STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151500	A. BUILDING 00 B. WING	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOSPICE OF THE CALUMET AREA INC	600 SUPERIOR AVE MUNSTER, IN 46321

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department Of Health in accordance with 42 CFR 418.113. Survey Dates: 6/16/2022 to 6/23/2022 Census: 38 At this Emergency Preparedness survey, Hospice of the Calumet Area was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, CFR 418.113.	E 0000		
E 0013 Bldg. 00	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the			

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	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the agency failed to develop and implement emergency preparedness policies and procedures based on their risk assessment The findings include: An agency document titled "Emergency Management Procedures-Field Patients" revised 7/11/2019, stated "To establish guidelines for Hospice of the Calumet Area (HCA) partners and volunteers to follow when caring for field patients and their caregivers in the event of an emergency or disaster ... Emergency Procedures Related Specific High-Risk Events Tornados ... Winter Storms ... Flooding ... Power Outage ... This Plan was developed based on the completion of a facility-based risk Assessment that utilized an all-hazard approach. The risk assessment identified types of hazards that the organization is most susceptible to ...." An agency document titled "Emergency Preparedness Community Risk Assessment" dated 2022-2023 received on 6/20/2022, evidenced Ice/Snow/Blizzards, Flooding, earthquake, and tornado as the facility's high-risk hazards. Record review of the agency's risk assessment and policies and procedures failed to evidence a plan for earthquakes in their policies and	E 0013	The Performance Improvement Coordinator has updated the emergency management program to include earthquakes, specifically under the emergency preparedness plan. A new policy titled earthquake has been instituted and staff were educated 7/19/2022. Information for the patient/caregiver instructions as well as hospice staff will be added to the 'emergency procedures related to specific high risk events' section in the emergency preparedness program in the attachment that is included with the policy titled emergency management procedures. The CEO will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	07/23/2022

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	procedures. During an interview on 6/20/2022 at 2:00 PM, the Performance Improvement officer/corporate compliance officer indicated she did not see the earthquakes listed in the plan.			
L 0000 Bldg. 00	This visit was for a Federal Recertification and State Re-licensure Survey of a Hospice provider. Survey Dates: 6/16/2022 to 6/23/2022 Census: 38 Quality Review Completed 07/13/2022	L 0000		
L 0521 Bldg. 00	418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions. Based on record review and interview, the agency failed to ensure the comprehensive assessment was accurate and included the assessment of wounds in 3 of 6 clinical records reviewed with wounds. (#4, 5, 9) The findings include:	L 0521	On 6/28/22, 7/13/22 and 7/20/22 the nursing staff was educated on the completion of a comprehensive assessment for patients, that all wounds are to be included in the admission and follow-up comprehensive assessments and	07/23/2022

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	1. Review of an agency policy obtained 6/22/2022, titled "Assessment - Comprehensive Assessment of the Patient" revised 4/21/2020, stated, "... The comprehensive assessment of the patient consists of discipline-specific assessment tools that address the following factors: ... Hospice of the Calumet Area (HCA) interdisciplinary group conducts and documents a patient-specific comprehensive assessment that identifies the patient's need for hospice care, including physical, medical, nursing, psychosocial, emotional and spiritual care...." 2. Review of an undated agency document obtained 6/22/2022, titled "Skin Care Protocol" stated, "... For any areas of skin breakdown, note location, stage (if a pressure ulcer) [wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage I (a pressure wound that is not open], size (length, width, depth), tissue type ... tenderness/pain, drainage, odor and condition of surrounding skin...." 3. Clinical record review on 6/16/2022, for patient #4, start of care 6/11/2022, evidenced an agency document titled "Skilled Nursing Visit Note" completed by the registered nurse (RN) and dated 6/11/2022, which indicated the visit was the initial assessment. Review indicated the patient had multiple venous stasis ulcers (wounds caused by damaged veins) to both legs which the patient would scratch causing the patient to bleed. Review failed to evidence the RN assessed the open areas per the agency's policy to include in the comprehensive assessment the measurements and descriptions of the wounds. During an interview on 6/22/2022, at 9:59 AM, RN C indicated she did not see an assessment of the		that comprehensive assessments reflect the correct gender of the patient. Nursing staff were asked to review wound care orders for their patients to make sure they were up to date. The HCA policy titled Assessment-Comprehensive Assessment of the patient was reviewed with the nursing staff. The Admission Coordinator will monitor with new admission chart review. Deficiency will be monitored by clinical record review. The Performance Improvement Team will monitor this deficiency as a Performance Improvement Project. 100% of the clinical records of patients with wounds will be audited quarterly for evidence that all comprehensive assessments include wound care and the assessments of wounds The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	

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	wounds in the initial assessment. 4. Clinical record review on 6/21/2022, for patient #5, start of care 3/24/2022, evidenced an agency document titled "Skilled Nursing Visit Note" completed by the RN and dated 3/24/2022, which indicated the visit was the initial assessment. Review indicated the patient had a pressure ulcer to the sacrum (the area on the back at the bottom of the spine and above the buttocks) and a deep tissue injury to the left hip. Review failed to evidence the registered nurse followed the agency's policy to include in the comprehensive assessment the measurements and descriptions of the wounds. During an interview on 6/22/2022, at 9:53 AM, registered nurse C indicated the wound assessment should include the size, location, and description of each wound. At 11:10 AM, RN C indicated the initial comprehensive assessment did not include a complete wound assessment of the sacrum and left hip. At 2:41 PM, RN C indicated there was not an assessment in the clinical record of the deep tissue injury to the left hip from the start of care date to current. 5. Clinical record review for patient #9 on 6/22/2022, start of care 6/14/2022, certification period 6/14/2022 to 9/11/2022, primary diagnosis of Encephalopathy (any brain disease that alters brain function or structure), evidenced an agency document titled, "Skilled Nursing Visit Note", dated 6/14/2022, and signed by RN H, which stated, " ... Assessment Type Hospice Comprehensive Assessment ... REVIEW OF			

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	SYSTEMS - REPRODUCTIVE Clinical Findings: ... Female Assessment ... Gynecologic Findings Post Menopausal ...." Clinical record review evidenced an agency document titled, "Hospice Plan of Care". The plan of care had a section titled, "Sex", which indicated the patient was male. Clinical record review of all other assessments indicated the patient was male. During an interview on 6/23/2022 at 1:30 PM, RN B indicated patient #9 was male. When informed of the findings, RN B indicated the reproductive assessment documented by RN H in the comprehensive assessment was incorrect.			
L 0543 Bldg. 00	418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. Based on observation, record review, and interview, the agency failed to ensure the services provided to the patients followed the plan of care in 1 of 4 active clinical records reviewed with wounds. (#4) The findings include: Review of an agency policy obtained 6/22/2022, titled "Plan of Care" revised 8/31/2021, stated, "... Hospice care and services provided to patients and their families are in accordance with an	L 0543	On 6/28/22, 7/13/22 and 7/20/22 the nursing staff was educated on the completion of a comprehensive assessment for patients, that all wounds are to be included in the visit documentation. Deficiency will be monitored by clinical record review. 100% of the clinical records of patients with wounds will be audited quarterly for evidence that all comprehensive assessments	07/23/2022

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	individualized, written plan of care ...." Review of an undated agency document obtained 6/22/2022, titled "Skin Care Protocol" stated, "... For any areas of skin breakdown, note location, stage (if a pressure ulcer) [wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage I (a pressure wound that is not open], size (length, width, depth), tissue type ... tenderness/pain, drainage, odor and condition of surrounding skin...." Clinical record review on 6/16/2022, for patient #4, start of care 6/11/2022, evidenced an agency document titled "Hospice Plan of Care" for certification period 6/11/2022 - 9/8/2022. Review indicated the nurse was to assess wound status including signs and symptoms of healing and complications. During an observation of care at the patient's home on 6/17/2022, at 10:30 AM, the patient was observed with multiple open areas to both legs. Registered Nurse (RN) D was observed cleaning the wounds and applying an ointment and band aids to 7 wounds on the front and back of the left leg. Review evidenced agency document titled "Skilled Nursing Visit Note" completed by the registered nurse (RN) and dated 6/17/2022. Review indicated RN D assessed the wounds to 5 wounds to the left leg. Review failed to evidence an assessment for all 7 wounds the RN provided wound care to on the left leg. During an interview on 6/22/2022, at 10:37 AM, RN C indicated all wounds should be assessed and documented in the visit notes.		include wound care and the assessments of wounds. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	

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L 0545 Bldg. 00	418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Based on record review and interview, the hospice agency failed to ensure all patients' plan of care was individualized to that specific patient and their needs in 13 of 13 clinical records reviewed. (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13) The findings include: 1. The agency policy titled "Plan of Care" revised 8/31/2021, stated "... Policy: Hospice care and services provided to patients and their families are in accordance with an individualized, written plan of care established by members of the interdisciplinary group (IDG) in collaboration with the patient's attending physician (if any), the patient or representative and the primary caregiver. ... 2. The plan of care will be developed by the IDG in accordance with the physician's orders and the initial and comprehensive assessment of the patient which identify the care and services necessary to meet the needs of the patient/caregiver. ... 4. The patient's plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions. The plan of care includes, but is not limited to: a. Identification of problems. b.	L 0545	On 6/28/22, 7/13/22 and 7/20/22 the nursing staff was educated on the revisions to the standard order set, and that physician foley catheter orders need to be specific to include: 1. Size of foley catheter to be inserted 2. When to irrigate the foley catheter 3. What to irrigate the foley catheter with 4. When to change the foley catheter or condom catheter On 6/28/22, 7/13/22 and 7/20/22 the nursing staff was educated on the elimination of the standard order set for wounds, and that physician wound care orders need to be specific to include: 1. Location of the wound 2. A set frequency of wound care for changing the dressing 3. Clear instruction on what wound care products to use On 6/28/22, 7/13/22 and 7/20/22	08/05/2022

