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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 10/07/2015 |
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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 follow up federal and state hospice recertification and relicensure survey.</p> <p>Survey dates: October 7, 2015</p> <p>Facility Number: 009501</p> <p>Medicaid Number: 200121620A</p> <p>Clinical Records Reviewed: 8</p> <p>Census: 102</p> <p>Community Home Health was found to be out of compliance with the Condition of Participation 418.64: Core Services.</p> | L 0000 | <p>Community Home Health leadership, in conjunction with Community Health Network leadership, determined that a change in our patient documentation was necessary. Therefore, please be advised that as of 11/4/2015 hospice moved to paper documentation and will remain on paper until the electronic system is rebuilt.</p> | |
| L 0533 Bldg. 00 | <p>418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT</p> <p>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</p> | | | |

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

TITLE

(X6) DATE

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

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| | <p>changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>Based on record review and interview, the 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 2 of 8 clinical records reviewed. (#20 and 22)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #20, Election date of 10/01/15, was reviewed on 10/07/15. The initial comprehensive assessment 10/01/15, indicated the patient had a wound to the sacrum. The IDG met on 10/06/15. The plan of care indicated "Wound care site - Sacrum. Process - Blank. Supplies - Blank. Frequency - Blank. The plan of care failed to be updated to include treatment, supplies, and frequency of wound treatment. 2. Clinical record #22, Election date of 08/30/14, was reviewed on 10/07/15. <ol style="list-style-type: none"> a. A physician order dated 09/16/15 was typed by Employee T. The order | L 0533 | <p>L0533 Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Corrections made to documentation moving forward for all clients cited. Effective 10/27/2015 a standing component of every 15 day IDG includes a discussion of if the patient has current or new wounds. Patients identified with wounds undergo an IDG discussion of the wound treatments, supplies, orders, frequency of wound treatment, patient's response to treatment and progress towards outcomes. If treatment includes the use of topical ointments the medication profile is reviewed concurrently while discussed to ensure topical ointment is listed. If heel protectors are part of the treatment order they are listed within the durable medical equipment. On 10/21/2015 all nursing staff received re-education regarding the wound ostomy and incontinence nurse who can only make recommendations. It is the nurse's responsibility to discuss with MD recommendations made</p> | 11/09/2015 |

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| | <p>indicated for bilateral heel protectors while in bed.</p> <p>b. A physician order dated 09/17/15 was typed by Employee T. The order indicated for menthol-zinc oxide to be applied topically three times daily.</p> <p>c. A Case Communication dated 09/21/15 by Employee U, a WOCN (Wound Ostomy Continence Nurse), indicated "Allevyn [type of dressing] every 5 days to heels ... No debridement needed unless wounds appear to be infected."</p> <p>d. A skilled nursing visit note dated 10/01/15, indicated the patient has a 2.5 centimeter fissure over the coccyx.</p> <p>e. The IDG met on 10/06/15. The plan of care failed to be updated to include the fissure over the coccyx and failed to include the progress toward desired outcome and the reassessment of the patient's response to current care / treatment being provided to the heels.</p> <p>3. The Administrator was interviewed on 10/7/15 at 2:40 PM. The Administrator had indicated the staff communicated with each other but there was no documentation of the communication.</p> | | <p>and record new orders received. This will be monitored through routine auditing as indicated below. Leadership re-evaluated the following policies: <i>Initial Comprehensive Assessment and Plan of Care, Patient Case Conferences and Nursing Services</i>. On 10/28/2015 these policies were taken to the team meeting for re-review with nursing staff. 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. Leadership reviewed 100% of all current hospice patient charts with wounds. Corrections made to documentation moving forward include: Effective 10/27/2015 a standing component of every 15 day IDG includes a discussion of if the patient has current or new wounds. Patients identified with wounds undergo an IDG discussion of the wound treatments, supplies, orders, frequency of wound treatment, patient's response to treatment and progress towards outcomes. If treatment includes the use of topical ointments the medication profile is reviewed concurrently while discussed to ensure topical ointment is listed. If heel protectors are part of the treatment order they are listed</p> | | | | |

