) continuous infusion had been discontinued on</p> | L 0549 | <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>1. Provided RN education regarding CoP requirements and agency policy regarding intravenous medication inclusion on the medication profile and infusion site care as ordered. Medication reconciliation completed.</p> <p>2. Initial Comprehensive Assessment and Plan of Care policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>3. Medication Reconciliation policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the</p> | 09/25/2015 |
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| | <p>07/21/15. The updated plan of care also indicated for the PICC (peripherally inserted central catheter) line dressing to be changed weekly.</p> <p>a. On 08/25/15 at 12:30 PM, the patient was observed to have an infusion pump in a black pouch that was connected by a tubing going to the patient's arm. The patient stated that the medication infusing in his arm was Dobutamine.</p> <p>b. Review of the patient's physician orders in the clinical record, a physician office had discontinued the patient's Dobutamine medication.</p> <p>c. Review of skilled nursing notes during week 5 (06/22 and 06/24), week 8 (07/14 and 07/18), and week 9 (07/20 and 07/22), failed to evidence that a skilled nurse provide PICC line dressing changes between 06/17/15 to 07/02/15 and between 07/11/15 to 07/30/15.</p> <p>2. An interview with the Director of Nursing, on 08/26/15 at 2:00 PM, stated that Employee A and the IDG should have recognized that the medication had been discontinued by error during IDG meetings.</p> <p>3. A policy titled Initial Comprehensive</p> | | <p>deficient practice for any client the facility identified as being affected.</p> <p>1.On 9.21.2015 hospice management reviewed all forms, policies and work flows regarding intravenous medication inclusion on the medication profile and infusion site care as ordered.</p> <p>2.Medication reconciliation completed on all active patients.</p> <p><input type="checkbox"/></p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p><input type="checkbox"/></p> <p>1.All forms, policies and work flows regarding intravenous medication inclusion on the medication profile were reviewed and infusion site care as ordered on 9.21.2015. Information emailed to RNs on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p><input type="checkbox"/></p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>1.Who is responsible Hospice leadership</p> <p>2.The system by which the responsible person(s) will monitor Clinical record review will consist of a random sample of 10% of admissions gathered from the monthly admissions report.</p> <p>3.Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Monthly monitoring beginning in November for October admissions</p> <p>4.Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need</p> | | | | |

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| NAME OF PROVIDER OR SUPPLIER COMMUNITY HOME HEALTH | STREET ADDRESS, CITY, STATE, ZIP CODE 9894 E 121ST ST FISHERS, IN 46037 |
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| (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 |
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| L 0591 Bldg. 00 | <p>Assessment and Plan of Care dated 04/28/15, indicated " ... 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 ... Drugs and treatment necessary to meet the needs of the patient "</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> <p>Based on record review and interview, the agency failed to ensure the Registered Nurse met the nursing needs of the patient and family in relation to assessing and documenting wound care for 2 of 17 clinical records reviewed. (#9 and 12)</p> <p>Findings include:</p> <p>1. Clinical record #9, Election date of 03/09/15, with an established plan of care for skilled nursing two times a week for 13 weeks. An initial skilled nursing assessment dated 03/09/15 indicated the patient had a pressure wound to the</p> | L 0591 | <p>for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Monitoring will be for 12 months</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>1. Provided RN education regarding CoP requirements and agency policy regarding intravenous medication inclusion on the medication profile and infusion site care as ordered. Medication reconciliation completed.</p> <p>2. Initial Comprehensive Assessment and Plan of Care policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>3. Medication Reconciliation policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected</p> | 09/25/2015 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151554 | | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 08/28/2015 | |
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| | <p>buttocks but the skilled nurse was not able to assess the wound. The clinical record failed to evidence a reason for the inability to assess the wound and failed to attempt to reassess the wound on the next skilled nursing visit dated 03/11/15. The patient died on 03/13/15.</p> <p>2. Clinical record #12, Election date of 03/31/15, with an established plan of care for skilled nursing two times a week for 14 weeks. A skilled nursing note dated 04/22/15, indicated the patient had a unstageable necrotic pressure area to the right heel.</p> <p>a. A physician's order dated 04/22/15, indicated for wound treatments to be done as follows: "Cleanse area with NS [normal saline], pat dry. Apply idosorb to wound bed, cover with secondary dressing, change daily and prn (as needed) for soilage ... "</p> <p>b. Skilled nursing visit notes dated 04/22, indicated treatment plan "New orders implemented." On 04/29, skilled nursing note indicated "wound care provided." On 05/06, 05/14, and 05/20, the skilled nursing note indicated "wound care provided ... treatment per physician orders." The skilled nurse failed to evidence the type of wound treatment that was provided for wound care.</p> | | <p>by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>1.On 9.21.2015 hospice management reviewed all forms, policies and work flows regarding intravenous medication inclusion on the medication profile and infusion site care as ordered.</p> <p>2.Medication reconciliation completed on all active patients.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>1.All forms, policies and work flows regarding intravenous medication inclusion on the medication profile were reviewed and infusion site care as ordered on 9.21.2015. Information emailed to RNs on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>1.Who is responsible Hospice leadership</p> <p>2.The system by which the responsible person(s) will monitor Clinical record review will consist of a random sample of 10% of admissions gathered from the monthly admissions report.</p> <p>3.Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Monthly monitoring beginning in November for October admissions</p> <p>4.Monitoring should be on-going. If</p> | | | | |