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	Measurable outcomes anticipated from implementing and coordinating the plan of care. c. A statement of the scope and frequency of services necessary to meet the specific patient and family needs. d. Interventions to manage pain and symptoms. e. Drugs and treatment necessary to meet the needs of the patient. f. Medical supplies and appliances necessary to meet the needs of the patient. g. Documentation of the patient's or representative's level of understanding, involvement and agreement with the plan of care, those impediments are documented in the patient's clinical record and the level of understanding or lack of understanding are recorded...." 2. Clinical record review on 6/23/2022 for patient #3, start of care 11/05/2020, and a primary diagnosis of Alzheimer's Disease (a brain disorder affecting memory and thinking) evidenced an agency document titled "Hospice Plan of Care" for certification period 4/29/2022 - 6/27/2022, dated and electronically signed by employee B on 4/26/2022, and dated and signed by the attending physician on 5/10/2022. This plan of care had an area subtitled "Additional Services" which stated, "Urinary Catheter: Insert Foley catheter or external catheter PRN [as needed] for relief of urinary retention or incontinence. Empty foley bag PRN. May irrigate PRN. Change indwelling catheter every 30 days PRN...." Review of the plan of care failed to evidence specific instructions for size and type of catheter to use, how to irrigate the catheter, the frequency for changing the catheter, and what indications were for PRN catheter change. 3. Clinical record review on 6/23/2022 for patient #7, start of care 3/31/2022, and a primary diagnosis of Cutaneous T-cell lymphoma (Cancer that		the nursing staff was educated on the revisions to the standard order set, and that physician suction orders need to be specific to include: 1. When to suction/how often to suction 2. What suction tip to be used 3. What pressure is to be used when suctioning. On 6/28/22, 7/13/22 and 7/20/22 the nursing staff was educated on the revisions to the standard order set, and that physician oxygen orders need to be specific to include: 1. What liters the oxygen to be set at 2. When to administer oxygen if there is a PRN order On 6/28/22, 7/13/22 and 7/20/22 the nursing staff was instructed to include all diagnosis on the Plan of Care. Client records cited in the deficiency have been reviewed and corrected. All active patient records are under review and revision. The Admission Coordinator will monitor with new admission chart review. The Patient Care Coordinator will review when patients are Recertified. 5% of the active daily census will be audited quarterly for evidence	

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	beings in the white blood cells) evidenced an agency document titled "Hospice Plan of Care" for certification period 3/31/2022 - 6/28/2022, dated and electronically signed by employee F on 4/4/2022, and dated and signed by the attending physician on 4/5/2022. This plan of care had an area subtitled "Additional Services" which stated, "Urinary Catheter: Insert Foley catheter or external catheter PRN [as needed] for relief of urinary retention or incontinence. Empty foley bag PRN. May irrigate PRN. Change indwelling catheter every 30 days PRN...." Review of the plan of care failed to evidence specific instructions for size and type of catheter to use, how to irrigate the catheter, the frequency for changing the catheter, and what indications were for PRN catheter change. Clinical record review on 6/23/2022 for patient #7 evidenced an agency document titled "Verbal Order signed by RN G and dated on 4/23/2022, and signed by the attending physician on 4/25/2022. This document stated: oxygen via device: Administer 2-4 liters per minute inhaled via nasal cannula PRN for dyspnea [shortness of breath]. This order failed to be included on the plan of care. 4. Clinical record review on 6/22/2022 for patient #1, start of care 2/9/2022, and a primary diagnosis of Post COVID-19 condition and Adult failure to thrive evidenced an agency document titled "Hospice Plan of Care" for certification period 5/10/2022 - 8/7/2022, dated and electronically signed by RN H on 5/9/2022, and dated and signed by the attending physician on 4/12/2022. This plan of care had an area subtitled "Additional Services" which stated, "Urinary Catheter: Insert Foley catheter or external catheter PRN [as needed] for relief of urinary retention or		that the patient's Plan of Care is individualized. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	

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	incontinence. Empty foley bag PRN. May irrigate PRN. Change indwelling catheter every 30 days PRN ... oxygen liters per minute 2-4 liters per minute via nasal cannula as needed May titrate up to 6 liters...." Review of the plan of care failed to evidence specific instructions for size and type of catheter to use, how to irrigate the catheter, the frequency for changing the catheter, and what indications were for PRN catheter change. 5. Clinical record review on 6/22/2022 for patient #11, start of care 9/30/2021, and a primary diagnosis of Malnutrition (the body does not get enough nutrients) evidenced an agency document titled "Hospice Plan of Care" for certification period 9/30/2021 - 12/28/2021, dated and electronically signed by the RN on 10/1/2021, and the attending physician on 10/2/2021. This plan of care had an area subtitled "Additional Services" which stated, "Urinary Catheter: Insert Foley catheter or external catheter PRN [as needed] for relief of urinary retention or incontinence. Empty foley bag PRN. May irrigate PRN. Change indwelling catheter every 30 days PRN ..."Review of the plan of care failed to evidence specific instructions for size and type of catheter to use, how to irrigate the catheter, the frequency for changing the catheter, and what indications were for PRN catheter change. 6. Clinical record review for patient #2 on 6/21/2022, start of care 6/14/2022, certification period 6/14/2022 to 9/11/2022, primary diagnosis of Senile degeneration of brain, evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Orders / Treatments:", which stated, " ... Urinary Catheter: Insert Foley catheter [a tube inserted through the urethra to drain the bladder]or external catheter PRN [as needed] for relief of urinary retention or incontinence. Empty foley			

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	bag PRN. May irrigate PRN. Change indwelling catheter every 30 days PRN ...." Review of the plan of care failed to evidence specific instruction for size and type of catheter to use, how to irrigate the catheter, set frequency for changing the catheter, and what indications were for PRN catheter change. Clinical record review evidenced an agency document titled, "VERBAL ORDER", identified by the administrator as part of the agency's plan of care, dated 6/16/2022, which stated, " ... PRN Wound Care for Stage II: Cleanse wound with normal saline and apply skin barrier and/or absorbent dressing. Change dressing every 3-5 days and PRN if soiled or dislodged ...." Review of the order failed to evidence the location of the wound. Review of the order failed to evidence set frequency for changing the dressing and clear instruction on what wound care products should be used. 7. Clinical record review for patient #8 on 6/22/2022, start of care 3/3/2022, certification period 6/1/2022 to 8/29/2022, primary diagnosis of Alzheimer's disease, evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Orders / Treatments:", which stated, " ... Urinary Catheter: Insert Foley catheter [a tube inserted through the urethra to drain the bladder]or external catheter PRN [as needed] for relief of urinary retention or incontinence. Empty foley bag PRN. May irrigate PRN. Change indwelling catheter every 30 days PRN ...." Review of the plan of care failed to evidence specific instruction for size and type of catheter to use, how to irrigate the catheter, set frequency for changing the catheter, and what indications were for PRN catheter change.			

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	8. Clinical record review for patient #9 on 6/22/2022, start of care 6/14/2022, certification period 6/14/2022 to 9/11/2022, primary diagnosis of Encephalopathy (any brain disease that alters brain function or structure), evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Orders / Treatments:", which stated, " ... Urinary Catheter: Insert Foley catheter [a tube inserted through the urethra to drain the bladder]or external catheter PRN [as needed] for relief of urinary retention or incontinence. Empty foley bag PRN. May irrigate PRN. Change indwelling catheter every 30 days PRN ...." Review of the plan of care failed to evidence specific instruction for size and type of catheter to use, how to irrigate the catheter, set frequency for changing the catheter, and what indications were for PRN catheter change. Clinical record review evidenced an agency document titled, "Skilled Nursing Visit Note", dated 6/14/2022, signed by RN (registered nurse) F, which stated, " ... Assessment Type Hospice Initial Assessment ... REVIEW OF SYSTEMS - REPRODUCTIVE ... [family member B] ... shares ... [patient #9] ... was informed of having breast cancer approx. 8 weeks ago ...." Review of the plan of care failed to evidence the patient had breast cancer. During an interview on 6/23/2022 at 3:53 PM, RN B indicated significant diagnoses should be included in the plan of care. When informed of the findings, RN B indicated RN F should have included the information in the admission prep note so the medical director could review it. RN B reviewed the patient's record and stated, "I don't see anything".			

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	9. Clinical record review for patient #10 on 6/22/2022 for patient #10 on 6/22/2022, start of care 5/11/2021, certification period 5/11/2021 to 8/8/2021, primary diagnosis of Heart failure evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Orders / Treatments:", which stated, " ... Urinary Catheter: Insert Foley catheter [a tube inserted through the urethra to drain the bladder]or external catheter PRN [as needed] for relief of urinary retention or incontinence. Empty foley bag PRN. May irrigate PRN. Change indwelling catheter every 30 days PRN ...." Review of the plan of care failed to evidence specific instruction for size and type of catheter to use, how to irrigate the catheter, set frequency for changing the catheter, and what indications were for PRN catheter change. 10. Clinical record review on 6/16/2022, for patient #4, start of care 6/11/2022, evidenced an agency document titled "Skilled Nursing Visit Note" completed by the registered nurse (RN) and dated 6/11/2022. Review indicated the visit was the initial assessment and indicated the patient required supplemental oxygen at 2 liters per minute and smoked everyday. Review indicated the patient had multiple venous stasis ulcers (wounds caused by damaged veins) to both legs which the patient would scratch causing the patient to bleed. Review of an agency document titled "Hospice Plan of Care" for certification period 6/11/2022 - 9/8/2022, evidenced the patient was to use oxygen 2-4 lpm and the nurse may titrate to 6 lpm. Review failed to evidence the plan of care was individualized to include patient-specific direction for the amount of oxygen to be administered and			

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	patient-specific direction for the titration of the oxygen. Review indicated the patient may have a foley catheter (a plastic tube inserted into the bladder to drain urine) inserted as needed. Review failed to evidence the plan of care included the size of the catheter to be inserted. Review indicated the foley catheter could be irrigated as needed and failed to evidence with what and how much was to be irrigate and for what indications the foley catheter was to be irrigated. Review failed to evidence the plan of care was individualized to include patient/caregiver education related to the safety of oxygen use. Review indicated the nurse was to perform wound care as per current physician orders. Review failed to evidence an order for wound care before 6/13/2022. During an interview on 6/22/2022, at 10:05 AM, RN C indicated the plan of care should include patient/caregiver education to not smoke while wearing oxygen and maintain distance from oxygen source while smoking. During an interview on 6/22/2022, at 2:03 PM, the patient family care coordinator indicated there was not a wound care order before 6/13/2022. The patient family care coordinator indicated the admission nurse should have included the wound orders on the plan of care at time of admission. 11. Clinical record review on 6/21/2022, for patient #5, start of care 3/24/2022, evidenced an agency document titled "Hospice Plan of Care" for certification period 3/24/2022 - 6/21/2022, which indicated the patient may have a foley catheter inserted as needed. Review failed to evidence the plan of care included the size of the catheter to be inserted. Review indicated the foley catheter could be irrigated as needed and failed to			

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	evidence with what and how much was to be irrigated and for what indications the foley catheter was to be irrigated. Review evidenced an agency document titled "Skilled Nursing Visit Note" dated 3/24/2022, which indicated the patient had a condom catheter (a plastic tube connected to a collection device that fits over the penis like a condom that drains urine from the body). Review of the plan of care failed to evidence orders for the condom catheter to include how often the condom catheter was to be changed. Review indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage I (a pressure wound that is not open) to the sacrum (the area on the back at the bottom of the spine and above the buttocks) and a deep tissue injury to the left hip. The plan of care failed to evidence an order for wound care to the pressure ulcer to the sacrum prior to 3/29/2022 and failed to evidence a wound order for the deep tissue injury to the left hip. During an interview on 6/22/2022, at 11:03 AM, RN C indicated the plan of care should include orders for the condom catheter. At 11:08 AM, RN C indicated the plan of care should have included a wound order for the pressure ulcer to the sacrum before 3/29/2022 and should include a wound order for the deep tissue injury to the left hip. Review of an agency document titled "Patient Changes Document" for the period 3/29/2022 - 4/12/2022, indicated the patient was to be suctioned as needed. Review failed to evidence the plan of care included with what the patient was to be suctioned, at what pressure, how often, and for what indications.			

