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	151575	A. BUILDING _____ B. WING _____	C 05/19/2022

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VIAQUEST HOSPICE OF INDIANA, LLC	724 WEST NAVAJO STREET WEST LAFAYETTE, IN 47906

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L 000	INITIAL COMMENTS This visit was for the investigation of 2 Federal complaints at Viaquest Hospice. On 5/18/22 at 12:45 PM, two (2) active patients were identified to be in Immediate Jeopardy and out of compliance with 42 CFR 418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient and 42 CFR 418.56 Condition of Participation: Interdisciplinary group, Care Planning, and Coordination of Services. The administrator was notified of the Immediate Jeopardy on 5/18/22 at 1:45 PM. The Immediate Jeopardy was not removed by exit on 5/19/22. The removal plan submitted by the hospice on 5/18/2022 was not acceptable. Survey Dates: 5/9/22, 5/10/22, 5/11/22, 5/12/22, 5/16/22, 5/17/22, 5/18/22, and 5/19/22 Complaint: IN 000377753 - Substantiated, related and unrelated federal deficiencies were cited. Complaint: IN 000368932 - Unsubstantiated, lack of sufficient information, unrelated deficiencies were cited. Census: 114 QR: Area 2 and 3	L 000		
L 520	INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT CFR(s): 418.54 This CONDITION is not met as evidenced by: Based on record review, observation, and interview, the hospice agency failed to ensure all	L 520		

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

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L 520	Continued From page 1 patients received an updated comprehensive assessment, which considered changes that occurred since the initial assessment, included progress toward goals and outcomes, and the patient's response to care and treatment as frequently as necessary, but no less frequently than every 15 days (See L 524) and the hospice agency failed to ensure all patients received an updated comprehensive assessment, which considered changes that occurred since the initial assessment, included progress toward goals and outcomes, and the patient's response to care and treatment as frequently as necessary, but no less frequently than every 15 days (See L 533.) These deficient practices affected 3 of 4 active patients whose clinical records were reviewed (Patients #1, 4, and 5) with the potential to affect all 114 active patients currently receiving hospice care. On 5/18/22 at 12:45 PM, an Immediate Jeopardy was identified with Patient #1 and Patient #4. The Administrator was notified of the Immediate Jeopardy on 5/18/22 at 1:45 PM. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services which could result in the agency not providing quality hospice care, thus being out of compliance with 42 CFR 418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient.	L 520		
L 524	CONTENT OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(c)	L 524		

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L 524	Continued From page 2	L 524		

The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.

This STANDARD is not met as evidenced by:
Based on record review and interview, the hospice agency failed to ensure all patients received a comprehensive assessment that identified the physical, psychosocial, emotional, and spiritual needs of the patients, related to their terminal illness, for 3 (Patients 4, 5, and 1) of 4 active records reviewed, out of a total sample of 6 patients.

Findings include:

1. The clinical record of Patient #4 revealed a benefit election date of 01/20/2022 and a terminal diagnosis of liver failure. The clinical record included a plan of care for the benefit period 01/20/2022 - 04/19/2022, which indicated the patient was to receive skilled nursing services, 3 visits per week for 1 week, then 2 visits per week for an undefined time frame. The plan of care indicated hospice nurse interventions and treatments included monitoring of Patient 4's Stage 1 pressure ulcers (type of wound caused by prolonged pressure on a body part, classified as "stages" between 1-4; a Stage 1 pressure ulcer is reddened and does not blanch but there is no open areas) on the sacrum / coccyx (bottom of the spine/tailbone) and mid-back.

An interview was conducted on 05/16/2022 at

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4:14 PM with Person #1, who confirmed they were Patient #4's primary caregiver, as documented in the clinical record. Person #1 confirmed that since Patient #4 began hospice services, the primary caregiver provided care to the patient's wounds, because of patient preference. The family member reported they took pictures of the patient's wounds, while providing wound care, and provide the pictures to the hospice nurse, at each visit.

The clinical record included a Nurse Visit Note completed at the Initial Start of Care, dated 01/20/2022, by Registered Nurse (RN) #10. The visit note indicated Patient #4 had Stage 1 pressure ulcers on the coccyx, that measured 2 centimeters (cm) in length, by 2 cm in width, by 0 cm in depth and on the patient's midback that measured 2 cm in length, by 3 cm in width, by 0 cm in depth. RN #10 documented "Patient has pressure areas to coccyx and spine, skin is intact but both areas are deep red and non-blanchable [does not turn white when pressure is applied] at this time." The assessment failed to evidence the patient with a request to have their wound care provided by a family member instead of the hospice staff.

The record revealed 13 subsequent in-person nurse visits were completed during the certification period. Six of 13 visits failed to evidence an assessment of Patient #4's wounds by the nurse nor notation that the patient refused an assessment by the nurse on 02/01/2022, 02/09/2022, 03/13/2022, 03/20/2022, 03/27/2022, and 04/03/2022. The assessments also failed to evidence the nurse reviewed any pictures of Patient 4's wounds, taken by Person #1.

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The record included a nurse visit note, completed by RN #10, and dated 02/25/2022. The visit note indicated Patient #4's sacral wound had worsened to a Stage 3 pressure ulcer (wound is open and extends to fat layer below the skin) and the wound on the mid-back had worsened to a Stage 2 pressure ulcer (wound is opened and layers of skin are affected). The nurse visit note failed to evidence wound measurements were obtained for both wounds for the basis to categorize the stages of the wounds.

The clinical record included a benefit period 4/20/2022 - 7/18/2022, with orders to receive skilled nursing services 1 visit every other week for 2 weeks, and 1 visit per week for 12 weeks. The plan of care revealed hospice nurse interventions and treatments included "monitor Stage 1 pressure areas to sacrum and medial back.

The record included a nurse visit note dated 4/24/2022, completed by RN #10. The note evidenced the nurse assessed Patient #4's Stage 3 sacral wound and measured 0.5 cm in length, by 0.5 cm in width, by 0.1 cm in depth. The visit note failed to evidence an assessment of the patient's Stage 2 mid-back pressure ulcer.

The record indicated there were 3 subsequent nurse visits completed between 4/24/22 and 5/18/2022. Two of the 3 visits (5/01/2022 and 5/08/2022) failed to evidence the nurse conducted an assessment of Patient #4's wounds nor that the patient refused an assessment. The nurse visit notes failed to evidence that the clinician reviewed pictures of the wounds, taken by Person #1.

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The record included a skilled nurse visit note dated 5/09/2022 and completed by RN #9. The record indicated the sheering wound of the patient's scrotum and buttocks continued and measured 1.0 cm in length, by 1.0 cm in width, by 0.1 cm in depth.

The clinical record included a nurse visit note dated 5/15/2022 and completed by RN #10. The visit note indicated the nurse measured Patient's #4's Stage 3 sacral wound and documented the measurements of 0.5 cm in length, by 0.5 cm in width, by 0.2 cm in depth, and the Stage 2 mid-back wound was documented as 4 cm in length, by 4 cm in width, by 0.1 cm in depth.

