STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151531	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEARBORN COUNTY HOSPITAL HOME HEALTH & HOSPICE	370 BIELBY RD LAWRENCEBURG, IN 47025

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L 0000 Bldg. 00	This visit was for a federal hospice validation survey requested by CMS. The survey also served the purpose of licensure. Survey Dates: 1/3, 1/4, 1/5, 1/8, 1/9, 2018 Provider ID 15-1531 Active Census 17 patients Undulicated 12 month admissions: 178 patients Sample: 13 records reviewed 3 home visits	L 0000	This Plan of Correction has been completed and submitted by Ricardo Horn, Director of Dearborn County Hospital Home Health and Hospice.	
L 0524 Bldg. 00	418.54(c) CONTENT OF COMPREHENSIVE ASSESSMENT 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. Based on record review and interview, the initial comprehensive assessment failed to identify the patients physicial needs related to skin integrity for 1 of 13 records reviewed. (#2). Findings Include: 1. The clinical record for patient #2, hospice benefit election and start of care date 12/8/17 was reviewed 1/3/2018 for the certification period	L 0524	The RN staff will be educated by 2-28-18 on performing a head to toe assessment upon every Initial comprehensive assessment. All disciplines including Nursing, Social Worker and Spiritual Counselor will perform their assessment within 5 days of the NOE being signed. Any changes to the patient's physical, psychosocial, emotional and spiritual needs will	02/02/2018

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

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	12/8/17 through 3/7/18. A. The record included a skilled nursing visit note with a comprehensive assessment completed by the nurse at start of care on 12/8/17. The review of systems completed by the nurse indicated the patient's integumentary system (skin) was within normal limits. B. A document found in the record titled Interdisciplinary Group (IDG) Conference Communication included an entry by the registered nurse which indicated the patient had a small stage 2 pressure ulcer noted on admission. C. In a 1/3/18 interview with the hospices' nursing manager, the manager stated the stage 2 pressure area indicated by the nurse on the IDG conference note was not included on the intial comprehensive assessment. 2. A 6/94 hospice agency policy, revised 2/09 and titled Initial Assessment and Initial Plan of Care stated " The RN initial assessment will include...initial problems, admitting orders and physician standing orders."		be addressed immediately and reviewed at the every two week IDG. The Social Worker from the hospital will provide coverage for the hospice agency. There has been a Bereavement Coordinator hired on 2-5-18 who will provide more in depth bereavement services. All current census patients are audited for assessments within 5 days. This measure will be tracked on the IDG compliance tracking form and measured on every active patient during the every two week IDG. The threshold for this measure will be 100% compliance. This measure will be tracked, trended and reported quarterly to the Department IOP committee, the Hospital IOP committee and annually to the Professional Advisory Committee. The Unit Manager will be responsible for compliance with this measure. If there is a trend by staff for noncompliance then the employee will be coached. If coaching does not correct compliance then progressive disciplinary action will be taken.	
L 0531 Bldg. 00	418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial			

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	bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care. Based on record review and interview, the hospice failed to ensure the comprehensive assessment included an initial bereavement risk assessment for 10 of 13 records reviewed. (Patients 1, 2, 5, 6, 7, 8, 9, 10, 11, and 12) Findings Include: 1. The clinical record for patient #5, start of care 11/24/17 was reviewed 1/4/18 for the certification period 11/24/17 through 2/21/18. The record failed to include an initial assessment of the bereavement needs of the patient's family and other individuals involved in the patient's care. 2. The clinical record for patient #6, start of care 10/3/17 was reviewed 1/5/18 for the certification period 10/3/17 through 12/31/17. The record failed to include an initial assessment of the bereavement needs of the patient's family. 3. The clinical record for patient #10, start of care 11/2/17 was reviewed 1/5/18 for the certification period 11/2/17 through 1/30/18. The record failed to include an initial assessment of the bereavement needs of the patient's family. 4. The clinical record for patient #12, start of care 12/30/17 was reviewed 1/8/18 for the certification period 12/30/17 through 3/28/18. The record failed to include an initial assessment of the bereavement needs of the patient's family and other individuals involved in the patient's care. 5. The clinical record for Patient # 1 with a hospice election of benefits and start of care date of	L 0531	All disciplines including Nursing, Social Worker and Spiritual Counselor will perform their assessment within 5 days of the NOE being signed. Any changes to the patient's physical, psychosocial, emotional and spiritual needs will be addressed immediately and reviewed at the every two week IDG. The Social Worker from the hospital will provide coverage for the hospice agency. The Social Worker will perform the bereavement risk assessment until the newly hired Bereavement Coordinator, hired on 2-5-18, takes on that role and who will provide more in depth bereavement services. All current census patients are audited for assessments within 5 days. This measure will be tracked on the IDG compliance tracking form and measured on every active patient during the every two week IDG. The threshold for this measure will be 100% compliance. This measure will be tracked, trended and reported quarterly to the Department IOP committee, the Hospital IOP committee and annually to the Professional Advisory Committee. The Unit Manager will be responsible for compliance with this measure. If there is a trend by	02/09/2018