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	During an interview on 6/22/2022, at 11:18 AM, RN C indicated the plan of care should explain the patient should be suctioned for difficulty breathing and gurgling. RN C indicated she believed the order was a standard order and not a patient-specific order. 12. Clinical record review on 6/17/2022, for patient #6, start of care 6/30/2021, evidenced an agency document titled "Hospice Plan of Care" for certification period 4/26/2022-6/24/2022. Review evidenced the patient may have a foley catheter inserted as needed. Review failed to evidence the plan of care included the size of the catheter to be inserted. Review indicated the foley catheter could be irrigated as needed and failed to evidence with what and how much was to be irrigate and for what indications the foley catheter was to be irrigated. 13. Clinical record review on 6/21/2022, for patient #12, start of care 6/21/2021, evidenced an agency document titled "Hospice Plan of Care" for certification period 6/21/2021-9/18/2021. Review evidenced the patient may have a foley catheter inserted as needed. Review failed to evidence the plan of care included the size of the catheter to be inserted. Review indicated the foley catheter could be irrigated as needed and failed to evidence with what and how much was to be irrigate and for what indications the foley catheter was to be irrigated. Review evidenced the patient was to use oxygen 2-4 lpm and the nurse may titrate to 6 lpm. Review failed to evidence the plan of care was individualized to include patient-specific direction for the amount of oxygen to be administered and patient-specific direction for the titration of the oxygen. 14. Clinical record review on 6/21/2022, for patient			

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	#13, start of care 7/26/2021, evidenced an agency document titled "Hospice Plan of Care" for certification period 7/26/2021-10/23/2021. Review evidenced the patient may have a foley catheter inserted as needed. Review failed to evidence the plan of care included the size of the catheter to be inserted. Review indicated the foley catheter could be irrigated as needed and failed to evidence with what and how much was to be irrigate and for what indications the foley catheter was to be irrigated. Review evidenced the patient was to use oxygen 2-4 lpm and the nurse may titrate to 6 lpm. Review failed to evidence the plan of care was individualized to include patient-specific direction for the amount of oxygen to be administered and patient-specific direction for the titration of the oxygen. 15. During an interview on 6/22/2022, at 10:14 AM, RN C indicated the plans of care did not include a size for the foley catheter. RN C indicated the plans of care included standard orders for the foley catheter and irrigation of the foley catheter and indicated the plans of care should be a follow-up order with specific patient orders for the size of the foley catheter and what the foley catheter should be irrigated with, how much, and reasons indicating irrigation was needed. 16. During an interview on 6/22/2022, at 10:08 AM, RN C indicated there should be some direction in the plan of care about what amount of oxygen the patient should have when a range is ordered and should have some direction about how and why the nurse should titrate oxygen.			
L 0548 Bldg. 00	418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services			

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	necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care. Based on record review and interview, the agency failed to ensure plans of care included measurable outcomes in 11 of 13 records reviewed (#1, 2, 3, 4, 5, 6, 7, 9, 11, 12, 13). The findings include: 1. Record review on 6/23/2022, evidenced an agency policy titled, "Plan of Care", revised 8/31/2021, which stated, " ... The plan of care will be developed by the IDG [interdisciplinary group] in accordance with the physician orders and the initial and comprehensive assessment of the patient which identify the care and services necessary to meet the needs of the patient / caregiver .... The patient's plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions. The plan of care includes, but is not limited to: a. Identification of problems. b. Measurable outcomes anticipated from implementing and coordinating the plan of care ...." 2. Clinical record review for patient #2 on 6/21/2022, start of care 6/14/2022, certification period 6/14/2022 to 9/11/2022, primary diagnosis of Senile degeneration of brain, evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Goals:", which stated, "Aide: Patient's personal care needs will be met ... Patient / caregiver will demonstrate necessary behaviors to maintain	L 0548	On 6/28/22, 7/13/22 and 7/20/22 the nursing staff was instructed that the patient's Plan of Care requires measurable goals for all disciplines. On 7/13/2022 the nursing staff was provided a list with measurable goals as currently available in the EMR – MatrixCare, as well as sample measurable goals. On 7/19/2022 the Social Workers and Spiritual Coordinators were instructed the patient's Plan of Care requires measurable goals. On 7/19/2022 the Social Workers and Spiritual Coordinators were provided a list with measurable goals as currently available in the EMR – MatrixCare, as well as sample measurable goals. Client records cited in the deficiency have been reviewed and corrected. All agency client records are under review and revision. The Admission Coordinator will monitor with new admission chart review. The Patient Care Coordinator will review when patients are Recertified. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this	08/05/2022

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	good safety awareness ... Patient / family will express satisfactory control of symptoms ... Provide patient / family with viable resources to meet needs of patient ..." Review of the plan of care failed to evidence measurable goals for safety, control of symptoms, and resources to meet patient needs. 3. Clinical record review for patient #9 on 6/22/2022, start of care 6/14/2022, certification period 6/14/2022 to 9/11/2022, primary diagnosis of Encephalopathy (any brain disease that alters brain function or structure), evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Goals:", which stated, "Chaplain: Patient and family will have spiritual needs met ... Patient's personal care needs will be met ... Promote safe personal care and hygiene ... Provide patient / family with viable resources to meet needs of patient ..." Review of the plan of care failed to evidence measurable goals for spiritual needs, personal care needs, and resources to meet patient needs. 4. Clinical record review on 6/23/2022 for patient #3, start of care 11/05/2020, and a primary diagnosis of Alzheimer's Disease (a brain disorder affecting memory and thinking) evidenced an agency document titled "Hospice Plan of Care" for certification period 4/29/2022 - 6/27/2022, dated and electronically signed by employee B on 4/26/2022, and dated and signed by the attending physician on 5/10/2022. This plan of care had an area subtitled "Goals" which stated Aide: Patient's personal care needs will be met ... Pt's [patient's family and SNF [skilled nursing facility] unit nurses/caregivers will verbalize knowledge/understanding if end-stage terminal process; and SNF caregivers will implement hospice-directed strategies for providing safe and effective comfort for Pt as she progresses through		deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	

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	end-stages of terminal disease process Family and caregiver maintain and modify environment according to patient's cognitive and comfort status Continuity of care will be maintained as appropriate to patient/caregiver needs Family/caregiver will verbalize understanding of Pt's pain and anxiety/restlessness management regimen Family/caregiver will verbalize understanding of disease process, including prognosis, symptoms, treatment, and complications ... This plan of care failed to evidence measurable goals for the patient and caregivers. 5. Clinical record review on 6/23/2022 for patient #7, start of care 3/31/2022, and a primary diagnosis of Cutaneous T-cell lymphoma (Cancer that beings in the white blood cells) evidenced an agency document titled "Hospice Plan of Care" for certification period 3/31/2022 - 6/28/2022, dated and electronically signed by employee F on 4/4/2022, and dated and signed by the attending physician on 4/5/2022. This plan of care had an area subtitled "Goals" which stated Aide: Patient's personal care needs will be met ... Primary family goal for [patient] to be comfortable ... Caregiver will verbalize understanding of pain and symptom management regimen ... Caregiver will demonstrate necessary behaviors to maintain good safety and symptom management regimen ... Family and caregiver will demonstrate the ability to cope with limitations ...." This document failed to evidence measurable goals for pain, safety, symptom management and caregiver's coping ability. 6. Clinical record review on 6/22/2022 for patient #1, start of care 2/9/2022, and a primary diagnosis of Post COVID-19 condition and Adult failure to thrive evidenced an agency document titled			

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	"Hospice Plan of Care" for certification period 5/10/2022 - 8/7/2022, dated and electronically signed by RN H on 5/9/2022, and dated and signed by the attending physician on 4/12/2022. This plan of care had an area subtitled "Goals" which stated "Aide: Patient's personal care needs will be met ... Continuity of care will be maintained as appropriate to patient/primary caregiver needs ... family/caregivers will demonstrate the knowledge and ability required to provide safe and effective comfort care for dependent patient who is terminally ill ... family/caregivers will verbalize understanding of her pain/discomfort regimen ... patient/caregiver can verbalize realistic expectations in performance roll ...." This document failed to evidence measurable goals for safety, pain and caregiver expectations. 7. Clinical record review on 6/22/2022 for patient #11, start of care 9/30/2021, and a primary diagnosis of Malnutrition (the body does not get enough nutrients) evidenced an agency document titled "Hospice Plan of Care" for certification period 9/30/2021 - 12/28/2021, dated and electronically signed by the RN on 10/1/2021, and the attending physician on 10/2/2021. This plan of care had an area subtitled "Goals" which stated "Maintain clean, safe environment Patient's personal care needs will be met ... Patient/Caregiver will verbalize understanding of pain management regimen Family/caregiver will verbalize understanding of s/s [signs/symptoms] of impending death Provide patient/family with viable resources to meet the needs of the patient ...." This document failed to evidence measurable goals for safety, pain and verbalizing understanding of impending death.8. Clinical record review on 6/16/2022, for patient #4, start of care 6/11/2022, evidenced an agency document			

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	titled "Hospice Plan of Care" for certification period 6/11/2022 - 9/8/2022. Review indicated the goals included, but were not limited to, patient/family will express satisfactory control of symptoms, patient/family will maintain necessary measures to reduce risk and avoid wound infection, and symptoms will be consistent with stage of disease process and problems managed as well as disease process will allow. Review failed to evidence the plan of care was individualized to include measurable goals specific to the patient. 9. Clinical record review on 6/21/2022, for patient #5, start of care 3/24/2022, evidenced an agency document titled "Hospice Plan of Care" for certification period 3/24/2022 - 6/21/2022. Review indicated the goals included, but were not limited to, patient/family/caregiver will demonstrate a healthy, functional approach to dealing with patient situation and anticipated loss, promote skin integrity, and promote safe personal care and hygiene. Review failed to evidence the plan of care was individualized to include measurable goals specific to the patient. 10. Clinical record review on 6/17/2022, for patient #6, start of care 6/30/2021, evidenced an agency document titled "Hospice Plan of Care" for certification period 4/26/2022-6/24/2022. Review indicated the goals included, but were not limited to, patient's personal care needs will be met, provide patient/family with viable resources to meet needs of patient, patient/family will express satisfactory control of patient's symptoms, and patient/family wishes regarding end of life choices are honored throughout care. Review failed to evidence the plan of care was individualized to include measurable goals specific to the patient. 11. Clinical record review on 6/21/2022, for patient			