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| | <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 ... 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 ... patient prognosis "</p> <p>6. 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: Initiates the plan of care developed with the Interdisciplinary Team and initiate revisions as indicated Informs physicians and appropriate staff and interdisciplinary team members of changes in patient conditions and needs "</p> | | <p>within the durable medical equipment. On 10/21/2015 all nursing staff received re-education regarding the wound ostomy and incontinence nurse who can only make recommendations. It is the nurse's responsibility to discuss with MD recommendations made and record new orders received. This will monitored through routine auditing as indicated below. Leadership re-evaluated the following policies: <i>Initial Comprehensive Assessment and Plan of Care, Patient Case Conferences and Nursing Services</i>. On 10/28/2015 these policies were taken to the team meeting for re-review with nursing staff. 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. Corrective actions taken to ensure the deficient practice does not reoccur included the following: Effective 10/27/2015 the content of IDG changed to include in depth discussion of wounds and their treatment plans. Patients identified with wounds undergo an IDG discussion of the wound treatments, supplies, orders, frequency of wound treatment, patient's response to treatment and progress towards outcomes. If treatment includes</p> | | | | |

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| | | | <p>the use of topical ointments the medication profile is concurrently reviewed while discussed to ensure topical ointment is listed. If heel protectors are part of the treatment order they are listed within the durable medical equipment. This process is applicable to both the hospice electronic documentation and paper documentation processes. Leadership re-evaluated the following policies: <i>Initial Comprehensive Assessment and Plan of Care, Patient Case Conferences and Nursing Services</i>. On 10/28/2015 these policies were taken to the team meeting for re-review with nursing staff. 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. Monitoring should include: Who is responsible? Administrator or qualified designee The system by which the responsible person(s) will monitor Hospice manager will conduct a post IDG content review of all patients with wounds to ensure wounds were appropriately addressed timely but no later than the next IDG. Results of review will be communicated to the administrator with corrective actions initiated by administrator if necessary. Frequency of monitoring. If "random"</p> | |

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| L 0549 | 418.56(c)(4) | | <p>monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Weekly IDG review of all patients discussed during that meeting. 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 of all wound patients will be ongoing for a period of 6 months or until compliance is achieved for a 3 month period. After compliance is achieved, monitoring will reduce to 50% of all wound patients for 12 months. If an issue with compliance is identified in that 12 month period, monitoring will return to 100% of wound patients until compliance is achieved for 3 consecutive months. At that time the monitoring would be reduced once again to 50%. The facility will continue to report to the advisory committee which reports to the Community Health Network Outcomes and Performance Committee (NOPC). The NOPC is a subcommittee of the Community Health Network board of directors. The board of directors will be updated through that committee as indicated.</p> | |

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| Bldg. 00 | <p>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.</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 plan of care to include treatments necessary to meet the needs of the patients for 3 of 8 clinical records reviewed. (#20, 22, and 23)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #20, Election date of 10/01/15, was reviewed on 10/07/15. The initial comprehensive assessment 10/01/15, indicated the patient had a wound to the sacrum. The IDG met on 10/06/15. The plan of care indicated "Wound care site - Sacrum. Process - Blank. Supplies - Blank. Frequency - Blank. The plan of care failed to be updated to include treatment, supplies, and frequency of wound treatment. Clinical record #22, Election date of 08/30/14, was reviewed on 10/07/15. <ol style="list-style-type: none"> A physician order dated 09/16/15 was typed by Employee T. The order | L 0549 | <p>L0549 Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Corrections made to documentation moving forward for each client cited. Effective 10/27/2015 a standing component of every 15 day IDG includes a discussion of if the patient has current or new wounds. Patients identified with wounds undergo an IDG discussion of the wound treatments, supplies, orders, frequency of wound treatment, patient's response to treatment and progress towards outcomes. If treatment includes the use of topical ointments the medication profile is reviewed concurrently while discussed to ensure topical ointment is listed. If heel protectors are part of the treatment order they are listed within the durable medical equipment. On 10/21/2015 all nursing staff received re-education regarding the wound ostomy and incontinence nurse who can only make recommendations. It is the nurse's responsibility to discuss with MD recommendations made and record new orders received. This will monitored through</p> | 11/09/2015 | | | |