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	7-21-17, was reviewed. The initial MSW (Masters of Social Work) assessment dated 7-25-17, the initial RN (Registerd Nurse) assessment dated 7-21-17 and the initial Chaplain assessment dated 7-25-17 failed to evidence a bereavement assessment had been conducted. 6. The clinical record of Patent # 7 with a hospice election of benefits and start of care date of 12-5-17 was reviewed. The initial MSW assessment dated 12-6-17, the initial RN assessment dated 12-5-17, and the Chaplain assessment dated 12-6-17 failed to evidence a bereavement assessment had been conducted. 7. The clinical record of Patient # 8 with a hospice election of benefits and start of care date of 11-27-17 was reviewed. The initial MSW assessment dated 11-28-17, the initial RN assessment dated 11-27-17, and the Chaplain assessment dated 11-28-17 failed to evidence a bereavement assessment had been conducted. 8. The clinical record of Patient # 9 with a hospice election of benefits and start of care date of 11-27-17 was reviewed. The initial MSW assessment dated 11-28-17, the initial RN assessment dated 11-27-17, and the Chaplain assessment dated 11-28-17 failed to evidence a bereavement assessment had been conducted. 9. The clinical record of Patient #11 with a hospice election of benefits and start of care date of 12-20-17 was reviewed. The initial MSW assessment dated 12-21-17, the initial RN assessment dated 12-20-17, and the Chaplain assessment dated 12-21-17 failed to evidence a bereavement assessment had been conducted.		staff for noncompliance then the employee will be coached. If coaching does not correct compliance then progressive disciplinary action will be taken.	

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	10. An agency policy titled: "Bereavement Services" was reviewed and stated, " ... The hospice social worker is responsible for the development, the implementation and coordination of the bereavement program ... The goals of the Bereavement Program are: 1. Evaluation/assessment of grief needs and risk factors associated with grief. " 11. An interview was conducted with the nurse manager of hospice on 1-8-17 at 11:33 AM. The nurse manager reported there were no bereavement assessment in the record and there were no further documents to be provided.			
L 0533 Bldg. 00	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. Based on record review, and interview, the interdisciplinary group failed to ensure updates of the comprehensive assessment included assessments of the patient and family's needs by all members of the IDG at least every 15 days for 10 of 13 (# 1, 2, 3, 4,5, 7, 8, 9, 10, 11) records reviewed.	L 0533	The Clinical staff will be educated on the process to complete an IDG prep note prior to IDG to provide an update to the plan of care including orders to be signed by the Medical Director. All disciplines will include a prep	02/09/2018