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	#12, start of care 6/21/2021, evidenced an agency document titled "Hospice Plan of Care" for certification period 6/21/2021-9/18/2021. Review indicated the goals included, but were not limited to, patient's personal care needs will be met and patient/family will express satisfactory control of patient's symptoms. Review failed to evidence the plan of care was individualized to include measurable goals specific to the patient. 12. Clinical record review on 6/21/2022, for patient #13, start of care 7/26/2021, evidenced an agency document titled "Hospice Plan of Care" for certification period 7/26/2021-10/23/2021. Review indicated the goals included, but were not limited to, patient/family will express satisfactory control of patient's symptoms, personal care needs will be met, maintain clean and safe environment, family will demonstrate ability to care for dependent patient, and patient/family verbalizes anxiety relief. Review failed to evidence the plan of care was individualized to include measurable goals specific to the patient. 13. During an interview on 6/22/2022, at 10:51 AM, RN C indicated the goals were standard and automatically pulled from the care plan. RN C indicated a measurable goal for skin integrity would be the patient would have no new wounds and no worsening wounds. 14. During an interview on 6/22/2022, at 2:12 PM, the patient family care coordinator indicated the goals were not measurable on the plan of care other than the pain goal. The patient family care coordinator indicated she now understood the goals should be measurable and patient specific.			
L 0549	418.56(c)(4) CONTENT OF PLAN OF CARE			

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Bldg. 00	[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 record review and interview, the agency failed to ensure the plan of care included all drugs and treatment necessary to meet the needs of the patient in 13 of 13 clinical records reviewed. (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13) The findings include: 1. Record review on 6/23/2022, evidenced an agency policy titled, "Plan of Care", revised 8/31/2021, which stated, " ... The plan of care will be developed by the IDG [interdisciplinary group] in accordance with the physician orders and the initial and comprehensive assessment of the patient which identify the care and services necessary to meet the needs of the patient / caregiver .... The patient's plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions. The plan of care includes, but is not limited to: a. Identification of problems. b. Measurable outcomes anticipated from implementing and coordinating the plan of care. c. A statement of the scope and frequency of services necessary to meet the specific patient and family needs. d. Interventions to manage pain and symptoms. e. Drugs and treatment necessary to meet the needs of the patient. F. Medical supplies and appliances necessary to meet the needs of the patient ...." 2. Clinical record review for patient #2 on 6/21/2022, start of care 6/14/2022, certification period 6/14/2022 to 9/11/2022, primary diagnosis	L 0549	On 6/28/22, 7/13/22 and 7/20/22 nursing staff education included: 1. revisions to the standard order set in the EMR 2. medication and liters of oxygen ranges and titrations will no longer be used 3. medication orders need a dose and a route 4. a patient specific dosed must be used for medication 5. all medications the patient is taking must be listed on the medication profile 6. PRN orders need an indication for use 7. Medication changes must have an order and be included in the Plan of Care 8. One wound cannot have 2 different wound care orders Client records cited in the deficiency have been reviewed and corrected. All active hospice patient records are under review and revision. The Performance Improvement Coordinator will review all orders and error/correct when necessary and re-educate staff. 5% of the active daily census will be audited quarterly for evidence that patient's Plan of Care includes drugs and treatments	08/05/2022

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	of Senile degeneration of brain, evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Medication:", which stated, "acetaminophen [a pain relieving and fever reducing medication] milligrams 325 - 1000 By Mouth; every 4 hours; PRN [as needed] for fever or pain ... lorazepam [an anti-anxiety medication] 2mg/ml [milligrams per milliliter]concentrate; Take 0.5 milligrams PO [by mouth]/SL [under the tongue] every one hour; PRN for anxiety, shortness of breath and nausea. Hospice SN [skilled nurse] may titrate ... morphine [a pain medication] 20 mg/ml concentrate; Take 2.5 milligrams PO/SL every 1 hour; PRN for pain and shortness of breath. Hospice SN may titrate ... senokot s [a laxative /stool softener] 1-2 By Mouth; daily as needed; May titrate. Max daily dose 8 tablets ...." Review of the plan of care failed to evidence instruction for dosing acetaminophen. Review of the plan of care failed to evidence instruction on titrating lorazepam, morphine, and senokot s. 3. Clinical record review for patient #8 on 6/22/2022, start of care 3/3/2022, certification period 6/1/2022 to 8/29/2022, primary diagnosis of Alzheimer's disease, evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Medication:", which stated, "acetaminophen [a pain relieving and fever reducing medication] milligrams 325 - 1000 By Mouth; every 4 hours; PRN [as needed] for fever or pain ... lorazepam [an anti-anxiety medication] 2mg/ml [milligrams per milliliter]concentrate; Take 0.5 milligrams PO [by mouth]/SL [under the tongue] every one hour; PRN for anxiety, shortness of breath and nausea. Hospice SN [skilled nurse] may titrate ... morphine [a pain medication] 20 mg/ml concentrate; Take 2.5 milligrams PO/SL every 1		necessary to meet the needs of the patient. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	

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	hour; PRN for pain and shortness of breath. Hospice SN may titrate ... senokot s [a laxative /stool softener] 1-2 By Mouth; daily as needed; May titrate. Max daily dose 8 tablets ...." Review of the plan of care failed to evidence instruction for dosing acetaminophen. Review of the plan of care failed to evidence instruction on titrating lorazepam, morphine, and senokot s. Clinical record review evidenced an agency document titled, "Communication Notes". An entry by RN (registered nurse) D, dated 6/15/2022, stated " ... Has regular BM [bowel movement] pattern with miralax [a laxative] and prune juice ...." Review of the plan of care failed to evidence Miralax. 4. Clinical record review for patient #9 on 6/22/2022, start of care 6/14/2022, certification period 6/14/2022 to 9/11/2022, primary diagnosis of Encephalopathy (any brain disease that alters brain function or structure), evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Medication:", which stated, " ... diazepam [an anti-anxiety and anti-seizure medication] milligrams 5 By Mouth; every hour; PRN for agitation / restlessness. Hospice SN [skilled nurse] may titrate ... haloperidol [an anti-psychotic] milligrams 0.5 By Mouth; every hour; PRN for agitation / restlessness. Hospice SN may titrate ... lorazepam [an anti-anxiety medication] 2mg/ml [milligrams per milliliter]concentrate; Take 0.5 milligrams PO [by mouth]/SL [under the tongue] every one hour; PRN for anxiety, shortness of breath and nausea. Hospice SN [skilled nurse] may titrate ... morphine [a pain medication] 20 mg/ml concentrate; Take 2.5 milligrams PO/SL every 1 hour; PRN for pain and shortness of breath.			

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	Hospice SN may titrate ...." Review of the plan of care failed to evidence instruction on titrating diazepam, haloperidol, lorazepam and morphine. 5. Clinical record review for patient #10 on 6/22/2022, start of care 5/11/2021, certification period 5/11/2021 to 8/8/2021, primary diagnosis of Heart failure evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Medication:", which stated, "acetaminophen milligrams 325 - 1000 By Mouth; every 4 hours; PRN [as needed] for fever or pain ... Albuterol [an inhaled medicine to help difficulty breathing] ... Inhale 2 puff(s) inhaled once a day as needed ... lorazepam Take 0.5 milligrams PO [by mouth]/ SL [under the tongue] every 1 hour; PRN [as needed] for anxiety, shortness of breath and nausea. Hospice SN may titrate ... morphine ... Take 2.5 milligrams PO / SL every 1 hour; PRN for pain and shortness of breath. Hospice SN may titrate ... senokot s tab(s) 1-2 By Mouth; daily as needed; May titrate ...." Review of the plan of care failed to evidence instruction on titrating lorazepam, morphine and senokot s. Review of the plan of care failed to evidence an indication for use of Albuterol and senokot s. 6. Clinical record review on 6/23/2022, for patient #3, start of care 11/05/2020, and a primary diagnosis of Alzheimer's Disease (a brain disorder affecting memory and thinking) evidenced an agency document titled "Hospice Plan of Care" for certification period 4/29/2022 - 6/27/2022, dated and electronically signed by employee B on 4/26/2022, and dated and signed by the attending physician on 5/10/2022. This plan of care had an area subtitled "Medication" which stated " acetaminophen milligrams 325 - 1000 By Mouth every 4 hours PRN for fever or pain; Do not exceed 4000 mg in 24 hours ... morphine milligrams 2.4 milligrams;			

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	every 1 hour PRN for pain and shortness of breath. Hospice SN may titrate ... lorazepam milligrams 0.5; every one hour; PRN for anxiety, shortness of breath. Hospice SN may titrate. The plan of care failed to include a patient-specific dosage of acetaminophen and failed to include orders on how the skilled nurse was to titrate the medication. 7. Clinical record review on 6/23/2022 for patient #7, start of care 3/31/2022, and a primary diagnosis of Cutaneous T-cell lymphoma (Cancer that begins in the white blood cells) evidenced an agency document titled "Hospice Plan of Care" for certification period 3/31/2022 - 6/28/2022, dated and electronically signed by employee F on 4/4/2022, and dated and signed by the attending physician on 4/5/2022. This plan of care had an area subtitled "Medication" which stated " acetaminophen milligrams 325 - 1000 By Mouth every 4 hours PRN for fever or pain; Do not exceed 4000 mg in 24 hours ... haloperidol milligrams 0.5 By Mouth; every hour; PRN for agitation/restlessness. Hospice nurse may titrate Concentration 2mg/ml ... lorazepam milligrams 0.5; every one hour; PRN for anxiety, shortness of breath. Hospice SN may titrate ... morphine milligrams 2.4 milligrams; every 1 hour PRN for pain and shortness of breath. Hospice SN may titrate ... Senokot S tab(s) [tablet(s)] 1-2 By Mouth daily as needed May titrate Max daily dose 8 tablets...." The plan of care failed to include a patient-specific dosage of acetaminophen and senokot and failed to include orders on how the skilled nurse was to titrate the medication. 8. Clinical record review on 6/22/2022 for patient #1, start of care 2/9/2022, and a primary diagnosis of Post COVID-19 condition and Adult failure to			