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| | <p>indicated for bilateral heel protectors while in bed.</p> <p>b. A physician order dated 09/17/15 was typed by Employee T. The order indicated for menthol-zinc oxide to be applied topically three times daily.</p> <p>c. A Case Communication dated 09/21/15 by Employee T, A WOCN (Wound Ostomy Continence Nurse), indicated "Allevyn every 5 days to heels ... No debridement needed unless wounds appear to be infected."</p> <p>d. A skilled nursing visit note dated 10/01/15, indicated the patient has a 2.5 centimeter fissure over the coccyx.</p> <p>e. The IDG met on 10/06/15. The plan of care failed to be updated to include the treatment of the newly identified fissure over the coccyx and failed to include the progress toward desired outcome and the reassessment of the patient's response to current care / treatment being provided to the heels. The medication profile failed to include location of the menthol-zinc oxide to be applied.</p> <p>3. The Clinical Director and Administer was interviewed on 10/07/15 at 2:40 PM, and was in agreement that the Registered</p> | | <p>routine auditing. Leadership re-evaluated the following policy: <i>Initial Comprehensive Assessment and Plan of Care</i>. On 10/28/2015 this policy was taken to the team meeting for re-review with nursing staff.</p> <p>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. The corrective actions taken for each client that could be affected are the same as above and include the following: Effective 10/27/2015 a standing component of every 15 day IDG includes a discussion of if the patient has current or new wounds. Patients identified with wounds undergo an IDG discussion of the wound treatments, supplies, orders, frequency of wound treatment, patient's response to treatment and progress towards outcomes. If treatment includes the use of topical ointments the medication profile is reviewed concurrently while discussed to ensure topical ointment is listed. If heel protectors are part of the treatment order they are listed within the durable medical equipment. On 10/21/2015 all nursing staff received re-education regarding the wound ostomy and incontinence nurse</p> | | |

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| | <p>Nurses should have included the treatments in the plan of care.</p> <p>4. 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 treatments necessary to meet the needs of the patient "</p> | | <p>who can only make recommendations. It is the nurse's responsibility to discuss with MD recommendations made and record new orders received. This will monitored through routine auditing. Leadership re-evaluated the following policy:<i>Initial Comprehensive Assessment and Plan of Care</i>. On 10/28/2015 this policy was taken to the team meeting for re-review with nursing staff.</p> <p>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. The systemic changes the facility made followed the same steps as above and included the following: Effective 10/27/2015 the content of IDG changed to include in depth discussion of wounds and the treatment plans. Patients identified with wounds undergo an IDG discussion of the wound treatments, supplies, orders, frequency of wound treatment, patient's response to treatment and progress towards outcomes. If treatment includes the use of topical ointments the medication profile is concurrently reviewed while discussed to ensure topical ointment is listed. If heel protectors are part of the treatment order they are listed within the durable medical</p> | | |

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| | | | <p>equipment. This process is applicable to both the hospice electronic documentation and paper documentation processes. Leadership re-evaluated the following policy: <i>Initial Comprehensive Assessment and Plan of Care</i>. On 10/28/2015 this policy was taken to the team meeting for re-review with nursing staff. 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. Who is responsible? Administrator or qualified designee The system by which the responsible person(s) will monitor: Hospice manager will conduct a post IDG content review of all patients with wounds to ensure wounds were appropriately addressed timely but no later than the next IDG. Results of review will be communicated to the administrator with corrective actions initiated by administrator if necessary. Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Weekly IDG review as listed above. Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring,</p> | |

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| L 0587 Bldg. 00 | Based on record review and interview, the agency failed to ensure Registered Nurses met the nursing needs of the patient in relation to assessing and documenting wound care for 3 out of 13 clinical records reviewed of patients who reside in a facility with wounds. | L 0587 | <p>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 of all wound patients will be ongoing for a period of 6 months or until compliance is achieved for a 3 month period. After compliance is achieved, monitoring will reduce to 50% of all wound patients for 12 months. If during that 12 month period issues arise with compliance, the audits will increase to 100% until compliance is achieved for 3 months. At that time the audits would be reduced to 50% for 12 months. The facility will continue to report to the advisory committee which reports to the Community Health Network Outcomes and Performance Committee (NOPC). The NOPC is a subcommittee of the Community Health Network board of directors. The board of directors will be updated through that committee as indicated.</p> <p>See corrective action on L0591</p> | 11/09/2015 |