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	Findings Include: 1. In an interview with the hospice's clinical manager on 1/3/18 at 2:30 PM the manager explained that the IDG performed updates of the assessments through use of the interdisciplinary group conference communication notes completed by each member of the IDG. 2. The clinical record for patient #2, start of care and hospice benefit election date 12/8/17 was reviewed 1/3/18. A. The record included an initial assessment by the medical social worker on 12/11/17, the record included interdisciplinary group conference communication notes dated 12/13/17 and 12/26/17 which failed to include updated assessments by the medical social worker. B. The record included an intial nursing assessment completed on 12/8/17. The record included an interdisciplinary group conference communication note dated 12/26/17 which failed to include an updated assessment by the registered nurse. 3. The clinical record for patient #3, start of care and hospice benefit election date 12/1/17 was reviewed 1/4/18. The record included interdisciplinary group communication notes dated 12/13/17 and 12/26/17 which failed to include updated assessments by the medical social worker. 4. The clinical record for patient #5, start of care and hospice benefit election dated 11/24/17 was reviewed 1/4/18, the record included interdisciplinary group conference communication notes dated 12/13/17 and 12/26/17 which failed to		note to include an update for the previous two-week period and verbal orders to be signed by the Medical Director for the next IDG period. The target threshold for this measure will be 100% compliance. Every active patient will be reviewed during each IDG. This compliance rate will be reported quarterly to the department IOP and annually to the Professional Advisory Committee. The Unit Manager will be responsible for compliance with this measure. If there is a trend by staff for noncompliance then the employee will be coached. If coaching does not correct compliance then progressive disciplinary action will be taken.	

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	include updated assessments by the medical social worker. 5. The clinical record for patient #10, start of care and hospice benefit election date 11/2/17 was reviewed 1/5/18. the record included interdisciplinary group conference communication notes dated 12/13/17 and 12/26/17 which failed to include updated assessments by the medical social worker. 6. The clinical record for patient # 1, with a start of care date of 7-21-17, was reviewed and the IDG meeting notes dated 12-13-17 and 12-26-17 failed to evidence a collaboration note by the social worker. 7. The clinical record for patient # 4, with a start of care date of 12-11-17, was reviewed and the IDG meeting notes dated 12-13-17 and 12-26-17 failed to evidence a collaboration note by the social worker. 8.The clinical record for patient # 7, with a start of care date of 12-6-17, was reviewed and the IDG meeting notes dated 12-13-17 and 12-26-17 failed to evidence a collaboration note by the the social worker. 9. The clinical record for patient # 8, with a start of care date of 11-27-17, was reviewed and the IDG meeting notes dated 12-13-17 and 12-26-17 failed to evidence a collaboration note by the social worker. 10. The clinical record for patient # 9, with a start of care date of 11-27-17, was reviewed and the IDG meeting note dated 12-13-17 failed to failed to evidence a collaboration note by the social worker. The IDG meeting note dated 12-26-17			

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	failed to evidence a collaboration note by the social worker and the registered nurse. 11. The clinical record for patient # 11, with a start of care date of 12-20-17, was reviewed and the IDG meeting note dated 12-26-17 failed to evidence a collaboration note by the social worker or the registered nurse. 12. A 12/08 agency policy titled Comprehensive Assessment stated "The comprehensive assessment will 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."			
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 record review and interview the agency failed to ensure care and services had been provided in accordance with the plan of care for 2(# 1, 10) of 13 records reviewed. Findings Include: 1. The clinical record for patient #10, hospice benefit election and start of care date 11/2/17 was reviewed 1/5/18. A. The record included a Hospice Plan of	L 0543	**The Clinical staff were educated on 2-8-18 on the process to complete an IDG prep note prior to IDG to provide an update to the plan of care including orders to be signed by the Medical Director.** **All disciplines will include a prep note to include an update for the previous two-week period and verbal orders to be signed by the**	02/09/2018