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	thrive evidenced an agency document titled "Hospice Plan of Care" for certification period 5/10/2022 - 8/7/2022, dated and electronically signed by RN H on 5/9/2022, and dated and signed by the attending physician on 4/12/2022. This plan of care had an area subtitled "Medication" which stated " ... lorazepam milligrams 0.5; every one hour; PRN for anxiety, shortness of breath. Hospice SN may titrate ... morphine milligrams 2.4 milligrams; every 1 hour PRN for pain and shortness of breath. Hospice SN may titrate ... oxygen liters per minute 2-4 via nasal cannula as needed May titrate up to 6 liters ... Senna-docusate sodium 8.6 /50 mg tablet orally 2 times a day as needed for relief/control of constipation; may titrate ...." The plan of care failed to include orders on how the skilled nurse was to titrate the medication. 9. Clinical record review on 6/22/2022 for patient #11, start of care 9/30/2021, and a primary diagnosis of Malnutrition (the body does not get enough nutrients) evidenced an agency document titled "Hospice Plan of Care" for certification period 9/30/2021 - 12/28/2021, dated and electronically signed by the RN on 10/1/2021, and the attending physician on 10/2/2021. This plan of care had an area subtitled "Medication" which stated " ... lorazepam 2 mg/ml concentrate take 0.5 milligrams PO/SL [by mouth/sublingual]; every one hour; PRN for anxiety, shortness of breath and nausea. Hospice SN may titrate ... morphine 20 mg/ml concentration. Take 2.5 mg PO/SL; every 1 hour PRN for pain and shortness of breath. Hospice SN may titrate ...." The plan of care failed to include orders on how the skilled nurse was to titrate the medication. 10. Clinical record review on 6/16/2022, for patient #4, start of care 6/11/2022, evidenced an agency document titled "Hospice Plan of Care" for			

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	certification period 6/11/2022 - 9/8/2022. Review indicated the patient's medications included, but were not limited to, acetaminophen 325 milligrams (mg) to 1000 mg and senokot 1-2 tabs daily as needed. Review failed to evidence the plan of care was individualized to include patient-specific dosage direction for medications ordered with a dosage range and failed to include the indications for use for when senokot was to be administered. Review indicated the patient's medications included, but were not limited to, lorazepam, morphine, and senokot and indicated the skilled nurse may titrate. Review failed to evidence the plan of care was individualized to include patient-specific direction for the titration of the lorazepam, morphine, and senokot. Review of an agency document titled "Medication Profile" dated 6/22/2022, indicated aspirin (a medication used to treat pain, fever, and/or prevention of stroke) 325 mg was discontinued on 6/17/2022. During an interview on 6/17/2022, at 11:33 AM, the patient's caregiver indicated aspirin 325 mg caused the patient nausea, vomiting, and stomach pain. The patient's caregiver indicated she has aspirin 81 mg to give the patient. During an interview on 6/17/2022, at 11:33 AM, RN D indicated giving the patient aspirin 81 mg daily was fine. Review failed to evidence the plan of care included aspirin 81 mg. During an interview on 6/22/2022, at 10:32 AM, RN C indicated the change in dose for the aspirin should have been included on the plan of care.			

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	11. Clinical record review on 6/21/2022, for patient #5, start of care 3/24/2022, evidenced an agency document titled "Hospice Plan of Care" for certification period 3/24/2022 - 6/21/2022. Review indicated the patient's medications included, but were not limited to, acetaminophen 325 mg to 1000 mg, atropine (medication used to dry up secretions) 1-4 drops every 2-4 hours, and senokot 1-2 tabs daily as needed. Review failed to evidence the plan of care was individualized to include patient-specific dosage direction for medications ordered with a dosage range and failed to include the indications for use for when senokot was to be administered. Review indicated the patient's medications included, but were not limited to, lorazepam, morphine, and senokot and indicated the skilled nurse may titrate. Review failed to evidence the plan of care was individualized to include patient-specific direction for the titration of the lorazepam, morphine, and senokot. Review of an agency document titled "Patient Changes Document" for the period 4/12/2022-4/26/2022, indicated the patient's medications included, but were not limited to, scopolamine (a medication used to treat nausea, vomiting, and/or to dry up secretions). Review failed to evidence the dose and route the scopolamine was to be administered. During an interview on 6/22/2022, at 11:26 AM, RN C indicated the route and dose was not included. 12. Clinical record review on 6/17/2022, for patient #6, start of care 6/30/2021, evidenced an agency document titled "Hospice Plan of Care" for certification period 4/26/2022-6/24/2022. Review indicated the patient's medications included, but			

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	were not limited to, acetaminophen 325 mg to 1000 mg and Senokot 1-2 tabs daily. Review failed to evidence the plan of care was individualized to include patient-specific dosage direction for acetaminophen and Senokot ordered with a dosage range. Review indicated the patient's medications included, but were not limited to, lorazepam, morphine, haldol (a medication used to treat certain types of mental disorders), and senokot and indicated the nurse may titrate. Review failed to evidence the plan of care was individualized to include patient-specific direction for the titration of the lorazepam, morphine, haldol, and senokot. 13. Clinical record review on 6/21/2022, for patient #12, start of care 6/21/2021, evidenced an agency document titled "Hospice Plan of Care" for certification period 6/21/2021-9/18/2021. Review indicated the patient's medications included, but were not limited to, acetaminophen 325 mg to 1000 mg. Review failed to evidence the plan of care was individualized to include patient-specific dosage direction for acetaminophen ordered with a dosage range. Review indicated the patient's medications included, but were not limited to, lorazepam and morphine and indicated the nurse may titrate. Review failed to evidence the plan of care was individualized to include patient-specific direction for the titration of the lorazepam and morphine. Review indicated bacitracin (an antibiotic ointment) was to be applied 1-2 times a week and as needed to skin tears and indicated bacitracin was to be applied daily as needed for skin tears. Review failed to evidence the plan of care was individualized to the specific needs of the patient for the frequency of the bacitracin. During an interview on 6/22/2022, at 11:44 AM, RN C indicated one bacitracin entry needed to be			

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	removed from the plan of care and indicated both orders could not be correct. 14. Clinical record review on 6/21/2022, for patient #13, start of care 7/26/2021, evidenced an agency document titled "Hospice Plan of Care" for certification period 7/26/2021-10/23/2021. Review indicated the patient's medications included, but were not limited to, acetaminophen 325 mg to 1000 mg, and senokot 1-2 tabs daily. Review failed to evidence the plan of care was individualized to include patient-specific dosage direction for acetaminophen and senokot ordered with a dosage range. Review indicated the patient's medications included, but were not limited to, lorazepam, morphine, and senokot and indicated the nurse may titrate. Review failed to evidence the plan of care was individualized to include patient-specific direction for the titration of the lorazepam, morphine, and senokot. 15. During an interview on 6/22/2022, at 10:16 AM, RN C indicated the plan of care should include specific orders for the titration of medications and indicated the medication should have a specific dose.			
L 0550 Bldg. 00	418.56(c)(5) 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:] (5) Medical supplies and appliances necessary to meet the needs of the patient. Based on record review and interview, the agency failed to include all durable medical equipment (DME) and medical supplies necessary to meet the patient's needs in the plan of care in 3 of 8 active records reviewed. (#5, 6, 7)	L 0550	On 6/28/22, 7/13/22 and 7/20/22 the nursing staff was informed that all DME must be included on the patient's Plan of Care. Examples: rollator, shower chair,	08/05/2022

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	The findings include: 1. The agency policy titled "Plan of Care" revised 8/31/2021, stated "... Policy: Hospice care and services provided to patients and their families are in accordance with an individualized, written plan of care established by members of the interdisciplinary group (IDG) in collaboration with the patient's attending physician (if any), the patient or representative and the primary caregiver. ... 2. The plan of care will be developed by the IDG in accordance with the physician's orders and the initial and comprehensive assessment of the patient which identify the care and services necessary to meet the needs of the patient/caregiver. ... 4. The patient's plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions. The plan of care includes, but is not limited to: ... . f. Medical supplies and appliances necessary to meet the needs of the patient...." 2. Clinical record review on 6/23/2022 for patient #7, start of care 3/31/2022, and a primary diagnosis of Cutaneous T-cell lymphoma (Cancer that beings in the white blood cells) evidenced an agency document titled "Hospice Plan of Care" for certification period 3/31/2022 - 6/28/2022, dated and electronically signed by employee F on 4/4/2022, and dated and signed by the attending physician on 4/5/2022. This plan of care had an area subtitled "Supplies" which stated "Overbed table, Adult diapers Urinal-Male; pressure release mattress; Bed Rails, Bed Pan; Hospital Bed; Other: BSC (bedside commode ...." This document failed to include all of patient #7's durable medical equipment. Clinical record review on 6/22/3022 for patient #7		wheelchair, hoyer, catheter supplies, condom catheter, suction tips, Broda chair Client records cited in the deficiency have been reviewed and corrected. All agency client records are under review and revision. The Admission Coordinator will review new admission charts. The Patient Care Coordinator will review when patients are Recertified. 5% of the active daily census will be audited quarterly for evidence that the patient's Plan of Care are specific and all DME and supplies are included on the Plan of Care. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	

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	evidenced an agency document titled "Skilled Visit Note" dated 5/10/2022. This document had a subsection titled "Narrative Note" which stated, " ... ambulates with a rollator with slow and deliberate steps. The rollator failed to be included on the patient's plan of care. Clinical record review on 6/22/2022 for patient #7 evidenced an agency document titled "Skilled Visit Note" dated 5/20/2022. This document had a subsection titled "Narrative Note" which stated, "... Pt was assisted in the shower today with shower chair and handheld shower device ...." The agency failed to include the shower chair on the patient's plan of care. Clinical record review on 6/22/2022 for patient #7 evidenced an agency document titled "Skilled Visit Note" dated 5/20/2022. This document had a subsection titled "Narrative Note" which stated, " ... Pt is up in wheelchair upon nurse arrival ...." The agency failed to include the wheelchair on the patient's plan of care. During an interview on 6/23/3022 at 2:11 PM, the clinical coordinator indicated any durable medical equipment the patient has should be listed on the plan of care. 3. Clinical record review on 6/21/2022, for patient #5, start of care 3/24/2022, evidenced agency documents titled "Skilled Nursing Visit Note" completed by the registered nurse. Document dated 3/24/2022, indicated the patient had a condom catheter (a plastic tube connected to a collection device that fits over the penis like a condom that drains urine from the body). Document dated 3/25/2022, indicated the patient transfers with the use of a hoyer (a mechanical lift device).			