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| L 0671 Bldg. 00 | <p>4. The Director of Nursing was interviewed on 08/26/15 at 4:15 PM. The Director of Nursing stated that the nurse should be documenting the type of treatment provided in the nursing visit notes.</p> <p>5. An updated policy titled Nursing Services dated 04/28/14, indicated " ... Hospice provides nursing services, as appropriate, and according to acceptable standards of practice in compliance with Federal, State, and local laws and regulations ... The duties of the registered nurse include the following: Initial and ongoing assessments of the patient's nursing needs ... documents patient's clinical and progress notes "</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 observation, record review, and interview, the agency failed to ensure a intravenous medication was included on</p> | | | L 0671 | <p>you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Monitoring will be for 12 months</p> <p>1.Describe what the facility did to correct the deficient practice for each client cited in the deficiency. 1.Provided RN education regarding CoP requirements and agency policy</p> | | 09/25/2015 |

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| | <p>the medication profile for 3 of 17 records reviewed. (# 5, 9, and 12)</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care (SOC) 05/29/15, included an initial comprehensive assessment and updates dated 07/21/15, 08/04/15, and 08/18/15. Each updated plans of cares indicated that the Dobutamine (vasopressor - increase blood pressure) continuous infusion had been discontinued on 07/21/15. The updated plan of care also indicated for the PICC (peripherally inserted central catheter) line dressing to be changed weekly.</p> <p>a. On 08/25/15 at 12:30 PM, the patient was observed to have an infusion pump in a black pouch that was connected by a tubing going to the patient's arm. The patient stated that the medication infusing in his arm was Dobutamine.</p> <p>b. Review of the patient's physician orders in the clinical record, a physician office had discontinued the patient's Dobutamine medication. The clinical record failed to provide accurate information of the patient's active medications.</p> | | <p>regarding intravenous medication inclusion on the medication profile and infusion site care as ordered. Medication reconciliation completed.</p> <p>2.Initial Comprehensive Assessment and Plan of Care policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>3.Medications Reconciliation policy reviewed 9.21.2015 and distributed it to staff electronically on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>1.On 9.21.2015 hospice management reviewed all forms, policies and work flows regarding intravenous medication inclusion on the medication profile and infusion site care as ordered.</p> <p>2.Medications reconciliation completed on all active patients.</p> <p>☐</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>☐</p> <p>1.All forms, policies and work flows regarding intravenous medication inclusion on the medication profile were reviewed and infusion site care as ordered on 9.21.2015. Information emailed to RNs on 9.25.2015. Hard copy to be provided to RNs at team meeting on 9.30.2015.</p> <p>☐</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality</p> | |

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| | <p>c. Review of skilled nursing notes during week 5 (06/22 and 06/24), week 8 (07/14 and 07/18), and week 9 (07/20 and 07/22), failed to evidence that a skilled nurse documented PICC line dressing changes between 06/17/15 to 07/02/15 and between 07/11/15 to 07/30/15.</p> <p>2. An interview with the Director of Nursing, on 08/26/15 at 2:00 PM, stated that Employee A and the IDG should have recognized that the medication had been discontinued by error during IDG meetings.</p> <p>3. A policy titled Initial Comprehensive Assessment and Plan of Care dated 04/28/15, indicated " ... 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 ... Drugs and treatment necessary to meet the needs of the patient "</p> | | <p>assurance program will be put into place.</p> <p>1. Who is responsible Hospice leadership</p> <p>2. The system by which the responsible person(s) will monitor Clinical record review will consist of a random sample of 10% of admissions gathered from the monthly admissions report.</p> <p>3. Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Monthly monitoring beginning in November for October admissions</p> <p>4. Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Monitoring will be for 12 months</p> | | |