2. The clinical record of Patient #5 included a plan of care for the benefit election period of 02/12/2022 - 04/12/2022, with an election date of 02/23/2020, and terminal diagnosis of heart disease, high blood pressure and chronic kidney disease; The patient resided at an assisted living facility. The plan of care indicated the patient was to receive skilled nursing services with visits once, every two weeks for 2 weeks, once a week for 7 weeks, and 4 PRN (as needed) visits.

The record included a skilled nurse visit, dated 02/24/2022 and completed by RN #9, that indicated observation of a new sheering wound on Patient #5's left hip and buttocks. The nurse visit note revealed the wound measured 5 cm in length, by 5 cm in width, by 0.1 cm in depth.

The record included a plan of care for the benefit period of 4/13/2022 - 6/11/2022 with orders for skilled nursing services, with visits once a week for 9 weeks and 3 PRN (as needed) visits.

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The record included a skilled nurse visit note, dated 4/23/202 and completed by RN #10. The visit note indicated the patient's sheering wound to the scrotum and buttocks had resolved. The visit note failed to evidence the nurse assessed the patient's tracheostomy and urinary catheter.

3. Clinical record for Patient #1 included a documents titled, "RN Hospice Start of Care" comprehensive assessment dated 4/6/22 and the "Hospice Physician Order #5048" addendum to the comprehensive assessment, dated 4/8/22. Patient #1's diagnoses included athersclerotic heart disease of native coronary artery without angina pectoris, and secondary diagnoses including vascular dementia without behavioral disturbance, stage 2 pressure ulcer of left buttock, abrasion of right elbow, generalized anxiety disorder, depression, wedge compression fracture of lumbar vertebrae, diverticulosis of intestine, pre-diabetes, bilateral sensorineural hearing loss, stress incontinence, full incontinence of bowels, and a history of falling.

The assessment failed to indicate an assessment of Patient #1's pain that included the location, intensity, frequency, duration, impact on activities and quality of life, and interventions to mitigate the pain. The assessment failed to indicate methods to be used to identify, measure, and report pain for Patient #1, who had advanced dementia and could not answer questions. The assessment failed to indicate all body systems were reviewed for new or ongoing symptoms, failed to assess Patient #1's advanced dementia and its impact on the Patient #1's ability to understand services and share / express spiritual, psychosocial, and emotional needs.

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L 533	Continued From page 7	L 533		
L 533	UPDATE OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(d) The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the agency failed to ensure all patients received an updated comprehensive assessment, which considered changes that occurred since the initial assessment, included progress toward goals and outcomes, and the patient's response to care and treatment as frequently as necessary, but no less frequently than every 15 days for 3 of 4 active records reviewed (4, 5, and 1) of a total sample of 6 patients. Findings include: 1. The clinical record of Patient #4 revealed a benefit election date of 01/20/2022 and a terminal diagnosis of liver failure. The clinical record included a plan of care for the benefit period 01/20/2022 - 04/19/2022, with orders to receive skilled nurse care 3 visits per week for 1 week, then 2 visits per week for an undefined time frame. The plan of care indicated hospice nurse	L 533		

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interventions and treatments included monitoring of Patient 4's Stage 1 pressure ulcers (type of wound caused by prolonged pressure on a body part, classified as "stages" between 1-4; a Stage 1 pressure ulcer is reddened and does not blanch but has no open areas) on the sacrum/coccyx (bottom of the spine/tailbone) and mid-back.

The record included an initial Start of Care nurse visit, conducted on 01/20/2022 by Registered Nurse (RN) #10. The nurse visit notes indicated Patient#4 had a Stage 1 pressure ulcer on the patient's coccyx measuring 2 centimeters (cm) in length by 2 cm in width by 0 cm in depth and a Stage 1 pressure ulcer on the patient's mid back measuring 2 cm in length by 3 cm in width by 0 cm in depth. RN #10 documented "Patient has pressure areas to coccyx and spine, skin is intact but both areas are deep red and non-blanchable [does not turn white when pressure is applied] at this time."

An interview was conducted on 05/16/2022 at 4:14 PM with Person #1, who confirmed they were Patient #4's primary caregiver, as documented in the clinical record. Person #1 relayed that since Patient 4 began services, the Person #1 had provided all wound care as was Patient 4's preference. Person #1 reported they take pictures of Patient 4's wounds, while providing care, and provide the pictures, to the hospice nurse for review, during each visit. The record failed to evidence the hospice Interdisciplinary Group (IDG) updated the patient's plan of care to evidence Patient 4's preference for Person #1 to provide the wound care instead of hospice clinicians.

The record included IDG meeting summaries for

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the meetings held on 01/28/2022, 02/11/2022, and 02/25/2022. The meeting summaries failed to evidence the IDG updated the comprehensive assessment to reflect Patient 4's progress towards goals.

The record included a nurse care visit, completed on 02/25/2022 at 3:53 PM by RN #10. The visit note indicated Patient 4's sacral wound had worsened to a Stage 3 pressure ulcer (wound is open and extends to fat layer below skin) and the wound on the mid back had worsened to a Stage 2 pressure ulcer (wound is opened and layers of skin are affected).

The record included an IDG meeting summary for meetings held on 03/11/2022. The summary failed to evidence the IDG updated the patient's comprehensive assessment to reflect the change in patient's wound status.

The record included an IDG meeting summary for a meeting held on 4/08/2022. The meeting summary failed to evidence the IDG updated the comprehensive assessment to reflect the patient's progress towards goals.

The record included a plan of care for the benefit period 4/20/2022 - 7/18/2022 with patient care orders for skilled nurse care visits of 1 visit every other week for 2 weeks and then 1 visit per week for 12 weeks.

The record included an IDG meeting summary for the meeting held on 5/06/2022. The meeting summary failed to evidence the IDG updated the comprehensive assessment to reflect the patient's progress towards goals.

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2. The clinical record of Patient #5 included a plan of care for the benefit election period of 02/12/2022 - 04/12/2022, with a hospice election date of 02/23/2020, and terminal diagnoses of heart disease with high blood pressure and chronic kidney disease; Patient #5 resided at an assisted living facility. The plan of care included orders for skilled nurse care visits once every two weeks for 2 weeks, then once a week for 7 weeks, and 4 PRN (as needed) visits.

The record included a nurse care visit, dated 02/24/2022 and completed by RN #9 that indicated a new sheering wound was observed on Patient 5's left hip and buttocks. The nurse document the wound measured 5 cm in length, by 5 cm in width, by 0.1 cm in depth.

The record included an IDG meeting summary for a meeting held on 3/18/2022 and 4/08/2022. The summaries failed to evidence the IDG updated the comprehensive assessment to reflect Patient 5's progress towards goals.

The record included a plan of care for the benefit period of 4/13/2022 - 6/11/2022. The plan of care included orders for nurse care visits once a week for 9 weeks and 3 PRN visits.

The record included a nurse visit note, dated 4/23/2022 and completed by by RN #10. The visit note indicated Patient 5's sheering wound to the scrotum and buttocks had resolved.

The record included a nurse care visit note, dated 5/09/2022 and completed by RN #9. The record indicated the sheering wound of Patient 5's scrotum and buttocks, was still present, and measured 1.0 cm in length, by 1.0 cm in width, by

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0.1 cm in depth.