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	Review of an agency document titled "Hospice Plan of Care" for certification period 3/24/2022 - 6/21/2022, failed to evidence the plan of care included the condom catheter supplies and the hoyer lift. During an interview on 6/22/2022, at 11:03 AM, RN C indicated the plan of care should include the condom catheter supplies and the hoyer lift. 4. Clinical record review on 6/17/2022, for patient #6, start of care 6/30/2021, evidenced an agency document titled "Nurse Practitioner Visit Note" dated 5/28/2022. Review indicated the patient was sitting in a Broda chair (a medical positioning chair used to promote safety, pressure relief, and correct posture). Review evidenced an agency document titled "Hospice Plan of Care" for certification period 4/26/2022-6/24/2022, which failed to evidence the patient's medical equipment included a Broda chair. During an interview on 6/22/2022, at 10:47 AM, RN C indicated the Broda chair was not included in the plan of care and should be.			
L 0555 Bldg. 00	418.56(e)(2) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (2) Ensure that the care and services are provided in accordance with the plan of care. Based on record review and interview, the agency failed to ensure medications were given in accordance with the plan of care in 2 of 2 inpatient clinical records reviewed. (patient #9, #11)	L 0555	On 6/28/22, 7/13/22 and 7/20/22 nursing staff education included: 1. revisions to the standard order set in the EMR	08/05/2022

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	The findings include: 1. An agency policy titled "Medication Administration" revised 4/21/2020, stated, "... No change may be made to the medication dosage or route without a physician's order...." 2. An agency policy titled "Pain and Symptom Management" revised 12/15/2018, stated "The interdisciplinary group (IDG) will make every effort to effectively manage pain and control symptoms for Hospice of the Calumet Area (HCA) patients ... 5. Pain is reassessed during the completion of the hospice follow-up visit and hospice comprehensive assessment, every shift at the WJR residence, anytime of patient states that his/her pain level has changed, and whenever pain medication or dosage is changed. This information is documented in the patient's clinical record. The symptom assessment skills are also reassessed during completion of the hospice follow-up visit and hospice comprehensive assessment ... d. Each nurse will document medication administration on the Medical Profile and the Medication Administration Record ... When titrating medications, medication orders will be updated, which will update the Medication Profile and the Medication Administration Record ..." 3. An undated agency document titled "Written Guidelines for Symptom Control" received on 6/20/2022, stated "Titration Guidelines 1. Add total dosage of opioid given in 24 hours ... 2. Divide by dosing schedule ... If pain is particularly severe, the calculated dosage may be increased by an additional 20% to insure control ...."		2. medication and liters of oxygen ranges and titrations will no longer be used Client records cited in the deficiency have been reviewed and corrected. All agency client records are under review and revision. The Performance Improvement Coordinator will review all orders and error/correct when necessary and re-educate staff. 5% of the active daily census will be audited quarterly for evidence that patient medications are given in accordance to the Plan of Care. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	

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	4. Clinical record review on 6/22/2022 for patient #11, start of care 9/30/2021, and a primary diagnosis of Malnutrition (the body does not get enough nutrients) evidenced an agency document titled "Hospice Plan of Care" for certification period 9/30/2021 - 12/28/2021, dated and electronically signed by the RN on 10/1/2021, and the attending physician on 10/2/2021. This plan of care had an area subtitled "Medication" which stated "... morphine 20 mg/ml concentration. Take 2.5 mg PO/SL; every 1 hour PRN for pain and shortness of breath. Hospice SN may titrate ...." Clinical record review on 6/22/2022 for patient #11, evidenced an agency document titled "Hospice of the Calumet Area/William J Riley Residence Class II, III, IV, V Drugs Sign Out Sheet" which evidenced patient #11 was given 5 mg of Morphine on 9/30/21 at 5:25 PM, 5 mg of Morphine on 10/1/2021 at 3:50 PM, 5 mg of Morphine on 10/2/2021 at 10:15 PM, and 5 mg of Morphine at 1:50 AM. The agency failed to give the correct initial dose of 2.5 mg and subsequent doses of Morphine. During an interview on 6/20/2022 at 2:32 PM, the clinical coordinator indicated they have written guidelines for pain control. Nurses should start at the lowest dose and then increase the dosage or they can decrease the time between doses. She indicated a new order needs to be written for the increased dose, but the nurse can see what the last dose given to the patient was. During an interview on 6/22/2022 at 10:16 AM, the clinical coordinator indicated the medication order should be updated when a medication was titrated. She indicated nurses can give an increased dose for the first dosage if the nurse feels the ordered dose will not be effective.			

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	5. Clinical record review for patient #9 on 6/22/2022, start of care 6/14/2022, certification period 6/14/2022 to 9/11/2022, primary diagnosis of Encephalopathy (any brain disease that alters brain function or structure), evidenced an agency document titled, "Hospice Plan Of Care". The plan of care had a subsection titled, "Medication:", which stated, " ... diazepam [an anti-anxiety and anti-seizure medication] milligrams 5 By Mouth; every hour; PRN for agitation / restlessness. Hospice SN [skilled nurse] may titrate ... lorazepam [an anti-anxiety medication] 2mg/ml [milligrams per milliliter]concentrate; Take 0.5 milligrams PO [by mouth]/SL [under the tongue] every one hour; PRN for anxiety, shortness of breath and nausea. Hospice SN [skilled nurse] may titrate ... morphine [a pain medication] 20 mg/ml concentrate; Take 2.5 milligrams PO/SL every 1 hour; PRN for pain and shortness of breath. Hospice SN may titrate ...." Clinical record review evidenced an agency document titled, "HOSPICE OF THE CALUMET AREA, INC.-RILEY RESIDENCE DISPOSITION OF DRUGS". This document evidenced a sign-out sheet for Lorazepam, which evidenced a dose of 1 mg (milligram) of Lorazepam was given on 6/16/2022, and 1.5 mg was given on 6/20/2022. The document evidenced a sign-out sheet for Diazepam, which evidenced a dose of 10 mg of Diazepam was given on 6/17/2022. The document evidenced a sign-out sheet for Morphine, which evidenced a dose of 5 mg of Morphine was given on 6/16/2022, a dose of 10 mg was given on 6/18/2022, and a dose of 15 mg was given on 6/20/2022. Review of the plan of care and medication profile failed to evidence orders for the increased dosage			

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	of Lorazepam, Diazepam, and Morphine. During an interview on 6/20/2022, at 2:33 PM, RN B indicated a nurse may titrate a medication dose, they should write a new order and update the medication profile with the new dose so the next nurse knows what amount has been given.			
L 0556 Bldg. 00	418.56(e)(3) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (3) Ensure that the care and services provided are based on all assessments of the patient and family needs. Based on clinical record review and interview the agency failed to ensure assessments were complete to ensure they were meeting the needs of the patient in 1 of 2 inpatient hospice records reviewed. (patient #11) The findings include: An agency policy titled "Pain and Symptom Management" revised 12/15/2018, stated "The interdisciplinary group (IDG) will make every effort to effectively manage pain and control symptoms for Hospice of the Calumet Area (HCA) patients. 1. The nurse assesses the patient's pain and other symptoms as part of the initial assessment. Based on findings, the nurse ensures that the patient's care and support needs are met. All disciplines assess pain or distress as part of their comprehensive assessment and during follow-up visits. ... 5. Pain is reassessed during the completion of the hospice follow-up visit and hospice comprehensive assessment, every shift at the WJR residence, anytime of patient states that	L 0556	On 7/20/22 nursing staff education included pain and symptom management. The HCA pain and symptom management policy was reviewed. Specifics - Pain is re-assessed during completion of the Hospice Follow-up Visit and Hospice Comprehensive Assessment, every shift at the WJR Residence, any time a patient states that his/her pain level has changed, and whenever pain medication or dosage is changed. This information is documented in the patient's clinical record. The symptom assessment scales are also re-assessed during completion of the Hospice Follow-up Visit and Hospice Comprehensive Assessment. 5% of the active daily census will be audited quarterly for evidence	07/23/2022

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	his/her pain level has changed, and whenever pain medication or dosage is changed. This information is documented in the patient's clinical record. The symptom assessment skills are also reassessed during completion of the hospice follow-up visit and hospice comprehensive assessment ...." Clinical record review on 6/22/2022 for patient #11, start of care 9/30/2021, and a primary diagnosis of Malnutrition (the body does not get enough nutrients) evidenced an agency document titled "Hospice Plan of Care" for certification period 9/30/2021 - 12/28/2021, dated and electronically signed by the RN on 10/1/2021, and the attending physician on 10/2/2021. This plan of care had an area subtitled "Medication" which stated "... lorazepam 2 mg/ml concentrate take 0.5 milligrams PO/SL [by mouth/sublingual]; every one hour; PRN for anxiety, shortness of breath and nausea. Hospice SN [skilled nurse] may titrate ... morphine 20 mg/ml concentration. Take 2.5 mg PO/SL; every 1 hour PRN for pain and shortness of breath. Hospice SN may titrate ...." Clinical record review on 6/22/2022 for patient #11, evidenced an agency document titled "Hospice of the Calumet Area/William J Riley Residence Class II, III, IV, V Drugs Sign Out Sheet" which evidenced patient #11 was given 5 mg of Morphine on 9/30/21 at 5:25 PM, 5 mg of Morphine on 10/1/2021 at 3:50 PM, 5 mg of Morphine on 10/2/2021 at 10:15 PM, and 5 mg of Morphine at 1:50 AM. Clinical record review on 6/22/2022 for patient #11, evidenced an agency document titled "Hospice of the Calumet Area/William J Riley Residence Class II, III, IV, V Drugs Sign Out Sheet" which evidenced patient #11 was given 0.5 mg of		that the patient's pain level is assessed prior to and after pain medication is given. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	

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	lorazepam doses on 9/30/21 at 5:25 PM, 10/1/2021 at 3:50 PM, 10/2/2021 at 10:15 PM, 10/3/2021 at 1:50 AM. Clinical record review on 6/22/2022 for patient #11, evidenced an agency document titled "MAR [medication administration record] History Report" this document indicated patient #11 received 5 mg of Morphine doses on 10/1/2021 at 4:10 AM, 10/1/2021 at 3:50 PM, 10/2/2021 at 12:24 AM, 10/2/2021 at 10:15 PM, and 10/3/2021 at 1:50 AM. This document failed to evidence the reason for administering the medication and failed to evidence patient #11 was reassessed for the effectiveness of the medication. Clinical record review on 6/22/2022 for patient #11, evidenced an agency document titled "MAR History Report" this document evidenced patient #11 received 0.5 mg lorazepam doses on 10/1/2021 at 4:10 AM, 10/1/2021 at 3:50 PM, 10/2/2021 at 12:24 AM, 10/2/2021 at 10:15 PM, and 10/3/2021 at 1:50 AM. This document failed to evidence the reason for administering the medication and failed to evidence patient #11 was reassessed for the effectiveness of the medication. Clinical record review on 6/22/2022 for patient #11 evidenced agency documents titled "Skilled Visit Notes" dated 9/20/2021, 10/1/2021, 10/2/2021, and 10/2/2021. These documents failed to evidence patient #11 was assessed for pain prior to medication administration, and failed to evidence the patient was reassessed for pain to ensure medication effectiveness. Clinical record review on 6/22/2022 for patient #11 evidenced agency documents titled "Shift Running Document" dated 9/20/2021, 10/1/2021, 10/2/2021, and 10/2/2021. These documents failed			