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	Care for the certification period 11/2/17 through 1/30/18 with orders for the hospice aide to visit twice weekly. B The hospice aide visit notes indicated the aide made only one visit for the week of 11/19/17 through 11/25/17 and only one visit for the week of 12/17/17 through 12/23/17 2. The clinical record for patient # 1 was reviewed with the following findings: A The IDG meeting conducted 10-4-17 and 10 -18-17 established the frequency of skilled nursing visits as 3 times weekly for 2 weeks. There were only 2 skilled nurse visits notes for 10-16-17 and 10-19-17 during the week of 10-15-17 to 10-21-17. There were no missed visit notes or orders to change the frequency of the skilled nurse visits from 2 to 3 weekly. 3. An agency hospice policy titled: "Plan of Care" was reviewed and stated: "... the plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions, including the following: ... a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs ... The plan of care is a fluid document that is reviewed and revised by the IDG as frequently as the patient's condition requires but no less frequently than every 15 calendar days .... " 4. An interview was conducted on 1/4/18 at 11:28 AM, with the nursing manager regarding the missed skilled nurse, and hospice aide visit notes. The manager confirmed visit notes were missing and there was no additional documentation to be provided.		**Medical Director for the next IDG period. The clinical staff were educated on the correct process to document a missed visit on 2-8-18.** **All patient's care and services are reviewed during the IDG to ensure that orders are obtained for all services and that all care is individualized to meet the patients/family's needs.** **This measure will be added to the department chart audit form. An audit will be conducted monthly on 100% of patients during the month until 100% compliance is met then the audit will be done on 10% of the census on a quarterly basis as per the QAPI policy. The threshold for compliance will be 100%. If the target goal is not met then coaching and progressive disciplinary action will take place for the RN who is not being compliant. This measure will be reported to the department IOP committee and also reported in the Annual Program Evaluation for the Professional Advisory Committee and the Board of Trustees.** **The Unit Manager will be responsible for compliance with this measure. If there is a trend by staff for noncompliance then the employee will be coached. If coaching does not correct compliance then progressive disciplinary action will be taken.**	

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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 observation, record review and interview, the agency failed to address all assessment findings of the comprehensive and updated assessments in the plan of care in 3 (#'s 2, 5 and 10 of 13 records reviewed. Findings include: 1. The clinical record for patient #2, start of care 12/8/17 was reviewed 1/3/17 for the certification period 12/8/17 through 3/7/18. The record contained an Interdisciplinary Group Conference Note completed by the registered nurse on 12/13/17 which indicated the patient had a small stage 2 pressure ulcer. The hospice failed to address the pressure ulcer and evaluation of the patient's skin integrity in the plan of care. 2. At a 1/5/18 home visit to patient #5 who resided in a skilled nursing facility, employee B, a registered nurse (RN) discussed the status of an existing wound on the patient's right leg with the facility nurse. Employee B was observed to	L 0545	The RN staff will be educated by 2-28-18 on performing a head to toe assessment upon every Initial comprehensive assessment. All disciplines including Nursing, Social Worker and Spiritual Counselor will perform their assessment within 5 days of the NOE being signed. Initial assessments will be used to create an individualized plan of care to include any orders needed to provide care. Any changes to the patient's physical, psychosocial, emotional and spiritual needs will be addressed immediately and reviewed by the IDG team at the every two week IDG. **The Clinical staff were educated on 2-8-18 on the process to complete an IDG prep note prior to IDG to provide an update to the plan of care including orders to be signed by the Medical Director.**	02/09/2018

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	assess the wound. The hospice failed to address the wound and evaluation of the patient's skin integrity in the plan of care. 3. The clinical record for patient#10, start of care 11/2/17 was reviewed 1/5/17 for the certification period 11/2/17 through 1/30/18. A. The Plan of Care dated 11/2/17 included the following diagnoses: Unspecified open wound to left lower leg. Cellulitis of left lower limb. The plan of care failed to include interventions and goals regarding skin integrity or the open wound to the left lower extremity. B. A document titled Patient/Caregiver Communication dated 12/13/17 indicated a family member called to report patient had open area on heel that was scabbed. It was red but had no warmth. The hospice failed to address the new open area on the plan of care. 4. The hospice's policy titled Plan of Care, dated 12/08 stated "The plan of care is a fluid document that is reviewed and revised by the IDG as frequently as the patient's condition requires but no less frequently that every 15 calender days. The revised plan of care includes information from the patient's updated comprehensive assessments and will include documentation regarding outcome/goal measurements." 5. The Director of Operations, and the Clinical Manager had no further information or documentation by the end of the exit conference on 01/9/18 at 11:00 a.m.		**All disciplines will include a prep note to include an update for the previous two-week period and verbal orders to be signed by the Medical Director for the next IDG period.** **All patient's (100%) care and services are reviewed during the IDG to ensure that orders are obtained for all services and that all care is individualized to meet the patients/family's needs.** **This measure will be added to the department chart audit form. An audit will be conducted monthly on 100% of patients during the month until 100% compliance is met then the audit will be done on 10% of the census on a quarterly basis as per the QAPI policy. The threshold for compliance will be 100%. If the target goal is not met then coaching and progressive disciplinary action will take place for the RN who is not being compliant. This measure will be reported to the department IOP committee and also reported in the Annual Program Evaluation for the Professional Advisory Committee and the Board of Trustees.** **The Unit Manager will be responsible for compliance with this measure. If there is a trend by staff for noncompliance then the employee will be coached. If coaching does not correct compliance then progressive disciplinary action will be taken.**	