The record included an IDG meeting summary for a meeting held on 4/29/2022 which failed to evidence the IDG updated the comprehensive assessment to reflect Patient 5's progress towards goals.

3. A home visit was conducted at Patient #1's residence, an assisted living facility (ALF) apartment, on 5/12/22 at 3:30 PM with RN #9. Upon entry to the apartment, noted Patient 1 was sitting on the commode and a mepilex dressing, heavily soiled with feces, was noted and covered Patient 1's left outer and inner buttock. RN #9 removed the dressing and revealed a round, open area that was heavily soiled with feces and measured 0.5 cm x 0.5 cm x 0.2 cm, a 0.1 cm increase in depth since the most recent wound assessment, dated 4/06/22 (Wound #1). Upon further retraction by RN #9 of Patient 1's buttocks, observed a stage 2 pressure ulcer over the coccyx. RN #9 indicated wound #1 looked worse than it did on admission and that the pressure ulcer noted to the coccyx was new. Wound #2 was observed to be a scabbed skin tear at the right elbow. A skin tear was observed on the left forearm with multiple intact steri strips and a geri sleeve, from a reported fall on 5/11/22. Patient #1 had scattered bruising over their extremities and 3 discolored areas to the buttocks. RN #9 indicated the hospice clinicians provided wound care when present at the ALF and the ALF nurses provided wound care at all other times. RN #9 confirmed that the location of wound #1 would likely require wound hygiene and a new dressing each time the patient was toileted or was incontinent throughout the day and night.

A review of the admission comprehensive

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assessment, dated 4/6/22, indicated wound #1 was a stage 2 pressure ulcer on the left lower buttock and measured 1 cm x 1.5 cm x 0.1 cm and was described as round, partial thickness, intact granulation tissue, with indistinct edges. The wound was without exudate nor odor, and indicated epithelialization was "50 -<75%" with no necrotic tissue and had 0 - 25% necrotic tissue slough and eschar. The comprehensive assessment indicated wound #2 measured 1.5 cm x 1.5 cm x 0 cm. The depth description indicated non-blanchable with intact granulation tissue, indistinct edges, a small amount of bloody exudate, with 100% epithelialization. There was no necrotic tissue and 0 - 25% necrotic tissue slough and eschar. An assessment narrative indicated "Patient has 4 noted areas to buttocks. Scabbed area noted to right buttock measured 1.2 cm by 1 cm and a pink area noted to left upper buttock. Skin remains intact at this time. Hardened scabbed area to left buttock measuring 1 cm by 1 cm and a stage 2 to left buttock measuring 1 cm x 1 cm by 0 cm. Patient also has a skin tear to right elbow ... Bruising noted to bilateral arms."

A review of a RN visit note titled "Nurse Visit Report" and dated 4/7/22, 4/16/22, 4/22/22, 4/28/22, and 5/07/22 failed to evidence Patient 1's wounds were observed nor assessed by the hospice nurse and failed to include an updated assessment of all body systems.

On 5/12/22 at 12:20 PM, the agency administrator indicated wounds were to be assessed with every dressing change and should be measured at least twice a week. The administrator was asked for the agency's wound care policy and stated, "We're told we have no

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L 533	Continued From page 13 wound care policy." On 5/12/22 at 1:13 PM, the administrator indicated having contacted RN #10 on 5/11/22, prior to a nurse care visit, that was scheduled for Patient #1, to notify RN#10, that the patient had fallen (on 5/11/22) and was reported by the ALF to have sustained an injury. The administrator instructed RN #10 to "be sure to assess the wound" during the visit. The administrator indicated RN #10 later reported, the wound was not assessed during the 5/11/22 visit because the ALF staff had already applied a dressing. On 5/13/22 at 3:15 PM, RN #10 indicated to have observed the stage 2 buttock wound about 2 weeks earlier and stated, "It's healed now, and it's blanchable. It's more like a stage 1 now." RN #10 indicated, when asked, to not know how often a wound was to be measured. When asked for the reason for the 5/11/22 nurse care visit, RN #10 indicated the visit scheduled was an aide supervisory visit and that the ALF nurse had already assessed the left arm injury, therefore did not require an assessment from the hospice nurse.	L 533		
L 536	IDG, CARE PLANNING, COORDINATION OF SERVICES CFR(s): 418.56 This CONDITION is not met as evidenced by: Based on record review and interview the Interdisciplinary Group (IDG) failed to supervise care and services (See L 539); failed to ensure the skilled nurse implemented the plan of care and failed to ensure an individualized plan of care was developed (See L 543), and failed to ensure	L 536		

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L 536	Continued From page 14 the IDG directed, coordinated, and supervised the care and services (See L 554) in a total sample of 4 active patient records reviewed out of a total sample of 6 patients. These deficient practices affected 3 of 4 active patients whose clinical records were reviewed (Patients #1, 4, and 5) with the potential to affect all 114 active patients currently receiving hospice care. On 5/18/22 at 12:45 PM, an Immediate Jeopardy was identified for Patient's #1 and #4 and the administrator was notified on 5/18/22 at 1:45 PM. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services which could result in the agency not providing quality health care, thus being out of compliance with 42 CFR 418.56 Condition of Participation: Interdisciplinary group care planning, and coordination of services.	L 536		
L 539	APPROACH TO SERVICE DELIVERY CFR(s): 418.56(a)(1) (1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. This STANDARD is not met as evidenced by:	L 539		

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Based on record review and interview, the IDG (Interdisciplinary Group) failed to supervise care and services for 3 of 4 active records reviewed (4, 5, and 1) out of a total sample of 6 patients.

Findings include:

1. The clinical record of Patient #4 indicated a benefit election date of 01/20/2022 and a terminal diagnosis of liver failure. The record included an initial plan of care for the benefit period 01/20/2022 - 04/19/2022 which indicated the patient was to receive skilled nursing services with 3 visits per week for 1 week then 2 visits per week for an undefined time frame. The plan of care indicated hospice nurse interventions and treatments included monitoring the patient's Stage 1 pressure ulcers (type of wound caused by prolonged pressure on a body part, classified as "stages" between 1-4; a Stage 1 pressure ulcer is reddened and does not blanch but has no open areas) on the sacrum / coccyx (bottom of the spine / tailbone) and mid back.

An interview was conducted on 05/16/2022 at 4:14 PM with Person #1, who confirmed they were Patient #4's primary caregiver as documented in the clinical record. Person #1 relayed that since Patient #4 began hospice services, the primary caregiver had provided all wound care to the patient's wounds, as was patient preference.

The record included 13 skilled nursing visit notes that were completed during the certification period, 8 of which failed to evidence the nurse provided wound care nor that the patient refused the wound care (01/21/2022, 01/22/2022,02/01/2022, 02/09/2022, 03/13/2022,

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03/20/2022, 03/27/2022, 04/03/2022). The visit notes indicated " ... Wound care not provided; Caregiver completed care" for both wounds during these visits.

The record included Interdisciplinary Group (IDG) meeting summaries for meetings held on 01/28/2022 and 02/11/2022. The summaries indicated Hospice Physician #2 noted "[Patient #4] has pressure areas to coccyx and spine." The summaries failed to evidence any other IDG members noted the presence and / or status of the patient's wounds, including the Administrator / RN, and failed to evidence the IDG discussed the patient's wound care was being provided only by the caregiver.