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	to evidence patient #11 was assessed for pain prior to medication administration, and failed to evidence the patient was reassessed for pain to ensure medication effectiveness. During an interview on 6/23/2022 at 1:23 PM, the clinical coordinator indicated there should be a documented assessment before and after pain medication was given.			
L 0558 Bldg. 00	418.56(e)(5) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. Based on record review and interview, the hospice agency failed to ensure coordination of care with the skilled nursing facility to ensure medication/dosage/administration was current and correct, in 1 of 2 patient clinical records reviewed that resided in a healthcare facility. (#3) The findings include: 1. An agency policy titled "Nursing Facility Residents - Coordination of Care," revised 12/15/2018, stated "... Policy: HCA [Hospice of the Calumet Area] ensures that mechanisms are in place to provide for coordination of all hospice services provided to patients residing in facilities. Procedure: 1. HCA designates the RN [registered nurse] case manager as the member of the interdisciplinary group (IDG) that is responsible for a patient who is a resident of a facility. The designated IDG member is responsible for: a.	L 0558	On 6/28/22 and 7/20/22 the nursing staff was re-educated on coordination of care with the skilled nursing facility regarding medication administration and treatments: 1. the patient's medication profile shall match the medication profile at the patient's facility including the same route, dosage, and frequency 2. the Plan of Care must include the correct diet for the patient The HCA Nursing Facility Residents Coordination of Care policy was also reviewed. All current facility Coordinated Services Plan of Care were reviewed for compliance and updated if not compliant.	07/23/2022

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	providing overall coordination of the hospice care of the resident with facility representatives; b. communicating with facility representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family. As part of the patient visit, hospice staff will meet with a facility representative to obtain an update on the patient's condition, provide education on end of life care as needed and review the plan of care ... 3. The following information is provided to the facility: a. the most recent hospice plan of care specific to each patient ... f. hospice medication information specific to each patient ...." Clinical record review on 6/23/2022, for patient #3, start of care 11/05/2020, and a primary diagnosis of Alzheimer's Disease (a brain disorder affecting memory and thinking) evidenced an agency document titled "Hospice Plan of Care" for certification period 4/29/2022 - 6/27/2022, dated and electronically signed by employee B on 4/26/2022, and dated and signed by the attending physician on 5/10/2022. This plan of care had an area subtitled "Nutrition" which stated "Mechanical Soft." This plan of care also had an area subtitled "Medication" which stated "acetaminophen milligrams 325 - 1000 By Mouth every 4 hours PRN [as needed] for fever or pain; Do not exceed 4000mg in 24 hours ... Aspercreme with Lidocaine 4% topical cream apply 1 application topical 2 times a day for pain. Apply thin layer to right upper back ... morphine milligrams 2.4 milligrams; every 1 hour PRN for pain and shortness of breath. Hospice SN [skilled nurse] may titrate ... Nystatin topical 100000 units/g [gram] topical powder take one application applied 3 rimes day as needed; apply under breast folds 3X/day after cleaning area with mild		5% of the active daily census will be audited quarterly for evidence that the patient's medication profile is up to date. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	

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	soap and water and patting dry...." Clinical record review on 6/23/2022, of a document titled "Physician Order Report" from facility A evidenced an area subtitled "Medication Flow Sheet" which stated, "Diet: Mechanical soft, PUREE MEAT ... Morphine 20 mg/mL (4mg/mL) give 0.25 mL oral every hour PRN ... acetaminophen capsule 325 mg 2 tablets oral every 4 hours PRN ...." Clinical record review on 6/23/2022, failed to evidence the hospice agency coordinated care with facility A regarding the correct dosage of morphine, acetaminophen, Aspercreme, and Nystatin, and failed to ensure they had the correct diet for patient #3. During an interview on 6/24/2022 at 3:06 PM, employee B indicated the plan of care and the medications listed on agency A's documents should be the same as what was on the agency's plan of care.			
L 0579 Bldg. 00	418.60(a) PREVENTION The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. Based on observation, record review, and interview, the agency failed to follow standard precautions in 1 of 2 home visits with the registered nurse (RN). (#4) The findings include: Review of an agency policy obtained on 6/22/2022, titled "Standard Precautions" revised 8/27/2019, stated, "... Change gloves between	L 0579	On 7/13/22 and 7/20/22 nursing staff education included Standard Precautions and wound care. The HCA Standard Precautions policy was reviewed. All nurses were assigned Relias courses: 1. bloodborne pathogens 2. standard precautions and infection control in homecare The Patient Care Coordinator has	07/23/2022

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	tasks and procedures on the patient if the hands will move from a contaminated body-site ... to a clean body-site ... Remove gloves promptly after use, before touching uncontaminated items and environmental surfaces ... Always perform hand hygiene after removing gloves...." During an observation of care at the home of patient #4, start of care 6/11/2022, on 6/17/2022, at 10:59 AM, RN D was observed wearing gloves while cleaning multiple open areas on the right lower leg by spraying liquid on a clean gauze pad from a bottle labeled "Wound Cleanser". RN D was not observed removing gloves and performing hand hygiene after cleaning one wound and before cleansing another wound. RN D was observed rinsing multiple wounds on the right lower leg with a solution in a syringe titled "normal saline [a liquid solution]" and drying with a clean dry gauze. RN D was not observed removing gloves and performing hand hygiene after rinsing and drying one wound and before rinsing and drying another wound on the right leg. RN D was observed applying an ointment from a tube labeled "triple antibiotic ointment" to a clean gauze pad and applied the ointment to the open areas on the right lower leg. RN D was observed applying a bandaid to one open area to the right lower leg. RN D was observed cleaning multiple open areas to the left lower leg with the wound cleanser. RN D was not observed removing gloves and performing hand hygiene after applying ointment and a bandaid to the open area on the right lower leg and before cleansing the wounds on the left lower leg and was not observed removing gloves and performing hand hygiene after cleansing one wound on the left lower leg and before cleansing another wound on the left lower leg. RN D was observed rinsing the wound on the left lower leg with normal saline and		reviewed hand hygiene and wound care with RN D with return demonstration. The Patient Care Coordinator will be responsible for monitoring this deficient practice so it does not recur.	

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	a patting dry with a dry gauze. RN D was not observed removing gloves and performing hand hygiene after rinsing and drying one wound on the left lower leg and before rinsing and drying another wound on the left lower leg. RN D was observed applying ointment to a clean gauze and applying ointment and covering with a bandaid to open areas on the left lower leg. RN D was not observed removing gloves and performing hand hygiene after applying ointment and a bandaid to one wound and before applying ointment and a bandaid to another wound on the left lower leg. During an interview on 6/17/2022, at 4:59 PM, the patient family care coordinator indicated gloves should be removed and hand sanitizer should be applied after cleaning wounds and before applying wound dressing. The patient and family care coordinator indicated gloves should be changed and hand sanitizer should be applied in between wound care to different wounds.			
L 0580 Bldg. 00	418.60(b)(1) CONTROL The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that- (1) Is an integral part of the hospice's quality assessment and performance improvement program; and Based on record review and interview, the agency failed to maintain a program for the surveillance, identification, and investigation of infectious diseases. The findings include: Review of an agency policy obtained 6/22/2022,	L 0580	On 6/28/22, 7/13/22 and 7/20/22 nursing staff education included documentation of patient infections in the correct section of the visit note. Information will not pull to the EMR infection report for infection surveillance when infections are not properly	07/23/2022

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	titled "Infection Control Program" revised 1/1/2014, stated, "... HCA's [Hospice of the Calumet Area] infection control program includes, but is not limited to the following components: ...collection and analysis of surveillance data related to infections among Partners, volunteers and hospice patients ...." Clinical record review on 6/21/2022, for patient #5, start of care 3/24/2022, evidenced an agency document titled "Skilled Nursing Visit Note" completed by the registered nurse and dated 3/28/2022. This document indicated the patient's urine had an odor and the patient had a history of urinary tract infections. Review indicated the patient was to start Bactrim (an antibiotic). Review of the agency's infection log failed to evidence an infection investigation was completed for the patient. During an interview on 6/22/2022, at 11:29 AM, registered nurse (RN) C indicated the nurse should have documented the patient's infection under the infection tab on the flowsheet and indicated the infection report was not generated because the nurse did not document the infection correctly.		documented. The Performance Improvement Coordinator will review the records of patients when antibiotics are ordered. 5% of the active daily census will be audited quarterly for evidence that infections are properly documented in the EMR. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	
L 0584 Bldg. 00	418.62(a) LICENSED PROFESSIONAL SERVICES Licensed professional services provided directly or under arrangement must be authorized, delivered, and supervised only by health care professionals who meet the appropriate qualifications specified under §418.114 and who practice under the hospice's policies and procedures. Based on record review and interview, the agency failed to ensure nursing services followed the	L 0584	On 6/28/22, 7/13/22 and 7/20/22 nursing staff education included	07/23/2022

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	hospice's policies and procedures in 1 of 2 discharged records reviewed receiving wound care (#10). The findings include: Record review on 6/23/2022 evidenced an agency policy titled, "SKIN CARE PROTOCOL", dated 4/16/2009, which stated, " .... For any areas of skin breakdown, note location, stage (if pressure ulcer), size (length, width, depth), tissue type (granulating or eschar), tenderness / pain, drainage, odor and condition of surrounding skin (redness, maceration [softening and breaking down of the skin]) ...." Clinical record review of the electronic medical record (MatrixCare) for patient #10 on 6/22/2022, start of care 5/11/2021, certification period 5/11/2021 to 8/8/2021, primary diagnosis of Heart failure, evidenced a wound flowsheet. The wound flowsheet evidenced entries dated 5/21/2021, 5/24/2021, 5/27/2021 and 6/3/2021. Each of the entries failed to evidence wound measurements. Clinical record review failed to evidence any wound measurements. During an interview on 6/23/2022 at 1:32 PM, RN [registered nurse] C indicated the nurse should measure wounds once a week, usually on the first visit on the week. When informed of the findings, RN C and RN B reviewed the clinical record, and indicated it failed to evidence any wound measurements.		wound care and documentation 1. assess and measure wounds – location, stage, size, tissue type, tenderness/pain, drainage, odor, and the condition of the surrounding skin in the visit note and flowsheet 2. wounds are to be measured once per week, first visit of the week 3. perform wound care as ordered 100% of current patients with wounds have been reviewed. 100% of the clinical records of patients with wounds will be audited quarterly for evidence that all comprehensive assessments include wound care and the assessments of wounds. Wound status and wound care will be discussed at IDG. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	
L 0604 Bldg. 00	418.72 PHYS, OCCUPNL THERAPY & SPEECH-LANG PATHOLOGY Physical therapy services, occupational therapy services, and speech-language			