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L 0549 Bldg. 00	418.56(c)(4) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (4) Drugs and treatment necessary to meet the needs of the patient. Based on record review and interview the agency failed to ensure the written plan of care established necessary and specific skilled nursing treatment and services to be provided to 1 of 13 patients. (Patient #1) Findings include: 1. The clinical record of patient # 1 with a start of care date of 7-21-17 was reviewed. The hospice plan of care for 10-19-17 to 1-16-18 had the following order: "SN (skilled nurse) : Perform wound care/dressing change: clean normal saline, antibiotic ointment, adaptic (a dressing) ,telfa and ABD (abdominal) pad secure with kerlix (stretch gauze wrap) every other day. May change ABD and kerlix PRN (as needed) drainage." The agency failed to evidence the anatomical location of the wound to be treated and the type of antibiotic ointment to be used on the wound. A. The IDG (interdisciplinary group conference) communication notes were reviewed with the following findings: i. A note dated 10-18-17 identified, "now has left leg redness and warm with slight edema and was started on Keflex (antibiotic) for 7 days. When he/she completed his/her antibiotic the edema and redness was gone. But returned and	L 0549	The RN staff will be educated on the correct way to document a wound care order/treatment to include the specific antibiotic ointment used and the location of the wound. All current patient's were reviewed for compliance during the IDG. All wound care orders (100%)will be reviewed for completeness by the Unit Manager during the every two week IDG. The threshold for this measure will be 100%. All orders for drugs and treatments will be reviewed by the IDG Team every two weeks to ensure compliance. The Unit Manager will be responsible for compliance with this measure. If there is a trend by staff for noncompliance then the employee will be coached. If coaching does not correct compliance then progressive disciplinary action will be taken.	02/28/2018

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	151531	A. BUILDING 00 B. WING	01/09/2018

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	when leg examined 2 days later was found to be angry red and hot. He/she was started on clindamycin for 7 days. with 2 day left there is still slight edema and leg is pink ... another week of clindamycin ordered." ii. The note dated 11-1-17 (Thursday) reported: "he/she will complete his/her 3rd round of Clindamycin on Friday (11-2-17)." iii. The note dated 11-16-17 failed to mention condition of left leg. B. The skilled nurse visit notes were reviewed with the following findings: i. A note dated 10-16-17 reported: "RLE (right lower extremity) slight edema to calf, ankle more edematous than calf and warm. C/O (complaining of) tenderness rated 2/10. [Doctor's name] called regarding RLE. Intervention: Perform wound care /dressing change: cleanse with wound cleanser, antibiotic ointment and mepilex." ii. A note dated 10-18-17 reported: "Signs and symptoms of skin infection swelling. Intervention: Perform wound care/dressing change: clean normal saline, antibiotic ointment, adaptic (a dressing) , telfa and ABD (abdominal) pad secure with kerlix (stretch gauge wrap) every other day. May change ABD and Kerlix PRN (as needed) drainage. iii. A note dated 10-23-17 reported: "signs and symptoms of skin infection, localized swelling ...RLE Intervention: perform wound care dressing change: Cleanse with wound cleanser, antibiotic ointment and mepilex secured with kerlix change every 2-3 days.			