The record included an IDG meeting summary for a meeting held on 02/25/2022 [no time noted]. The summary indicated RN #10 noted "Pressure ulcers to back and sacrum continue." The summary failed to evidence any other IDG members noted the presence and/or status of the patient's wounds, including Hospice Physician #2, and failed to evidence the IDG discussed that the patient's wound care was not being provided by the hospice clinicians, but by the primary caregiver.

The record included a nurse visit note completed on 02/25/2022 at 3:53 PM by RN #10. The visit note indicated the patient's sacral wound had worsened to a Stage 3 pressure ulcer (wound is open and extends to fat layer below skin) and the wound on the mid back had worsened to a Stage2 pressure ulcer (wound is opened and layers of skin are affected).

The record included an IDG meeting summary for

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a meeting held on 03/11/2022 and 04/08/2022. The summaries failed to evidence the deterioration of the patient's wounds, failed to evidence any IDG members noted the presence and/or status of the patient's wounds, including the Administrator/RN and Hospice Physician #2, and failed to evidence the IDG discussed the patient's wound care was being provided only by the primary caregiver.

The record included an IDG meeting summary for a meeting held on 03/25/2022. The summary indicated RN #10 noted "pressure areas to sacrum and mid back, condition deteriorating." The summary failed to evidence the specific deterioration of the wounds, failed to evidence any IDG members noted the presence and/or status of the patient's wounds, including Hospice Physician #2, and failed to evidence the IDG discussed the patient's wound care was being provided only by the caregiver.

The record included an IDG meeting summary for a meeting held on 4/22/2022. The summary indicated RN #10 noted " ... Wounds: Stage 2 pressure ulcers to spine and coccyx. Condition continues to decline despite daily treatment of cleansing with [normal saline] ...." RN #10 also noted nurse visit frequency was to be 1 visit per week. The summary failed to evidence how the wounds were declining, such as measurements increasing or increased presence of slough, failed to evidence the current order for cleaning the wounds and skilled nurse visit frequency, failed to evidence any other IDG members noted the presence and/or status of the patient's wounds, including Hospice Physician #2, and failed to evidence the IDG discussed the patient's wound care was being provided only by the caregiver.

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The record included an IDG meeting summary for a meeting held on 05/06/2022. The summary indicated "Wounds: pressure area to sacrum and midback" and the patient was to receive skilled nursing services of 1 visit per week. The summary failed to evidence the current order for skilled nurse visit frequency and failed to evidence any other IDG members noted the presence and/or status of the patient's wounds, including Hospice Physician #2, and failed to evidence the IDG discussed the patient's wound care was being provided only by the caregiver.

2. The clinical record of Patient #5 included a plan of care for the benefit election period of 02/12/2022 - 04/12/2022, which indicated a hospice election date of 02/23/2020, with terminal diagnoses of heart disease with high blood pressure and chronic kidney disease. Patient #5 resided at an assisted living facility. The plan of care indicated Patient #5 was to receive skilled nursing services, with visits once every two weeks for 2 weeks, then once a week for 7 weeks, and 4 PRN (as needed) visits. The plan of care indicated nursing interventions included, but not limited to, education on tracheostomy care and suctioning, education of indwelling urinary catheter, and wound care to pressure ulcer on scrotum every visit and as needed. The plan of care failed to evidence the indication for as needed nursing visits and failed to evidence the frequency and who was responsible for changing the patient's tracheostomy and urinary catheter (hospice or assisted living facility).

The record included a skilled nurse visit, dated 02/24/2022 and completed by RN #9, which indicated a new sheering wound was observed on

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Patient 5's left hip and buttocks. The nurse documented the wound measured 5 cm in length, by 5 cm in width, by 0.1 cm in depth.

The record included a physician order dated 02/25/2022 which indicated dressing change orders for Patient 5's sheering wound to the scrotum / buttocks. The order indicated the dressing was to be changed daily and as needed for "dislodgement or soilage." The order failed to evidence who was to change the dressing (hospice or assisted living facility).

The record included an IDG meeting summary for a meeting held on 3/18/2022 and 4/08/2022. The summaries failed to evidence the IDG members discussed who was to provide Patient 5's wound, trach, and urinary catheter care.

The record included a plan of care for the benefit election period of 4/13/2022 - 6/11/2022. The plan of care indicated the patient was to receive skilled nursing services with visits once a week for 9 weeks plus 3 PRN visits. The plan of care indicated nursing interventions included but were not limited to education on tracheostomy care and suctioning, education of indwelling urinary catheter, and wound care to pressure ulcer on scrotum every visit and as needed (no indication for PRN changes evidenced). The plan of care failed to evidence the wound care orders for the patient's sheering wound to the scrotum / buttocks, including the frequency, and who was responsible to change Patient 5's tracheostomy and urinary catheter (hospice or assisted living facility).

The record included a skilled nursing visit noted dated 4/23/2022, completed by RN #10. The visit

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note indicated the patient's sheering wound to the scrotum and buttocks had resolved.

The record included a skilled nursing visit note dated 5/09/2022, completed by RN #9. The record indicated the sheering wound to the patient's scrotum and buttocks was still present and measured 1.0 cm in length, by 1.0 cm in width, by 0.1 cm in depth.

The record included an IDG meeting summary for a meeting held on 04/29/2022. The summary failed to evidence the IDG members discussed who was to provide the patient's wound, trach, and urinary catheter care.

3. A review the clinical record for Patient #1 evidenced a document "Hospice IDG Comprehensive Assessment and Plan of Care Update Report," dated 4/6/22 - 4/8/22, evidenced diagnoses of a stage 2 pressure ulcer to the left buttock and abrasion of the right elbow, and an order for skilled nurse visits 2 times a week for 1 week, then 1 time a week for 12 weeks, with 3 prn visits for symptom management. A review of the "Hospice Certification and Plan of Care, "evidenced an order dated 4/6/22, "Hospice nurse to perform wound care to left inner buttock utilizing clean technique - cleanse with normal saline, pat dry, apply medihoney to wound bed, change daily until healed and prn." The clinical record failed to evidence an updated order and frequency of daily dressing changes to the patient's buttocks, to incorporate the 4/6/22 order into the care plan.

An order dated 4/6/22 indicated "Hospice nurse A section titled Current Meeting Summary," included a clinical summary "Patient has 4 noted areas to buttocks. Scabbed area noted to right

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buttock measuring 1.2 cm by 1 cm. Pink area noted to left upper buttock. Skin remains intact at this time. Hardened scabbed area to left buttock measuring 1 cm by 1 cm, and a stage 2 to left buttock measuring 1 cm by 1.5 cm by 0.1 cm. Patient also has a skin tear to right elbow. Treatments in place, bruising noted to bilateral arms." This report failed to evidence the IDG had reviewed and incorporated into the plan of care the changed frequency of visits and treatment orders from the 4/6/22 order.