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| L 0591 Bldg. 00 | <p>The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance the Condition of Participation 418.64: Core Services.</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 3 out of 13 clinical records reviewed of patients who reside in a facility with wounds. (#20, 22 and 23)</p> <p>Findings include:</p> <p>1. The clinical record of patient #20, Election date of 10/01/15, was reviewed on 10/07/15.</p> <p>a. The initial comprehensive assessment dated 10/01/15, performed by Employee R, a Registered Nurse,</p> | L 0591 | L0591 Describe what the facility did to correct the deficient practice for each client cited in the deficiency. For each patient cited, the facility took the following steps for correction: On 10/7/2015 the entire hospice team was supplied with a copy of the State Operations Manual, Appendix M for re-education. Effective 10/8/2015 the hospice director returned to the field to provide care to patients and complete dual visits with nursing staff. The administrator temporarily assumed day to day operations. Beginning 10/8/2015 records for all current patients (including all clients cited) with wounds were reviewed to assess compliance with topical medications listed on the profile, orders contained all the required | 11/09/2015 |

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| | <p>indicated the patient had a wound to the sacrum but was unable to assess. The Registered Nurse failed to include reason for the inability to assess the wound.</p> <p>b. Employee S, a Registered Nurse, made a nursing visit on 10/02/15. The Registered Nurse failed to include a skin / wound assessment of the sacrum.</p> <p>c. The IDG met on 10/06/15. The plan of care indicated "Wound care site - Sacrum. Employee S made a nursing visit on 10/06/15. The Registered Nurse failed to include a wound assessment of the sacrum.</p> <p>2. The clinical record of patient #22, Election date of 08/30/14, was reviewed on 10/07/15.</p> <p>a. A physician order dated 09/16/15 was typed by Employee T. The order indicated for bilateral heel protectors while in bed.</p> <p>b. A physician order dated 09/17/15 was typed by Employee T. The order indicated for menthol-zinc oxide to be applied topically three times daily.</p> <p>c. A Case Communication dated 09/21/15 by Employee T, a WOCN (Wound Ostomy Continence Nurse),</p> | | <p>wound components, wounds were assessed, measured and documented at least weekly, and coordination of care demonstrated with facility staff. Beginning 10/8/2015 one on one staff education started with the director, risk management and/or wound, ostomy and incontinence nurse as opportunities for improved documentation were identified. Beginning 10/8/2015 elearning modules for wound care were assigned to nurses for completion. See Exhibit 1. Beginning 10/8/2015 nursing dual visits were conducted with RN case manager and the wound, ostomy, and incontinence nurse as opportunities for improved documentation were identified. During weekly team meetings on 10/14,10/21 and 10/28 all nursing staff received education related to wound care orders, wound assessments and wound documentation. Training material attached. See Exhibit 2,3,4. Leadership re-evaluated the <i>Nursing Services</i> policy. On 10/28/2015 the <i>Nursing Services</i> policy was taken to the team meeting and nurses re-educated.</p> <p>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. The facility reviewed all</p> | | |

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| | <p>indicated "Allevyn [type of dressing] every 5 days to heels ... No debridement needed unless wounds appear to be infected."</p> <p>d. A nursing visit was made by Employee T on 10/01/15. The visit note indicated the patient had a 2.5 centimeter fissure over the coccyx as reported by the skilled nursing facility nurse. Further review of the nursing notes revealed the skilled nursing facility Medical Director changed the coccyx dressing on 09/24/15. The last documented assessment of the coccyx wound by a hospice nurse was performed on 07/31/15, by Employee T. The clinical note failed to include assessment of the patient's coccyx, heels and patient response to the menthol-zinc oxide.</p> <p>3. The clinical record of patient #23, Election date of 04/24/15, was reviewed on 10/07/15.</p> <p>a. A physician's order dated 09/04/15 was typed by Employee S. The order indicated, "SN [skilled nurse] to perform and / or teach patient / caregiver wound care as follows: cleanse area on coccyx with NS [normal saline], pat dry. Apply Calmoseptine to edges of open area then apply hydrogel fluffed gauze and cover with mediflex daily and prn [as needed]</p> | | <p>of the patients who could be affected by taking the same steps as above which included the following: On 10/7/2015 the entire hospice team was supplied with a copy of the State Operations Manual, Appendix M for re-education. Effective 10/8/2015 the hospice director returned to the field to provide care to patients and complete dual visits with nursing staff. The administrator temporarily assumed day to day operations. Beginning 10/8/2015 records for all current patients (starting with all clients cited) with wounds were reviewed to assess compliance with topical medications listed on the profile, orders contained all the required wound components, wounds were assessed, measured and documented at least weekly, and coordination of care demonstrated with facility staff. Concurrent chart audits with corrective actions identified and acted upon. Beginning 10/8/2015 one on one staff education started with the director, risk management and/or wound, ostomy and incontinence nurse as opportunities for improved documentation were identified. Beginning 10/8/2015 elearning modules for wound care were assigned to nurses for completion. See Exhibit 1. Beginning 10/8/2015 nursing dual visits were conducted with RN case manager and the wound, ostomy, and incontinence nurse</p> | | | | |