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	iv. A noted dated 10-25-17 reported: "signs and symptoms of skin infection redness, warm to touch ... RLE ... narrative note: Patient took last scheduled Clindamycin antibiotic this visit.. Call placed to [Doctor's name] office per this writer as right lower extremity remains slightly red and warm to touch ...." v. A note dated 10-27-17 reported: "cellulitis,swelling, pain, tenderness of area, skin redness or inflammation ... narrative note: ... Patient also to continue on antibiotics as prescribed for redness right lower extremity." vi. A note dated 10-30-17 reported: " signs and symptoms of skin infection: ... noted or verbalized. Intervention: Perform wound care/dressing change: cleanse with wound cleanser, antibiotic ointment and mepilex secured with kerlix change every 2-3 days. RLE skin tear cover with bandaid for protection due to still has resolving blood blister." vii. A note dated 11-1-17 reported: " signs and symptoms of skin infection : none noted or verbalized...narrative notes ... Remains on ATB (antibiotic) at this time per MD order for history of right lower leg redness. Lower leg not red this visit. no edema noted ...." There was no further documentation regarding skin condition of RLE or interventions for patient # 1 after 11-1-17. C. An interview with the Nurse Manager was conducted on 1-5-17 at 1:20 PM regarding the anatomical site and specific antibiotic ointment to be used for wound treatment. He/She reported there was no further information to be provided. An agency wound care policy was requested and			

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	the hospice director reported there was no agency wound care policy.			
L 0552 Bldg. 00	418.56(d) REVIEW OF THE PLAN OF CARE The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. Based on clinical record review, observation and interview the hospice failed to ensure all members of the IDG reviewed and revised the plan of care to meet the needs reflected in the updated assessments for 3 out of 13 (#, 2, 3,and 5) records reviewed. Findings Include: 1. In an interview with the hospice's clinical manager on 1/3/18 at 2:30 PM the manager explained that the IDG plan of care was updated through use of the interdisciplinary group conference notes completed by each member of the IDG. 2. The clinical record for patient #2 was reviewed 1/3/18 for the certification period 12/8/17 through 3/7/18. A. The record failed to evidence the registered nurse documented, revised and updated the patient's interdisciplinary group conference notes dated 12/26/17 B. The record failed to evidence the social worker documented, revised and updated the patient's interdisciplinary group conference notes	L 0552	The Clinical staff will be educated on the process to complete an IDG prep note prior to IDG to provide an update to the plan of care including orders to be signed by the Medical Director. All hospice patients Plans of Care were and will be reviewed at the every two week IDG. A Social Worker will be hired to complete the Social Worker role. In the interim, a Social Worker from the Hospital will complete the IDG prep notes. A Bereavement Coordinator has been hired (2-5-18) and will proceed with the role of bereavement and volunteer services. All disciplines will include a prep note to include an update for the previous two-week period and verbal orders to be signed by the Medical Director for the next IDG period. The target threshold for this measure will be 100% compliance. Every active patient will be reviewed during each IDG. This compliance rate will be reported quarterly to the department IOP and annually to the	02/28/2018

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	dated 12/13/17 or 12/26/17. 3. The clinical record for patient #3 was reviewed 1/4/18 for the certification period 12/1/17 through 2/28/17. The record failed to evidence the social worker documented revised and updated the interdisciplinary group conference notes dated 12/13/17 and 12/27/17. 4. The clinical record for patient #5 was reviewed 1/4/18 for the certification period 11/24/17 through 2/21/18 A. At a home visit on 1/5/18, employee B, a registered nurse (RN) discussed the status of an existing wound on the patient's right leg with the nurse at the facility where the patient resides. Employee B was observed to assess the wound to the patient's right leg. The initial comprehensive assessment completed on 11/24/17 and the nurses notes dated 11/28/17, 11/30/17, 12/4/17, 12/11/17, 12/15/17, 12/18/17, 12/21/17, 12/26/17, 12/27/17 and 12/29/17 indicated the patient's skin was intact at the time of the assessment. B. The record failed to evidence the nurse had updated and revised the patient's plan of care to include management of the wound to the patient's leg. 5. The hospice's policy titled Plan of Care, dated 12/08 stated "The plan of care is a fluid document that is reviewed and revised by the IDG as frequently as the patient's condition requires but no less frequently that every 15 calender days. The revised plan of care includes information from the patient's updated comprehensive assessments and will include documentation regarding outcome/goal measurements."		Professional Advisory Committee. The Unit Manager will be responsible for compliance with this measure. If there is a trend by staff for noncompliance then the employee will be coached. If coaching does not correct compliance then progressive disciplinary action will be taken.	