A review of the "Hospice IDG Comprehensive Assessment and Plan of Care Update Report," dated 4/8/22 - 4/22/22 evidenced the left buttock wound and right elbow abrasion diagnoses. The narrative evidenced the same measurements and description from the 4/6/22 narrative. The narrative failed to evidence the IDG had reviewed and discussed Patient #1 current needs progress toward healing. The IDG document failed to evidence goals and the status of Patient #1's integumentary system.

A review of the "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated 4/22 - 5/6/22 evidenced "Pressure area stg [stage] 1 to buttocks, skin tear to L [left] elbow. Narrative to include changes since last IDG ... no new infections or wounds ... SN plan/goal for the next 2 weeks: continue with current care plan. Frequency 1x/wk. This report failed to evidence the IDG had discussed the patient's current wound needs based on an updated comprehensive assessment, and reviewed and revised the plan of care treatments, interventions, and goals.

On 5/11/22 at 3:54 PM, the administrator

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indicated the IDG occurred every 2 weeks for each patient. The IDG duties included review of pending admissions, the patient's appropriateness for hospice, pending recertifications, and any additional disciplines needed to meet the patients' needs. When asked if the documentation for Patient #1 evidenced the IDG had discussed assessment of integumentary impairments to include the stage of identified pressure wounds with wound measurements or their progress, the administrator indicated the IDG did not include those details.

On 5/12/22 at 10:12 AM, the medical director was interviewed concerning the IDG process. When queried as to whether a patient's wound descriptions and measurements, plan for treatment, prevention of further deterioration of patients' integumentary status, and goals were discussed, the medical director indicated the IDG discussed all patients each meeting. The medical director indicated the IDG discussed pending admissions, anyone up for recertification, the list of reported falls, infections, antibiotics, and other services needed to meet the patients' needs. When asked if wound descriptions and measurements were reviewed for patients with integumentary impairments, the medical director stated, "I'm told if something happens. The conversation about wounds isn't that in depth. It's mentioned and I assume adequate care is provided. No one specifically says a complicated wound is getting better. I assume they're being cared for and I'll be notified if they need something. My assumption is everyone has a role and will notify me of changes. I can only go with what's told to me. I'm assuming nursing is documenting."

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L 543	PLAN OF CARE CFR(s): 418.56(b) 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. This STANDARD is not met as evidenced by: Based on record review and interview, the hospice agency failed to ensure the skilled nurse implemented the plan of care in 1 of 4 active clinical records reviewed (Patient 4) and failed to ensure an individualized plan of care was developed (Patient #5) in a total sample of 4 active patient records reviewed in a total sample of 6 patients. Findings include: 1. The clinical record of Patient #4 indicated a benefit election date of 01/20/2022 and terminal diagnosis of liver failure. The record included an initial plan of care for the benefit period 01/20/2022 - 04/19/2022 which indicated skilled nursing services were ordered 3 visits per week for 1 week then 2 visits per week for an undefined time frame. The plan of care indicated hospice nurse interventions and treatments included monitoring the patient's Stage 1 pressure ulcers (type of wound caused by prolonged pressure on a body part, classified as "stages" between 1-4; a Stage 1 pressure ulcer is reddened and does not blanch but has no open areas) on the	L 543		

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sacrum/coccyx (bottom of the spine/tailbone) and mid back. The nurse could apply an Allevyn dressing (type of wound dressing) for "preventative [sic]." The order failed to evidence the frequency and specific indication for applying the dressing.

The record included a physician order, dated 01/22/2022, which indicated the wound care was changed to "cleanse wound with soap and water, dry, apply moisture barrier cream to open areas, apply foam border dressing. Family to provide wound care in absence of hospice nurse." The order failed to evidence the frequency the dressing changes were to be performed.

The record included a nurse visit completed on 02/25/2022 at 3:53 PM by RN #10. The visit note indicated the patient's sacral wound had worsened to a Stage 3 pressure ulcer (wound is open and extends to fat layer below skin) and the wound on the mid back had worsened to a Stage 2 pressure ulcer (wound is opened and layers of skin are affected).

The record included a physician order dated 03/05/2022, which indicated the wound care was to change to "clean area with soap and water, dry, apply Medihoney [medicated ointment used to treat wounds], apply foam border dressing. Family to provide wound care in absence of hospice nurse." The order failed to evidence the frequency the dressing changes were to be performed.

An interview was conducted on 05/16/2022 at 4:14 PM with Person #1, who confirmed they were Patient #4's primary caregiver as documented in the clinical record. Person #1

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relayed that since Patient #4 began hospice services, the primary caregiver had provided all wound care to the patient's wounds, as was Patient 4's preference.

The record included a recertification plan of care for the benefit period 4/20/22 - 7/18/22 which included orders that Patient #4 was to receive skilled nursing services, 1 visit every other week for 2 weeks, then 1 visit per week for 12 weeks. The plan of care indicated hospice nurse interventions and treatments included but not limited to, "monitor Stage 1 pressure areas to sacrum and medial back. Allevyn dressing may be applied for preventative[sic]." The plan of care failed to reflect the current status of the patient's wounds, failed to reflect an individualized plan as to who was to perform the dressing changes, and failed to evidence the updated wound care orders.

The record included an IDG meeting summary for a meeting held on 4/22/22. The summary indicated RN #10 noted " ... Wounds: Stage 2 pressure ulcers to spine and coccyx. Condition continues to decline despite daily treatment of cleansing with [normal saline] ...." The record included a physician order dated 04/24/2022 which indicated the wound care was to change to "Cleanse area with wound cleanser, dry, apply Medihoney, apply foam border dressing." The order failed to evidence the location and frequency the dressing changes were to be performed and who was to perform the wound care. The IDG failed to modify the patient's treatment due to the patient's continued deterioration of wounds.

2. The clinical record of Patient #5 included a

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plan of care for the benefit election period of 02/12/2022 - 04/12/2022, with an hospice election date of 02/23/2020, and terminal diagnoses of heart disease with high blood pressure and chronic kidney disease, and that Patient #5 resided at an assisted living facility. The plan of care contained an order for skilled nursing services with visits once every 2 weeks for 2 weeks, followed by once a week for 7 weeks, and 4 PRN (as needed) visits. The plan of care nursing interventions included, but were not limited to, education on tracheostomy care and suctioning, education of indwelling urinary catheter, and wound care to pressure ulcer on scrotum every visit and as needed. The plan of care failed to be individualized to the patient's tracheostomy, urinary catheter, and wound care needs, including who was to provide the care required and how frequently the care was to be performed.

The record included a skilled nurse visit documented as conducted on 02/24/2022 by RN #9 which indicated a new sheering wound was observed on the patient's left hip and buttocks. The nurse document the wound measured 5 cm in length, by 5 cm in width, by 0.1 cm in depth.

The record included a physician order dated 02/25/2022 which indicated dressing change orders for the patient's sheering wound to the scrotum / buttocks. The order indicated the dressing was to be changed daily and as needed for "dislodgement or soilage." The order failed to evidence who was to change the dressing (hospice or skilled nursing facility).