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	pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice. Based on record review and interview, the agency failed to provide physical and occupational therapy services in 1 of 2 home visits conducted with the registered nurse. (#4) The findings include: Review of an agency policy obtained 6/22/2022, titled "Physical, Occupational, Speech and Other Therapies" dated 12/2/2008, stated, "... Physical therapy services, occupational therapy services ... are provided when necessary for the management of symptoms ... During the comprehensive assessment of the patient, the need for physical, occupational ... services is evaluated. When these services are needed to help the patient reach optimal functioning, a physician's order is obtained and the services to be provided are included in the patient's plan of care...." Clinical record review on 6/16/2022, for patient #4, start of care 6/11/2022, evidenced an agency document titled "Skilled Nursing Visit Note" completed by the registered nurse (RN) and dated 6/11/2022. Review indicated the patient required occasional assistance and/or rest periods with ambulation and swayed but was able to catch himself. Review indicated the patient was deconditioned and weak. Review failed to evidence the patient was offered physical and occupational therapy. During an interview on 6/17/2022, at 10:30 AM, the patient indicated he ambulates outside using a cane. Patient indicated he wants to improve so he can return to the city and walk around to shop and visit his friends.	L 0604	HCA policy Physical, Occupational, Speech and Other Therapies and indications for physical therapy was reviewed with the IDG on 7/19 and again with nursing staff on 7/20/2022.Patient need for therapies will be monitored through IDG. Patient #4 revoked his hospice Medicare benefit on 6/27/2022. 100% of the active patients were re-evaluated for therapy need at IDG on 7/13/22 and 7/20/22. The Patient Care Coordinator will be responsible for monitoring this deficient practice so it does not recur.	07/23/2022

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	During an interview on 6/21/2022, at 1:35 PM, the patient's caregiver indicated she was unaware the agency provided physical and occupational therapy and indicted she thought therapy would be good for the patient so he could keep his strength for as long as possible. During an interview on 6/22/2022, at 2:03 PM, the family patient care coordinator indicated therapy would be provided if therapy would improve the patient's quality of life and help the patient do the things the patient likes to do. The family patient care coordinator indicated the patient could benefit from having therapy services and indicated the RN had not followed up on it yet.			
L 0626 Bldg. 00	418.76(g)(2) HOSPICE AIDE ASSIGNMENTS AND DUTIES (2) A hospice aide provides services that are: (i) Ordered by the interdisciplinary group. (ii) Included in the plan of care. (iii) Permitted to be performed under State law by such hospice aide. (iv) Consistent with the hospice aide training. Based on observation, record review and interview, the hospice aide failed to provide all services ordered in the patient's plan of care in 1 of 1 hospice aide visit. (patient #3) The findings include: An agency policy titled "Hospice Aide Assignments and Duties" revised 4/21/2020, stated "Hospice Aides (HA) are expected to complete all assignments under the supervision of an RN [Registered Nurse] ... HAs are expected to complete all scheduled assignments ... 3. A hospice aide provides services that are a. Ordered	L 0626	Hospice aide education on 7/14/2022 included assignments and documentation: 1. aide assignments are to be reviewed prior to providing care to the patient 2. only assigned tasks may be completed 3. the RN Case Manager should be kept up to date with activities and status of the patient 4. communication to the RN is necessary when patient assignments need to be revised	07/23/2022

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	by the interdisciplinary group. b. included in the plan of care. c. Permitted to be performed under State law by such hospice aide. d. Consistent with the hospice aide training and competency ...." Clinical record review on 6/23/2022, for patient #3, start of care 11/05/2020, and a primary diagnosis of Alzheimer's Disease (a brain disorder affecting memory and thinking) evidenced an agency document titled "Aide Care Plan" with a subsection titled Interventions," which stated "Hygiene-Shampoo" Clinical record review on 6/23/2022, for patient #3, evidenced an agency document titled "Aide Visit Note" dated 6/17/2022, and signed by Hospice Aide E, with a subsection titled "Care Plan Documentation" which stated "Hygiene-Shampoo-Done." During a home visit on 6/17/2022, at 9:35 AM, Hospice Aide E was observed providing care to patient #3. Hospice Aide E was observed giving a bed bath to patient #3. Hospice Aide E failed to shampoo patient #3's hair during this visit. During an interview on 6/20/2022 at 12:17 PM, the clinical coordinator indicated if the patient has no order to shampoo her hair as part of the aide care plan, the aide should have completed the task or documented why it was not completed.		5. document who performs tasks if completed prior to your visit 6. review of drop-down options for assignments not completed HCA policies reviewed 7/14/2022: Documentation Requirements Hospice Aide Assignments and Duties Aide E reported to the Patient Care Coordinator that a shampoo was completed for patient #3 during the visit, the shampoo was completed after the Surveyor left the patient room. The HCA policy Hospice Aide Supervision was reviewed with the RNs on 7/20/2022. The RNs were re-instructed on 7/20/2022 to complete the following at each aide supervisory visit: 1. assess the quality of care being provided by the aide, 2. make sure the services ordered by the IDG Team meet the patient and family needs and 3. Assess the adequacy of the aide services in relationship to the needs of the patient and the family and 4. Review and update the aide care plan as needed. 5. Assess patient and family satisfaction with the care provided and 6. Hospice Aide compliance with the established care plan. 100% of the active clinical records of patients with aide services were reviewed for this deficient practice by the Case Managing RN. 5% of the active daily census will	

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			be audited quarterly for evidence that hospice aide supervisory visits are completed and the aide care plan is correct. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	
L 0672 Bldg. 00	418.104(a)(1) CONTENT Each patient's record must include the following: (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes. Based on record review and interview, the agency failed to ensure the clinical record included clinical notes for 1 of 9 active clinical records reviewed. (#5) The findings include: Review of an agency policy obtained on 6/22/2022, titled "Documentation Requirements" revised 9/4/2019, stated, "... All visit documentation should be closed within 24 hours of the visit...." Clinical record review on 6/21/2022, for patient #5, start of care 3/24/2022, failed to evidence documentation of skilled nursing visits provided to the patient since 5/17/2022 except for a visit on	L 0672	On 6/28/22, 7/13/22 and 7/20/22 nursing staff education included timeliness of documentation in the patient's record by reviewing the current policy: All clinical record entries should be made as soon as possible after the care is provided or an event or observation is made. When documenting in the electronic clinical record, the majority of the documentation should be completed during the visit. All visit documentation should be closed within 24 hours of the visit. RN C has completed his documentation.	07/23/2022

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	6/7/2022. During an interview on 6/22/2022, at 11:31 AM, registered nurse (RN) C indicated visit notes should be completed within 24 hours per agency policy and was unsure why the nurse visits were not documented since 5/17/2022. When queried if there were any additional skilled nursing visits completed that were not yet included in the clinical record, RN C indicated she would check. During an interview on 6/22/2022, at 2:30 PM, the patient family care coordinator indicated RN D was behind in completing his documentation and it was unacceptable. Review of a untitled agency document provided on 6/22/2022, at 3:00 PM, indicated RN D provided skilled nurse visits to the patient on 6/3/2022, 6/10/2022, 6/14/2022, 6/17/2022, and 6/22/2022 and indicated RN D was working on completing the documentation.		5% of the active daily census will be audited quarterly for evidence that notes are completed according to policy. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	
L 0680 Bldg. 00	418.104(c) PROTECTION OF INFORMATION The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department's rules regarding personal health information as set out at 45 CFR parts 160 and 164. Based on observation, record review and interview, the agency failed to ensure the clinical record was safeguarded against unauthorized use. The findings include: Review of an agency policy obtained on 6/22/2022, titled "Clinical Records, HCA [Hospice	L 0680	On 6/17/2022 the HCA policies: 1. Clinical Records Hospice Patients and 2. Maintenance, Protection and Retention of Agency Records were reviewed with the branch staff. On 6/18/2022 the CEO moved the documents to a secure area until they were shredded.	07/23/2022

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	of the Calumet Area] Hospice Patients" revised 4/21/2020, stated, "... Access to patient clinical records is restricted to members of the IDG [interdisciplinary group] and Partners or volunteers who require such access to perform their jobs effectively...." During an observation at the branch location on 6/17/2022, at 9:12 AM, cardboard boxes labeled "To Be Shredded" were observed in an unlocked, open room. Inside of the cardboard boxes were agency documents with clinical information to include patient names. During an interview on 6/17/2022, at 2:08 PM, the administrator indicated clinical documents were to be shredded after they were scanned into the electronic health record. During an interview on 6/22/2022, at 10:44 AM, the administrator indicated the documents located in the cardboard boxes in the open room at the branch location used to be stored in a locked office but the water heater burst and the documents had to be moved temporarily.		The Team Leader for the branch will be responsible for monitoring the location of patient records that need to be shredded. The CEO will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	
L 0683 Bldg. 00	418.104(e)(2) DISCHARGE OR TRANSFER OF CARE (2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with §418.26, the hospice must forward to the patient's attending physician, a copy of- (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested. Based on record review and interview, the agency failed to provide to the patient's physician a copy of the discharge summary per the agency's policy in 1 of 3 closed records reviewed with a patient death. (#13)	L 0683	On 6/28/22, 7/13/22 and 7/20/22 nursing staff education included the completion of a discharge summary for every patient, and that notifying the Medical Director	07/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151500	A. BUILDING 00 B. WING	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOSPICE OF THE CALUMET AREA INC	600 SUPERIOR AVE MUNSTER, IN 46321

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	The findings include: Review of an agency policy obtained 6/22/2022, titled "Death of a Patient" revised 5/1/2015, stated, "... The patient's death is pronounced, documented on ... the Agency Discharge Summary and communicated in accordance with State laws and regulations...." Review on 6/20/2022, of an untitled agency document indicated patient #13, start of care 7/26/2021, expired on 7/8/2021. Clinical record review on 6/21/2022, for patient #13 failed to evidence a discharge summary. During an interview on 6/22/2022, at 11:57 AM, registered nurse (RN) C indicated the discharge summary should have been completed and sent to the physician. At 4:22 PM, RN C indicated there was not a discharge summary in the clinical record.		at IDG did not meet the intent of the regulation. The Performance Improvement Coordinator will complete a discharge summary for the patient if it is not completed by the nurse who went on the post-mortem visit. 100% of the discharged patient charts will be audited weekly for the discharge summary. The discharge summary status should read 'sent to physician'. The Performance Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected to 100% compliance. Monitoring will take place for at least 3 quarters. Monitoring will then continue with routine quarterly clinical record reviews.	