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| | <p>for soilage "</p> <p>b. A nursing visit was made by Employee S on 09/25/15. The visit note indicated the patient had a stage II pressure ulcer that measured 2 x 2 x .10 (length x width x depth) centimeters on the coccyx. The nursing visit note failed to include if treatment was performed to the wound site and if current treatment was effective to the wound site.</p> <p>c. A nursing visit was made by Employee S on 10/01/15. The visit note indicated the patient had a stage I pressure ulcer that measured 1 x 1 x 0.10 (length x width x depth) centimeters on the coccyx. The nursing visit note failed to include if treatment was performed to the wound site.</p> <p>4. Employee T was interviewed on 10/07/15 at 2:15 PM. Employee T stated she was not able to assess patient #22's wound due to a large tumor around the vaginal area that was causing the patient pain. Employee T stated the patient would refuse for her to assess. Employee T stated she would speak with the facility staff nurse and stated she should have included the coordination in her visit notes. Employee T stated that it was hard to coordinate with the home health aide due to the patient's refusal of the aide and</p> | | <p>as opportunities for improved documentation were identified. During weekly team meetings on 10/14,10/21 and 10/28 all nursing staff received education related to wound careorders, wound assessments and wound documentation. Training material attached. See Exhibit 2,3,4. Leadership re-evaluated the <i>Nursing Services</i> policy. On 10/28/2015 the <i>Nursing Services</i> policy was taken to the team meeting and nurses re-educated. Describe the steps or systemic changes the facility has made or will make to ensure that he deficient practice does not recur, including any in-services, but this also should include any system changes you made. The same corrective action steps listed above also apply to how the facility will ensure that the deficient practice does not reoccur and includes the following: On 10/7/2015 the entire hospice team was supplied with a copy of the State Operations Manual, Appendix M for re-education. Effective 10/8/2015 the hospice director returned to the field to provide care to patients and complete dual visits with nursing staff. The administrator temporarily assumed day to day operations. Beginning 10/8/2015 records for all current patients with wounds were reviewed to assess compliance with topical</p> | | |

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| | <p>also stated that sometimes the facility was not cooperative with arrangements for her to assess the patient.</p> <p>5. The Clinical Director and Administer was interviewed on 10/07/15 at 2:40 PM. The Clinical Director stated that patient #23 did not have documentation of the hospice nurse providing treatment. The Clinical Director stated it was the expectation for the hospice nurse to look at the wounds at least once a week. The Clinical Director and the Administrator stated that as part of their plan of correction dated for 09/25/15, the staff was educated on wound assessments and documentation on 09/23/15.</p> <p>6. 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 Provides services in accordance with agency policies and procedures and physician orders "</p> | | <p>medications listed on the profile, orders contain all the required wound components, wounds were assessed, measured and documented at least weekly, and coordination of care is demonstrated with facility staff. Concurrent chart audits with corrective actions identified and acted upon. Beginning 10/8/2015 one on one staff education started with the director, risk management and/or wound, ostomy and incontinence nurse as opportunities for improved documentation were identified. Beginning 10/8/2015 elearning modules for wound care were assigned to nurses for completion. See Exhibit 1. Beginning 10/8/2015 nursing dual visits were conducted with RN case manager and the wound, ostomy, and incontinence nurse as opportunities for improved documentation were identified. During weekly team meetings on 10/14,10/21 and 10/28 all nursing staff received education related to wound care orders, wound assessments and wound documentation. Training material attached. See Exhibit 2,3,4. Leadership re-evaluated the <i>Nursing Services</i> policy. On 10/28/2015 the <i>Nursing Services</i> policy was taken to the team meeting and nurses re-educated. 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>assurance program will be put into place. Who is responsible? Administrator or qualified designee The system by which the responsible person(s) will monitor Director, risk management and quality assurance will continue to perform chart audits on all patients with wounds to assess compliance with topical medications listed on the profile, wound care orders contain required components, wounds are assessed, measured and documented at least weekly, and coordination of care demonstrated with facility staff. Corrective actions identified due to documentation and care will be acted upon. Corrective actions follow the disciplinary process up to and including termination.</p> <p>Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. Director, risk management and quality assurance will continue to perform chart audits on all the patients with wounds to assess compliance with topical medications listed on the profile, wound care orders contain required components, wounds are assessed, measured and documented at least weekly, and coordination of care demonstrated with facility staff. Monitoring will continue for 6 months or when compliance has</p> | |