The record included a plan of care for the benefit election period of 4/13/22 - 6/11/22 and included

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L 543	Continued From page 27 orders for skilled nursing services with visits once a week for 9 weeks plus 3 PRN visits. The plan of care with orders for the nursing interventions that included, but not limited to, education on tracheostomy care and suctioning, education of indwelling urinary catheter, and wound care to pressure ulcer on scrotum, every visit, and as needed (no indication for PRN changes evidenced). The plan of care failed to include who was responsible to provide the care needs identified and the frequency (hospice or skilled nursing facility) the care was to be preformed for the tracheostomy, urinary catheter, and wound care needs.	L 543		
L 554	COORDINATION OF SERVICES CFR(s): 418.56(e)(1) The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to- (1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided. This STANDARD is not met as evidenced by: Based on record review and interview the hospice failed to ensure the interdisciplinary group (IDG) directed, coordinated, and supervised the care and services for 2 of 4 active patients reviewed (Patient's 4 and 5) of a total sample of 6 patient records reviewed. Findings include: 1. The clinical record of Patient #4 indicated a benefit election date of 01/20/2022 and a terminal	L 554		

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diagnosis of liver failure. The record included an initial plan of care for the benefit period 01/20/2022 - 04/19/2022 with order for skilled nursing services of 3 visits per week for 1 week, then 2 visits per week for an undefined time frame. The plan of care indicated hospice nurse interventions and treatments included monitoring Patient 4's Stage 1 pressure ulcers (type of wound caused by prolonged pressure on a body part, classified as "stages" between 1-4; a Stage 1 pressure ulcer is reddened and does not blanch but has no open areas) on the sacrum/coccyx (bottom of the spine/tailbone) and mid back.

An interview was conducted on 5/16/2022 at 4:14 PM with Person #1, who confirmed they were Patient #4's primary caregiver as documented in the clinical record. Person #1 confirmed that since Patient #4 began hospice services, the primary caregiver had provided all wound care to Patient 4's wounds, based on Patient 4's expressed preference.

The record included 13 skilled nursing visit notes that were completed during the certification period, 8 of which failed to evidence the nurse provided wound care nor the patient refused the wound care (01/21/2022, 01/22/2022,02/01/2022, 02/09/2022, 03/13/2022, 03/20/2022, 03/27/2022, 04/03/2022). The visit notes indicated " ... Wound care not provided; Caregiver completed care" for both wounds during these visits.

The record included Interdisciplinary Group (IDG) meeting summaries for meetings held on 01/28/2022, 02/11/2022, and 02/25/2022. The summaries failed to evidence the IDG discussed the status of the patient wounds and failed to evidence the IDG developed and supervised an

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individualized plan for wound care monitoring and treatment which met the patient's requests and ensured the wounds were being monitored appropriately.

The record included a nurse visit completed on 02/25/2022 at 3:53 PM by RN #10. The visit note indicated the patient's sacral wound had worsened to a Stage 3 pressure ulcer (wound is open and extends to fat layer below skin) and the wound on the mid back had worsened to a Stage 2 pressure ulcer (wound is opened and layers of skin are affected).

The record included an IDG meeting summary for meetings held on 3/11/22, 3/25/22, 4/08/22, and 4/22/22. The summaries failed to evidence the IDG discussed the status of the patient wounds, developed and supervised an individualized plan for wound care monitoring and treatment, that met Patient 4's preferences.

The record included a recertification plan of care for the benefit period 4/20/22 - 7/18/22 with orders for skilled nursing services of 1 visit every other week for 2 weeks, followed by 1 visit per week for 12 weeks.

The record included 4 nurse visits which were conducted during this certification period, through the date of record review on 5/18/22, the visit dates were 4/24/22, 5/01/22, 5/08/22, and 5/15/22. These visit notes failed to evidence the nurse completed wound care nor that the patient / caregiver refused care and indicated wound care was not provided by the hospice clinician, that the primary caregiver completed care for both wounds during these visits.

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The record included an IDG meeting summary for a meeting held on 5/06/22. The summary failed to evidence the IDG discussed the status of the patient wounds and failed to evidence the IDG developed and supervised an individualized plan for wound care monitoring and treatment which met the patient's requests and ensured the wounds were being monitored appropriately.

2. The clinical record of Patient #5 included a plan of care for the benefit period of 02/12/22 - 04/12/22, a hospice election date of 02/23/2020, and terminal diagnoses of heart disease with high blood pressure and chronic kidney disease, and that Patient #5 resided at an assisted living facility. The plan of care indicated Patient #5 was ordered skilled nursing services, with visits to be once every two weeks for 2 weeks, then once a week for 7 weeks, and 4 PRN (as needed) visits. The plan of care indicated nursing interventions included, but not limited to, education on tracheostomy care and suctioning, education of indwelling urinary catheter, and wound care to pressure ulcer on scrotum every visit, and as needed. The plan of care failed to evidence the indication for as needed nursing visits and failed to evidence the frequency and who was responsible for changing the patient's tracheostomy and urinary catheter (hospice or assisted living facility).

The record included a skilled nurse visit documented as conducted on 02/24/2022 by RN #9 which indicated a new sheering wound was observed on the patient's left hip and buttocks. The nurse document the wound measured 5 cm in length, by 5 cm in width, by 0.1 cm in depth.

The record included a physician order, dated

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02/25/2022, to change the treatment order for Patient #5's sheering wound of the scrotum / buttocks . The order was to change the dressing daily and as needed for "dislodgement or soilage." The order failed to evidence who was to change the dressing daily (hospice or assisted living facility).

The record included an IDG meeting summary for a meeting held on 3/18/22 and 4/08/22. The summaries failed to evidence the IDG discussed the status of the patient wounds, tracheostomy, and urinary catheter, and failed to evidence the IDG developed and supervised an individualized plan for wound, tracheostomy, and urinary catheter care monitoring and treatment.

The record included a plan of care for the benefit election period of 04/13/2022 - 06/11/2022. The plan of care indicated the patient was to receive skilled nursing services, with visits once a week for 9 weeks and 3 PRN visits and nursing interventions included, but were not limited to, education on tracheostomy care and suctioning, education of indwelling urinary catheter, and wound care to pressure ulcer on scrotum every visit and as needed (no indication for PRN changes evidenced). The plan of care failed to evidence the wound care orders for the patient's sheering wound to the scrotum / buttocks and failed to evidence the frequency and who was responsible for changing the patient's tracheostomy and urinary catheter (hospice or assisted living facility).

The record included a skilled nursing visit documented as conducted on 4/23/22 by RN #10. The visit note indicated Patient 5's sheering wound to the scrotum and buttocks had resolved.

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L 554	Continued From page 32 The record included a skilled nursing visit note dated 5/09/22 and completed by RN #9. The record indicated the sheering wound to the patient's scrotum and buttocks was still present and measured 1.0 cm in length, by 1.0 cm in width, by 0.1 cm in depth. The record included an IDG meeting summary for a meeting held on 4/29/22. The summary failed to evidence the IDG discussed the status of the patient wounds, tracheostomy, and urinary catheter, and failed to evidence the IDG developed and supervised an individualized plan for wound, tracheostomy, and urinary catheter care monitoring and treatment.	L 554		
L 591	NURSING SERVICES CFR(s): 418.64(b)(1) (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure the nursing needs of all patients were met as identified in the patient's comprehensive assessment and updated assessments for 3 of 4 active records reviewed (Patients 4, 5, and 1) out of a total sample of 6 patients. Findings include:	L 591		

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1. An agency job description for the position of Registered Nurse (RN) Case Manager/RN, effective 02/01/2019, indicated the nurse was responsible for assuming "primary responsibility for a patient / family caseload that includes the assessing, planning, implementing, and evaluating phases of the nursing process ...."

