### Summary Statement of Deficiencies

**S 671**

S 671 418.104 CLINICAL RECORDS

A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient’s attending physician and hospice staff. The clinical record may be maintained electronically.

This STANDARD is not met as evidenced by:

Based on record review and interview, the agency failed to ensure each clinician recorded correct clinical information for 1 of 1 active patients receiving services in their home.

(#1)

The findings include:

Review of an agency policy titled "Medication Administration" dated January 2020, stated "Policy ... To ensure personnel perform medication administration within scope of practice and state and federal regulations ... Procedure ... 1. Classification and routes of medication an RN, LPN/LVN may administer or assist with under the direction of physician, are on the classification list. ... "

Clinical record review on 11/22/2021, for patient S671.  

**Clinical record #1 was corrected by clinician who made visit on 10/28/2021. She clarified the 20 cc narcotic count was Morphine 100mg/5 ml liquid.**

### Provider Plan of Correction

**S671**

Education will be provided to all skilled nursing staff regarding the requirement that a clinical record containing past and current findings be maintained for each hospice patient. Education will include that the clinical record contain correct clinical information that is available to the patient’s attending physician and hospice staff, including narcotic type and amount upon each nursing visit. This in-service education will be completed by 12/17/2021.

100% of patient records will be audited for accuracy of correct clinical information including accurate narcotic type and count documented with each skilled nursing visit.

This audit process will include each skilled nurse visit note for one month. If 100% compliance is achieved after one month, to prevent re-occurrence, 25% of active patient records will be audited monthly with a compliance threshold of 100%. Once compliance threshold is met for 3 months, audits will decrease to 10% quarterly for two quarters. Results will be presented to QAPI for
#1, start of care 7/6/2021, with a diagnosis of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), evidenced an agency document titled "SN [skilled nurse] Visit Note" from 10/28/2021 and signed by RN C. This document had an area subtitled "Pain Management" which indicated a narcotic had 20 cc's remaining. Review failed to evidence the name of the narcotic the patient had in the home. Review failed to evidence complete and correct information in the clinical documentation.

During an interview on 11/22/2021, at 12:30 PM, administrator A indicated the name of the narcotic was not documented on the SN visit note for 10/28/2021.

<table>
<thead>
<tr>
<th>S 773</th>
<th>S 773 418.112(d) HOSPICE PLAN OF CARE</th>
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<tbody>
<tr>
<td></td>
<td>In accordance with §418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care.</td>
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This STANDARD is not met as evidenced by:

Based on record review, and interview, the

| S 773 | Clinical record #2 was corrected by clinician. Hospice medical director provided order clarification for Lorazepam 2mg/ml liquid rather then tabs. Clinician then reconciled medication with facility staff and facility medication orders for consistency and accuracy of plan of care. |

Education will be provided to all skilled nursing staff regarding the requirement to

tracking, trending and recommendations for revised action steps if the results fall below the threshold.

Responsible person: Administrator or designee

12/17/2021
| Hospice failed to ensure all hospice care provided was in accordance with this hospice plan of care for 1 of 1 home visits that occurred in a skilled nursing facility. (#2) The findings include Review of an agency policy titled "Medication Administration" dated January 2020, stated "Policy ... To ensure personnel perform medication administration within scope of practice and state and federal regulations ... Procedure ... 1. Classification and routes of medication an RN, LPN/LVN may administer or assist with under the direction of physician, are on the classification list. " Clinical record review on 11/22/2021, for patient #2, start of care 11/7/2021, terminal diagnosis of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), evidenced an agency document titled "Client Medication Report" which indicated the patient was prescribed Lorazepam (sedative and controlled substance) 0.5 mg (milligrams) every 4 hours as needed in tablet form. This document also indicated the patient was prescribed Lorazepam 1 mg every 4 hours scheduled. Record review of an entity B document titled "[Entity B Order Review Report]" indicated the patient was prescribed Lorazepam 0.5 mg every 4 hours as needed in the liquid concentrate form. | Establish and maintain a written hospice plan of care in consultation with SNF/NF or ICF/MR representatives. Education will include that all hospice care provided must be in accordance with this hospice plan of care. The plan of care must include medication name, dose, route and form. Education will also be provided regarding need to update SNF/NF caregivers on changes to medications and plan of care. This in-service education will be completed by 12/17/2021. Plan of care will be audited for 100% of patients to insure plan of care/medication profile are consistent with hospice plan of care. The audit process will include each patient record/facility record, reviewed with each visit for six weeks. Audits will continue until 100% compliance is achieved. To prevent re-occurrence 25% of active patient records will be audited monthly with a compliance threshold of 100%. Once compliance threshold is met for 3 months, audits will decrease to 10% quarterly for two quarters. Results will be presented to QAPI for tracking, trending and recommendations for revised action steps if the results fall below the threshold. Responsible person: Administrator or designee |
This document also indicated the patient was prescribed Lorazepam 0.5 mg every 4 hours while the patient is awake in the liquid concentrate form. Review of entity B document failed to evidence the medication orders matched the orders provided by the hospice. Review failed to evidence the entity B medication list and the hospice medication list were consistent with one another.

During an interview on 11/22/2021, at 12:43 PM, administrator A indicated the medications must have been entered in a different form on the agency's medication report.