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| L 0671 Bldg. 00 | <p>418.104 CLINICAL RECORDS</p> <p>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.</p> <p>Based on record review and interview, the agency failed to ensure initial bereavement assessments were contained in the electronic medical record.</p> <p>Findings include:</p> <p>1. A plan of correction that was provided to the Indiana State Department of Health indicated the plan of correction for initial</p> | L 0671 | <p>been maintained for 3 consecutive months. Monitoring will continue for an additional 6 months post compliance with 50% of all wound patients. Monitoring will then continue in the quarterly chart review by hospice leadership and quality assurance for 12 months. The facility will continue to report to the advisory committee which reports to the Community Health Network Outcomes and Performance Committee (NOPC). The NOPC is a subcommittee of the Community Health Network board of directors. The board of directors will be updated through that committee as indicated.</p> <p>L0671 Describe what the facility did to correct the deficient practice for each client cited in the deficiency The agency took the following steps for those clients cited: On 10/5/2015, 2 days prior to the survey, our facility recognized that the bereavement form was no longer visible on the electronic form although it was being completed. A Help Desk ticket</p> | 11/09/2015 | |

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| | <p>bereavement assessments was completed by 09/25/15.</p> <p>2. Clinical record #18, Election date of 10/02/15. Review of the medical social worker initial evaluation dated 10/06/15, indicated the initial bereavement assessment section of the visit note was not completed.</p> <p>3. Clinical record #19, Election date of 09/30/15. Review of the medical social worker initial evaluation dated 09/30/15, indicated the initial bereavement assessment section of the visit note was not completed.</p> <p>4. Clinical record #20, Election date of 10/01/15. Review of the medical social worker initial evaluation dated 10/02/15, indicated the initial bereavement assessment section of the visit note was not completed.</p> <p>5. After entering the agency on 10/07/15 @ 11:30 AM, the Administrator stated upon the conducting chart audits on Monday, October 5, 2015, it was identified that the initial bereavement assessments were not being saved in the patients electronic clinical records after the social worker entered the data. The Administrator stated that no chart audits had been conducted prior to the 09/25/15</p> | | <p>was submitted to our IT department immediately. On that same day, the Social Workers were instructed by the administrator to begin documenting, in narrative form, an abbreviated Bereavement Anticipatory Grief assessment as a separate contact or an addendum until the issue was resolved. On 10/6/2015, the IT group installed the fix to allow content to display correctly within the Bereavement Anticipatory Grief form. On 10/7/2015, the Clinical Analyst created a report which searched for contacts that the smartdata element CHN#3139 (the SDE from the bereavement assessment form) was used from 9/23-10/5. Results indicated the form was used 44 different times for 42 different patients. At that time the report could not display the results only the fact someone did make a selection within the form. On 10/8/2015, the administrator verified with social workers the updated was received by each of them and the form correctly displayed the information recorded. There was one social worker whose computer did not receive the update. A help desk ticket was created on 10/8/2015 and issue was resolved on 10/9/2015. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what</p> | | |