2. The clinical record of Patient #4 indicated a benefit election date of 01/20/2022 and terminal diagnosis of liver failure. The record included an initial plan of care for the benefit period 01/20/2022 - 04/19/2022 which indicated the patient was to receive skilled nursing services with 3 visits per week for 1 week then 2 visits per week for an undefined time frame. The plan of care indicated hospice nurse interventions and treatments included monitoring the patient's Stage 1 pressure ulcers (type of wound caused by prolonged pressure on a body part, classified as "stages" between 1-4; a Stage 1 pressure ulcer is reddened and does not blanch but has no open areas) on the sacrum/coccyx (bottom of the spine/tailbone) and mid back. The nurse could apply an Allevyn dressing (type of wound dressing) for "preventative [sic]."

The record included an initial start of care visit conducted on 01/20/2022 by Registered Nurse (RN) #10. The visit notes indicated Patient#4 had a Stage 1 pressure ulcer on the patient's coccyx measuring 2 centimeters (cm) in length by 2 cm in width by 0 cm in depth and a Stage 1 pressure ulcer on the patient's mid back measuring 2 cm in length by 3 cm in width by 0 cm in depth. RN #10 documented "Patient has pressure areas to coccyx and spine, skin is intact but both areas are deep red and non-blanchable [does not turn white

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when pressure is applied] at this time."

The record indicated 13 subsequent in-person nurse visits were completed during the certification period, 6 of which failed to evidence the nurse assessed Patient #4's wounds nor the patient refused an assessment on 02/01/2022, 02/09/2022, 03/13/2022, 03/20/2022, 03/27/2022, and 04/03/2022.

The clinical record included a nurse visit note documented as completed on 02/25/2022 by RN #10. The visit note revealed Patient #4's sacral wound had worsened to a Stage 3 pressure ulcer (wound is open and extends to fat layer below the skin) and the wound on the mid-back had worsened to a Stage 2 pressure ulcer (wound is opened and layers of skin are affected). The nurse's note failed to evidence a complete wound assessment was conducted, to include wound measurements.

The clinical record included a benefit period 04/20/2022 - 07/18/2022, which indicated the patient was ordered to receive skilled nursing services with 1 visit every other week for 2 weeks, and 1 visit per week for 12 weeks. The plan of care revealed hospice nurse interventions and treatments included "monitor Stage 1 pressure areas to sacrum and medial back."

The record included a nurse visit note documented as completed on 04/24/2022 by RN #10. The nurse's note documented the nurse measured Patient #4's Stage 3 sacral wound as measuring 0.5 cm in length, by 0.5 cm in width, by 0.1 cm in depth. The visit note failed to evidence an assessment of the patient's Stage 2 mid-back pressure ulcer.

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The record indicated 3 subsequent nurse visit notes documented as completed between 04/24/22 and 5/18/2022, 2 of which failed to evidence the nurse conducted a wound assessment of Patient #4's wounds nor the patient having refused an assessment (05/01/2022 and 05/08/2022).

3. The clinical record of Patient #5 included a plan of care for the benefit election period of 02/12/2022 - 04/12/2022, which indicated a hospice election date of 02/23/2020, a terminal diagnosis of heart disease with high blood pressure and chronic kidney disease, and the patient resided at an assisted living facility. The plan of care indicated the patient was to receive skilled nursing services with visits once every two weeks for 2 weeks, once a week for 7 weeks, and 4 PRN (as needed) visits.

The record included a skilled nurse visit documented as conducted on 02/24/2022 by RN #9 which indicated a new sheering wound was observed on the patient's left hip and buttocks. The nurse document the wound measured 5 cm in length, by 5 cm in width, by 0.1 cm in depth.

The record included a plan of care for the benefit election period of 04/13/2022 - 06/11/2022. The plan of care indicated the patient was to receive skilled nursing services with visits once a week for 9 weeks plus 3 PRN visits.

The record included a skilled nursing visit documented as conducted on 04/23/2022 by RN #10. The visit note indicated the patient's sheering wound to the scrotum and buttocks had resolved. The visit note failed to evidence the

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nurse assessed the patient's tracheostomy and urinary catheter.

The record included a skilled nursing visit documented as conducted on 05/09/2022 by RN #9. The record indicated the sheering wound to the patient's scrotum and buttocks was still present and measured 1.0 cm in length, by 1.0 cm in width, by 0.1 cm in depth.
4. A review of the start of care comprehensive assessment for Patient #1, dated 4/6/22, indicated the patient had a stage 2 pressure ulcer to the left buttock, which received dressing changes daily. The comprehensive assessment also indicated the patient had an abrasion to the right elbow, which received antibiotic ointment and a dressing change twice daily.

A review of a RN visit note titled "Nurse Visit Report and dated 4/7/22, failed to evidence that the wounds were observed and assessed by the hospice nurse, and failed to evidence the nurse oversaw care of the wounds by Entity #2, an assisted living facility.

A review of a RN visit note dated 4/16/22 failed to evidence that the wounds were observed and assessed by the hospice nurse, and failed to evidence the nurse oversaw care of the wounds by Entity #2, an assisted living facility.

A review of an RN visit note dated 4/22/22 failed to evidence that the wounds were observed and assessed by the hospice nurse, and failed to evidence the nurse oversaw care of the wounds by Entity #2, an assisted living facility.

A review of an RN visit note dated 4/28/22 failed to evidence that the wounds were observed and

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assessed by the hospice nurse, and failed to evidence the nurse oversaw care of the wounds by Entity #2, an assisted living facility.

A review of an RN visit note dated 5/7/22 failed to evidence that the wounds were observed and assessed by the hospice nurse, and failed to evidence the nurse oversaw care of the wounds by Entity #2, an assisted living facility.

On 5/12/22 at 12:20 PM, the agency administrator indicated wounds were assessed with every dressing change and should be measured at least twice a week. The administrator was asked for the agency's wound care policy and stated, "We're told we have no wound care policy."

On 5/12/22 at 1:13 PM, the administrator indicated contacting RN #10 on 5/11/22, prior to an already scheduled visit for patient #1, to notify the RN the patient had fallen earlier that day and had a wound. The administrator instructed RN #10 to "be sure to assess the wound" during the visit. The administrator indicated RN #10 later reported not assessing the wound because it was covered and had already been assessed by the ALF nurse.