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	6. In a 1/5/18 interview, the clinical manager acknowledged the interdisciplinary group conference notes were not updated by the social worker and registered nurse in accordance with agency policy			
L 0629 Bldg. 00	418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES (I) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit. Based on record review and interview, the hospice failed to ensure hospice aide supervisory visits were made to the patients home by a registered nurse every 14 days for 1 of 4 patients with hospice aide services in a sample of 13 patients. (#10) Findings Include: 1. The clinical record for patient 10 was reviewed 1/5/18 for the certification period 11/2/17 through 1/30/18. The interdisciplinary group developed a plan of care for the patient which included orders for visits from the hospice aide 2 times weekly from 11/5/17 through 12/30/17. A. The record included hospice aide visit notes on 11/7/17, 11/10/17, 11/14/17, 11/16/17, 11/21/17, 11/28/17, 12/1/17, 12/5/17, 12/7/17, 12/10/1, 12/14/17, 12/21/17, 12/28/17, and 12/30/17. B. The record included supervisory visit notes completed by the registered nurse on	L 0629	The RN and Aide staff will be educated on importance of supervising the HHA and were to document the supervision in the EMR. All RN staff will supervise Aide staff within 14 days. The RNs are responsible for compliance and the Unit Manager will be responsible on this measure. All patients (100%) with Aide services will be monitored by the Unit Manager for 100% compliance. The Aide supervisory review report will be run on a weekly basis to ensure compliance. The report will indicate those Supervisory visits that are due and those that have been missed. This measure will be added to the department chart audit form and an audit of 100% of active charts will be conducted	02/09/2018

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	12/26/17 and 12/28/17. Supervisory visits were not completed by the registered nurse every 14 days. 2. The program director acknowledged hospice aide supervisory visits were not completed every 14 days for patient #10 when interviewed on 1/9/18 at 11:00 am. 3. A 6/30/94 hospice agency policy titled Personal Care Services stated " The services of personal caregivers are available to patients and families on a part-time, intermittent basis. These services are supervised by a registered nurse every two weeks.		monthly until 100% compliance is met then the audit will be done on 10% of the census on a quarterly basis as per the QAPI policy. The threshold for this measure is 100% compliance. If the target goal is not met then coaching and progressive disciplinary action will take place for the RN who is not being compliant. This measure will be reported to the department IOP committee and the Annual Program Evaluation for the Professional Advisory Committee and the Board of Trustees	
L 0782 Bldg. 00	418.112(f) ORIENTATION AND TRAINING OF STAFF Hospice staff must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements. Based on agency document review and interview, the hospice failed to ensure orientation of skilled nursing facilities was completed for staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping in 1 of 1 facilities reviewed.	L 0782	The Director will contact all contracted SNF to determine need for initial Hospice training. The will not accept any new referrals from SNF until mandatory education requirement is met. The Director will be responsible to provide annual education to the SNF that are contracted for hospice. The Director will develop, coordinate and implement a training module for the local SNF's	03/31/2018

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	Findings Include: 1. A document titled Nursing Facility Services Agreement, dated 9/1/2012 was reviewed 1/5/2018. On page 9 section c, the document stated " Hospice Care Training. Hospice shall provide orientation and ongoing hospice care training to facility's personnel as necessary to facilitate the provision of safe and effective care to hospice patient's. Such orientation must include hospice policies and procedures regarding methods of comfort, pain control and symptoms management as well as principles about death and dying, individual responsed to death, patient rights, appropriate forms and recordkeeping requirements." 2. In an interview with the hospice director on 1/5/2018 at 9:55 am, the director stated the hospice had not provided any training or ongoing orientation of the facility staff regarding the services provided by hospice or the hospice philosophy since the intitial development of the contract with the facility in 2012.		to include the hospice philosophy, hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms and record keeping. There will 100% compliance with this measure. This measure will be audited annually by the Director and reported to the Professional Advisory Committee.	