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| | plan of correction date. The agency provided a Service Desk work order ticket for the computer system breakdown. The agency failed to ensure that the electronic clinical record contained the specific initial bereavement assessments by the plan of correction date. | | actions the facility took to correct the deficient practice for any client the facility identified as being affected. The agency took the same steps for all patients who could be affected. On 10/5/2015, the Social workers were instructed by the administrator to document in narrative format an abbreviated Bereavement Anticipatory Grief assessment as a separate contact or an addendum until the issue was resolved. On 10/6/2015, the IT group installed the fix to allow content to display correctly within the Bereavement Anticipatory Grief form. On 10/7/2015, the Clinical Analyst created a report which searched for contacts that the smartdata element CHN#3139 (the SDE from the bereavement assessment form) was used from 9/23-10/5. Results indicated the form was used 44 different times for 42 different patients. At that time the report could not display the results only the fact someone did make a selection within the form. On 10/8/2015, the administrator verified with social workers the update was received by each of them and the form correctly displayed the information recorded. There was one social worker whose computer did not receive the update. A help desk ticket was created on 10/8/2015 and issue was resolved on 10/9/2015. Describe the steps or systemic | | |

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| | | | <p>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. Systematic changes included reviewing processes for the electronic medical record and a conversion to paper documentation through the following steps: On 10/6/2015, the IT group installed he fix to allow content to display correctly within the Bereavement Anticipatory Grief form. Process Update: Electronic Documentation until paper conversion on 11/4/2015. The Clinical Analyst notifies the business relationship manager of content contained in system updates that affects end user functionality. The business relationship manager notifies hospice staff via email of up-coming changes and date of implementation The business relationship manager validates with the operational areas affected by the system update that the updates were received and working as anticipated During team meetings on 10/14/2015,10/21/2015, and 10/28/2015 staff were educated verbally if changes are identified that were not previously communicated to them to call help desk to notify of issue. Process Update: Conversion to Paper Documentation effective</p> | |

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| | | | 11/4/2015. On 10/23/2015, due to hospice specific electronic documentation issues the decision was made to convert to paper documentation. On 10/24/2015, planning and development of paper documentation system began. Timeline for conversion, including processes, policies and workflows, occurred 10/24 to 11/4/2015. Commercial hospice forms were identified on 10/24 and ordered on 10/26/2015. Staff training occurred on 11/2 and 11/3 with go live of 11/4/2015. Benefits verses risks were discussed in regards to moving immediately to an electronic systems down paper process followed by conversion to paper documentation system verses staying on the electronic system for 11 more calendar days. Due to the time needed for staff to become oriented to the paper system the decision was made to continue on the electronic system with intense concurrent auditing of the record in the interim until the paper process began on 11/4/2015. 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. Monitoring should include: Monitoring of the Electronic Documentation System took place until the conversion to paper began on 11/4/2015. Who | |

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| | | | <p>is responsible? Electronic monitoring up to the paper conversion on 11/4/2015: The Business Relationship Manager (IT) and hospice leadership The system by which the responsible person(s) will monitor: The Business relationship manager to provide list of system changes needing validated Hospice leadership will validate the system changes by visual inspection and record date Log will be maintained electronically Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needsto be included, i.e., weekly, monthly, etc. With each system update affecting end user functionality 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. Ongoing Paper Documentation System effective11/4/2015 Who is responsible? Administrator or qualified designee The system by which the responsibleperson(s) will monitor Record review and audits by health information management Frequency of monitoring. If "random"</p> | |

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| | | | <p>monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. QA Each record will be reviewed upon admission for completion by Health Information Management. Each record will be audited monthly for completion by Health Information Management. Each record will be audited upon discharge for completion by Health Information Management. 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. Each record will be reviewed upon admission for completion by Health Information Management. Each record will be audited monthly for completion by Health Information Management. Each record will be audited upon discharge for completion by Health Information Management. Ongoing monitoring will take place for each of the above The facility will continue to report to the advisory committee which reports to the Community Health Network Outcomes and Performance Committee (NOPC). The NOPC is a subcommittee of the Community Health Network board of directors. The board of</p> | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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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 10/07/2015 |
| NAME OF PROVIDER OR SUPPLIER COMMUNITY HOME HEALTH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 9894 E 121ST ST FISHERS, IN 46037 | | |
| (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 | |
| | | | directors will be updated through that committee as indicated. | | |