On 5/13/22 at 3:15 PM, RN #10 indicated seeing the stage 2 buttock wound about 2 weeks ago and stated, "It's healed now, and it's blanchable. It's more like a stage 1 now." RN #10 indicated not knowing how often a wound was to be measured. When asked remove if the visit made on 5/11/22 was because the patient fell and had a skin tear, RN #10 indicated it was an aide supervisory visit and the facility nurse had already assessed the left arm wound, so it didn't require

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOSPICE OF INDIANA, LLC	724 WEST NAVAJO STREET WEST LAFAYETTE, IN 47906

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L 591	Continued From page 38 assessment from the hospice nurse.	L 591		
L 651	GOVERNING BODY AND ADMINISTRATOR CFR(s): 418.100(b) A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body. This STANDARD is not met as evidenced by: Based on record review and interview, the Governing Body failed to ensure the hospice adopted a policy to guide clinicians and set minimum expectations in the assessment, measurement, care, reporting, and documentation of any patient integumentary impairment for 1 of 1 Governing Body, which detrimentally affected the hospice's ability to provide for the comfort and dignity of 3 (Patients 1, 4, and 5) of 4 active patients reviewed out of a patient sample of 6 patients. The findings included: 1. A review of an article, Wound Care, Clinical Practice Guidelines, Version 1.2, copyright 2020, https://ehhi.com/sites/default/files/AccessWoundCareGuidelines.pdf, revealed "At a minimum, the wound/ulcer shall be measured ... once a week or when care is provided if the wound care is	L 651		

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L 651	Continued From page 39	L 651		

ordered less than once a week ..."

2. A review of the clinical record for Patient #1 evidenced a document "RN Hospice Start of Care" comprehensive assessment for Patient #1, dated 4/6/22, and the "Hospice Physician Order #5048" addendum to the comprehensive assessment, dated 4/8/22, the patient diagnoses included stage 2 pressure ulcer of left buttock, abrasion of the right elbow.

A home visit was conducted with Patient #1 in the patient's assisted living facility (ALF) apartment on 5/12/22 at 3:30 PM, with RN 9. The wound measured 0.5 cm x 0.5 cm x 0.2 cm, a 0.1 cm increase in depth since the most recent wound assessment last done on 4/6/22 (36 days between wound measurements.) During this visit, feces was observed in the sacral dressing when it was removed.

On 5/13/22 at 3:15 PM, RN #10 indicated not knowing how often a wound was required to be measured.

3. A review of the clinical record for Patient #4 evidenced the plan of care indicated hospice nurse was ordered to monitor Patient 4's Stage 1 pressure ulcers (type of wound caused by prolonged pressure on a body part, classified as "stages" between 1-4; a Stage 1 pressure ulcer is reddened and does not blanch but has no open areas) on the sacrum/coccyx (bottom of the spine/tailbone) and mid-back.

A review of the initial start of care note documented as completed on 01/20/2022 by Registered Nurse (RN) #10, evidenced Patient #4 had a Stage 1 pressure ulcer on the coccyx

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L 651	Continued From page 40	L 651		

measuring 2 centimeters (cm) length, 2 cm width, 0 cm depth and a Stage 1 pressure ulcer on Patient #4's midback was documented as measuring 2 cm length, 3 cm width, 0 cm depth. RN #10 documented "Patient has pressure areas to coccyx and spine, skin is intact but both areas are deep red and non-blanchable [does not turn white when pressure is applied] at this time."

A review of nurse visit notes revealed 13 subsequent in-person nurse visits were completed during the certification period, 6 of which failed to evidence the nurse assessed Patient #4's wounds nor that Patient #4 refused an assessment on 02/01/2022, 02/09/2022, 03/13/2022, 03/20/2022, 03/27/2022, and 04/03/2022.

A review of a nurse visit note documented as completed on 04/24/2022 by RN #10, revealed Patient #4's Stage 3 sacral wound measured 0.5 cm in length, 0.5 cm in width, by 0.1 cm in depth. The visit note failed to evidence an assessment of the patient's Stage 2 mid-back pressure ulcer.

A review of a visit noted revealed visit notes dated 05/01/2022 and 05/08/2022, that failed to evidence the nurse conducted a wound assessment of Patient #4's wounds, nor that Patient 4 had refused an assessment.

4. A review of the clinical record of Patient #5 evidenced it contained a plan of care for the benefit election period of 02/12/2022 - 04/12/2022. Patient 5 orders included skilled nursing services every two weeks for 2 weeks, once a week for 7 weeks, and 4 PRN (as needed) visits. The plan of care evidenced orders the nursing interventions included wound care to

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L 651	Continued From page 41 pressure ulcer on the scrotum every visit and as needed. A review of a skilled nursing visit documented as conducted on 04/23/2022 by RN #10, revealed the patient's sheering wound to the scrotum and buttocks had resolved. A review of the next skilled nursing visit documented as conducted on 05/09/2022 (17 days later) by RN #9, revealed the sheering wound to the patient's scrotum and buttocks was present and measured 1.0 cm length, 1.0 cm width, 0.1 cm depth. 5. On 5-12-2022 at 12:20 PM, when the above concerns were shared with the administrator --- to include clinicians having failed to document an assessment of the patients' integumentary impairments at least weekly and to conduct and document a complete wound assessment of all wounds identified for patients, the documented deterioration of the wounds' status without additional interventions to facilitate patients' comfort and dignity, and failure of a staff member to know the accepted clinical standard of practice for wound assessment, the administrator verified the above clinical record findings and indicated "We're told we have no wound care policy" [to direct clinical practice, care planning, and documentation.]	L 651		
L 662	TRAINING CFR(s): 418.100(g)(2) (2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties.	L 662		

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L 662	Continued From page 42	L 662		

This STANDARD is not met as evidenced by:
Based on record review and interview, the hospice agency failed to provide an initial orientation which addressed an employee's specific job duties for 3 of 3 registered nurse employee files reviewed (Branch Manager #1 and #2, and RN#9).

Findings include:

1. An agency policy #COR 3.29, titled "Orientation & Training," and last revised 10/21/2021, indicated but was not limited to " ... Procedure. A. Orientation ... 4. Items to be covered with the employee ... f. Review of job responsibilities ...."

2. An agency job description for the position of administrator, effective 03/01/2022, indicated but was not limited to " ... Accountability Objectives: The Hospice Administrator ... ensures adequate personnel education ...."

3. An agency job description for the position of Registered Nurse (RN) Case Manager / RN, effective 02/01/2019, indicated the nurse was responsible for assuming "primary responsibility for a patient / family caseload that includes the assessing, planning, implementing, and evaluating phases of the nursing process. Administer ... treatments as prescribed by the physician ... Participate in company orientation and in-service training programs ...."

4. The personnel file of RN #9 indicated a hire date of 11/16/2020. The file included a "RN Skills Competency Checklist" completed on 02/23/2021. The competency checklist failed to evidence the skills related to "Home Safety ...

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L 662	Continued From page 43 Shortness of Breath ... Pain Management ... Vaccinations ... Medications" were completed. 5. The personnel file of Branch Director #1, a registered nurse, with hire date of 07/19/2021 and was promoted to the role of Branch Director on 12/21/2021. The personnel file failed to evidence an orientation was conducted specific to the employee's branch director duties. 6. The personnel file of Branch Director #2, a registered nurse, with hire date of 02/14/2022. The personnel file failed to evidence an orientation was conducted specific to the employee's branch director duties. 7. An interview was conducted with the Administrator on 05/18/2022 at 4:18 PM. During the interview, the Administrator confirmed the two branch directors had not completed orientation specific to their job title.	L 662		